



STATE OF GEORGIA

CONTRACT BETWEEN

THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH

AND

[CONTRACTOR]

FOR

PROVISION OF SERVICES TO GEORGIA FAMILIES

RFP/RFQC No.: DCH0000100

Contract No.

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THIS CONTRACT is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as “DCH” or the “Department”) and [CONTRACTOR] (hereinafter referred to as the “Contractor”) and is made effective on the date signed by the DCH Commissioner after any approval required by the Centers for Medicare and Medicaid Services (CMS) (hereinafter referred to as the “Contract Effective Date”).

WHEREAS, DCH is responsible for health care policy, purchasing, planning and regulation pursuant to the Official Code of Georgia Annotated (O.C.G.A.) § 31-2-1 *et seq.*;

WHEREAS, DCH is the single State agency designated to administer medical assistance in Georgia under Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. §§ 49-4-140 *et seq.* (the “Medicaid Program”), and is charged with ensuring the appropriate delivery of health care services to Medicaid recipients and PeachCare for Kids® Members;

WHEREAS, DCH, through the Department of Administrative Services (“DOAS”), issued an electronic Request for Qualified Contractors (“eRFQC”), ES-RFQC-40199-465, in November 2014 to pre-determine the suppliers who met the qualifications to be eligible to respond to a Request for Proposals;

WHEREAS, DCH caused Request for Proposals Number DCH0000100 (hereinafter the “RFP”) to be issued through DOAS, which is attached to this Contract as *Exhibit 1* and is expressly incorporated as if completely restated herein, to obtain the services of a Vendor to administer the provisions of the State’s Medicaid Managed Care Program, Georgia Families and the Section 1115 family planning waiver, Planning for Healthy Babies Program;

WHEREAS, Contractor, having been determined to be an eligible supplier pursuant to the eRFQC, submitted to DCH and DOAS a Technical Proposal in response to the RFP (attached to this Contract as *Exhibit 2* and hereinafter referred to as “Contractor’s Proposal”), which is expressly incorporated into this Contract as if completely restated herein;

WHEREAS, Contractor, including its Subcontractors, represents that it has the skills, qualifications, expertise, financial resources and experience necessary to perform the services described in Contractor’s Proposal and this Contract in compliance with all applicable federal and state laws and regulations, including but not limited to Chapters 21 and 21A respectively of Title 33 of the Official Georgia Code Annotated;

WHEREAS, DCH accepts Contractor’s Proposal and enters into this Contract with Contractor for the provision of various services for the Department; and

WHEREAS, DCH and Contractor agree that the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (hereinafter referred to as “CMS”) must approve this Contract as a condition precedent to its becoming effective for any purpose.

NOW, THEREFORE, FOR AND IN CONSIDERATION of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Department and the Contractor (each individually a “Party” and collectively the “Parties”) hereby agree as follows:

1.0 SCOPE OF SERVICES

- 1.0.1 The Contractor will provide care management services to Georgia Families, Medicaid and PeachCare for Kids ® Members and Planning for Healthy Babies (P4HB) Participants. PeachCare for Kids ® is Georgia’s Children’s Health Insurance Program (CHIP), and the P4HB program is Georgia’s Section 1115 family planning waiver program. A summary of the required responsibilities to be carried out by the Contractor include:
- 1.0.1.1 Provision of access to health care services, including but not limited to physical health service, behavioral health services, dental services and Care Coordination;
 - 1.0.1.2 Provision of access to P4HB services;
 - 1.0.1.3 Provision of Member education and outreach including:
 - 1.0.1.3.1 Member call center
 - 1.0.1.3.2 Member handbook and Member ID cards
 - 1.0.1.3.3 Ongoing education and outreach to Members
 - 1.0.1.3.4 Provider directory
 - 1.0.1.4 Development and maintenance of a network of Providers and facilities adequate to deliver all Covered Services;
 - 1.0.1.5 Provision of a primary care physician (PCP) to serve as the medical home for all Members. The PCP serves as the single point of accountability and coordination—primarily for primary care;
 - 1.0.1.6 Provision of a Dental Home for Members under the age of twenty-one (21). The Dental Home is responsible for coordinating all dental care for the Member;
 - 1.0.1.7 A Provider services function to act as the point of contact for its Provider network, provide educational material, maintain a Provider Call Center, facilitate provider complaints and address provider contract and payment issues;
 - 1.0.1.8 Ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, second opinion, Discharge Planning, and case management;
 - 1.0.1.9 Provision of a System of Care approach to Care Coordination and continuity of care, which ensures a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. This includes: Transition of Care, Discharge Planning, Care Coordination, Disease Management, and Case Management;
 - 1.0.1.10 Provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member’s Condition is not amenable to improvement, maintain the Member’s current health status by implementing measures

to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s);

- 1.0.1.11 Develop an adequate system and staff to ensure the provision of health care services under this Contract are properly documented, paid for and reported; and
 - 1.0.1.12 Design and implement an information management system for the purpose of integrating all components of the delivery of care to the Members. The system shall have the capability to securely store and transmit information, interface with other relevant systems and report data in a format specified by DCH.
- 1.0.2 The Parties agree that DCH retains Contractor to furnish all of the goods, services, and other deliverables contemplated by this Contract.
- 1.0.3 The Parties agree that the Department shall not pay or otherwise compensate the Contractor for any services, goods, or deliverables outside of the above Scope of Services, which includes Contractor's Proposal to the extent agreed upon by DCH and this Contract. The Department shall not make any exceptions or waivers on this matter. In the event of a dispute regarding whether an item is within the Scope of Services, the Parties will attempt to reach a mutually agreeable solution. If the Parties fail to reach a mutually agreeable solution, Section 30, Conflict Resolution, of this Contract shall govern and not be subject to appeal.
- 1.0.4 If written correspondence is received by the Contractor from DCH and the Contractor believes that the correspondence will cause a change to the Scope of Services contemplated by this Contract, the Contractor shall advise the Project Leader listed in Section 32, Notice, of this Contract (hereinafter referred to as "DCH Project Leader") in writing within ten (10) Business Days of receiving the initial correspondence from DCH at the address indicated in Section 32 of this Contract. The Contractor shall request the DCH Project Leader's written confirmation that the Scope of Services has changed.
- 1.0.4.1 The Notice shall state the following:
 - 1.0.4.1.1 The nature and circumstances of the communication regarded as a change in the Scope of Services by the Contractor;
 - 1.0.4.1.2 The date of the communication;
 - 1.0.4.1.3 The identification of the documents involved;
 - 1.0.4.1.4 The particular technical requirements or contract requirements regarded as changed;
 - 1.0.4.1.5 The direct and foreseeable effect of the communication regarded as a change in the Scope of Services contemplated by the Contract, including the number of hours required from Contractor's staff to accomplish the change and the manner and sequence of performance or delivery of

supplies or services, identifying which supplies or services are or will be affected; and

1.0.4.1.6 A detailed cost analysis of the alleged change, including a schedule setting forth the associated staffing costs (including staff names and hourly costs), with the totals for these categories not exceeding amounts based upon specific assumptions.

1.0.5 The DCH Project Leader shall respond within ten (10) Business Days of receipt of the Contractor's notice.

1.0.5.1 The DCH Project Leader's response shall either:

1.0.5.1.1 Countermand the correspondence that Contractor regards as a change;

1.0.5.1.2 Deny that the correspondence constitutes a change in the Scope of Services contemplated by the Contract;

1.0.5.1.3 Confirm in writing that the correspondence is a change to the Scope of Services contemplated by the Contract; or

1.0.5.1.4 Advise the Contractor that additional information is required to evaluate the Notice and establish the deadline by which the Contractor must provide such information.

1.0.6 If the Contractor complies with any order, direction, interpretation, or determination, written or oral, without providing notice in accordance with this subsection, DCH shall not be liable for any increased price, delay in performance, or contract non-conformance by the Contractor.

1.1 **BACKGROUND**

1.1.1 In 2003, the DCH identified unsustainable Medicaid growth and projected that without a change to the system, Medicaid would require fifty percent (50%) of all new State revenue by 2008. In addition, Medicaid Utilization was driving more than thirty-five percent (35%) of total growth each year. For that reason, DCH decided to employ a care management approach to organize its fragmented System of Care, enhance access, achieve budget predictability, explore possible cost containment opportunities and focus on system-wide performance improvements. Furthermore, DCH believed that managed care could continuously and incrementally improve the quality of Health Care and services provided to patients and improve efficiency by utilizing both human and material resources more effectively and more efficiently.

1.1.2 The DCH Division of Managed Care and Quality submitted a State Plan Amendment to CMS in 2004 to implement Georgia Families, a full-risk mandatory Medicaid Managed Care program. Georgia Families includes the following Members:

1.1.2.1 *Recipients of Medicaid and PeachCare for Kids®*: Effective June 1, 2006, the State of Georgia implemented Georgia Families through which Health Care services are delivered to eligible recipients of Medicaid and PeachCare for Kids®.

- 1.1.2.2 *Planning for Healthy Babies:* In 2011, DCH implemented the P4HB program to reduce the number of low birth weight (LBW) and very low birth weight (VLBW) births in Georgia. Through the Georgia Families program, P4HB participants receive Family Planning Services and *interpregnancy* care (IPC) services. Additionally, women participating in the IPC component of P4HB receive Primary Care visits; management and treatment of chronic diseases; substance use disorder (SUD) treatment (detoxification and intensive outpatient rehabilitation); Case Management; Resource Mother Outreach (support services such as supportive counseling, non-emergency transportation, and linkage to community resources); limited dental services; and additional prescription drugs (non-family planning).
- 1.1.3 DCH's intent in maintaining a care management approach to serve Georgia Families Members is to:
 - 1.1.3.1 Continually and significantly improve the Quality of health care *and* services provided to Members;
 - 1.1.3.2 Offer Care Coordination to Members;
 - 1.1.3.3 Enhance access to Health Care services;
 - 1.1.3.4 Achieve budget predictability as well as cost containment;
 - 1.1.3.5 Create system-wide performance improvements; and
 - 1.1.3.6 Improve efficiency at all levels.
- 1.1.4 Georgia Families is designed to:
 - 1.1.4.1 Improve the Health Care status of the Member;
 - 1.1.4.2 Establish a member-provider relationship through its use of Medical Homes;
 - 1.1.4.3 Establish a climate of contractual accountability for improving health outcomes;
 - 1.1.4.4 Slow the rate of expenditure growth in the Medicaid program; and
 - 1.1.4.5 Expand and strengthen Members' responsibility and engagement in their Health Care.
- 1.1.5 Since 2006, Georgia Families has evolved from a startup program focused on operations to a more mature program focusing on Quality of care, Care Management Organization (CMO) accountability and Member outcomes. DCH has regularly gathered meaningful stakeholder feedback about the program and has used this feedback to enhance the program. For example, in 2011, DCH conducted over thirty (30) focus groups with Members and Advocates, Providers, Vendors and Legislators; solicited feedback through online surveys; and convened three (3) Task Forces and one (1) Workgroup. Through this collaborative process, DCH worked with the CMOs to implement a variety of Quality Improvement Initiatives to improve Quality and health outcomes

of Members, broadened its Georgia Families Monitoring and oversight activities and has implemented or is in process of implementing administrative simplifications to improve the Member and Provider experience. Below are examples of initiatives DCH has implemented specific to Georgia Families and overarching Medicaid initiatives that also impact Georgia Families.

1.1.5.1 Quality Improvement Initiatives

- 1.1.5.1.1 DCH is collaborating with the National Initiative for Children's Healthcare Quality (NICHQ) and the Georgia OB/Gyn Society to increase postpartum care rates, incorporate the reproductive life plan discussion into the postpartum care visit, and encourage reproductive life plan and long-acting reversible contraceptive discussions in the antepartum visits.
- 1.1.5.1.2 In 2014, DCH collaborated with the then CMOs to consolidate Performance Improvement Projects (PIPs) into one common, "Bright Futures" PIP to drive improvements in all of the activities performed during each preventive health visit as described in the Bright Futures Periodicity Schedule.
- 1.1.5.1.3 In partnership with the then CMOs, DCH implemented a statewide PIP to reduce avoidable emergency room visits.
- 1.1.5.1.4 DCH engaged its External Quality Review Organization to provide tutorials to the then CMOs on conducting PIPs.
- 1.1.5.1.5 DCH encourages Provider use of electronic health record systems through Health Information Technology (Health IT) incentive programs. Increased use of electronic health records was an intervention employed by the then CMOs to decrease avoidable emergency room visits. In 2014, Georgia reported an increased percentage of practices using electronic health records through Referral to Georgia-HITREC. Through May 2014, Georgia issued more than \$217 million in payments of federal funds to eligible providers for their Medicaid Electronic Health Records (EHR) Incentive Program, including payments to Providers serving Georgia Families Members.
- 1.1.5.1.6 DCH developed a program that awarded the then CMOs with auto-assignment of Members based on the CMOs' Quality of the services provided. DCH reviews nineteen (19) performance measures as part of the auto-assignment algorithm per each six (6)-month cycle. Being awarded auto-assignees for high-quality services encouraged the CMOs to achieve better Quality outcomes for their Members.

1.1.5.2 Monitoring and Oversight Activities

- 1.1.5.2.1 DCH has enhanced its oversight and Monitoring of CMO performance through the expansion and accreditation of HEDIS®-based performance

measurement, demonstrated improvement through performance improvement projects (PIPs) and cross-state agency collaboration initiatives. In 2014, DCH measured fifty-four (54) HEDIS/NCQA Quality Metrics.

1.1.5.3 Administrative Simplifications

1.1.5.3.1 DCH plans to implement a real-time eligibility system in 2016 to streamline the eligibility determination, program Enrollment and facilitate the service authorization process.

1.1.5.3.2 DCH is implementing a Credentialing Verification Program to simplify the Medicaid and Georgia Families Enrollment process for Providers and improve efficiencies by reducing administrative burden. Providers will submit electronic applications and other required materials to a Credentialing Verification Organization (CVO) contracted by DCH. The CVO will process the Provider credentialing or re-credentialing Information to apply to the fee-for-service and managed care delivery Systems. The CMOs will not conduct separate credentialing and re-credentialing processes.

1.1.5.3.3 DCH implemented standardized prior authorization request forms and an electronic portal through which Providers submit all prior authorization requests. This Information, in turn, is provided to the appropriate CMO for review, as CMOs retain authority for prior authorization of services for their Members. The CMOs then return the disposition of the prior authorization request to the common portal. Using such a portal allows for standardization and creates efficiencies for Providers. For example, if a Provider submits a prior authorization request for a surgery and the Member is in process of transitioning to a new CMO, the Provider is not required to resubmit the prior authorization request to the new CMO. The new CMO will access the Information submitted for the initial CMO to review for its review and approval process.

1.2 ELIGIBILITY FOR GEORGIA FAMILIES

1.2.1 Medicaid

1.2.1.1 The following Medicaid eligibility categories are required to enroll in Georgia Families (hereinafter referred to as “GF”):

1.2.1.1.1 Low Income Families – Adults and children who meet the standards of the former AFDC (Aid to Families with Dependent Children) program.

1.2.1.1.2 Transitional Medicaid – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit.

- 1.2.1.1.3 Pregnant Women (Right from the Start Medicaid – RSM) – Pregnant women with family income at or below two hundred twenty percent (220%) of the federal poverty level who receive Medicaid through the RSM program.
- 1.2.1.1.4 Children (Right from the Start Medicaid – RSM) – Children less than nineteen (19) years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family.
- 1.2.1.1.5 Children (newborn) – A child born to a woman who is eligible for Medicaid on the day the child is born.
- 1.2.1.1.6 Women Eligible Due to Breast and Cervical Cancer – Women less than sixty-five (65) years of age who have been screened through Title XV Center for Disease Control (CDC) screening and have been diagnosed with breast or cervical cancer.
- 1.2.1.1.7 Refugees – Individuals, as defined under O.C.G.A. § 38-3-3, including but not limited to those who have the required Immigration and Naturalization Service (INS) documentation showing they meet a status of asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims.
- 1.2.1.1.8 Planning for Health Babies 1115 Demonstration Waiver Participants (otherwise known as P4HB participants) – This Demonstration includes three distinct groups: Women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal poverty level and are eligible for Family Planning Only Services; Women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal poverty level who have delivered a very low birth weight infant and are eligible for Family Planning Services and Interpregnancy Care Services; and Women ages eighteen (18) through forty-four (44) who are current Medicaid recipients, have delivered a very low birth weight infant and are eligible for Resource Mother services only.

1.2.2 PeachCare for Kids®

- 1.2.2.1 PeachCare for Kids® – The Children’s Health Insurance Program (CHIP) in Georgia. Children less than nineteen (19) years of age who have family income that is less than two hundred forty-seven percent (247%) of the federal poverty level, who are not eligible for Medicaid, or any other health insurance program, and who cannot be covered by the State Health Benefit Plan are eligible for services under PeachCare for Kids®.

1.2.3 Exclusions

- 1.2.3.1 The following recipients are excluded from Enrollment in GF, even if the recipient is otherwise eligible for GF per Section 1.2.1 and Section 1.2.2:
 - 1.2.3.1.1 Recipients eligible for Medicare.
 - 1.2.3.1.2 Recipients that are Members of a Federally Recognized Indian Tribe.
 - 1.2.3.1.3 Recipients that are enrolled in fee-for-service Medicaid through Supplemental Security Income prior to enrollment in GF.
 - 1.2.3.1.4 Medicaid children enrolled in the Children’s Medical Services program administered by the Georgia Department of Public Health.
 - 1.2.3.1.5 Children enrolled in the Georgia Pediatric Program (GAPP).
 - 1.2.3.1.6 Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.
 - 1.2.3.1.7 Individuals enrolled in a Hospice category of aid.
 - 1.2.3.1.8 Individuals enrolled in a Nursing Home category of aid.
 - 1.2.3.1.9 Individuals enrolled in a Community Based Alternatives for Youths (CBAY).
- 1.2.3.2 The following recipients are excluded from the P4HB 1115 Demonstration (hereinafter referred to as “the Demonstration”):
 - 1.2.3.2.1 Women who become pregnant while enrolled in the Demonstration.
 - 1.2.3.2.2 Women determined to be infertile (sterile) or who are sterilized while enrolled in the Demonstration.
 - 1.2.3.2.3 Women who became eligible for any other Medicaid or commercial insurance program.
 - 1.2.3.2.4 Women who no longer meet the Demonstration’s eligibility requirements.
 - 1.2.3.2.5 Women who are or become incarcerated.

1.3 **SERVICE REGIONS**

- 1.3.1 For the purposes of coordination, planning, and analysis, DCH has divided the State, by county, into six (6) Service Regions. See **Attachment I** for a listing of the counties in each Service Region.

1.3.2 Members will choose or will be assigned to a CMO.

1.3.3 Contractor shall provide health care services and meet all other requirements set forth in this Contract in all six (6) Service Regions within the State.

1.4 **DEFINITIONS**

For purposes of this Contract the following terms are defined as follows:

340B Drug Pricing Program: The program administered by HRSA that requires drug manufacturers to provide covered outpatient drugs to eligible health care organizations/covered entities at significantly reduced rates. Eligible organizations/covered entities must register and be enrolled with the 340B program and comply with all 340B Program requirements.

Abandoned Call: A call in which the caller elects a valid option and is either not permitted access to that option or disconnects from the system.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for Health Care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the Care Management Organization (CMO) to act within the time frames provided in 42 CFR 438.408(b).

Activities of Daily Living (ADL): Daily self-care activities including bathing, dressing, feeding, toileting, grooming, and transferring (walking, transferring from bed to wheelchair or wheelchair to toilet, etc.) and continence.

Administrative Claiming for Education (ACE): The Georgia Medicaid Administrative Claiming for Education (ACE) program allows reimbursement to Local Education Agencies (LEA) for approved administrative activities that support the Medicaid program. Reimbursement is available through a quarterly claiming process.

Administrative Law Hearing: The appeal process administered by the State in accordance with O.C.G.A. §49-4-153 and as required by federal law available to Members and Providers after they exhaust the Contractor's Appeals Process.

Administrative Review: The formal reconsideration of a proposed Action, as a result of the proper and timely submission of a Provider's request, Member's request, or a request by DCH.

Administrative Service(s): The contractual obligations of the Contractor that include but are not limited to Utilization Management, network management, Quality improvement, marketing, enrollment, Member Services, Claims payment, Information Systems, financial management, and reporting.

Advance Directives: A written instruction, such as a living will or durable power of attorney for Health Care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of Health Care when the individual is incapacitated.

After-Hours: Provider office/visitation hours extending beyond the normal business hours of a Provider. This may include Saturday hours.

Aged, Blind or Disabled (ABD): Medical assistance for persons who are aged (sixty-five (65) years of age or older), legally blind, and/or disabled. These individuals receive Fee-for-Service Medicaid and are not eligible for the Georgia Families Program.

Agent: An entity that contracts with the State of Georgia to perform administrative functions, including but not limited to: Fiscal Agent Contractor activities; outreach, eligibility, and Enrollment activities; Information Systems and technical support, etc.

Aim Statement: A written and measurable description of desired improvement that defines a clear and firm intention for improvement and is time-specific, measurable and focused on the population that will be affected by the improvement activity. The Aim Statement should be easy to remember and answer the following questions: What will we improve? For whom? How much? By when?

Appeal: A request for review of an action, as “action” is defined in 42 C.F.R. §438.400.

Appeals Process: The overall process that includes Appeals at the Contractor level and access to the State Fair Hearing process (the State’s Administrative Law Hearing).

Assess: The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

Attestation: The Contractor attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.

Authoritative Host: A system that contains the master or “authoritative” data for a particular data type, e.g. Member, Provider, CMO, etc. The Authoritative Host may feed data from its master data files to other systems in real time or in batch mode. Data in an Authoritative Host is expected to be up-to-date and reliable.

Authorized Representative: A person authorized by the Member in writing to make health-related decisions on behalf of a Member, including, but not limited to Enrollment and Disenrollment decisions, filing Appeals and Grievances with the Contractor, and choice of a Primary Care Physician (PCP). The Authorized Representative is the Parent, Adoptive Parent or legal guardian for a child. For an adult, this person is the legal guardian (guardianship action), health care power of attorney, other person that has power of attorney, or another signed HIPAA compliant document indicating who can make decisions on behalf of the Member. For Foster Care Members and Juvenile Justice Members, the Authorized Representative is DFCS or DJJ respectively.

Automatic Assignment (Auto-Assign or Auto-Assignment): The assignment of a Member to a CMO or PCP pursuant to the provisions of this Contract.

Bed Days: A day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

Behavioral Health: The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five [DSM 5] published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in Behavioral Health usually have symptoms, behaviors and/or skill deficits which impede their functional abilities and affect their quality of life.

Behavioral Health Crisis: An intensive behavioral, emotional or psychiatric situation that exceeds an individual's current resources and coping mechanisms which, if left untreated, could result in an emergency situation.

Behavioral Health Home (BHH): A Behavioral health home is responsible for the integration and coordination of the individual's health care (physical as well as behavioral health care services). Behavioral Health Home providers do not need to provide all the services themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated.

Behavioral Health Services: Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Benefits: The Health Care services set forth in this Contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible for.

Blocked Call: A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Border Provider: Providers located within fifty (50) miles of the Georgia border. Border Providers are located in Alabama, Florida, North Carolina, South Carolina and Tennessee.

Business Days: Monday through Friday from 9:00 a.m. to 5:00 p.m. EST, excluding State holidays.

Calendar Days: All seven days of the Week.

Calendar Years: January through December.

Capitated Service: Any Covered Service for which the Contractor receives an actuarially sound Capitation Payment.

Capitation: A Contractual arrangement through which a Contractor agrees to provide specified Health Care services to Members for a fixed amount per Member per month.

Capitation Payment: A payment, fixed in advance, that DCH makes to the Contractor for each Member covered under this Contract for the provision of Covered Services and who are assigned to the Contractor. Capitation Payments are unique for each program. For instance, Capitation Payments may be referred to as P4HB Capitation Payments, Foster Care/Juvenile Justice Capitation Payments, or Adoption Assistance Capitation Payments. This payment is made regardless of whether the Member receives Covered Services

or Benefits during the period covered by the payment. Payments are contingent upon the availability of appropriated funds.

Capitation Rate: The fixed monthly amount, including the Value-Based Purchasing (VBP) withhold, that the Contractor is paid by DCH for each Member assigned to the Contractor to ensure that Covered Services and Benefits under this Contract are provided. Capitation Rates are unique for each program. For instance, Capitation Rates may be referred to as Georgia Families Capitation Rates, P4HB Capitation Rates, Foster Care/Juvenile Justice Capitation Rates or Adoption Assistance Capitation Rates. Payments are contingent upon the availability of appropriated funds.

Care Coordination: The process of actively linking a Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified.

Care Management Organization (CMO): An entity organized for the purpose of providing Health Care, with a health maintenance organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers, and furnishes Health Care services on a capitated basis to Members.

Case Management: A Person-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote Quality cost-effective outcomes. Case Management serves as a means for achieving Member wellness and autonomy through advocacy, communication, education, and identification of services and resources. Interventions are undertaken with the purpose of helping Members receive appropriate care. Case Management is distinguished from Utilization Management in that it is voluntary and it is distinguished from Disease Management by its intensity and focus on any disease(s) or condition(s) the Member has.

Category of Eligibility: Defined set of requirements used to identify individuals who are eligible for Medicaid, Peach Care for Kids and P4HB and the services the individuals are eligible for. Requirements may include age; being pregnant, disabled, or blind; meeting income and asset requirements and being a U.S. citizen or a qualified alien. Non-qualified aliens or undocumented immigrants may be eligible for emergency assistance only.

Category of Service (COS): Classifications of the service types and the Providers authorized to deliver the services as defined by DCH.

Centers for Medicare & Medicaid Services (CMS): The Agency within the U.S. Department of Health and Human Services responsible for the Medicare, Medicaid and the Children's Health Insurance Programs.

Certified Nurse Midwife (CNM): A registered professional nurse who is legally authorized under State law to practice as a nurse-midwife, and has completed a program of study and clinical experience for nurse-midwives or equivalent.

Children's Health Insurance Program (CHIP formerly State Children's Health Insurance Program (SCHIP)): A joint federal-state Health Care program for targeted, low-income children, established pursuant to Title XXI of the Social Security Act. Georgia's CHIP is called PeachCare for Kids®.

Children's Intervention School Services (CISS): The Georgia Medicaid program that provides reimbursement for specified medically-necessary services that are received in schools and provided by or arranged by a Local Education Agency (LEA) for Medicaid-eligible students under the age of twenty-one (21) with an Individualized Education Program (IEP).

Children's Medical Services: Administered by the Department of Public Health, the Children's Medical Services program provides care coordination and other needed medical/health services for eligible children and their families who are not enrolled in managed care. Children's Medical Services program may provide, arrange for and/or pay for comprehensive physical evaluations, diagnostic tests, inpatient/outpatient hospitalization, medications, and other medical treatments, therapy, Durable Medical Equipment, hearing aids related to the child's eligible condition, and genetic counseling.

Chronic Condition: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is considered Routine Care.

Claim: A bill for services, a line item of services, or all services for one recipient within a bill.

Claim Adjustment: A claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, payment amount can be changed.

Claims Administrator: The entity engaged by DCH to provide Administrative Service(s) to the CMOs in connection with processing and adjudicating risk-based payment, and recording Encounter Claims data for Members.

Clean Claim: A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: (i) A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; (ii.) A Claim for which Fraud is suspected; and (iii.) A Claim for which a Third Party Resource should be responsible.

Cold-Call Marketing: Any unsolicited contact by the CMO, with a Potential Member, for the purposes of marketing a Member's selection or Enrollment in a particular CMO.

Community Mental Health Rehabilitation Services (CMHRS): Services that are intended for the maximum reduction of mental disability and restoration of an individual to his or her best possible functional level.

Completion/Implementation Timeframe: The date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the Contractor.

Condition: A disease, illness, injury, disorder, of biological, cognitive, or psychological basis for which evaluation, monitoring and/or treatment are indicated.

Consecutive Enrollment Period: The consecutive twelve (12) month period beginning on the first day of Enrollment or the date the notice is sent, whichever is later. For Members that use their option to change CMOs without cause during the first ninety (90) Calendar Days of Enrollment, the twelve-month Consecutive Enrollment Period will commence when the Member enrolls in the new CMO. This is not to be construed as a guarantee of eligibility during the Consecutive Enrollment Period.

Consulting Provider: The Provider who evaluates a Member at the request of the Member's Primary Care or referring Provider. The consultation may occur via a Telemedicine mode of delivery.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): CAHPS surveys ask Medicaid and PeachCare for Kids[®] Members or their parents/guardians to report on and evaluate their experiences with their health care. The surveys cover topics that are important to Members and focus on aspects of quality that Members and parents/guardians are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The acronym CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). DCH uses the Adult and Child CAHPS surveys.

Contested Claim: A Claim that is denied because the Claim is an ineligible Claim, the Claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the Claim requires special treatment.

Continuing Care Provider: A Provider who formally agrees: to provide to enrolled individuals in Medicaid, screening, diagnosis, and treatment for conditions identified during EPSDT screening visits (within the Provider's capacity) or referral to a Provider capable of providing the appropriate services; maintains a complete health history, including information received from other Providers; is responsible for providing needed physician services for acute, episodic and/or chronic illnesses and conditions; and ensures accountability by submitting reports reasonably required by the Contractor and/or DCH.

Contract: The written agreement between the State and the Contractor; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Award: The date upon which the Apparent Successful Vendor Letter(s) is issued by the Department of Administrative Services.

Contract Effective Date: The date when the rights and obligations under the Contract become operational. For purposes of this Contract, the Effective Date is the date upon which the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS) approves the Terms and Conditions of the Contract.

Contract Execution Date: The date upon which all Parties have signed the Contract.

Contractor: The Care Management Organization with a valid Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner that contracts hereunder with the State for the provision of comprehensive Health Care services to Members on a capitated basis.

Contractor's Representative: The individual legally empowered to bind the Contractor, using his/her signature block, including his/her title.

Coordination of Care: The deliberate organization of Member care activities by a CMO between two or more Providers involved in a Member's care, in order to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required Member care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Co-payment: The part of the cost-sharing requirement for Members in which a fixed monetary amount is paid for certain services/items received from the Contractor's Providers.

Core Services: Those supports/services provided by outpatient Behavioral Health agencies offering a comprehensive range of Mental Health, addictive disease, and/or specialty services that meet conditions of the Medicaid program specifically under the Medicaid Rehabilitation Option. Also known as Community Behavioral Health Rehabilitation Services.

Corrective Action: A reaction to a problem, complaint or issue that has already occurred. The actions initiated are intended to fix the problem/issue and modify the quality system so that the process that caused it is monitored to prevent a recurrence. Documentation for a Corrective Action provides evidence that the problem was recognized, corrected and proper controls were implemented to make sure that it does not happen again. The process for reacting to problems, complaints or other issues includes:

- i. Reviewing and defining the problem/issue
- ii. Finding the cause of the problem/issue
- iii. Developing an action plan to correct the problem/issue and prevent a recurrence
- iv. Implementation of the action plan
- v. Evaluating the effectiveness of the correction

Corrective Action Plan: The detailed written plan required by DCH to correct or resolve a deficiency or event that may result in the assessment of a Liquidated Damage or sanction against the CMO.

Corrective Action Preventive Action (CAPA) Process: A step-by-step process for completing and documenting preventive and corrective actions. The steps assist investigators in detecting potential problems or reacting to existing problems and eliminating or correcting them. The CAPA process may be linked to liquidated damages.

Corrective Action Preventive Action (CAPA) Program: A fundamental management tool that provides a simple step by step process for completing and documenting corrective or preventive actions. The end result of implementation of this program is a complete, well documented investigation and solution that will satisfy DCH's requirements and form the basis for an effective continuous improvement plan. Liquidated damages may be linked to this program.

Cost Avoidance: A method of paying Claims in which the Provider is not reimbursed until the Provider has demonstrated that all available health insurance has been exhausted.

Covered Services: Those Medically Necessary Health Care services provided to Members, the payment or indemnification of which is covered under this Contract.

Credentialing Verification Organization (CVO): An entity contracted by the State to determine the qualifications and ascribed privileges of providers to render specific Health Care services. The entity will

make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families.

Crisis: A condition of instability/danger or dramatic emotional or circumstantial upheaval in a person's life requiring action or change.

Critical Access Hospital (CAH): A hospital that meets the CMS requirements to be designated as a Critical Access Hospital and that is recognized by DCH as a Critical Access Hospital for purposes of Medicaid.

Cultural Competency: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Deliverable: A document, manual or report submitted to DCH by the Contractor to fulfill requirements of this Contract.

Demonstration (also Family Planning Waiver, Planning for Health Babies, or the P4HB Program): The 1115 Demonstration waiver program in Georgia supported by CMS that expands the delivery of family planning services to uninsured women, ages eighteen (18) through forty-four (44), who have family income at or below 200 percent of the Federal Poverty Level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). Georgia's only 1115 Demonstration waiver is referred to as the Family Planning Waiver, Planning for Healthy Babies, or the P4HB Program. This Demonstration includes three distinct groups: women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the FPL and are eligible for Family Planning Only Services; women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the FPL who have delivered a very low birth weight (VLBW) infant and are eligible for Family Planning Services and Interpregnancy Care Services; and women ages eighteen (18) through forty-four (44) who are current Medicaid recipients, have delivered a VLBW infant and are eligible for Resource Mother services only.

Demonstration Disenrollment: The removal of a P4HB participant from participation in the Demonstration.

Demonstration Enrollee: An individual meeting P4HB Program eligibility requirements who selects or is otherwise assigned to a Georgia Families CMO in order to receive Demonstration services.

Demonstration Enrollment: The process by which an individual eligible for the P4HB program applies to utilize a Georgia Families CMO to receive Demonstration services and such application is approved by DCH or its Agent.

Demonstration Period: The period during which the Demonstration is effective based on approval from CMS.

Demonstration Provider: A physician, advanced practice nurse or other health care provider who meets the State's Medicaid provider enrollment requirements for the Demonstration; hospital, facility, or pharmacy licensed or otherwise authorized to provide Demonstration related Services to P4HB participants within the State or jurisdiction in which they are furnished. Also known as a P4HB Provider.

Demonstration Related Emergency Medical Condition: A medical condition resulting from a Demonstration related Service and manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the woman in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. A Demonstration related Emergency Medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

Demonstration Related Post Stabilization Services: Covered Services related to a Demonstration related Emergency Medical Condition that are provided after a P4HB participant is stabilized in order to maintain the stabilized condition or to improve or resolve the P4HB participant's condition.

Demonstration Related Services: Those Demonstration Services identified in the CMS Special Terms and Conditions and approved by CMS that are available to P4HB participants.

Demonstration Related Urgent Care Services: Medically Necessary treatment of a Demonstration related injury, illness or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Dental Home: A Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the State Plan. P4HB members are not eligible for a Dental Home.

Dental Subspecialty Providers: Specialized dental providers including endodontists, oral pathologists, orthodontists, oral surgeons, periodontists, pedodontists, and prosthodontists.

Department of Behavioral Health and Developmental Disabilities (DBHDD): The Georgia state agency that provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD serves people of all ages with the most severe and likely to be long-term conditions, including consumers with forensic issues.

Department of Community Health (DCH): The single state Agency in the State of Georgia responsible for oversight and administration of the Medicaid program, the PeachCare for Kids® program, the Planning for Healthy Babies Program and the State Health Benefit Plan (SHBP).

Department of Community Health Performance, Quality and Outcomes Unit (DCH PQO Unit): A unit within the DCH Medicaid Division charged with ensuring that all aspects of the department's Quality Strategic Plan are implemented, and defining enhancements to the plan that would drive health improvements for Georgia's Medicaid population served by the CMOs.

Department of Public Health: The Georgia state agency with the ultimate responsibility for the health of communities and the entire population.

Diagnostic Related Group (DRG): Any of the payment categories that are used to classify patients and especially Medicare patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred. The payment category is determined primarily by the principal diagnosis, surgical procedure used, age of patient, and expected length of stay in the hospital.

Diagnostic Services: Any medical procedures or supplies recommended by a physician or other licensed medical practitioner, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature or extent of illness, injury, or other health deviation in a Member.

Discharge: Point at which Member is formally released from a hospital, by the treating physician, an authorized member of the physician's staff or by the Member after they have indicated, in writing, their decision to leave the hospital against medical advice.

Discharge Planning Pilot Program: A pilot program the CMOs will implement with hospitals(s) that agree to participate to improve coordination for Members being discharged from the hospital. The intent of this program is to improve quality of care and outcomes, as well as to reduce readmissions.

Disenrollment: The removal of a Member from enrollment with a CMO, but not necessarily from the Medicaid or PeachCare for Kids® programs.

Documented Attempt: A bona fide, or good faith, attempt on the part of a CMO to contract with a Provider. Such attempts may include written correspondence that outlines contracted negotiations between the parties, including rate and contract terms disclosure, as well as documented verbal conversations, to include date and time and parties involved.

Driver Diagrams: A road map for changes and interventions that provides a way to organize thoughts around what needs to be done in order to achieve the aim. There are two types of drivers:

- i. Primary drivers – system components that will contribute to improving outcomes; and
- ii. Secondary drivers – elements of the associated primary drivers that help create the changes. The secondary drivers are interventions expected to affect primary drivers and thus outcomes, and are evidence-based, necessary and sufficient for improvement.

Durable Medical Equipment (DME): Equipment, including assistive technology, which:

- i. Can withstand repeated use;
- ii. Is used to service a health or functional purpose;
- iii. Is ordered by a qualified practitioner to address an illness, injury or disability; and
- iv. Is appropriate for use in the home, work place, or school.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit: A comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age twenty-one (21), as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The EPSDT benefit also covers Medically Necessary diagnostic services. The Contractor is required to arrange for and cover, under the EPSDT benefit, any Medicaid covered service listed in Section 1905(a) of the Act if that treatment or service is determined to be Medically Necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age twenty-one (21) enrolled in the Medicaid and PeachCare for Kids® programs. P4HB Members are not eligible for the EPSDT Benefit.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program: The program that defines the policy, reimbursement, and oversight for the EPSDT services described under the EPSDT Benefit. The goal of the EPSDT program is to ensure that individual children get the health care they need when they need it.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

Emergency Medical Screening: An examination: (i.) provided on hospital property, and provided for that patient for whom it is requested or required, (ii.) performed within the capabilities of the hospital's emergency room (ER) (including ancillary services routinely available to its ER), (iii.) the purpose of which is to determine if the patient has an Emergency Medical Condition, and (iv.) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or Physician Assistant as permitted by State statutes and regulations and hospital bylaws .

Emergency Services: Covered inpatient and outpatient services furnished by a qualified Provider needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the Prudent Layperson standard.

Encounter: A distinct set of Health Care services provided to a Member enrolled with a CMO on the dates that the services were delivered.

Encounter Claims: Records of Claims paid by the CMO, or by its Subcontractors, to Providers that have provided Health Care services to Members. The CMO is required to submit Encounter Claims to the State's Data Warehouse vendor and Fiscal Agent Contractor that include required, optional, and situational data fields as specified in the Encounter Data Companion Guides, relevant 837 and National Council for Prescription Drug Programs standards, and other Encounter Claims data reporting documentation, where applicable.

Enrollment: The process by which an individual eligible for Medicaid or PeachCare for Kids® applies (whether voluntary or mandatory) to utilize the Contractor's plan in lieu of the Fee-for-Service program and such application is approved by DCH or its Agent.

Enrollment Broker: The entity engaged by or on behalf of DCH to assist in outreach, education and Enrollment activities associated with the Georgia Families and P4HB programs.

Enrollment Period: The twelve (12) month period commencing on the effective date of Enrollment.

Evaluate: The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

Expedited Review: For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision with twenty-four (24) hours and provide notice as expeditiously as the Member's health condition requires and no later than three (3) Business Days after receipt of the request for service. The Contractor may extend the twenty-four (24) hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's interest.

External Quality Review (EQR): The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the Health Care services that a CMO or its Subcontractors furnish to Members.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, and other related activities.

Family Planning Provider: A physician, advanced practice nurse, or other Health Care provider who meets the State's Medicaid provider enrollment requirements for providing family planning services to eligible Members.

Family Planning Services: Family planning services and supplies include at a minimum:

- i. Education and counseling necessary to make informed choices and understand contraceptive methods;
- ii. Initial and annual complete physical examinations;
- iii. Follow-up, brief and comprehensive visits;
- iv. Pregnancy testing;
- v. Contraceptive supplies and follow-up care;
- vi. Diagnosis and treatment of sexually transmitted diseases; and
- vii. Infertility assessment.

Family Planning Waiver: See Demonstration.

Federally Qualified Health Center (FQHC): An entity that provides outpatient health programs pursuant to Section 1905(l) (2) (B) of the Social Security Act.

Federal Financial Participation (FFP): The funding contribution that the Federal government makes to the Georgia Medicaid and PeachCare for Kids® programs.

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services. Federal Poverty Levels are used to determine eligibility for certain programs and benefits.

Fee-for-Service (FFS): A method of reimbursement based on payment for specific services rendered to eligible Medicaid and PeachCare for Kids® individuals that are not participants in the Georgia Families or Georgia Families 360° programs.

Financial Relationship: A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity that equates to at least five percent (5%) or more of the disclosing entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation arrangement with an entity. This includes a mortgage, deed of trust, note or other obligation.

Fiscal Agent Contractor (FAC) or Fiscal Agent: The entity contracted with DCH to process Medicaid and PeachCare for Kids® Claims and other non-Claim specific payments.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law.

Full Month: All Calendar Days included in a month (i.e., all 28, 30 or 31 days of the month in consideration).

Full Quarter: Three consecutive Full Months starting with the first Full Month of the Calendar Year.

Full Time Provider: defined as a location operating for more than sixteen (16) hours in an office location each Week.

Geographic Access: A Provider Network fulfilling access criteria within set geographic restrictions.

Georgia Crisis and Access Line (GCAL): A twenty-four (24)-hour phone line sponsored by DBHDD to assist with coordinating access to care or provide support in an emergency or crisis.

Georgia Families: The risk-based managed care delivery program for Medicaid and PeachCare for Kids® in which DCH contracts with CMOs to manage the care of eligible Members.

Georgia Families 360°: The risk-based managed care delivery program for Foster Care Members, Adoption Assistance Members and Juvenile Justice Members.

Georgia Health Information Network (GaHIN): The technical infrastructure used to facilitate secure electronic exchange of electronic health records among authorized health care providers throughout the entire State of Georgia.

GaHIN Authorized User/Member Affiliate: Qualified Entities and GaHIN Member Users having authorized access to the GaHIN.

GaHIN Member Agreements: Written agreements that GaHIN and/or its Agents determine are required as a condition for a Qualified Member's participation in the network.

GaHIN Member Users/Member Affiliates: Any entity, organization or individual person who has been identified and authorized by a Qualified Member to access the GaHIN, in a manner defined by the

respective Qualified Member, in compliance with an agreement between the Member User and the Qualified Member and applicable law. Member Users may include, but are not limited to, hospitals or Health Care systems, and employees, Contractors, or agents of a Qualified Member.

Georgia Pediatric Program (GAPP): The program serving medically fragile children operating in part under a Home-and-Community Based Waiver.

Georgia Technology Authority (GTA): The State agency that manages the State's information technology (IT) infrastructure, i.e. data center, network and telecommunications services and security, establishes policies, standards and guidelines for State IT, promotes an enterprise approach to State IT, and develops and manages the State portal.

Grievance: An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights.

Grievance System: The overall system that addresses the manner in which the CMO handles Grievances at the Contractor level.

Health Care: Health Care means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental Condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Healthcare Effectiveness Data and Information Set (HEDIS®): A widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA).

Health Care Professional: A physician or other Health Care Professional, including but not limited to podiatrists, optometrists, chiropractors, psychologists, dentists, physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians licensed in the State of Georgia.

Health Check Program: The Early and Periodic Screening components of the EPSDT benefit are covered under this program pursuant to Title XIX of the Social Security Act.

Health Information Technology: Hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. Source is ARRA - H.R.1 -115 Sec. 3000 (5).

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV: Enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, the legislation was signed into law on February 17, 2009, to promote the adoption and meaningful use of Health Information

Technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that includes requirements to protect the privacy of individually identified health information in any format, including written or printed, oral and electronic, to protect the security of individually identified health information in electronic format, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers. When referenced in this Contract it includes all related rules, regulations and procedures.

Health Maintenance Organization: an entity organized for the purpose of providing Health Care and has a Health Maintenance Organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers and furnishes Health Care services on a capitated basis to Members.

Health Professional Shortage Area (HPSA): An area designated by the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental or mental health providers. These areas can be geographic, demographic or institutional in nature. A care area can be found using the following website: <http://hpsafind.hrsa.gov/>.

Health Risk Screening: The Health Risk Screening is used to collect comprehensive information on FC Members or AA Members.

Historical Provider Relationship: A Provider who has been the main source of Demonstration, Medicaid or PeachCare for Kids® services for the Member or P4HB participant during the previous year (decided on by the most recent Provider on the Member's or P4HB participant's Claim history).

Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)): A law enacted by the Georgia state legislature and codified as O.C.G.A. § 31-8-179 et seq. The Hospital Medicaid Financing Program Act establishes (i) a hospital provider fee that is assessed by the State on Hospital Medicaid Financing Program Act Providers and (ii) an additional add-on payment with each CMO Claim payment that is equal to 11.88% of the Hospital Medicaid Financing Program Act Provider's contracted reimbursement rate with the CMO.

Hospital Medicaid Financing Program Act Provider: An institution licensed pursuant to Chapter 7 of Title 31 of the Official Code of Georgia Annotated which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, and other specialty hospitals but shall not include psychiatric hospitals as defined in paragraph (7) of Code Section 37-3-1, Critical Access Hospitals as defined in paragraph (3) of Code Section 33-21A-2, or any state owned or state operated hospitals.

Immediately: Within twenty-four (24) clock hours.

Implementation Phase: The period of time from the Contract Effective Date through the Operational Start Date.

Incentive Arrangement: Any mechanism under which a Contractor may receive additional funds over and above the Capitation Payments, excluding Provider incentive payments made under Value Based Purchasing, for exceeding targets specified in the Contract.

Incurred-But-Not-Reported (IBNR): Estimate of unpaid Claims liability, includes received but unpaid Claims.

Individualized Education Program (IEP): A mandate of the IDEA that defines the individualized objectives of a child who has been found with a disability, as defined by federal regulations. The IEP is intended to help children reach educational goals more easily than they otherwise would and refers both to the educational program to be provided to a child with a disability and to the written document that describes that educational program.

Individualized Family Service Plan (IFSP): A document developed when a child under the age of three (3) is found eligible for early-intervention services. The IFSP focuses on the child and family and the services that a family needs to help them enhance the development of their child.

Individually Identifiable Health Information: See Protected Health Information.

Individuals with Disabilities Education Act (IDEA): A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Individuals with Disabilities Education Act (IDEA) Part B: A law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to infants, toddlers, children and youth with disabilities. Part B focuses on children and youth ages three (3) to twenty-one (21) and their receipt of special education and related services. For Medicaid Members aged three (3) to twenty-one (21), the CMOs are not responsible for reimbursing Local Education Agencies for the provision of Medically Necessary IDEA Part B services, provided pursuant to an IEP in the school setting.

Individuals with Disabilities Education Act (IDEA) Part C: Part C of IDEA serves infants and toddlers through age two (2) with developmental delays or who have diagnosed physical or mental conditions with high probabilities that these conditions will result in developmental delays.

Information: (i) Structured Data: Data that adhere to specific properties and Validation criteria that is stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; and (ii.) Document: Information that does not meet the definition of Structured Data that includes, at minimum, text, files, spreadsheets, electronic messages and images of forms and pictures.

Information System/Systems: A combination of computing hardware and software that is used in: (i.) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. Structured Data (which may include digitized audio and video) and documents; and/or (ii.) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

In-Network Provider: A Provider that has entered into a Provider contract with the Contractor to provide Health Care services.

Inpatient Facility: Hospital or clinic for treatment that requires at least one overnight stay.

Insolvent: Unable to meet or discharge financial liabilities.

Interpregnancy Care (IPC): A benefit available to those P4HB participants who meet the Demonstration's eligibility requirements and who delivered a Very Low Birth Weight baby on or after initiation of the Demonstration.

Interpregnancy Care Service Providers: Those Demonstration Providers serving the IPC P4HB participants including Nurse Case Managers and Resource Mothers.

Interpregnancy Care Services: Services available under the Demonstration for P4HB participants who meet the eligibility criteria for the IPC program. These services are in addition to Family Planning Services and include: limited primary care services; management and treatment of chronic diseases; Substance Abuse treatment (detoxification and intensive outpatient rehabilitation); case management, including Resource Mothers outreach; limited dental; prescription drugs (non-family planning) for the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery and Non-Emergency Transportation.

Interpretation Services: The act or result of explaining, discovering, or ascertaining the meaning of all non-English language between speakers who speak different languages. Interpretation Services allow the transference of meaning between spoken languages. The interpreter must be fluent in both the original language and the target language and must translate the language to make it understandable. Interpretation Services are available free of charge to Potential Members and enrolled Members.

Key Staff: Contractor's staff which includes the Chief Executive Officer, Member Services Director, Provider Services Director, Utilization Management Director, Medical Director, Quality Management Director, Health Services Director and the Program Implementation Manager. Key Staff must be full-time employees located in Georgia with no other client responsibilities other than the Georgia Families, Georgia Families 360° or P4HB programs.

Limited-English-Proficient Population: Individuals with a primary language other than English who must communicate in that language if the individual is to have an equal opportunity to participate effectively in, and benefit from, any aid, service or benefit provided by the Health Care Provider.

Local Education Agency (LEA): The official designation for a school district in the State of Georgia.

Long Term: A period greater than thirty (30) Calendar Days.

Low Birth Weight (LBW): Birth weight below 2,500 grams (5.5 pounds).

Mandated Reporters: People in professions who have regular contact with vulnerable people such as children, disabled persons and senior citizens and are therefore legally required to report (or cause a report to be made) when abuse, neglect or exploitation is observed or are suspected. The specific professionals are typically named in state law. Georgia identified Mandated Reporters in the Official Code of Georgia

Annotated for adults and children §§ 30-5-1, et seq. and 19-7-5(c)(1) which include, but are not limited to: Physicians licensed to practice medicines, interns or residents; dentists; psychologists; chiropractors; podiatrists; pharmacists; physical therapists; occupational therapists; licensed professionals and counselors; nursing personnel; social work personnel; day care personnel; employees of a public or private agency engaged in professional health-related services; and law enforcement personnel.

Mandatory Enrollment: The process whereby an individual eligible for the Demonstration, Medicaid or PeachCare for Kids® is required to enroll in a CMO, unless otherwise exempted or excluded, to receive covered Demonstration, Medicaid or PeachCare for Kids® services.

Marketing: Any communication from a CMO to any Demonstration, Medicaid or PeachCare for Kids® eligible individual that can reasonably be interpreted as intended to influence the individual to enroll in that particular CMO, or not enroll in or disenroll from another CMO.

Marketing Materials: Materials that are produced in any medium, by or on behalf of a CMO, and can reasonably be interpreted as intended to market to any Member.

Material Subcontractor: A Subcontractor, excluding Providers, receiving Subcontractor payments from the Contractor in amounts equal to or greater than ten (10) million dollars annually during the State fiscal year.

Measurable: Applies to a Contractor objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.

Medicaid: The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act, which in Georgia is administered by DCH.

Medicaid Care Management Organizations Act: O.C.G.A. §33-21A-1, *et seq.* Medicaid Care Management Organizations Act. A bill passed by the Georgia General Assembly, signed into law by the Governor, and effective July 1, 2008 which outlines several administrative requirements with which the administrators of the Medicaid Managed Care plan must comply. Some of the requirements include dental Provider networks, emergency room Claims payment requirements, eligibility verification, and others.

Medicaid Eligible: An individual eligible to receive services under the Medicaid Program but not necessarily enrolled in the Medicaid Program.

Medicaid Management Information System (MMIS): Computerized system used for the processing, collecting, analysis, and reporting of Information needed to support Medicaid and CHIP functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manual.

Medical Director: The Georgia-licensed physician designated by the Contractor to exercise general supervision over the provision of health service Benefits by the Contractor.

Medical Home: A person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers, and where appropriate, the individual's family and other supports. A focal point for information sharing and referral to specialists and sub-specialists as well as community evaluations and interpretation of specialists.

Medical Records: The complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's participating Primary Care or Demonstration Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

Medical Screening: An examination used to identify an unrecognized or recognized disease in individuals without signs or symptoms.

Medically Necessary Services (includes concepts of Medically Necessary and Medical Necessity): Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary Services are those that are:

- i. Required to correct or ameliorate a defect, physical or mental illness, or a Condition
- ii. Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's medical Condition
- iii. Compatible with the standards of acceptable medical practice
- iv. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
- v. Not provided solely for the convenience of the Member or the convenience of the Health Provider
- vi. Not primarily custodial care unless custodial care is a Covered Service or benefit under the Member's evidence of coverage
- vii. Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available

Member: A Medicaid, P4HB, or PeachCare for Kids® recipient who is currently enrolled in a CMO unless otherwise noted.

Mental Health: A state of emotional and psychological well-being in which the individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.

Mental Illness: A behavioral or psychological syndrome or disorder that presents as a mental or behavioral anomaly and reflects an underlying psychobiological dysfunction the consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning).

Methodology: The planned process, steps, activities or actions taken by the Contractor to achieve a goal or objective, or to progress toward a positive outcome.

Monitoring: The process of observing, evaluating, analyzing and conducting follow-up activities.

National Committee for Quality Assurance (NCQA): An organization that sets standards, and evaluates and accredits health plans and other managed care organizations.

National Provider Identifier (NPI): A unique ten digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). Providers must use their NPI to identify themselves in all HIPAA transactions.

Neonatal Intensive Care Unit (NICU): Hospital unit which provides intensive care services for sick and premature newborns.

Neonatal Intensive Care Unit (NICU) Supplemental Payments: Payments made to the Care Management Organizations for Georgia Families Members when those Members receive certain services in a NICU.

Net Capitation Payment: The Capitation Payment, adjusted for the applicable VBP Withhold, made by DCH to the Contractor excluding NICU Supplemental Payments, Obstetrical Delivery Payments, or other medical services that are on a per occurrence basis rather than a per Member basis.

Non-Capitated Services: Services not included in the CMO's Capitation Rate.

Non-Emergency Transportation (NET): A ride, or reimbursement for a ride, provided so that a Member or P4HB participant with no other transportation resources can receive services from a medical provider. NET does not include transportation provided on an emergency basis, such as trips to the Emergency Room in life threatening situations.

Non-Institutional Claims: Claims submitted by a medical Provider other than a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF/ID).

Normal Birth Weight: Birth weight greater than or equal to 2,500 grams (5.5 pounds).

Nurse Practitioner Certified (NP-C): A registered professional nurse who is licensed by the State of Georgia and meets the advanced educational and clinical practice requirements beyond the two (2) or four (4) years of basic nursing education required of all registered nurses.

Objective: Measurable step, generally in a series of progressive steps, to achieve a goal.

Obstetrical Delivery Payment: A one-time payment made to the Care Management Organization for the delivery of a Georgia Families newborn. This payment is in addition to the Georgia Families Capitation Payment for the newborn. The Care Management Organization is eligible for the Obstetrical Delivery Payment based on submission of the paid Claim associated with the related obstetrical and/or hospital services as defined by DCH. Also known as the OB Kick Payment.

Office of Insurance and Safety Fire Commissioner: The Agency in the State of Georgia responsible for licensing, overseeing, regulating, and certifying insuring entities.

Ombudsman Coordinator: An employee of the Contractor who is responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that Members have access to Covered Services and non-Covered Services. The Ombudsman Coordinator is also responsible for interacting with DCH's equivalent Ombudsman staff and submitting reports to DCH.

Ombudsman Liaison: An employee of the Contractor who is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to Health Care services, and identifying the communication and education needs of Members, Providers and caregivers. The Ombudsman Liaison must assist Members and Providers in coordinating services with local community organizations and working with advocacy

organizations. The Ombudsman Liaison is also responsible for interacting with DCH's equivalent Ombudsman staff and submitting reports to DCH.

Operational Start Date: The date upon which the Contractor begins providing services to Members under the Contract. The anticipated Operational Start Date is July 1, 2016; however, DCH reserves the right to set a later date in its sole discretion.

Ordering, Prescribing, Referring (OPR) Provider: Pursuant to the Patient Protection and Affordable Care Act and resulting regulations at 42 CFR 455.410(b), a physician or non-physician practitioner that orders, prescribes or refers services for a Member. OPR providers must be enrolled in Medicaid as either a participating Medicaid Provider or as an OPR Provider and his or her National Provider Identifier (NPI) number must be included on submitted claims.

Out-of-Network Provider: A Provider of services that does not have a Provider contract with the Contractor.

Parent Company: A company which owns and controls other companies, usually known as subsidiaries.

Part Time Practice: A location operating for less than sixteen (16) hours in an office location each Week.

Participating Provider: A Provider that has signed a contract with CMOs to provide services to Members.

Patient Centered Medical Home (PCMH): Georgia recognizes Providers as PCMHs if they have received NCQA PCMH recognition. A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care. A medical home achieves these goals through a high level of accessibility, providing excellent communication among patients, physicians and staff and taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.

Patient Protection and Affordable Care Act (PPACA): The Patient Protection and Affordable Care Act is a federal statute, signed into law on March 23, 2010. The law includes numerous health-related provisions that will take effect over a four year period, including expanding Medicaid eligibility, subsidizing insurance premiums, establishing health insurance exchanges and support of medical research. Also known as ACA.

PeachCare for Kids®: The State of Georgia's Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act.

Performance Improvement Project (PIP): A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy benefit management services including but not limited to claims processing and maintenance of associated systems and related processes.

Physical Health: The treatment focused on the care and oversight of the general medical Condition of a person and related Physical Health Care services.

Physician Assistant (PA): A trained, licensed individual who performs tasks that might otherwise be performed by physicians or under the direction of a supervising physician.

Physician Incentive Plan: Any compensation arrangement between a Contractor and a Provider that is designed to identify and reward desired behavior or outcomes.

Physician Practice Connections-Patient Centered Medical Home (PPC®-PCMH): The PPC-PCMH is a Recognition Program that emphasizes systematic use of patient-centered, coordinated care management processes. In order to obtain the PPC-PCMH Recognition, the entity must meet specific elements in the following categories: (1) Access and Communication, (2) Patient Tracking and Registry Functions, (3) Care Management, (4) patient Self-Management and Support, (5) Electronic Prescribing, (6) Test Tracking, (7) Referral Tracking, (8) Performance Reporting and Improvement, and (9) Advanced Electronic Communication.

Planning for Healthy Babies Program (P4HB): The name of the 1115 Family Planning Demonstration Waiver Program in Georgia. See definition of Demonstration.

Population Health Management (PHM): The management, integration and outcome measurement of any program affecting the health and productivity of your organization, i.e. corporate wellness, disease management, catastrophic case management, Utilization Management, Employee Assistance Program (EAP), disability, and/or worker's compensation programs.

Post-Stabilization Services: Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

Potential Member: A Medicaid or CHIP recipient who is subject to mandatory Enrollment in a CMO but is not yet the Member of a specific CMO.

Potential P4HB Participant: An individual meeting the eligibility requirements for the Demonstration who is subject to mandatory Enrollment in a CMO but is not yet enrolled in a specific CMO.

Pre-Certification: Review conducted prior to a Member's admission, stay or other service or course of treatment in a hospital or other facility.

Preconception Health Care: The primary prevention of maternal and perinatal morbidity and mortality comprised of interventions that identify and modify biomedical, behavioral and social risks to pregnancy outcomes for women and their offspring. To have maximal impact on pregnancy outcomes, strategies to address risks must occur before conception or before prenatal care is typically initiated.

Preferred Health Organization (PHO): A coordinated care plan that: (i.) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (ii.) provides for reimbursement for all covered benefits regardless of whether the benefits are provided with the network of providers; and (iii.) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

Pregnancy Rate: The number of pregnancies occurring to females in a specified age group per 1,000 females in the specified age group. The rate is calculated by using the following formula: $\text{Pregnancy rate} = [\text{Number of pregnancies in age group} / \text{Female population in age group}] * 1000$. Rates that use Census Population Estimates in the denominator are unable to be calculated when the selected population is unknown.

Prevalent Non-English Language: A language other than English, spoken by a significant number or percentage of Potential Members or P4HB participants.

Preventive Action: An intervention initiated to stop a potential problem from occurring. A Preventive Action assumes that adequate monitoring and controls are in place in the Quality system to assure that potential problems are identified and eliminated before they happen. If something in the Quality system indicates that a possible problem is or may develop, a Preventive Action must be implemented to avert and then eliminate the potential situation. Documentation for a Preventive Action provides evidence that an effective Quality system has been implemented that is able to anticipate, identify and eliminate potential problems. The process for detecting potential problems/issues and eliminating them includes:

- i. Identifying the potential problem/issue
- ii. Finding the cause of the potential problem/issue
- iii. Developing a plan to prevent the occurrence of the problem/issue
- iv. Implementing the plan
- v. Reviewing the actions taken and the effectiveness in preventing the problem

Preventive Services: Services provided by a physician or other licensed health practitioner within the scope of his or her practice under State law to: prevent disease, disability, and other health Conditions or their progression; treat potential secondary Conditions before they happen or at an early remediable stage; prolong life; and promote physical and mental health and efficiency.

Primary Care: All Health Care services and laboratory services, including periodic examinations, preventive Health Care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of Referrals to specialty Providers described in this Contract, and for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner or alternative Provider types such as specialists to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP): A licensed health care practitioner, usually a doctor, nurse practitioner, or physician assistant who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required Primary Care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, OB/GYNs, Physicians' Assistants, or nurse practitioners. The PCP's role is to:

- i. Provide preventive care and teach healthy lifestyle choices
- ii. Identify and treat common medical conditions
- iii. Assess the urgency of your medical problems and direct you to the best place for that care
- iv. Make referrals to medical specialists when necessary

Primary Dental Provider (Dentist): A licensed dentist who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required general dental services to Georgia Families and Georgia Families 360° Members. A Dentist shall include general dental practitioners provided that the Dentist is able and willing to carry out all Dentist responsibilities in accordance with these Contract provisions and licensure requirements. The Dentist is responsible for coordinating referrals, as needed, with Dental Subspecialty Providers and all subsequent dental care.

Prime Contractor: Primary Contractor of the Contract who holds full responsibility of the completion of the job. The Contractor, regardless of use of Subcontractors, is the Prime Contractor of this Contract.

Prior Authorization: Authorization granted in advance of the rendering of a service after appropriate medical review. Also known as Pre-Authorization or Prior Approval.

Prior Authorization Portal: The electronic web-based system through which Providers and the CMOs communicate about Prior Authorization requests submitted by Providers.

Proposed Action: The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMO to act within the time frames provided in 42 CFR 438.408(b).

Prospective Payment System (PPS): A method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Protected Health Information (PHI): A subset of health information, including demographic information collected from an individual and (1) created or received by a health care provider, health plan, employer, or health care clearinghouse, and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) is a reasonable basis to believe the information can be used to identify the individual. This information is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health information (i) in education records covered by the Family Educational Rights and Privacy Act, (ii) in employment records held by a covered entity in its role as employer; (iii) regarding persons who have been deceased for more than fifty (50) years; and (iv) in records described at 20 U.S.C. § 1232g (a) (4) (B) (iv).

Provider: Any person (including physicians or other Health Care Professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide Health Care Services that has contracted with a Care Management Organization to provide health care services to Members.

Provider Complaint: A written expression by a Provider, which indicates dissatisfaction or dispute with the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.

Provider Contract: Any written contract between the Contractor and a Provider that requires the Provider to perform specific parts of the Contractor's obligations for the provision of Health Care services under this Contract.

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

Provider Number (or Provider Billing Number): An alphanumeric code utilized by health care payers to identify providers for billing, payment, and reporting purposes.

Provider Withhold: A percentage of payments or set dollar amounts that a Contractor deducts from a Provider's payment or fee, or salary payment, and that may or may not be returned to the Provider, depending on specific predetermined factors.

Prudent Layperson: A person with average knowledge of health and medicine who could reasonably expect the absence of immediate medical attention to result in an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that could cause:

- i. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

Psychiatric Residential Treatment Facility (PRTF): A separate, standalone entity providing a range of comprehensive psychiatric services to treat the psychiatric Condition of residents under age twenty-one (21) years on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's Condition or prevent further regression so that the services will no longer be needed. (42 CFR §483.352, subpart D of part 441).

Qualified Electronic Health Record: "An Electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists; and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relevant to health care quality; and to exchange electronic health information with and integrate such information from other sources." Source is ARRA - H.R.1 -115 Sec. 3000 (13)

Qualified Entities (QEs): Entities that have permission from DCH and/or its designee to access services available on the GaHIN Network and meet a set of DCH-established criteria, have completed an approval process, and have signed participation documentation with Contractor. QEs ensure that Participant Users

and/or vendors with which they have agreements comply with the applicable terms of participation and related policy documentation.

Qualified Member: Individuals who meet a set of established criteria, successfully complete the approval process, and sign agreements to abide by GaHIN policies. GaHIN Member Users have permission to access, consume, and make available data transport services on the statewide health information network.

Quality: The degree to which a CMO increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

Query-Based Exchange: Technology and functionality that GaHIN Authorized Users/Member Affiliates will use to search for and locate individual Member records.

Rapid Cycle Process Improvement: A quality improvement method that identifies, implements, and measures changes made to improve a process or a system. Rapid-cycle improvement implies that changes are made and tested over short time frames (weeks to months) rather than years.

Re-admission: Subsequent admissions of a patient to a hospital or other health care institution for treatment within thirty (30) Calendar Days of the date of Discharge.

Recoupment: The recovery by the Contractor of any Medicaid debt by reducing present or future Medicaid payments and applying the amount withheld to the indebtedness.

Referral: A request by a PCP for a Member to be evaluated and/or treated by a different physician, usually a specialist.

Referral Services: Those Health Care services provided by a Health Care Professional other than the Primary Care Provider and which are ordered and approved by the Primary Care Provider or the Contractor.

Referring Provider: The Provider who has evaluated the Member, determined the need for a consultation (or other service), and has arranged the services of the consulting provider for the purpose of diagnosis and/or treatment.

Reinsurance: An agreement whereby the Contractor transfers risk or liability for losses, in whole or in part, sustained under this Contract. A reinsurance agreement may also exist at the Provider level.

Remedial Action: Action required immediately to remedy a situation until a thorough investigation and a permanent solution is implemented. When remedial actions are necessary, the actions and the resources required must be listed and the steps that must be taken immediately to avoid any further adverse effects are explained. All actions taken are documented and become part of the 'Action Plan' section of the Corrective Action/Preventive Action actions. If a remedial action is all that is needed, a rationale for that decision and appropriate follow up must be documented.

Remedy: The State's means to enforce the terms of the Contract through performance guarantees and other actions.

Reprocessing (Claims): Upon determination of the need to correct the outcome of one or more Claims processing transactions, the subsequent attempt to process a single Claim or batch of Claims.

Requirements Analysis Documents (RADs): A set of documents that describe the technical and business process requirements of each Deliverable identified in the Contract. Each requirement is defined in such way that its achievement is capable of being objectively verified by a prescribed method (for example inspection, demonstration, analysis, or test) and serves as a contractual basis between DCH and Contractor. DCH shall post such RADs on the DCH website and the Contractor shall access this information as determined by DCH. DCH reserves the right to modify the RADs as needed. The initial RADs will be developed by DCH during the Implementation Phase.

Resource Mother: A paraprofessional that provides a broad range of services to P4HB IPC participants and their families.

Resource Mother Outreach: Service under the P4HB program made available to women who receive Medicaid benefits and gives birth to a VLBW baby. The Resource Mother Outreach section offers support to mothers and provides them with information on parenting, nutrition, and healthy lifestyles.

Responsible Health Organization: Includes CMOs and FFS and is the party stated on the DCH MMIS portal as evidenced by the Provider's screen print out when the service is rendered within seventy-two (72) hours of that screen shot.

Revenue Codes: A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).

Routine Care: Treatment of a Condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physicians' office) or by the patient.

Rural Health Clinic (RHC): A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to Primary Care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, Physician Assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least fifty percent (50%) of the time with a mid-level practitioner. RHCs may also provide other Health Care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs.

Rural Health Services: Medical services provided to rural sparsely populated areas isolated from large metropolitan counties.

Security Rule: Establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic Protected Health Information. Ref. 45 CFR Part 160 and Subparts A and C of Part 164.

Service Authorization: A Provider's request for services for Georgia Families Members.

Service Region: A geographic area defined by the State that is used for reporting and analytical purposes.

Short Term: A period of thirty (30) Calendar Days or less.

Span of Control: Information systems and telecommunications capabilities that the CMO itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The CMO span of control also includes Information Systems and telecommunications capabilities outsourced by the CMO.

Stabilized: With respect to an Emergency Medical Condition; that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, the woman has delivered (including the placenta).

State: The State of Georgia.

State Fair Hearing: See Administrative Law Hearing.

State Health Benefit Plan (SHBP): The health benefit plan administered by the Georgia Department of Community Health covering State employees, public school teachers, public school employees, retirees and their eligible dependents, and other entities under such acts for health insurance.

State Plan: A comprehensive written statement submitted by DCH describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal Financial Participation (FFP) in the State program.

State-Vaccine-Eligible Child: With respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B) of the Social Security Act.

Subcontract: Any written contract between the Contractor and a third party, including a Provider, to perform a specified part of the Contractor's obligations under this Contract.

Subcontractor: Any third party who has a written Contract with the Contractor that have been assigned delegated functions and who have interactions with Members' Coordination of Care or the delivery of care.

Subcontractor Payments: The all-inclusive amount the Contractor pays a Subcontractor for services rendered.

Substance Abuse: Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. The term may also reference the field of clinical study and treatment of individuals who have experienced chronic disease related to substance abuse.

System Access Device: A device used to access Information System functions; can be any one of the following devices if it and the System are so configured: (i.) Workstation (stationary or mobile computing device), (ii.) Network computer/"winterm" device, (iii.) "Point of Sale" device, (iv.) Phone, or (v.) Multi-function communication and computing device, e.g. Personal Digital Assistant (PDA).

System Function Response Time: Based on the specific sub-function being performed:

- i. Record Search Time: The time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
- ii. Record Retrieval Time: The time elapsed after the retrieve command is entered until the record data begins to appear on the monitor.
- iii. Print Initiation Time: The elapsed time from the command to print a screen or report until it appears in the appropriate queue.
- iv. On-line Claims Adjudication Response Time: The elapsed time from the receipt of the transaction by the Contractor from the Provider and/or switch vendor until the Contractor hands-off a response to the Provider and/or switch vendor.

System of Care: A spectrum of effective, highly-coordinated community-based services and supports for children and youth with or at risk for mental health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families' and youths' needs to help them to function better at home, in school, in the community, and throughout life.

System of Care core values and philosophy include an expectation that services and supports: are culturally and linguistically competent; ensure availability and access to effective traditional and nontraditional services as well as natural and informal supports that address physical, emotional, social, and educational needs; are planned in true partnership with the child and family and a family peer professional representative; and include intensive care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

This definition is culled from an Issue Brief by the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, <http://gucchdtacenter.georgetown.edu/resources/>. The Contractor will reference and incorporate revised definitions, protocol, and operations as indicated according to published updates issued by the National Technical Assistance Center for Children's Mental Health.

System Unavailability: Failure of the system to provide a designated user access based on service level agreements or software/hardware problems within the Contractor's Span of Control.

Telecommunication Device for the Deaf (TDD): Special telephony devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones.

Telemedicine: Delivery of medical or other health services provided to a patient utilizing real-time interactive communication equipment to exchange the patient's information from one site to another via an electronic communication system.

Third Party Resource: Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or

part of the medical cost of injury, disease or disability of a Member applicant for or recipient of medical assistance.

Transition of Care: The movement of patients between health care practitioners and/or settings as their condition and care needs change during the course of a chronic or acute illness. For FC Members, JJ Members and AA Members, Transition of Care planning may involve activities or needs related to a Member's placement in DFCS custody or under DJJ supervision, transition from FFS Medicaid or commercial health plans to the Georgia Families 360° program; transition from a CMO to the Georgia Families 360° CMO, changes in Residential Placement, aging out of Foster Care or exiting DJJ supervision.

Translation Services: The act or process of changing or converting one language to another language. The translator must be fluent in both the original source language and the target language and must translate the language to make it understandable. Translation Services may also include the use of computer tools or technology. Translation Services are available free of charge to Potential Members and enrolled Members.

Unique Provider: A provider who furnishes, bills, or is paid for health care services provided to Members and who has been assigned a designated National Provider Identifier (NPI). The provider is identified utilizing the designated NPI number. Multiple practice locations are not taken into consideration when identifying the Provider.

Unique Provider Identifier: The National Provider Identifier (NPI) number assigned to an individual provider notwithstanding the provider's multiple office or practice locations.

Urgent Care: Medically Necessary treatment for an injury, illness, or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Utilization: The rate patterns of service usage or types of service occurring within a specified time.

Utilization Management (UM): A service performed by the Contractor which seeks to assure that Covered Services provided to Members are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established or administered by DCH.

Utilization Review (UR): Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of Health Care services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, Discharge Planning, or retrospective review.

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Value-Based Purchasing: An enhanced approach to purchasing and program management that focuses on value over volume. It is part of a comprehensive strategy that aligns incentives for Members, Providers, Contractor and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.

Value-Based Purchasing (VBP) Performance Management Team (PMT): Monitors CMO performance on VBP initiatives. Members of the VBP Performance Management Team include:

- i. Medicaid Director
- ii. DCH senior level employee(s)
- iii. Leadership from Georgia healthcare departments that support Medicaid: quality management, provider networks, medical management, member services, community outreach and finance
- iv. Contract Liaisons
- v. Representatives from DCH and Contractor's legal departments, as appropriate
- vi. As appropriate, management from enterprise functions (e.g., communications, information technology)
- vii. Key leadership from the Contractor (e.g., Medical Director Chief Operating Officer or other designee approved by DCH)
- viii. As appropriate, operational-level Contractor staff

Value-Based Purchasing Withhold: DCH will withhold five percent (5%) of the Contractor's Capitation Payments for the Value-Based Purchasing program. DCH may return all, part or none of the withheld funds to the Contractor as incentive payments based on the Contractor achieving identified VBP performance targets. The maximum incentive payment to the Contractor will be the full five percent (5%) VBP Withhold.

Very Low Birth Weight (VLBW): Birth weight below 1,500 grams (3.3 pounds).

Virtual Health Record (VHR): A virtual view of many data sources that contain patient health records. The VHR enables authorized users to query Member health information.

Week: The traditional seven-day week, Sunday through Saturday.

Work Week: The traditional work week, Monday through Friday.

Working Days: Monday through Friday but shall not include Saturdays, Sundays, or State and Federal holidays.

1.5 **ACRONYMS**

For purposes of this Contract the following acronyms are defined as follows:

AA Member – Adoption Assistance Member

AAPD – American Academy of Pediatric Dentistry

ABD – Aged Blind Disabled

ACE – Administrative Claiming for Education

ACIP – Advisory Committee on Immunization Practices

AD – Addictive Disease

ADL – Activities of Daily Living

AFDC – Aid to Families with Dependent Children

AHRQ – Agency for Healthcare Research and Quality

AICPA – American Institute of Certified Public Accountants

BHH - Behavioral Health Home

BIN – Bank Identification Number

CAH – Critical Access Hospital

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CAPA – Corrective Action Preventive Action

CAPTA – Child Abuse Prevention and Treatment Act

CASA – Court Appointed Special Advocate

CBAY – Community-Based Alternatives for Youth

CCFA – Comprehensive Child and Family Assessment

CCP – Comprehensive Community Providers

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CFT – Child and Family Team

CHIP – Children’s Health Insurance Program – formerly known as the State Children’s Health Insurance Program (SCHIP)

CISS – Children’s Intervention School Services

CLIA – Clinical Laboratory

CMHRS – Community Mental Health Rehabilitation Services

CMO – Care Management Organization

CMP – Community Medicaid Providers

CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwives

COA – Certificate of Authority

COMP – Comprehensive Supports Waiver Program

COS – Category of Service

CPS – Child Protective Services

CSB – Community Service Boards

CVO – Credentialing Verification Organization

DBHDD – Department of Behavioral Health and Developmental Disabilities

DCH – Department of Community Health

DECAL – Department of Early Care and Learning

DFCS – Division of Family and Children Services

DJJ – Department of Juvenile Justice

DMAP – Division of Medical Assistance Plans

DME – Durable Medical Equipment

DO – Doctor of Osteopathy

DOE – Department of Education

DPH – Department of Public Health

DRG – Diagnostic Related Group

EB – Enrollment Broker

ED - Emergency Department

EDI – Electronic Data Interchange

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ER – Emergency Room

eRFP – electronic Request for Proposal

eRFQC – electronic Request for Qualified Contractors

EVS - Eligibility Verification System

FAC - Fiscal Agent Contractor

FC Member – Foster Care Member

FFP – Federal Financial Participation

FFS – Fee-for-Service

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

GaHIN – Georgia Health Information Network

GAPP – Georgia Pediatric Program

GCAL – Georgia Crisis and Access Line

GEPS – Georgia Enterprises for Products and Services

GF – Georgia Families

GF 360 – Georgia Families 360°

GFMOOC – Georgia Families Monitoring and Oversight Committee

GTA - Georgia Technology Authority

HEDIS – Healthcare Effectiveness Data and Information Set

HHS – US Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Maintenance Organization

HPSA – Health Professional Shortage Area

IBNR – Incurred-But-Not-Reported

ICAMA – Interstate Compact on Adoption and Medical Assistance

ICF/ID – Intermediate care facility for the intellectually disabled

ICPC – Interstate Compact on the Placement of Children

ICWP – Independent Care Waiver Program

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IFI – Intensive Family Intervention

IFSP – Individualized Family Service Plan

INS – U.S. Immigration and Naturalization Services

IPC – Interpregnancy Care component of the 1115 Demonstration Waiver

JJ Member – Juvenile Justice Member

JPPS – Juvenile Parole/Probation Specialist

LBW – Low Birth Weight

LEAs – Local Education Agencies

LIM – Low-Income Medicaid

LIPT – Local Interagency Planning Team

MDT – Multidisciplinary Team

MMIS – Medicaid Management Information System

MSHCN – Members with Special Health Care Needs

NAIC – National Association of Insurance Commissioners

NCM – Nurse Care Manager

NCQA – National Committee for Quality Assurance

NCTSN – National Child Traumatic Stress Network

NET – Non-Emergency Transportation

NICU – Neonatal Intensive Care Unit

NOIA – Notice of Intent to Award

NOW – New Options Waiver Program

NP-C – Certified Nurse Practitioners

NPI – National Provider Identifier

O.C.G.A. – Official Code of Georgia Annotated

OSAH – Office of State Administrative Hearings

P4HB – Planning for Healthy Babies 1115 Demonstration Waiver

PA – Physician Assistant

PBM – Pharmacy Benefit Manager

PCMH - Patient Centered Medical Home

PCP – Primary Care Provider

PDF – Portable Document Format file

PDSA – Plan Do Study Act

PHI – Protected Health Information

PHM – Population Health Management

PHO - Preferred Health Organization

PIP – Performance Improvement Project

PMPM – Per Member Per Month

PPACA – Patient Protection and Affordable Care Act

PPC®-PCMH - Physician Practice Connections-Patient Centered Medical Home

PPS – Prospective Payment System

PQO - Performance, Quality and Outcomes

PRTF – Psychiatric Residential Treatment Facility

QAPI – Quality Assessment Performance Improvement

QEs – Qualified Entities

RBWO – Room Board and Watchful Oversight

RFP – Request for Proposal

RHC – Rural Health Clinic

RIAT – Regional Interagency Team

RSM – Right from the Start Medicaid

SED – Severe Emotional Disorder

SHBP – State Health Benefit Plan

SHD – Systems Help Desk

SP – Specialty Providers

SSA – Social Security Act

SSI – Supplemental Security Income

SUD – Substance use Disorder

SUCCESS – System for the Uniform Calculation and Consolidation of Economic Support

TANF – Temporary Assistance for Needy Families

TCN – Transaction Control Number

TDD – Telecommunication Device for the Deaf

UM – Utilization Management

UPIN – Unique Provider Identifier Number

UR – Utilization Review

VBP – Value Based Purchasing

VFC – Vaccines for Children

VHR – Virtual Health Record

VLBW – Very Low Birth Weight

W3C – World Wide Web Consortium

2.0 DCH RESPONSIBILITIES

2.1 GENERAL PROVISIONS

2.1.1 DCH is responsible for administering the GF program. The Department will administer the Contract, monitor Contractor performance, and provide oversight in all aspects of the Contractor operations.

2.2 LEGAL COMPLIANCE

2.2.1 DCH will comply with, and will monitor Contractor’s compliance with, all applicable State and federal laws and regulations, including but not limited to, implementing and abiding by all requirements established by CMS.

2.3 ELIGIBILITY AND ENROLLMENT

2.3.1 The State of Georgia has the sole authority for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for Enrollment in GF. DCH or its Agent will determine eligibility for PeachCare for Kids® and will collect applicable premiums. DCH or its Agent will continue responsibility for the electronic eligibility verification system (EVS).

2.3.2 DCH has sole authority for determining the enrollment process subject to compliance with all applicable laws and the State Plan.

2.3.2.1 Following the Contract Execution Date, DCH shall determine whether an initial open enrollment period for all Georgia Families members will be provided to allow members to select a CMO in accordance with the enrollment process established by DCH including any threshold percentage limiting the number of enrolled Members in a single plan. Any such initial open enrollment period shall be conducted in accordance with RFP Section 1.1.5 Transition Planning or such other transition plan approved by DCH in its sole discretion. DCH’s approved transition plan shall support each CMO reaching a minimum of 200,000 enrolled members during the initial open enrollment period; however, thereafter, notwithstanding anything to the contrary herein, DCH shall have no obligation to ensure any CMO receives or maintains a minimum number of enrolled members.

2.3.2.2 DCH or its Agent will review the Medicaid Management Information System (MMIS) file daily and send written notification and information within two (2) Business Days to all Members who are determined eligible for GF. A Member shall have thirty (30) Calendar Days to select a CMO and a PCP. Each Family Head of Household shall have thirty (30) Calendar Days to select a CMO and PCP for each Member. DCH or its Agent will issue a daily notice of all Enrollments to the CMO.

- 2.3.3 If the Member does not choose a CMO within thirty (30) Calendar Days of being deemed eligible for GF or during any open enrollment period, DCH or its Agent will Auto-Assign the individual to a CMO using the following algorithm:
- 2.3.3.1 If an immediate family member(s) of the Member is already enrolled in one CMO, the Member will be Auto-Assigned to that plan;
 - 2.3.3.2 If there are no immediate family members already enrolled and the Member has a Historical Provider Relationship with a Provider, the Member will be Auto-Assigned to the CMO where the Provider is contracted;
 - 2.3.3.3 If the Member does not have a Historical Provider Relationship with a Provider in any CMO, or the Provider contracts with all plans, the Member will be Auto-Assigned based on an algorithm determined by DCH that may include quality, cost or other measures.
 - 2.3.3.4 If the Potential P4HB participant does not choose a CMO within thirty (30) Calendar Days of being deemed eligible for the Demonstration, DCH or its Agent will Auto-Assign the individual to a CMO using the algorithm described in Section 2.3.3 for Members.
 - 2.3.3.5 Women already enrolled in GF due to pregnancy will have an expedited enrollment into the Demonstration upon termination of their pregnancy benefits. Members determined to be eligible for the Demonstration must be afforded the opportunity to choose a new CMO, if desired, for the delivery of Demonstration related Services. All P4HB participants will have thirty (30) Calendar Days from the date of eligibility notification to choose a CMO.
 - 2.3.3.6 The Contractor will notify its current pregnant Members at least thirty (30) Calendar Days prior to the expected date of delivery and prior to the date upon which the Member will end RSM, that they may be eligible to enroll in the Demonstration and may choose to switch to a different CMO for receipt of Demonstration services. Members who do not make a choice will be deemed to have chosen to remain in their current CMO for receipt of the Demonstration services they are eligible to receive.
- 2.3.4 Enrollment, whether chosen or Auto-Assigned, will be effective at 12:01 a.m. on the first (1st) Calendar Day after the Member's selection or Auto Assignment.
- 2.3.5 DCH or its Agent may include quality measures in the Auto-Assignment algorithm. Members will be Auto-Assigned to those plans that have higher scores based on quality, cost, or other measures to be defined by DCH. This factor will be applied after determining that there are no Historical Provider Relationships.
- 2.3.6 In any Service Region or on a statewide basis, DCH may, at its discretion, set a threshold percentage for the enrollment of Members in a single plan and change this threshold percentage at its discretion. Members will not be Auto Assigned to a CMO that exceeds this threshold unless a family member is enrolled in the CMO or a Historical Provider Relationship exists with a Provider that does not participate in any other CMO in the Service Region. When DCH changes the

threshold percentage applicable statewide or in any Service Region, DCH will provide the CMOs with a minimum of fourteen (14) days advance notice in writing.

- 2.3.7 DCH or its Agent will have five (5) Business Days to notify Members and the CMO of the Auto-Assignment. Notice to the Member will be made in writing and sent via surface mail. Notice to the CMO will be made via file transfer.
- 2.3.8 DCH or its Agent will be responsible for the consecutive Enrollment period and re-Enrollment functions. Unless a Member is disenrolled or ineligible, the Member will remain enrolled with the selected or auto-assigned CMO for a period of twelve (12) consecutive months. The consecutive twelve (12) month period begins on the first day of Enrollment or the date the notice is sent to the Member, whichever is later. Prior to month twelve (12), DCH or its Agent will notify the Member of the upcoming option to change to a different CMO. This is considered the Member's enrollment anniversary. If the Member does not elect to change CMO effective on their enrollment anniversary, the Member shall remain in its current CMO.
- 2.3.9 Conditioned on continued eligibility, all Members will be enrolled in a CMO for a period of twelve (12) consecutive months.
- 2.3.10 DCH or its Agent will automatically enroll a Member into the CMO in which he or she was most recently enrolled if the Member has a temporary loss of eligibility, defined as sixty (60) Calendar Days or less. In this circumstance, the consecutive Enrollment period will continue as though there has been no break in eligibility, keeping the original twelve (12) month period.
- 2.3.11 DCH or its Agent will notify Members at least once every twelve (12) months, and at least sixty (60) Calendar Days prior to the date upon which the consecutive Enrollment period ends (the annual Enrollment opportunity), that they have the opportunity to switch CMOs. Members who do not make a choice will be deemed to have chosen to remain with their current CMO.
- 2.3.12 In the event a temporary loss of eligibility has caused the Member to miss the annual Enrollment opportunity, DCH or its Agent will enroll the Member in the CMO in which he or she was enrolled prior to the loss of eligibility. The Member will receive a new sixty (60) Calendar Day notification period beginning the first day of the next month.
- 2.3.13 In accordance with current operations, DCH or its Agent will issue a Medicaid number to a newborn upon notification from the hospital, or other authorized Medicaid Provider.
- 2.3.14 DCH will notify Contractor that a Member is an expectant mother based on the pregnancy Category of Service. Upon notification from DCH, the CMO shall mail a newborn enrollment packet to the expectant mother. This packet shall include information that the newborn will be Auto-Assigned to the mother's CMO and that she may, if she wants, select a PCP for her newborn prior to the birth by contacting her CMO. The mother shall have ninety (90) Calendar Days from the day a Medicaid number was assigned to her newborn to choose a different CMO.
- 2.3.15 DCH may, at its sole discretion, elect to modify the Auto-Assignment algorithm, threshold percentage and/or use quality, cost, or other measures to conduct auto-assignments for reasons it deems necessary and proper.

2.4 DISENROLLMENT

- 2.4.1 DCH or its Agent will process all CMO Disenrollments. This includes Disenrollments due to non-payment of the PeachCare for Kids® premiums, loss of eligibility for GF due to other reasons, and all Disenrollment requests Members or P4HB participants or the Contractor submits via telephone, surface mail, internet, facsimile, and in person.
- 2.4.2 DCH or its Agent will make final determinations about granting Disenrollment requests and will notify the Contractor via file transfer and the Member or P4HB participant via surface mail of any Disenrollment decision within five (5) Calendar Days of making the final determination. Whether requested by the Member or P4HB participant or the Contractor the following are the timeframes for approved disenrollment:
- 2.4.2.1 If the Disenrollment request is received by DCH or its Agent on or before the managed care monthly process on the twenty-fourth (24th) Calendar Day of the month, the Disenrollment will be effective at midnight the first (1st) day of the month following the month in which the request was filed; and
- 2.4.2.2 If the Disenrollment request is received by DCH or its agent after the managed care monthly process on the twenty-fourth (24th) Calendar Day of the month, the Disenrollment will be effective at midnight the first (1st) day of the second (2nd) month following the month in which the request was filed.
- 2.4.3 If a Member is hospitalized in an acute inpatient facility on the first day of the month their Disenrollment is to be effective, the Member will remain enrolled until the end of the month of their Discharge from the inpatient facility. When Disenrollment is necessary due to a change in eligibility category, or eligibility for GF, the Member will be disenrolled according to the timeframes identified in Section 2.4.2.
- 2.4.4 When Disenrollment is necessary because a Member loses Medicaid or PeachCare for Kids® eligibility (for example, he or she has died, been incarcerated, or moved out-of-state) Disenrollment shall be immediate.

2.5 MEMBER SERVICES AND MARKETING

- 2.5.1 Contractor shall produce and make available all marketing materials in English and all prevalent, non-English languages spoken within the State of Georgia. Prevalent, non-English languages shall be identified (1) on a county basis in accordance with the methodology outlined within Appendix A of the CMS Memo dated September 18, 2013 and attached hereto as **Attachment F** or (2) utilizing such other methodology approved by DCH. On a semi-annual basis or upon DCH's request, Contractor shall apply the approved methodology to reassess prevalent, non-English languages and translate all marketing materials into any newly identified prevalent, non-English languages.
- 2.5.2 DCH will review and prior approve all marketing materials.
- 2.5.3 DCH will provide the Contractor with DCH logos and designs when such logos and designs are appropriate to the written materials being produced.

2.6 COVERED SERVICES & SPECIAL COVERAGE PROVISIONS

- 2.6.1 For Medicaid and PeachCare for Kids®, Medically Necessary Services and Benefits pursuant to the Georgia State Medicaid and CHIP State Plans and the Georgia Medicaid Policies and Procedures Manuals are covered. Such Medically Necessary Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.
- 2.6.2 Specific services available under the P4HB Demonstration are outlined in **Attachment L** to this Contract.

2.7 NETWORK

- 2.7.1 DCH will provide to the Contractor up to date changes to the State’s list of excluded Providers, as well as any additional information that will affect the Contractor’s Provider network.
- 2.7.1.1 DCH may consider Contractors’ requests to waive network geographic access requirements in rural areas with insufficient potential Providers. All such requests shall be submitted in writing.
- 2.7.1.2 DCH will provide the State’s Provider Credentialing policies and processes to the Contractor upon execution of this Contract.

2.8 QUALITY MONITORING

2.8.1 General Provisions

- 2.8.1.1 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor. In accordance with 42 CFR 438.204, this strategy will, at a minimum, monitor:
- 2.8.1.1.1 The availability of services;
 - 2.8.1.1.2 The adequacy of the Contractor’s capacity and services;
 - 2.8.1.1.3 The Contractor’s coordination and continuity of care for Members;
 - 2.8.1.1.4 The coverage and authorization of services;
 - 2.8.1.1.5 The Contractor’s policies and procedures for selection and retention of Providers;
 - 2.8.1.1.6 The Contractor’s compliance with Member information requirements in accordance with 42 CFR §438.10;

- 2.8.1.1.7 The Contractor's compliance with State and federal privacy laws and regulations relative to Member's confidentiality;
 - 2.8.1.1.8 The Contractor's compliance with Member Enrollment and Disenrollment requirements and limitations;
 - 2.8.1.1.9 The Contractor's Grievance System;
 - 2.8.1.1.10 The Contractor's oversight of all Subcontractor relationships and delegations;
 - 2.8.1.1.11 The Contractor's adoption of practice guidelines, including the dissemination of the guidelines to Providers and Providers' application of them;
 - 2.8.1.1.12 The Contractor's quality assessment and performance improvement program; and
 - 2.8.1.1.13 The Contractor's health information systems.
- 2.8.1.2 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor for the Demonstration and the outcomes resulting from those services. This strategy is incorporated in **Attachment M**.

2.8.2 Value-Based Purchasing

- 2.8.2.1 Prior to the Operational Start Date, DCH will establish the VBP Performance Management Team, which will be responsible for planning, implementing and executing the VBP initiative. Key responsibilities include:
 - 2.8.2.1.1 Overseeing execution of the VBP model;
 - 2.8.2.1.2 Working collaboratively with the Contractor to meet identified performance measures and targets;
 - 2.8.2.1.3 Reviewing Contractor progress monthly, quarterly and annually;
 - 2.8.2.1.4 Identifying lessons learned and necessary adjustments;
 - 2.8.2.1.5 Determining incentive payouts;
 - 2.8.2.1.6 Assessing liquidated damages; and
 - 2.8.2.1.7 Communicating results to stakeholders.
- 2.8.2.2 DCH will publish a VBP Operations Manual and will be responsible for updates to such manual as determined by DCH.

2.9 COORDINATION WITH CONTRACTOR'S KEY STAFF

- 2.9.1 DCH will make diligent good faith efforts to facilitate effective and continuous communication and coordination with the Contractor in all areas of GF operations.
- 2.9.2 Specifically, DCH will designate individuals within the Department who will serve as a liaison to the corresponding individual on the Contractor's staff, including:
 - 2.9.2.1 A program integrity staff Member;
 - 2.9.2.2 A quality oversight staff Member;
 - 2.9.2.3 A Grievance System staff Member who will also ensure that the State Administrative Law Hearing process is consistent with the Rules of the Office of the State Administrative Hearings Chapter 616-1-2 and with any other applicable rule, regulation, or procedure whether State or federal;
 - 2.9.2.4 An information systems coordinator; and
 - 2.9.2.5 A contract compliance staff Member.

2.10 FORMAT STANDARDS

- 2.10.1 DCH will provide to the Contractor its standards for formatting all Reports requested of the Contractor. DCH will require that all Reports be submitted electronically.

2.11 FINANCIAL MANAGEMENT

- 2.11.1 In order to facilitate the Contractor's efforts in using Cost Avoidance processes to ensure that primary payments from the liable third party are identified and collected to offset medical expenses, DCH will include information about known Third Party Resources on the electronic Enrollment data given to the Contractor.
- 2.11.2 DCH will monitor Contractor compliance with federal and State physician and member incentive plan rules and regulations.

2.12 INFORMATION SYSTEMS

- 2.12.1 DCH will supply the following information to the Contractor:
 - 2.12.1.1 Application and database design and development requirements (standards) that are specific to the State of Georgia.
 - 2.12.1.2 Networking and data communications requirements (standards) that are specific to the State of Georgia.
 - 2.12.1.3 Specific information for integrity controls and audit trail requirements.

- 2.12.1.4 State web portal (Georgia.gov) integration standards and design guidelines.
- 2.12.1.5 Specifications for data files to be transmitted by the Contractor to DCH and/or its agents.
- 2.12.1.6 Specifications for point-to-point, uni-directional or bi-directional interfaces between Contractor and DCH systems.

2.13 READINESS AND ANNUAL REVIEW

2.13.1 DCH or its Agent will conduct a readiness review of each Contractor at least ninety (90) Calendar Days prior to Enrollment of Members in the CMO. DCH or its Agent will conduct the reviews to provide assurances that the Contractor is able and prepared to perform all administrative functions and is providing high quality of services to Members.

2.13.2 Specifically, DCH's review will document the status of the Contractor with respect to meeting program standards set forth in this Contract, as well as any goals established by the Contractor. A multidisciplinary team appointed by DCH will conduct the readiness and annual review. The scope of the reviews will include, but not be limited to, review and/or verification of the Contractor's Progress on the following:

- 2.13.2.1 Statewide network access;
- 2.13.2.2 System readiness;
- 2.13.2.3 Member and Provider call center readiness;
- 2.13.2.4 Staffing plan and staffing levels;
- 2.13.2.5 Progress and status in hiring and training staff and cross-training staff;
- 2.13.2.6 Transition of Care plan;
- 2.13.2.7 Training plan and training of Providers and CMO staff;
- 2.13.2.8 Development of policies and procedures, such as those addressing privacy and PCP and Dental Home assignment;
- 2.13.2.9 Provider education and outreach, including outreach plan for encouraging Providers to serve as Medical Homes or Dental Homes;
- 2.13.2.10 Care Management / Care Coordination;
- 2.13.2.11 Quality Management / Quality Improvement;
- 2.13.2.12 System of Care;
- 2.13.2.13 Utilization Management;

- 2.13.2.14 Physical Health and Behavioral Health Coordination;
 - 2.13.2.15 Participation in the Georgia Families Monitoring and Oversight Committee;
 - 2.13.2.16 Policies and procedures for the Grievance System and Complaint System; and
 - 2.13.2.17 Financial solvency.
- 2.13.3 The review will assess the Contractor's ability to meet any requirements set forth in this Contract and documents referenced herein.
- 2.13.4 Members may not be enrolled in a CMO until DCH has determined that the Contractor is capable of meeting these standards. A Contractor's failure to pass the readiness review thirty (30) Calendar Days prior to the beginning of service delivery may result in the assessment and payment of liquidated damages against Contractor, delayed operations and/or immediate Contract termination. Contractor's failure to pass the annual review may result in liquidated damages, corrective action and/or Contract termination.
- 2.13.5 DCH will provide the Contractor with a summary of the findings as well as areas requiring remedial action after each readiness review phase.

3.0 GENERAL CONTRACTOR RESPONSIBILITIES

- 3.0.1 Contractor shall promptly deliver all required goods and services in a professional and workmanlike manner according to the Contract including all applicable professional standards.
- 3.0.2 Contractor shall maintain qualified staff and any other necessary business resources throughout the duration of the Contract to meet scheduled deadlines and all other performance requirements.
- 3.0.3 Comply with all State and DCH policies and standards in effect during the performance of the Contract, including but not limited to DCH's policies and standards relating to personnel conduct, security, safety, confidentiality, privacy and ethics.
- 3.0.4 Contractor shall immediately notify DCH of any of the following changes with respect to Contractor:
- 3.0.4.1 Change in business address, telephone number, facsimile number or e-mail address;
 - 3.0.4.2 Change in entity status or nature;
 - 3.0.4.3 Change in business location;
 - 3.0.4.4 Change to a condition of insolvency (i.e. a state in which Contractor is unable to meet or discharge financial liabilities);
 - 3.0.4.5 Change in entity officers, executive employees, or entity structure;
 - 3.0.4.6 Material change in ownership or control (i.e. more than 5%);

- 3.0.4.7 Change in federal employee identification number or federal tax identification number;
- 3.0.4.8 Change in current litigation, audits and other governmental investigations, both in Georgia and in other states as well as at the federal level.
- 3.0.5 Contractor shall notify DCH of any of the following changes with respect to any Subcontractor(s):
 - 3.0.5.1 Change in corporate status or nature;
 - 3.0.5.2 Change in solvency; or
 - 3.0.5.3 Material change in ownership or control (i.e. more than 5%).
- 3.0.6 Contractor shall request and receive DCH's prior written consent (which shall not be unreasonably withheld) before taking any of the following actions:
 - 3.0.6.1 Change its legal status;
 - 3.0.6.2 Change its legal structure; or
 - 3.0.6.3 Sell, transfer, convey, or assign more than 5% ownership interest in the Contractor.
- 3.0.7 Should DCH not consent to any of the actions set forth in Section 3.0.6 and the Contractor desires to proceed with such action, then DCH may, at its option, elect to terminate this Contract at such date as determined by DCH.

4.0 SPECIFIC CONTRACTOR RESPONSIBILITIES

The Contractor shall complete the following actions, tasks, obligations, and responsibilities:

4.1 ENROLLMENT

4.1.1 Enrollment Procedures

- 4.1.1.1. DCH or its Agent is responsible for Enrollment, including Auto-Assignment to a CMO, Disenrollment, education on enrollment options, and outreach activities. The Contractor shall coordinate with DCH and its Agent as necessary for all Enrollment and Disenrollment functions.
- 4.1.1.2 DCH or its Agent will make every effort to ensure that individuals who are ineligible for Enrollment are not enrolled in GF. However, to ensure that such individuals are not enrolled in GF, the Contractor shall assist DCH or its Agent in the identification of individuals who are ineligible for Enrollment in GF, as set forth Section 1.2.3, should such individuals inadvertently become enrolled in GF.
- 4.1.1.3 DCH or its Agent will make every effort to ensure that individuals ineligible for Enrollment in the Demonstration are not enrolled in GF as P4HB Participants. However, to ensure that such individuals are not enrolled in the Demonstration, the

Contractor shall assist DCH or its Agent in the identification of P4HB Participants that are ineligible for enrollment in the Demonstration but have been inadvertently enrolled in GF as P4HB Participants.

4.1.1.4 The Contractor shall assist DCH or its Agent in the identification of individuals that become ineligible for Medicaid and PeachCare for Kids® (for example, those who have died, been incarcerated, or moved out-of-state, or no longer meet P4HB eligibility criteria due to sterilization).

4.1.1.5 The Contractor shall accept all eligible individuals for Enrollment as identified by DCH or its Agent without restrictions. The Contractor shall not discriminate against individuals on any basis, including but not limited to religion, gender, race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on any basis, including but not limited to religion, gender, race, color, or national origin or on the basis of health, health status, pre-existing Condition, or need for Health Care services.

4.1.2 Selection of a Primary Care Provider (PCP)

4.1.2.1 The Contractor shall provide all Members access to a Primary Care Provider (PCP), also referred to as a Medical Home, that serves as the single point of accountability and coordination—primarily for primary care. A PCP Model/Medical Home:

4.1.2.1.1 Is essentially a person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers and, when appropriate, the individual's family and other supports.

4.1.2.1.2 Serves as a focal point for information sharing and Referral to specialists and sub-specialists, as well as communication, evaluation and interpretation of specialist recommendations.

4.1.2.1.3 Typically relies on advanced health information systems to support evidence-based care and includes resources to support the Coordination of Care.

4.1.2.1.4 Will allow better access to health care, increased satisfaction with the care process and improved health and health outcomes.

4.1.2.2. The Contractor shall ensure an adequate number of PCPs are available within its network. Assignment of a PCP should be based on a Member's identified needs and preference as well as Provider agreement and accessibility. The PCP's role is to:

4.1.2.2.1 Provide preventive care and teach healthy lifestyle choices

4.1.2.2.2 Identify and treat common medical Conditions

- 4.1.2.2.3 Assess the urgency of the Member's medical problems and direct them to the most appropriate place for that care
- 4.1.2.2.4 Make referrals to specialists when necessary
- 4.1.2.3 The Contractor shall work with DCH and Providers to decrease potentially preventable admissions and Re-admissions and avoidable use of the emergency department. The Contractor shall send PCPs a monthly list of Members with potentially preventable admissions or Re-admissions and avoidable use of the emergency department. PCPs shall work with Providers and the Contractor to identify and address gaps and implement innovative solutions to decreasing potentially preventable admissions or Re-admissions as well as avoidable use of the emergency department.
- 4.1.2.4 The Contractor shall offer its Members the freedom of selecting a PCP to serve as a Medical Home. DCH or its Agent will encourage self-selection of a PCP and continuation of any existing satisfactory Provider relationship with the current PCP if the PCP participates in the Contractor's Network. Upon request from a Member, DCH or its Agent will provide counseling or assistance in selecting a PCP. If a Member fails to select a PCP, or if the Member has been Auto-Assigned to the CMO, the Contractor shall Auto-Assign Members to a PCP based on the following Algorithm:
 - 4.1.2.4.1 Auto-assign Member to a Provider with whom, based on FFS Claims history, the Member has a Historical Provider Relationship, provided that the geographic access requirements are met.
 - 4.1.2.4.2 If no Historical Provider Relationship exists, Auto-Assign Member to the assigned PCP of an immediate family member enrolled in the CMO, if the Provider is an appropriate Provider based on the age and gender of the Member.
 - 4.1.2.4.3 If other immediate family members do not have an assigned PCP, Auto-Assign Member to a Provider with whom a family member has a Historical Provider Relationship if the Provider is an appropriate Provider based on the age and gender of the Member.
 - 4.1.2.4.4 If no Member or family member has a relationship with a Provider Auto-Assign Member to a PCP, using an algorithm developed by the Contractor and approved by DCH, based on the age and sex of the Member, and geographic proximity.
 - 4.1.2.4.5 Pregnant Members may also select an obstetrician as their assigned PCP. If a pregnant Member fails to select an obstetrician, the Contractor may Auto-Assign the Member to an obstetrician, using an algorithm developed by the Contractor and approved by DCH, based on geographic proximity.

- 4.1.2.5 PCP assignment shall be effective immediately. The Contractor shall notify the Member via surface mail of their Auto-Assigned PCP within ten (10) Calendar Days of Auto-Assignment.
- 4.1.2.6 The Contractor shall submit its PCP Auto-Assignment Policies and Procedures during the Readiness Review at a date designated by DCH to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter.
- 4.1.2.7 The Contractor shall require that Members are assigned to the same PCP for a period of up to six (6) months, except for the following exceptions:
 - 4.1.2.7.1 Members shall be allowed to change PCPs without cause during the first ninety (90) Calendar Days following PCP selection
 - 4.1.2.7.2 Members shall be allowed to change PCPs with cause at any time. The following constitute cause for change:
 - 4.1.2.4.7.2.1 The PCP no longer meets the geographic access standards as defined in this Contract;
 - 4.1.2.4.7.2.2 The PCP does not, because of moral or religious objections, provide the Covered Service(s) the Member seeks; and
 - 4.1.2.4.7.2.3 The Member requests to be assigned to the same PCP as other family members.
 - 4.1.2.7.3 Members shall be allowed to change PCPs every six (6) months.
- 4.1.2.8 Primary Care services are not Covered Services under the Demonstration for Family Planning Only P4HB participants. However, Contractor shall encourage Family Planning Only P4HB participants to choose a Primary Care Provider. The Contractor shall maintain an up-to-date list of available Providers affiliated with the Georgia Association for Primary Health Care and other Providers serving the uninsured and underinsured populations who are available to provide primary care services. The Contractor must not use Demonstration funds to reimburse for primary care services delivered to Family Planning Only P4HB participants.

4.1.3 Dental Home

- 4.1.3.1 All Members under age twenty-one (21) shall have access to Dentists within thirty (30) minutes or thirty (30) miles of the Member's home address for urban areas and within forty-five (45) minutes or forty-five (45) miles for rural areas who will serve as the Members' Dental Home. The Dental Home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. The Dental Home is the Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the Medicaid State Plan.

- 4.1.3.2 Upon request from a Member, DCH or its Agent will provide counseling or assistance in selecting a Dental Home. DCH or its Agent will encourage self-selection of a Dentist and continuation of any existing satisfactory relationship with their current Dentist if the Dentist participates in the Contractor's network. If the Member does not make a selection with DCH or its Agent at time of CMO selection, fails to select a Dentist, or has been Auto-Assigned to the CMO, the Contractor shall Auto-Assign Members to a Dental Home using an algorithm developed by the Contractor and approved by DCH, based on geographic proximity.
 - 4.1.3.3 Dental Home assignment shall be effective immediately. The Contractor shall notify the Member via surface mail of their Dental Home Assignment within ten (10) Calendar Days of Auto-Assignment.
 - 4.1.3.4 The Contractor shall submit its Dental Home Auto-Assignment Policies and Procedures to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.
 - 4.1.3.5 IPC P4HB Members are not eligible for a Dental Home. IPC P4HB members are eligible for limited dental services which include emergency dental services.
- 4.1.4 Newborn Enrollment
- 4.1.4.1 All newborns shall be Auto-Assigned by DCH or its Agent to the mother's CMO. The Contractor shall notify DCH or its Agent of newborns born to enrolled Members who do not appear on the monthly roster.
 - 4.1.4.2 The Contractor shall provide assistance to any Member who is an expectant mother who contacts them wishing to make a PCP selection for her newborn and record that selection.
 - 4.1.4.3 Within twenty-four (24) hours of the birth, the Contractor shall ensure the submission of a newborn notification form to DCH or its Agent. If the mother has not made a PCP selection, the Contractor shall Auto-Assign the newborn to a PCP within thirty (30) Calendar Days of the birth. Auto-Assignment shall be made using the algorithm described in Section 4.1.2.4. Notice of the PCP Auto-Assignment shall be mailed to the mother within twenty-four (24) hours of assignment.
- 4.1.6 Assignment after Re-Enrollment
- 4.1.6.1 When a Member who selects a new CMO during annual Enrollment subsequently loses Medicaid or CHIP eligibility and is disenrolled for more than sixty (60) Calendar Days, the Member is not automatically assigned to the same CMO if re-determined as eligible and reenrolled in GF. Instead, the Member is permitted a new open Enrollment CMO selection. When a Member loses Medicaid or CHIP eligibility and is re-determined to be Medicaid or CHIP eligible and reenrolled in GF within sixty (60) days, the Member shall be automatically assigned to the same CMO.

4.1.7 Reporting Requirements

- 4.1.7.1 The Contractor shall submit to DCH monthly Member Data Conflict Reports as described in the Requirements Analysis Documents (RADs), as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.
- 4.1.7.2 The Contractor shall submit to DCH monthly Eligibility and Enrollment Reconciliation Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.2 **DISENROLLMENT**

4.2.1 Disenrollment Initiated by the Member

- 4.2.1.1 A Member may request Disenrollment or a change in CMO enrollment without cause during the ninety (90) Calendar Days following the date of the Member's initial Enrollment with the CMO or the date DCH or its Agent sends the Member notice of the Enrollment, whichever is later. A Member may request a change in CMO Enrollment without cause every twelve (12) months thereafter.
- 4.2.1.2 A Member may request Disenrollment or a change in CMO Enrollment for cause at any time. The following constitutes cause for requesting Disenrollment:
 - 4.2.1.2.1 The Member moves out of the CMO's Service Region;
 - 4.2.1.2.2 The CMO does not, because of moral or religious objections, provide the Covered Service the Member seeks;
 - 4.2.1.2.3 The Member needs related services to be performed and not all related services are available within the Network. The Member's or Participant's Provider or another Provider have determined that receiving related services from In-Network and Out-Of-Network Providers would subject the Member to unnecessary risk;
 - 4.2.1.2.4 The Member requests to be assigned to the same CMO as family member(s); and
 - 4.2.1.2.5 The Member's Medicaid Category of Eligibility changes to a category ineligible for GF, and/or the Member otherwise becomes ineligible to participate in GF.
- 4.2.1.3 Other reasons for Disenrollment initiated by the Member, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of Providers experienced in addressing the Member's Health Care needs. (DCH or its Agent shall make determination of these reasons).

4.2.1.4 The Contractor shall provide assistance to Members seeking to disenroll. This assistance shall consist of providing Disenrollment forms to the Member and referring the Member to DCH or its Agent who will make Disenrollment determinations.

4.2.2 Disenrollment Initiated by the Contractor

4.2.2.1 The Contractor shall complete all Disenrollment paperwork for Members it is seeking to disenroll.

4.2.2.2 The Contractor shall notify DCH or its Agent upon identification of a Member who it knows or believes meets the criteria for Disenrollment.

4.2.2.3 The Contractor may request Disenrollment if:

4.2.2.3.1 The Member's Utilization of services is Fraudulent or abusive.

4.2.2.3.2 The Member is placed in a long-term care nursing facility, State institution, or intermediate care facility for individuals with intellectual disabilities.

4.2.2.3.3 The Member's Medicaid eligibility category changes to a category ineligible for Georgia Families, and/or the Member otherwise becomes ineligible to participate in Georgia Families. Disenrollments due to Member eligibility will follow the normal monthly process as described in Section 4.2. Disenrollments will be processed as of the date that the Member eligibility category actually changes and will not be made retroactive, regardless of the effective date of the new eligibility category. Note exception when Members become eligible and enrolled in any retroactive program (such as SSI) after the date of an inpatient hospitalization.

4.2.2.3.4 The Member has died, been incarcerated, or moved out of State, thereby making them ineligible for Medicaid.

4.2.2.3.5 The P4HB participant no longer meets the eligibility criteria for the Demonstration.

4.2.2.3.6 The IPC P4HB participant has reached the end of the twenty-four (24) months of eligibility for the IPC component of the Demonstration.

4.2.2.3.7 The P4HB participant becomes pregnant while enrolled in the Demonstration.

4.2.2.3.8 The P4HB participant becomes infertile through a sterilization procedure.

4.2.2.4 Prior to requesting Disenrollment of a Member, the Contractor shall document at least three (3) interventions over a period of ninety (90) Calendar Days that occurred through treatment, Case Management, and Care Coordination to resolve any difficulty leading to the request. The Contractor shall provide at least one (1) written warning to the

Member, certified return receipt requested, regarding implications of his or her actions. This notice must be delivered within ten (10) Business Days of the Member's action.

4.2.2.5 The Contractor shall cite to DCH or its Agent at least one (1) acceptable reason for Disenrollment before requesting Disenrollment of the Member.

4.2.2.6 The Contractor shall submit Disenrollment requests to DCH or its Agent and the Contractor shall honor all Disenrollment determinations made by DCH or its Agent. DCH's decision on the matter shall be final, conclusive and not subject to appeal.

4.2.3 Unacceptable Reasons for Disenrollment Requests by Contractor

4.2.3.1 The Contractor shall not request Disenrollment of a Member for discriminating reasons, including but not limited to:

4.2.3.1.1 Adverse changes in a Member's health status;

4.2.3.1.2 Missed appointments;

4.2.3.1.3 Utilization of medical services;

4.2.3.1.4 Diminished mental capacity;

4.2.3.1.5 Pre-existing medical condition;

4.2.3.1.6 Uncooperative or disruptive behavior resulting from his or her special needs; or

4.2.3.1.7 Lack of compliance with the treating physician's plan of care.

4.2.3.2 The Contractor shall not request Disenrollment because of the Member's attempt to exercise his or her rights under the Grievance System.

4.2.3.3 The request of one PCP to have a Member assigned to a different Provider shall not be sufficient cause for the Contractor to request that the Member be disenrolled from the plan. Rather the Contractor shall utilize its PCP assignment process to assign the Member to a different and available PCP.

4.3 GEORGIA FAMILIES MEMBER SERVICES

4.3.1 General Provisions

4.3.1.1 The Contractor shall ensure that Members are aware of the following:

4.3.1.1.1 Member rights and responsibilities

4.3.1.1.2 The role of PCPs and Dental Home

- 4.3.1.1.3 The role of the Family Planning Provider and PCP (for IPC P4HB Participants only)
- 4.3.1.1.4 How to obtain care
- 4.3.1.1.5 What to do in an emergency or urgent medical situation (for P4HB participants information must address what to do in an emergency or urgent medical situation arising from the receipt of Demonstration related Services)
- 4.3.1.1.6 How to request a Grievance, Appeal, or Administrative Law Hearings
- 4.3.1.1.7 How to report suspected Fraud and Abuse
- 4.3.1.1.8 Providers who have been terminated from the Contractor's network
- 4.3.1.2 The Contractor must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting; and email that allow Members to submit questions and receive responses from the Contractor while protecting the confidentiality and PHI of the Members in all instances. The Contractor shall attempt to collect/obtain Member email addresses from Members. Upon request, the Contractor must provide materials in the format preferred by the Member.

4.3.2 Requirements for Written Materials

- 4.3.2.1 The Contractor shall make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. The Contractor shall notify all Members that information is available in alternative formats and how to access those formats.
- 4.3.2.2 The Contractor shall make all written information available in English, Spanish and all other prevalent non-English languages, as defined by DCH. For the purposes of this Contract, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH.
- 4.3.2.3 All written materials distributed to Members shall include a language block, printed in Spanish and all other prevalent non-English languages, that informs the Member that the document contains important information and directs the Member to call the Contractor to request the document in an alternative language or to have it orally translated.
- 4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5th) grade level. Suggested reference materials to determine whether this requirement is being met are:

- 4.3.2.4.1 Fry Readability Index;
 - 4.3.2.4.2 PROSE The Readability Analyst (software developed by Education Activities, Inc.);
 - 4.3.2.4.3 Gunning FOG Index;
 - 4.3.2.4.4 McLaughlin SMOG Index;
 - 4.3.2.4.5 The Flesch-Kincaid Index; or
 - 4.3.2.4.6 Other word processing software approved by DCH.
- 4.3.2.5 The Contractor shall provide written notice to DCH of any changes to any written materials provided to the Members. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.
- 4.3.2.6 The Contractor must submit all written materials, including information for the Contractor's Web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the Member materials within thirty (30) Calendar Days of submission. DCH reserves the right to require the discontinuation of any Member materials that violate the terms of this Contract.

4.3.3 Member Handbook Information Requirements

- 4.3.3.1 The Contractor shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Contractor shall make the Member and P4HB participant Handbook available to Members through the Contractor's web site. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant information packet to P4HB participant households.
- 4.3.3.2 The Member Handbook shall include all requirements set forth in 42 CFR 438.10, and the Member Handbook shall include, but not be limited to:
- 4.3.3.2.1 A table of contents;
 - 4.3.3.2.2 Information about the roles and responsibilities of the Member (this information to be supplied by DCH);
 - 4.3.3.2.3 Information about the role of the PCP including services provided and the role of the Medical Home;
 - 4.3.3.2.4 Information about choosing a PCP;
 - 4.3.3.2.5 Information about the Dental Home including services provided and how a Member can select a Dental Home;

- 4.3.3.2.6 Information about what to do when family size changes;
- 4.3.3.2.7 Appointment procedures;
- 4.3.3.2.8 Information on the benefits and services including a description of all available Georgia Families Benefits and Services;
- 4.3.3.2.9 Information on how to access services including a description of all available Georgia Family Benefits and Services;
- 4.3.3.2.10 Information on how to access services, including EPSDT services, non-emergency transportation (NET) services, and maternity and family planning services;
- 4.3.3.2.11 Information about the GaHIN including how information will be used by the CMOs and DCH to opt out of the GaHIN;
- 4.3.3.2.12 An explanation of any service limitations or exclusions from coverage;
- 4.3.3.2.13 Information about services that can be obtained through telemedicine;
- 4.3.3.2.14 A notice stating that the Contractor shall be liable only for those services authorized by the Contractor;
- 4.3.3.2.15 Information on where and how Members may access Benefits not available from or not covered by the Contractor;
- 4.3.3.2.16 The Medical Necessity definition used in determining whether services will be covered;
- 4.3.3.2.17 A description of Utilization Review policies and procedures used by the Contractor;
- 4.3.3.2.18 A description of all Pre-Certification, Prior Authorization or other requirements for treatments and services;
- 4.3.3.2.19 The policy on Referrals for specialty care and for other Covered Services not furnished by the Member's PCP;
- 4.3.3.2.20 Information on how to obtain services when the Member is out of the Service Region and for After-Hours coverage;
- 4.3.3.2.21 Cost-Sharing;
- 4.3.3.2.22 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the Contractor's toll-free telephone line and Web site;
- 4.3.3.2.23 A description of Member rights and responsibilities;

- 4.3.3.2.24 The policies and procedures for Disenrollment;
- 4.3.3.2.25 Information on Advance Directives;
- 4.3.3.2.26 A statement that additional information, including information on the structure and operation of the CMO and physician incentive plans, shall be made available upon request;
- 4.3.3.2.27 Information on the extent to which, and how, After-Hours and emergency coverage are provided, including the following:
 - 4.3.3.2.27.1 What constitutes an Urgent and Emergency Medical Condition, Emergency Services, and Post-Stabilization Services;
 - 4.3.3.2.27.2 The fact that Prior Authorization is not required for Emergency Services;
 - 4.3.3.2.27.3 The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent;
 - 4.3.3.2.27.4 The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered herein; and
 - 4.3.3.2.27.5 The fact that a Member has a right to use any hospital or other setting for Emergency Services.
- 4.3.3.2.28 Information about the Grievance Systems policies and procedures, as set forth in Section 4.14, which must include the following:
 - 4.3.3.2.28.1 The right to file a Grievance and Appeal with the Contractor;
 - 4.3.3.2.28.2 The requirements and timeframes for filing a Grievance or Appeal with the Contractor;
 - 4.3.3.2.28.3 The availability of assistance in filing a Grievance or Appeal with the Contractor;
 - 4.3.3.2.28.4 The toll-free numbers Members can use to file a Grievance or an Appeal with the Contractor by phone;
 - 4.3.3.2.28.5 The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing; and

4.3.3.2.28.6 Notice that if a Member files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the Member may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Member.

4.3.3.3 The following information must be available to P4HB participants on the Contractor's web site and mailed to P4HB participants upon request including but not limited to the following:

- 4.3.3.3.1 General Information pertaining to the Demonstration (eligibility, enrollment and Disenrollment criteria, and information pertaining to the Demonstration's program components – family planning only, IPC, Resource Mothers Outreach);
- 4.3.3.3.2 A list of Benefits and services available under each Demonstration component;
- 4.3.3.3.3 A list of service exclusions or limitations under each Demonstration component;
- 4.3.3.3.4 Information about the role of the Family Planning Provider;
- 4.3.3.3.5 Information about the role of a PCP for the IPC P4HB participant only;
- 4.3.3.3.6 Information about providers affiliated with the Georgia Association for Primary Health Care who are available to provide Primary care services and whose services are not covered under the Demonstration for Family Planning Only P4HB participants;
- 4.3.3.3.7 Information on where and how P4HB participants may access other benefits and services not available from or not covered by the Contractor under the Demonstration;
- 4.3.3.3.8 Information about appointment procedures;
- 4.3.3.3.9 Information on how to access Demonstration services, including non-emergency transportation (NET) available to the IPC P4HB participants only;
- 4.3.3.3.10 A notice stating that the Contractor shall be liable only for those Demonstration services authorized by CMS under the Demonstration;
- 4.3.3.3.11 A description of all pre-certification, prior authorization or other requirements for Demonstration related Services and treatments;
- 4.3.3.3.12 The geographic boundaries of the Service Regions;

- 4.3.3.3.13 Information on the availability of telemedicine services;
- 4.3.3.3.14 Notice of all appropriate mailing addresses and telephone numbers to be utilized by P4HB participants seeking information or authorization, including the Contractor's toll-free telephone line and web site;
- 4.3.3.3.15 A description of the P4HB participant's rights and responsibilities;
- 4.3.3.3.16 The policies and procedures for Disenrollment from the Demonstration;
- 4.3.3.3.17 Information on Advance Directives;
- 4.3.3.3.18 A statement that additional information, including information on the structure and operation of the CMO and physician incentive plans, shall be made available upon request;
- 4.3.3.3.19 Information on the extent to which, and how, After-Hours and emergency coverage are provided, including the following:
 - 4.3.3.3.19.1 What constitutes an Urgent and Emergency Demonstration related Medical Condition, Demonstration related Emergency Services, and Demonstration related Post Stabilization Services;
 - 4.3.3.3.19.2 The fact that Prior Authorization is not required for Demonstration related Emergency Services;
 - 4.3.3.3.19.3 The process and procedures for obtaining Demonstration related Emergency Services, including the use of the 911 telephone systems or its local equivalent;
 - 4.3.3.3.19.4 The location of any emergency settings and other locations at which Demonstration Providers and hospitals furnish Demonstration related Emergency and Post Stabilization Services; and
 - 4.3.3.3.19.5 The fact that a P4HB participant has a right to use any hospital or other setting for Demonstration related Emergency Services.
- 4.3.3.3.20 Information on the Grievance Systems policies and procedures, as described in Section 4.14 of the Contract. This description must include the following:
 - 4.3.3.3.20.1 The right to file a Grievance and Appeal with the Contractor;

- 4.3.3.3.20.2 The requirements and timeframes for filing a Grievance or Appeal with the Contractor;
- 4.3.3.3.20.3 The availability of assistance in filing a Grievance or Appeal with the Contractor;
- 4.3.3.3.20.4 The toll-free numbers P4HB participants can use to file a Grievance or an Appeal with the Contractor by phone;
- 4.3.3.3.20.5 The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
- 4.3.3.3.20.6 Notice that if the P4HB participant files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the P4HB participant may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the P4HB participant; and
- 4.3.3.3.20.7 Any Appeal rights that the State chooses to make available to Providers to challenge the failure of the Contractor to cover the Demonstration related Service.

4.3.3.4 The Contractor shall submit to DCH for review and approval initial versions, any changes and edits to the Member Handbook (including P4HB), and all other Member materials the Contractor plans to distribute at least thirty (30) Calendar Days before the effective date of change.

4.3.4 Member Rights

4.3.4.1 The Contractor shall have written policies and procedures regarding the rights of Members and shall comply with any applicable federal and State laws and regulations that pertain to Member rights. These rights shall be included in the Member Handbook and the P4HB Handbook. At a minimum, said policies and procedures shall specify the Member's right to:

- 4.3.4.1.1 Receive information pursuant to 42 CFR 438.10;
- 4.3.4.1.2 Be treated with respect and with due consideration for the Member's dignity and privacy;
- 4.3.4.1.3 Have all records and medical and personal information remain confidential;
- 4.3.4.1.4 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's Condition and ability to understand;

- 4.3.4.1.5 Participate in decisions regarding his or her Health Care, including the right to refuse treatment;
- 4.3.4.1.6 Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- 4.3.4.1.7 Request and receive a copy of his or her Medical Records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the records as specified in 45 CFR 164.524 and 164.526;
- 4.3.4.1.8 Be furnished Health Care services in accordance with 42 CFR 438.206 through 438.210;
- 4.3.4.1.9 Freely exercise his or her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the Member is treated;
- 4.3.4.1.10 Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the Covered Services provided to the Member for which DCH does not pay the Contractor; not be held liable for Covered Services provided to the Member for which DCH or the CMO does not pay the Health Care Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, Referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the services directly; and
- 4.3.4.1.11 Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60 and **Attachment J** of this Contract.

4.3.5 Provider Directory

- 4.3.5.1 The Contractor shall provide a Provider Directory to Members. The Contractor shall make the Provider Directory available to Members through the Contractor's web site. Upon request, the Contractor shall mail via surface mail a hard copy of the Provider Directory to enrolled Member households within three (3) Business Days of receipt of the request whether verbally or in writing. Hard copy Provider Directories shall include a statement indicating that changes to the Provider Network will occur and that Members are encouraged to review the online Provider Directory or contact the Contractor for current information as needed.
- 4.3.5.2 The electronic Provider Directory, at a minimum, shall be searchable by Provider name, Provider type/specialty and location (to include city, zip code, physical address, and county).

- 4.3.5.3 The Provider Directory shall include current names, locations, office hours, telephone numbers of and non-English language(s) spoken by, contracted Providers. This includes, at a minimum, information on PCPs, specialists, Family Planning Providers, dentists, pharmacies, vision providers, FQHCs and RHCs, mental health and substance abuse Providers, physical therapists, occupational therapists, speech therapists, and hospitals. The Provider Directory shall identify Providers that are not accepting new patients for any provided services and/or Providers that are only accepting specialty populations. The Provider Directory shall also identify if the location is a telemedicine presentation site. The online Provider Directory shall be updated within five (5) Business Days upon any change in the Provider Network, open and closed panels and Provider service offerings.
- 4.3.5.4 The Contractor shall submit an updated version to DCH of the Provider Network Listing spreadsheet for all requested Provider types upon request. DCH may require the Contractor to include in the submission executed Signature Pages of Provider Contracts and written acknowledgements from all Providers who are part of a Preferred Health Organization (PHO), IPA, or other Network stating that they know they are in the CMO's Network, know they are accepting Medicaid Members, any restrictions on which Members the Provider is seeing, and that they are accepting the terms and conditions of the Provider Contract.
- 4.3.5.5 The Contractor must submit the Provider Directory template and specifications for the Directory that will be provided on the web site to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated, thereafter. The Contractor shall not use the new template until notification of approval from DCH.

4.3.6 Member Identification (ID) Card

- 4.3.6.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes:
 - 4.3.6.1.1 Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP.
- 4.3.6.2 The Member ID Card must, at a minimum, include the following information:
 - 4.3.6.2.1 The Member's name;
 - 4.3.6.2.2 The Member's Medicaid or PeachCare for Kids® identification number;
 - 4.3.6.2.3 The PCP's name, address, and telephone numbers (including After-Hours number if different from business hours number);
 - 4.3.6.2.4 Dental Home name, address and telephone number (if the Member is eligible to receive Dental Home);

- 4.3.6.2.5 The name and telephone number(s) of the Contractor;
 - 4.3.6.2.6 The Contractor's twenty-four (24) hour, seven (7) day a week toll-free Member services telephone number;
 - 4.3.6.2.7 Instructions for emergencies;
 - 4.3.6.2.8 Minimum instructions to facilitate the submission of a Claim by a Provider;
 - 4.3.6.2.9 Processor Control Number and Bank Identification Number (BIN) Number for pharmacy Claims submission; and
 - 4.3.6.2.10 Toll free phone numbers for provider call centers to assist providers with Claims adjudication questions or issues.
- 4.3.6.3 The Contractor shall reissue the Member ID Card within seven (7) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.
- 4.3.6.4 The Contractor shall submit a front and back sample Member ID Card to DCH for initial review and approval, within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.
- 4.3.6.5 The Contractor shall mail via surface mail a P4HB participant ID Card to all new P4HB participants in the Demonstration within Seven (7) Calendar Days of receiving the notice of Enrollment from DCH or its Agent. The P4HB participant's ID Card will meet the requirements set forth for Member ID Cards in Sections 4.3.6.2 (excluding Section 4.3.6.2.4), 4.3.6.3 and 4.3.6.4, and will identify the Demonstration component in which the P4HB participant is enrolled:
- 4.3.6.5.1 A Pink color will signify the P4HB participants as eligible for Family Planning Services Only.
 - 4.3.6.5.2 A Purple color will signify the P4HB participants as eligible for Interpregnancy Care Services and Family Planning Services.
 - 4.3.6.5.3 A Yellow color will signify the P4HB participant as eligible for Case Management – Resource Mothers Outreach Only.
- 4.3.6.6 Each time the P4HB participant's ID card is issued or re-issued to a P4HB participant, the Contractor shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.

4.3.7 Toll-free Member Call Center

- 4.3.7.1 The Contractor shall operate a toll-free telephone line to respond to Member questions and comments.
- 4.3.7.2 The Contractor shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.
- 4.3.7.3 The Contractor shall submit these call center policies and procedures, including performance standards, to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.
- 4.3.7.4 The call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.
- 4.3.7.5 The Contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, the Contractor shall have an automated system available between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.
- 4.3.7.6 The Contractor shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for review and approval annually. At a minimum, the standards shall require that, on a Calendar month basis:
 - 4.3.7.6.1 Average Speed of Answer: Ninety percent (90%) of calls shall be answered by a person within thirty (30) seconds with the remaining ten percent (10%) answered within an additional thirty (30) seconds by a live operate measured weekly. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative.
 - 4.3.7.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.

- 4.3.7.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).
- 4.3.7.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a Call Center Representative.
- 4.3.7.6.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.
- 4.3.7.6.6 Accurate Response to Call Center Phone Inquiries: Call center representatives accuracy rate must be ninety percent (90%) or higher.
- 4.3.7.7 The Contractor shall establish remote phone monitoring capabilities for at least five (5) DCH staff. DCH or its Agent shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress and to identify the number of call center staff answering calls and the identity of the individual call center staff answering the calls.

4.3.8 Georgia Families Member Web Site

- 4.3.8.1 The Contractor shall develop and maintain a Program web site on which the Contractor will provide Member and P4HB webpages that provide general and up-to-date information about the CMO's program, including but not limited to the following:
 - 4.3.8.1.1 A searchable Member Handbook.
 - 4.3.8.1.2 All Member Information materials.
 - 4.3.8.1.3 A portal that allows Members to access a searchable Provider Directory.
 - 4.3.8.1.4 Information about how limited English speaking persons as well as those who are hearing impaired can access interpreter services.
 - 4.3.8.1.5 Pharmacy Preferred Drug List.
 - 4.3.8.1.6 Pharmacy Conditions for Coverage and Utilization Limits.
 - 4.3.8.1.7 What's New items.
 - 4.3.8.1.8 Frequently asked questions and answers.
 - 4.3.8.1.9 Reminder information about Medicaid eligibility redeterminations.
 - 4.3.8.1.10 Link to the DCH Medicaid web site and to the DCH P4HB web site.

- 4.3.8.1.11 General and up to date information about the Demonstration that incorporates DCH's messaging regarding the Demonstration.
- 4.3.8.1.12 Link to the DCH Enrollment Broker website.
- 4.3.8.2 The Web site must have the capability for Members to submit questions and comments to the Contractor and for Members to receive responses. The Contractor shall respond to Member inquiries within one (1) Business Day of receipt and resolve the issue within seventy-two (72) Clock Hours of receipt. The Contractor shall refer any inquiries to DCH that are not within the Contractor's scope of services (e.g., inquiries about the Fee-for-Service delivery system).
- 4.3.8.3 The Web site must comply with the marketing policies and procedures and with requirements for written materials described in this Contract and must be consistent with applicable State and federal laws. Information provided on the Member webpages must be written at no higher than a 5th grade reading level.
- 4.3.8.4 The Contractor must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Contractor must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades which support the ordinary operation, administration, and maintenance of the web site, the Contractor shall not modify the web site prior to receipt of DCH approval.
- 4.3.8.5 The web site must comply with DCH's requirements for information systems and webpage development, including but not limited to security controls that meet the requirements of this Contract. The Contractor's web site shall also be functionally equivalent, with respect to functions described in this Contract, to the web site maintained by the State's Medicaid Fiscal Agent. See <https://www.mmis.georgia.gov/portal/>.

4.3.9 Cultural Competency

- 4.3.9.1 In accordance with 42 CFR 438.206, the Contractor shall have a comprehensive written Cultural Competency Plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency, hearing impairment, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The Cultural Competency Plan must describe how the Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each. The cultural Competency Plan must include:
 - 4.3.9.1.1 Training to Member services staff and Contract Providers, including PCPs and Contractor staff at all levels, to receive ongoing education and training in culturally and linguistically appropriate service delivery;

- 4.3.9.1.2 Plan for interpretive services and written materials, consistent with Section 4.3.10 to meet the needs of Members whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member oriented materials, including the posting of signage in the languages of the commonly encountered group and/or groups represented in the service area;
 - 4.3.9.1.3 Identify community advocates and agencies that could assist Limited-English Proficiency and/or that provide other Culturally Competent services, which include methods of Outreach and referral;
 - 4.3.9.1.4 Incorporate Cultural Competence into Utilization Management, quality improvement and planning for the course of treatment;
 - 4.3.9.1.5 Identify and employ resources and interventions for high-risk health conditions found in certain cultural groups;
 - 4.3.9.1.6 Recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State.
- 4.3.9.2 The Contractor shall submit the Cultural Competency Plan to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter.
- 4.3.9.3 The Contractor may distribute a summary of the Cultural Competency Plan to the In-Network Providers if the summary includes information on how the Provider may access the full Cultural Competency Plan on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.

4.3.10 Interpretation Services

- 4.3.10.1 The Contractor shall provide oral interpretation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor shall notify its Members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member for interpretation services.

4.3.11 Translation Services

- 4.3.11.1 The Contractor shall provide translation services to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor shall notify its Members of the availability of oral translation services and to inform them of how to access oral translation services. There shall be no charge to the Member for translation services.

4.3.12 Reporting Requirements

- 4.3.12.1 The Contractor shall submit monthly Telephone and Internet Activity Reports to DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.4 **MARKETING**

4.4.1 Prohibited Activities

- 4.4.1.1 The Contractor is prohibited from engaging in the following activities:
 - 4.4.1.1.1 Directly or indirectly engaging in door-to-door, telephone, or other Cold-Call Marketing activities to Potential Members;
 - 4.4.1.1.2 Offering any favors, inducements or gifts, promotions, and/or other insurance products worth more than \$15.00 at one time and not more than \$50 annually per Member;
 - 4.4.1.1.3 Providing meals for Potential Members, regardless of value;
 - 4.4.1.1.4 Distributing plans and materials that contain statements that DCH determines are inaccurate, false or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in the Contractor's plan in order to obtain Benefits or in order to not lose Benefits or that the Contractor's plan is endorsed by the federal or State government, or similar entity; and
 - 4.4.1.1.5 Distributing information or materials that, according to DCH, mislead or falsely describe the Contractor's or other CMO's Provider network, the participation or availability of Network Providers, the qualifications and skills of Network Providers (including their bilingual skills); or the hours and location of Network services.

4.4.2 Allowable Activities

- 4.4.2.1 The Contractor shall be permitted to perform the following marketing activities:
 - 4.4.2.1.1 Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);
 - 4.4.2.1.2 Distribute general information through the use of social media platforms to contact a greater proportion of the Members or Potential Members served by the Contractor. Content intended for use on social media platforms must be approved by DCH prior to publication;

- 4.4.2.1.3 Make telephone calls, mailings and home visits only to Members currently enrolled in the Contractor's plan, for the sole purpose of educating the Member about services offered by or available through the Contractor.
 - 4.4.2.1.4 Reach out to former Members via telephone calls, mailings, and home visits for a period of up to forty-five (45) Calendar Days from the date the Member is disenrolled from the Contractor's plan for the sole purpose of surveying the former Member about services received while the Member was enrolled with the Contractor.
 - 4.4.2.1.5 Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the CMO's Provider network, provided that all CMOs in which the Provider participates have an equal opportunity to be represented; and
 - 4.4.2.1.6 Attend activities that benefit the entire community such as health fairs or other health education and promotion activities.
- 4.4.2.2 If the Contractor performs an allowable activity, the Contractor shall conduct these activities statewide.
- 4.4.2.3 All materials shall comply with the information requirements in 42 CFR 438.10 and detailed in Section 4.3.2 of this Contract.
- 4.4.3 State Approval of Materials
- 4.4.3.1 The Contractor shall submit to DCH for initial review within sixty (60) Calendar Days and approval, and as updated thereafter a detailed description of its Marketing Plan and copies of all Marketing Materials (written and oral) it or its Subcontractors plan to distribute.
 - 4.4.3.2 This requirement includes, but is not limited to posters, brochures, Web sites, and any materials that contain statements regarding the benefit package and Provider network-related materials. Neither the Contractor nor its Subcontractors shall distribute any marketing materials without prior, written approval from DCH.
 - 4.4.3.2 The Contractor shall submit any changes to previously approved Marketing Materials and receive approval from DCH of the changes sixty (60) Calendar Days before distribution.

4.5 GEORGIA FAMILIES COVERED BENEFITS AND SERVICES

4.5.1 Included Services

- 4.5.1.1 The Contractor shall at a minimum provide Medically Necessary services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals. Such Medically Necessary services shall be furnished in an

amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

4.5.1.2 The Contractor shall at a minimum provide to P4HB participants Demonstration related Services and Benefits pursuant to the CMS Special Terms And Conditions (STCs) pertaining to the Planning for Health Babies 1115 Demonstration Waiver Program.

4.5.1.3 Dental Preventive Services that carry a limitation per year shall be limited to a 12-rolling month period.

4.5.2 Individuals with Disabilities Education Act (IDEA) Services

4.5.2.1 For Members up to and including age two (2), the Contractor shall be responsible for Medically Necessary IDEA Part C services provided pursuant to an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).

4.5.2.2 For Members ages three (3) to twenty-one (21), the Contractor shall not be responsible for Medically Necessary IDEA Part B services provided pursuant to an IEP or IFSP. Such services shall remain in FFS Medicaid. The Contractor shall be responsible for all other Medically Necessary covered services.

4.5.3 Enhanced Services

4.5.3.1 In addition to the Covered Services provided above, the Contractor shall provide enhanced services to educate Members. The Contractor shall provide such services in a manner that will increase a Member's understanding of the availability of Covered Services, the importance of seeking and receiving such services and how doing so may help to improve outcomes. For example, the Contractor shall do the following:

4.5.3.1.1 Place strong emphasis on programs to enhance the general health and well-being of Members;

4.5.3.1.2 Make health promotion materials available to Members;

4.5.3.1.3 Participate in Medicaid fairs and community-sponsored health fairs;

4.5.3.1.4 Coordinate with community resources to facilitate a holistic approach to Member care; and

4.5.3.1.5 Provide education to Members, families and other Health Care Providers about early intervention and management strategies for various illnesses.

4.5.3.2 The Contractor shall not charge a Member for participating in health education services that are defined as either enhanced or Covered Services.

4.5.4 Medical Necessity

- 4.5.4.1 Contractor must ensure Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services available through the Georgia Medicaid State Plan. Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:
 - 4.5.4.1.1 Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;
 - 4.5.4.1.2 Compatible with the standards of acceptable medical practice in the community;
 - 4.5.4.1.3 Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
 - 4.5.4.1.4 Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and
 - 4.5.4.1.5 Not primarily custodial care unless custodial care is a Covered Service or benefit under the Members evidence of coverage.
- 4.5.4.2 There must be no other effective and more conservative or substantially less costly treatment, service and setting available.
- 4.5.4.3 For Medicaid children under twenty-one (21) years of age, the Contractor is required to provide Medically Necessary Services to correct or ameliorate physical and Behavioral Health disorders, a defect, or a condition identified during an EPSDT screening or preventive visit regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

4.5.5 Experimental, Investigational or Cosmetic Procedures, Drugs, Services, or Devices

- 4.5.5.1 Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manuals, in no instance shall the Contractor cover experimental, investigational or cosmetic procedures, drugs, services or devices or those not recognized by the Federal Food and Drug Administration, the United States Public Health Service, Medicaid and/or the Department's contracted peer review organization as universally accepted treatment.

4.5.6 Moral or Religious Objections

- 4.5.6.1 The Contractor is required to provide and reimburse for all Covered Services. If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, reimburse for, or provide coverage of a counseling or Referral service because of an objection on moral or religious grounds, the Contractor shall notify:

- 4.5.6.1.1 DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;
- 4.5.6.1.2 Members within sixty (60) Calendar Days before adopting the policy with respect to any service; and
- 4.5.6.1.3 Members before and during Enrollment.
- 4.5.6.2 The Contractor shall provide to the DCH Enrollment Broker for use in Member CMO selection counseling information with respect to any service the Contractor elects not to provide, reimburse for or provide coverage for a counseling or Referral service because of an objection on moral or religious ground.
- 4.5.6.3 The Contractor acknowledges that such objection will be grounds for recalculation of rates paid to the Contractor by DCH.

4.6 SPECIAL COVERAGE PROVISIONS

4.6.1 Emergency Services

- 4.6.1.1 Emergency Services shall be available without Prior Authorization or approval twenty-four (24) hours a day, seven (7) Days a week to treat an Emergency Medical Condition.
- 4.6.1.2 An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
 - 4.6.1.2.1 Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - 4.6.1.2.2 Serious impairment to bodily functions;
 - 4.6.1.2.3 Serious dysfunction of any bodily organ or part;
 - 4.6.1.2.4 Serious harm to self or others due to an alcohol or drug abuse emergency;
 - 4.6.1.2.5 Injury to self or bodily harm to others; or
 - 4.6.1.2.6 With respect to a pregnant woman having contractions: i. That there is inadequate time to effect a safe transfer to another hospital before delivery, or ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

- 4.6.1.3 The Contractor shall provide payment for Emergency Services when furnished to a Member by a qualified Provider, regardless of whether that Provider is in the Contractor's Provider Network. These services shall not be subject to Prior Authorization requirements. The Contractor shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Contractor shall also pay for any screening examination services conducted on a Member to determine whether an Emergency Medical Condition exists.
- 4.6.1.4 The Contractor shall provide payment for Demonstration related Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements. The Contractor shall be required to pay all Demonstration related Emergency Services that are Medically Necessary until the P4HB Participant is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether a Demonstration related Emergency Medical Condition exists.
- 4.6.1.5 The Contractor may not deny or inappropriately reduce payment to a Provider of Emergency Services for any evaluation, diagnostic testing, or treatment provided to a Member for an emergency condition or make payment for Emergency Services contingent on the Member or Provider of emergency health care services providing any notification, either before or after receiving Emergency Services.
- 4.6.1.6 In processing Claims for Emergency Services, the Contractor shall consider, at the time that a Claim is submitted, at least the following criteria:
- 4.6.1.6.1 The age of the patient;
 - 4.6.1.6.2 The time and day of the week the patient presented for services;
 - 4.6.1.6.3 The severity and nature of the presenting symptoms;
 - 4.6.1.6.4 The patient's initial and final diagnosis; and
 - 4.6.1.6.5 Any other criteria prescribed by the Department, including criteria specific to patients under eighteen (18) years of age.
- 4.6.1.7 The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a Prudent Layperson.
- 4.6.1.8 The attending emergency room physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or Discharge, and that determination is binding on the Contractor, who shall be responsible for coverage and payment.

- 4.6.1.9 The Contractor shall not retroactively deny a Claim for an emergency screening examination or a Demonstration related emergency screening examination because the Condition, which appeared to be an Emergency Medical Condition or Demonstration related emergency screening examination under the Prudent Layperson standard, turned out to be non-emergency in nature. Likewise, the Contractor shall not routinely or arbitrarily employ the practice of paying a triage rate that reduces reimbursement and places an administrative burden on the Provider to appeal such a payment. If an emergency screening examination or a Demonstration related emergency screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition or Demonstration related Emergency does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, the Contractor shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid program.
- 4.6.1.10 The Contractor may establish guidelines and timelines for submittal of notification regarding provision of Emergency Services and Demonstration related Emergency Services, but, the Contractor shall not refuse to cover an Emergency Service or Demonstration related Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, Contractor's representative, or DCH of the Member's screening and treatment within said timeframes.
- 4.6.1.11 When a representative of the Contractor instructs the Member to seek Emergency Services the Contractor shall be responsible for payment for the Medical Screening examination and for other Medically Necessary Emergency Services, without regard to whether the Condition meets the Prudent Layperson standard.
- 4.6.1.12 When a representative of the Contractor instructs the P4HB Participant to seek Demonstration related Emergency Services, the Contractor shall be responsible for payment for the Demonstration related Medical Screening examination without regard to whether the Condition meets the Prudent Layperson standard.
- 4.6.1.13 The Member who has an Emergency Medical Condition or Demonstration related Emergency Service shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific Condition or stabilize the patient.
- 4.6.1.14 Once the Member's Condition is stabilized, the Contractor may require Pre-Certification for hospital admission or Prior Authorization for follow-up care.
- 4.6.2 Post-Stabilization Services
- 4.6.2.1 The Contractor shall be responsible for providing access to and payment for Post-Stabilization care services and Demonstration related Post Stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to an Emergency Medical Condition or Demonstration related Emergency medical conditions, that are provided after a Member is stabilized in order to maintain

the stabilized Condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the Member's Condition.

- 4.6.2.2 The Contractor shall be responsible for payment for Post-Stabilization Services and Demonstration related Post Stabilization Services that are Prior Authorized or Pre-Certified by a Provider or organization representative, regardless of whether they are provided within or outside the Contractor's Network of Providers.
- 4.6.2.3 The Contractor is financially responsible for Post-Stabilization Services and Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider Network that are administered to maintain the Member's stabilized Condition for one (1) hour while awaiting response on a Pre-Certification or Prior Authorization request.
- 4.6.2.4 The Contractor is financially responsible for Post-Stabilization Services and Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network, that are not prior authorized by the Contractor or Contractor's representative but are administered to maintain, improve or resolve the Member's stabilized Condition if:
 - 4.6.2.4.1 The Contractor does not respond to the Provider's request for Pre-certification or Prior Authorization within one (1) hour;
 - 4.6.2.4.2 The Contractor cannot be contacted; or
 - 4.6.2.4.3 The Contractor's Representative and the attending physician cannot reach an agreement concerning the Member's care and the Contractor's physician (i.e., a Chief Medical Officer or Medical Director) is not available for consultation. In this situation the Contractor shall give the treating physician the opportunity to consult with the Contractor's physician and the treating physician may continue with care of the Member until the Contractor's physician is reached or one of the criteria below in Section 4.6.2.5 is met.
- 4.6.2.5 The Contractor's financial responsibility for Post-Stabilization Services and Demonstration related Post Stabilization Services it has not approved will end when:
 - 4.6.2.5.1 An In-Network Provider with privileges at the treating hospital assumes responsibility for the Member's care;
 - 4.6.2.5.2 An In-Network Provider assumes responsibility for the Member's care through transfer;
 - 4.6.2.5.3 The Contractor's Representative and the treating physician reach an agreement concerning the Member's care; or
 - 4.6.2.5.4 The Member is discharged.

4.6.2.6 In the event the Member receives Post-Stabilization Services or Demonstration related Post Stabilization Services from a Provider outside the Contractor's network, the Contractor shall reimburse the non-contracted Provider for the Post-Stabilization services at a rate equal to the rate paid by the Department for Claims that it reimburses directly. The Contractor is prohibited from billing the Member for Post-Stabilization services.

4.6.3 Urgent Care Services

The Contractor shall provide Urgent Care Services and Demonstration related Urgent Care Services to Members as necessary. Such services shall not be subject to Prior Authorization or Pre-Certification.

4.6.4 Family Planning Services

4.6.4.1 The Contractor shall provide access to Family Planning Services within the network to Members and P4HB Participants. In meeting this obligation, the Contractor shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act, for the provision of Family Planning Services. The Contractor shall verify its efforts and Documented Attempts to contract with Title X Clinics by maintaining records of communication. The Contractor shall not limit Members' or P4HB Participants' freedom of choice for family planning services to In-Network Providers and the Contractor shall cover services provided by any qualified Provider regardless of whether the Provider is In-Network. The Contractor shall not require a Referral if a Member or P4HB Participant chooses to receive Family Planning services and supplies from outside of the network.

4.6.4.2 The Contractor shall inform Members and P4HB Participants of the availability of family planning services and must provide services to Members and P4HB Participants wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy.

4.6.4.3 Family Planning Services and supplies for Members and P4HB Participants include at a minimum:

4.6.4.3.1 Education and counseling necessary to make informed choices and understand contraceptive methods;

4.6.4.3.2 Initial and annual complete physical examinations including a pelvic examination and Pap test;

4.6.4.3.3 Follow-up, brief and comprehensive visits;

4.6.4.3.4 Pregnancy testing;

4.6.4.3.5 Contraceptive supplies and follow-up care;

- 4.6.4.3.6 Diagnosis and treatment of sexually transmitted infections with the following exceptions: P4HB participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration;
 - 4.6.4.3.7 For P4HB participants: Drugs, supplies, or devices related to the women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirement; (subject to the national drug rebate program requirements); and
 - 4.6.4.3.8 Infertility assessments with the following exception – P4HB participants are excluded from receiving this benefit.
- 4.6.4.4 The Contractor shall furnish all services on a voluntary and confidential basis, even if the Member is less than eighteen (18) years of age.
- 4.6.5 Sterilizations, Hysterectomies and Abortions
- 4.6.5.1 In compliance with 42 C.F.R. § § 441.251 through 441.258, the Contractor shall cover sterilizations and hysterectomies, only if all of the following requirements are met:
 - 4.6.5.1.1 The Member is at least twenty-one (21) years of age at the time consent is obtained;
 - 4.6.5.1.2 The Member is mentally competent;
 - 4.6.5.1.3 The Member voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Services. This includes the completion of all applicable documentation;
 - 4.6.5.1.4 At least thirty (30) Calendar Days, but not more than one hundred and eighty (180) Calendar Days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. A Member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least seventy-two (72) hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty (30) Calendar Days before the expected date of delivery (the expected date of delivery must be provided on the consent form);
 - 4.6.5.1.5 An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a Member who is visually impaired, hearing impaired or otherwise disabled; and
 - 4.6.5.1.6 The Member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

- 4.6.5.2 A hysterectomy shall be considered a Covered Service only if the following additional requirements are met:
 - 4.6.5.2.1 The Member must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and
 - 4.6.5.2.2 The Member must sign and date the Georgia Families Sterilization Request Consent form prior to the Hysterectomy. Informed consent must be obtained regardless of diagnosis or age.
- 4.6.5.3 A hysterectomy shall not be considered a Covered Service for P4HB Members.
- 4.6.5.4 Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:
 - 4.6.5.4.1 If it is performed solely for the purpose of rendering a Member permanently incapable of reproducing;
 - 4.6.5.4.2 If there is more than one (1) purpose for performing the hysterectomy, but the primary purpose was to render the Member permanently incapable of reproducing; or
 - 4.6.5.4.3 If it is performed for the purpose of cancer prophylaxis.
- 4.6.5.5 Abortions or abortion-related services performed for family planning purposes are not Covered Services. Abortions are Covered Services if a Provider certifies that the abortion is Medically Necessary to save the life of the mother or if pregnancy is the result of rape or incest. The Contractor shall cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies.
- 4.6.5.6 The Contractor shall maintain documentation of all sterilizations, hysterectomies and abortions consistent with requirements in 42 CFR 441.206 and 42 CFR 441.256. The Contractor shall not accept documentation for informed consent completed or altered after the service was rendered. All documentation pertaining to sterilizations, hysterectomies, and abortions must be provided to DCH upon request.

4.6.6 Pharmacy

- 4.6.6.1 The Contractor is permitted to establish a Maximum Allowable Cost (MAC) schedule. However, the Contractor must ensure the MAC pricing schedule is evaluated for pricing appropriateness and updated as appropriate no less frequently than every two (2) weeks.
 - 4.6.6.1.1 The MAC must be reviewed no less frequently than every two (2) weeks to ensure:

- 4.6.6.1.1.1 Appropriateness of pricing;
- 4.6.6.1.1.2 MAC pricing schedule does not create a barrier to access to the medication;
- 4.6.6.1.1.3 Each medication represented on the MAC schedule has at least two (2) A-rated generic equivalents available in the Georgia marketplace;
- 4.6.6.1.2 The MAC pricing schedule must be posted on the Contractor's website; and
- 4.6.6.1.3 The Contractor must make available an inquiry and appeal process for Provider disputes over the MAC schedule or individual drugs subject to the MAC pricing with all inquiries and appeals being addressed within five (5) calendar days of the receipt of the Provider inquiry or appeal.
- 4.6.6.2 The Contractor shall provide pharmacy services either directly or through a Pharmacy Benefits Manager (PBM). The Contractor or its PBM may establish a preferred drug list if the following minimum requirements are met:
 - 4.6.6.2.1 Appropriate selection of drugs from therapeutic drug classes are accessible and are sufficient in amount, duration, and scope to meet Members' medical needs;
 - 4.6.6.2.2 The only excluded drug categories are those permitted under Section 1927(d) of the Social Security Act;
 - 4.6.6.2.3 A Pharmacy & Therapeutics Committee that advises and/or recommends preferred drug list decisions is established and maintained; and
 - 4.6.6.2.4 Over the counter medications specified in the Georgia State Medicaid Plan are included in the formulary.
- 4.6.6.3 The Contractor shall make available to P4HB participants folic acid and/or a multivitamin with folic acid.
- 4.6.6.4 The Contractor shall make the preferred drug list, utilization limits and conditions for coverage for prior authorized drugs available through its website and provide such documentation to DCH upon request.
- 4.6.6.5 The Contractor shall have an automated electronic Prior Authorization portal for the submission of Prior Authorization requests and encourage adoption by Providers. Regardless of whether Providers submit prior authorization requests manually or through the portal, the Contractor shall:

- 4.6.6.5.1 Provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization.
 - 4.6.6.5.2 Provide for the dispensing of at least a seventy-two (72)-hour supply of a covered outpatient prescription drug in an emergency situation.
 - 4.6.6.5.3 Resolve all pharmacy prior authorization requests within twenty-four (24) hours unless additional information is required from the prescriber. If additional information is needed from the prescriber, documented telephonic or other telecommunication contact with the prescriber must be made every twenty-four (24) hours up to a final disposition within seventy-two (72) hours of receipt of the request.
- 4.6.6.6 If the Contractor chooses to implement a mail-order pharmacy program, any such program must be established and maintained in accordance with State and federal law. The Contractor shall not require Members to use a mail-order pharmacy to receive covered pharmacy Benefits, but may allow Members to use a mail-order pharmacy if:
- 4.6.6.6.1 Mail-order delivery is clinically appropriate;
 - 4.6.6.6.2 The pharmacy is willing to accept payments and terms as described in this Contract;
 - 4.6.6.6.3 Cost sharing is no more than it is for Members utilizing services by retail pharmacy;
 - 4.6.6.6.4 The Member expressed desire to receive pharmacy services by mail-order; and
 - 4.6.6.6.5 The Member is allowed to cease mail-order pharmacy services and utilize retail pharmacies at any time.
- 4.6.6.7 Contractor must ensure that entities which are a part of the 340B Drug Pricing Program are identified for the purposes required under federal statute regarding drug rebates. Any arrangements that are made (e.g. 340B provider agrees to use or not use 340B drugs when providing services for the GF/GF 360 program, Contractor pays a reduced rate for 340B products, etc.) are at the discretion of Contractor and the providers. However, any time 340B product is used under the GF/GF 360 program, it will have to be identified within the encounter data on the claim pursuant to Section 4.16.3.6.18 to ensure that DCH does not include those claims in any drug rebate invoices, as required by federal statute.

4.6.7 Immunizations

- 4.6.7.1 The Contractor shall provide all Members less than twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
See: <http://www.cdc.gov/vaccines/schedules/hcp/index.html>.

- 4.6.7.2 The Contractor shall provide P4HB participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the ACIP guidelines as needed.
- 4.6.7.3 The Contractor shall collaborate with the Department of Public Health to ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccines for Children (VFC) program for Members eighteen (18) years of age and younger. Immunizations shall be given in conjunction with Well-Child/preventive care. See <http://dph.georgia.gov/vaccines-children-program> for additional information.
- 4.6.7.4 The Contractor shall develop a policy for collaborating with DPH. The Contractor shall work with DCH to address challenges in providing vaccines under the VFC program.
- 4.6.7.5 The Contractor shall ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccines for Children (VFC) program for P4HB Participants eighteen (18) years of age.
- 4.6.7.6 The Contractor shall provide all adult immunizations specified in the Georgia Medicaid Policies and Procedures Manuals.
- 4.6.7.7 The Contractor shall report all immunizations to the DPH Georgia Registry of Immunization Transactions and Services (GRITS) in a format to be determined by DCH.
- 4.6.7.8 The Contractor shall enter into an agreement with the Georgia Department of Public Health recognizing a Member of PeachCare for Kids® as a “State Vaccine Eligible Child” as permitted under Section 1928(b)(3) of the Social Security Act. At a minimum, this agreement shall permit the State to enjoy the discounted purchasing of vaccines for children covered under PeachCare for Kids® permitted under said Section and provide appropriate reimbursement to DPH for such vaccines utilized by the CMO’s membership.

4.6.8 Transportation

- 4.6.8.1 The Contractor shall provide emergency transportation and shall not retroactively deny a Claim for emergency transportation to an emergency Provider because the Condition, which appeared to be an Emergency Medical Condition under the Prudent Layperson standard, turned out to be non-emergency in nature.
- 4.6.8.2 The Contractor is not responsible for providing non-emergency transportation (NET) for its Members. Eligible Medicaid Members are to contact the assigned NET Broker for the county they live in to arrange for transportation. The Contractor is encouraged to collaborate with the NET Brokers and assist both the NET brokers and assigned Members with the coordination of NET services for assigned Members.

4.6.8.3 The Contractor may, however, coordinate other transportation for those Medicaid Members not eligible for transportation under the NET Broker contract. In the event Contractor performs such coordination, DCH shall not be responsible for any payment resulting from such services. The following Categories of Aid are not eligible for Non-Emergency Transportation:

- 4.6.8.3.1 177 – Family Planning Waiver
- 4.6.8.3.2 181 - P4HB Family Planning (only)
- 4.6.8.3.3 460 – SSI Qualified Medicare Beneficiary
- 4.6.8.3.4 466 - Specified Low Income Medicare Beneficiary
- 4.6.8.3.5 660 – Qualified Medicare Beneficiary
- 4.6.8.3.6 661 – Specified Low Income Medicare Beneficiary
- 4.6.8.3.7 662 – Q11 Beneficiary
- 4.6.8.3.8 664 – Qualified Working Disabled individuals
- 4.6.8.3.9 790 – Peachcare 101-150% FPL
- 4.6.8.3.10 791 – Peachcare 151-200% FPL
- 4.6.8.3.11 792 – 201-235% FPL
- 4.6.8.3.12 793 – Peachcare > 235% FPL
- 4.6.8.3.13 815 – Aged Inmate
- 4.6.8.3.14 817- Disabled Inmate
- 4.6.8.3.15 870 – Emergency Alien – Adult
- 4.6.8.3.16 873 – Emergency Alien - Child

4.6.9 Perinatal Services

4.6.9.1 The Contractor shall ensure that appropriate perinatal care is provided to women and newborn Members. The Contractor shall have adequate capacity such that any new Member who is pregnant is able to have an initial visit with her Obstetric Provider within fourteen (14) Calendar Days of Enrollment. The Contractor shall have in place a system that provides, at a minimum, the following services:

- 4.6.9.1.1 Pregnancy planning and perinatal health promotion and education for reproductive-age women;

- 4.6.9.1.2 Perinatal risk assessment of non-pregnant women, pregnant and post-partum women, and newborns and children up to five (5) months of age. The Contractor must have the capacity to electronically accept, in a timely manner, Perinatal Case Management Initial Assessments from local public health departments completing these assessments following the presumptive eligibility determination;
 - 4.6.9.1.3 Childbirth education classes to all pregnant Members and their chosen partner. Through these classes, expectant parents shall be encouraged to prepare themselves physically, emotionally, and intellectually for the childbirth experience. The classes shall be offered at times convenient to the population served, in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation and translation services if necessary pursuant to Sections 4.3.10 and 4.3.11 of this Contract;
 - 4.6.9.1.4 Access to appropriate levels of care based on risk assessment, including emergency care;
 - 4.6.9.1.5 Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
 - 4.6.9.1.6 Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
 - 4.6.9.1.7 Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.
- 4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery.

4.6.10 Parenting Education

- 4.6.10.1 In addition to individual parent education and anticipatory guidance to parents and guardians at EPSDT preventive visits, the Contractor shall offer or arrange for parenting skills education to expectant and new parents, at no cost to the Member.
- 4.6.10.2 The Contractor shall create effective ways to deliver this education, whether through classes, as a component of post-partum home visiting, or other such means. The educational efforts shall include topics such as bathing, feeding (including breast feeding), injury prevention, sleeping, illness, when to call the doctor, when to use the emergency room, etc. DCH shall approve education content, class schedule and locations. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation services if necessary pursuant to Section 4.3.11 of this Contract.

4.6.11 Mental Health and Substance Abuse

- 4.6.11.1 The Contractor shall provide integrated behavioral and physical health care for Members with mental illness including for those with dual-diagnoses. Integrated health care for Members with mental illness shall be focused equally on prevention and intervention utilizing predictive modeling to identify Members at risk as well as innovative and best-practice methods to encourage Member engagement in self-care behaviors. The Contractor shall provide a full range of recovery-based services and engage non-medical services and supports as indicated to provide holistic care focused on whole-health wellness, long-term independence, and skills building. This includes access to Certified Peer Supports for youth, adults and parents of youth with mental illness.
- 4.6.11.2 The Contractor shall have written Mental Health and Substance Abuse Policies and Procedures that explain how they will arrange or provide for covered mental health and substance abuse services. Such policies and procedures shall include Advance Directives. The Contractor shall assure timely delivery of mental health and substance abuse services and coordination with other acute care services.
- 4.6.11.3 Mental Health and Substance Abuse Policies and Procedures shall be submitted to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.
- 4.6.11.4 The Contractor shall permit Members to self-refer to an In-Network Provider for an initial mental health or substance abuse assessment.
- 4.6.11.5 The Contractor shall permit P4HB IPC Participants to receive Detoxification and Intensive Outpatient Rehabilitation Services as specified in the Special Terms and Conditions. (See Attachment L).
- 4.6.11.6 The Contractor shall permit all initial outpatient Behavioral Health (mental health and substance abuse) evaluation, diagnostic testing, and assessment services to be provided without Prior Authorization. The Contractor shall permit up to three (3) initial evaluations per year for Members younger than twenty-two (22) years of age without requiring additional Prior Authorization.
- 4.6.11.7 Following an initial evaluation, the Contractor shall permit up to twelve (12) outpatient counseling/therapy visits to be provided without Prior Authorization.
- 4.6.11.8 The Contractor shall promote the delivery of Behavioral Health services in the most integrated and person-centered setting including in the home, school or community, for example, when identified through care planning as the preferred setting by the Member. The delivery of home and community based Behavioral Health services may be incentivized by the Contractor for Providers who engage in this person-centered service delivery.

- 4.6.11.9 The Contractor shall provide emergency services diversion techniques and interventions (including but not limited to SBIRT-Screening, Brief Intervention and Referral to Treatment) for Members with mental illness and/or substance use.
- 4.6.11.10 The Contractor shall provide scalable intensity of case management, disease management, Care Coordination, and complex Care Coordination based on the intensity of the Member's need. Refer to Section 4.11.8 for more details.

4.6.12 Advance Directives

- 4.6.12.1 In compliance with 42 CFR 438.6 (i) (1)-(2) and 42 CFR 422.128, the Contractor shall maintain written policies and procedures for Advance Directives, including mental health advance directives. Such Advance Directives shall be included in each Member's medical record. The Contractor shall provide these policies to all Members eighteen (18) years of age and older and shall advise Members of:
 - 4.6.12.1.1 Their rights under the law of the State of Georgia, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; and
 - 4.6.12.1.2 The Contractor's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.
- 4.6.12.2 The information must include a description of State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) Calendar Days after the effective change.
- 4.6.12.3 The Contractor's information must inform Members that complaints may be filed with the Healthcare Facility Regulation Division, the State's Survey and Certification Agency..
- 4.6.12.4 The Contractor shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Members, and their responsibility to educate Members about this tool and assist them to make use of it.
- 4.6.12.5 The Contractor shall educate Members about their ability to direct their care using this mechanism and shall specifically designate which staff Members and/or network Providers are responsible for providing this education.

4.6.13 Member Cost-Sharing

- 4.6.13.1 The Contractor shall ensure that Providers assess Member co-payments consistent with those specified in **Attachment J**.
- 4.6.13.2 The Contractor shall ensure that Providers do not refuse to render services based on a Member's inability to pay the Member cost-share.

- 4.6.13.3. The Contractor shall ensure that Providers do not utilize other methods post-delivery of services (such as but not limited to collection agency) to fulfill Member cost-sharing responsibility.

4.6.14 Value Added Services

- 4.6.14.1 The Contractor is permitted to provide value added services to Members that address the needs of Members and improve health outcomes. Value added services exceed Georgia State Plan benefits and are designed to improve Members' wellbeing, encourage prudent use of health care benefits, and enhance the cost effectiveness of the Georgia Families program. DCH encourages the Contractor to consider the challenges in improving Member health outcomes in developing Value Added services.
- 4.6.14.2 The Contractor must submit any proposed value added services to DCH for review and approval prior to implementation. Additional value added services can be added at any time with DCH approval. The Contractor must provide a detailed list of value added services to the DCH Enrollment Broker.
- 4.6.14.3 Value added services cannot be discontinued once implemented without prior approval from DCH. Should DCH approve the Contractor's request for discontinuation of value added services, DCH reserves the right to initiate an open enrollment period for the Members assigned to the Contractor if value added benefits are discontinued.
- 4.6.14.4 Value added services are not considered during the Capitation Rate development process.

4.7 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) BENEFIT

4.7.1 General Provisions

- 4.7.1.1 The Contractor must ensure that Medicaid and PeachCare for Kids® children younger than twenty-one (21) years of age receive the services available under the federal EPSDT benefit.
- 4.7.1.2 The Contractor shall comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, diagnostic and treatment services. The Contractor shall comply with all EPSDT Program requirements pursuant to the Georgia Medicaid Policies and Procedures Manuals.
- 4.7.1.3 The Contractor shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the EPSDT Program. The EPSDT Plan shall emphasize outreach and compliance monitoring for children and adolescents (young adults), taking into account the multi-lingual, multi-cultural nature of the Georgia Families population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for ensuring compliance with DCH's EPSDT periodicity schedule, follow-up of missed appointments, including missed Referral appointments for problems

identified through preventive screens and exams. The EPSDT Plan shall also include procedures for referral, tracking and follow up for annual dental examinations and visits. The Contractor shall submit its initial EPSDT Plan to DCH for review and approval no later than within one hundred twenty (120) Calendar Days prior to the Operational Start Date and shall submit proposed updated drafts of the EPSDT Plan thereafter. The Contractor shall submit to DCH annually a report and evaluation of its EPSDT Plan according to DCH specifications.

- 4.7.1.4 The Contractor shall ensure Providers perform all components of the EPSDT preventive health visit according to the requirements documented in the DCH approved periodicity schedule. The visit must include a (i) comprehensive health and developmental history (including assessment of both physical and mental health development), (ii) comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam), (iii) appropriate immunizations (according to the schedules established by the ACIP for individuals 0 – 18 years of age and nineteen (19) and older), (iv) laboratory tests (including blood lead level assessment appropriate to age and risk), and (v) health education (including anticipatory guidance.) All five (5) components must be performed for the visit to be considered an EPSDT preventive health visit.

4.7.2 Outreach and Informing

- 4.7.2.1 The Contractor's EPSDT outreach and informing process shall include:
 - 4.7.2.1.1 The importance of preventive care;
 - 4.7.2.1.2 The periodicity schedule and the depth and breadth of services;
 - 4.7.2.1.3 How and where to access services, including necessary transportation and scheduling services; and
 - 4.7.2.1.4 A statement that services are provided without cost.
- 4.7.2.2 The Contractor shall inform its newly enrolled families with EPSDT eligible children about the EPSDT benefit within thirty (30) Calendar Days of Enrollment with the EPSDT Plan. This requirement includes informing pregnant women and new mothers, either before or within seven (7) days after the birth of their children, that Health Check services are available.
- 4.7.2.3 The Contractor shall provide to each PCP, on a monthly basis, a list of the PCP's EPSDT eligible Members who appear not to have had an encounter during the initial ninety (90) Calendar Days of CMO enrollment, and/or who are not in compliance with the EPSDT periodicity schedule. The Contractor shall require its Providers to contact the Members' parents or guardians to schedule an appointment for those screens and services that appear not to be in compliance with the EPSDT periodicity schedule. If the PCP has medical record evidence that appropriate screens have occurred for the Member, the Contractor must incorporate these visits into its tracking system and

remove the Member from the PCP's list of Members who are non-compliant with the EPSDT periodicity schedule.

4.7.2.4 Informing of the Health Check Program may be oral (on the telephone, face-to-face, or via films/tapes) or written and may be done by Contractor personnel or Health Care Providers. At a minimum, the Contractor shall provide written notification to its families with Health Check eligible children when appropriate periodic assessments or needed services are due. The Contractor shall conduct all outreach and informing in non-technical language at or below a fifth (5th) grade reading level. The Contractor shall use accepted methods for informing persons who are blind or deaf, or who cannot read or understand the English language, in accordance with requirements for written material as described in Section 4.3.2. The Contractor shall document all outreach efforts it makes to inform Members (or their parents/guardians) regarding Health Check services.

4.7.2.5 The Contractor may provide incentives to Members and/or Providers to encourage compliance with the periodicity schedules, as described in Section 4.12.5.

4.7.3 Early and Periodic Screenings – the Preventive Health Visit

4.7.3.1 PCPs within the Contractor's network are responsible for providing, at the time of the Member's preventive visit, all of the EPSDT required components along with those identified in the State's periodicity schedule. The required EPSDT components include:

4.7.3.1.1 A comprehensive health and developmental history (including assessment of both physical and mental health development);

4.7.3.1.2 A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam);

4.7.3.1.3 Appropriate immunizations (according to the schedule established by ACIP for individuals eighteen (18) years of age and younger and individuals nineteen (19) years of age and older;

4.7.3.1.4 Certain laboratory tests (including the federally required blood lead level assessment appropriate to age and risk screening);

4.7.3.1.5 Health Education (including anticipatory guidance);

4.7.3.1.6 Measurements (including head circumference for infants and body mass index);

4.7.3.1.7 Sensory screening (vision and hearing);

4.7.3.1.8 Oral health assessment; and

- 4.7.3.1.9 Sexually Transmitted Infection/ Human Immunodeficiency Virus (STI/HIV) screening.
- 4.7.3.2 The Contractor's contracts with its network hospitals/birthing centers shall ensure the EPSDT initial newborn preventive visit occurs in the hospital/birthing center. The newborn preventive visit should be completed within twenty-four (24) hours after birth and prior to discharge of the infant.
- 4.7.3.3 The Contractor shall provide for a blood lead screening test for all EPSDT eligible children at twelve (12) and twenty-four (24) months of age. Children between thirty-six (36) months of age and seventy-two (72) months of age should receive a blood lead screening test if there is no record of a previous test.
- 4.7.3.4 The Contractor shall have a lead Case Management program for EPSDT eligible children and their households when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter. The lead Case Management program shall include education, a written Case Management plan that includes all necessary referrals, coordination with other specific agencies, environmental lead assessments, and aggressive pursuit of non-compliance with follow-up tests and appointments. The Contractor must ensure reporting of all blood lead levels to the Department of Public Health.
- 4.7.3.5 The Contractor shall have procedures for Referral of those eligible for the Health Check Program and follow up with oral health professionals, including annual dental examinations and services by an oral health professional. Dental visits must be performed by a dentist, or other licensed dental professionals working under the supervision of a dentist according to the provisions of Georgia's scope of practice laws, and can occur in settings other than dentist's office, such as a clinic or a school. The Contractor's oral health providers must follow the American Academy of Pediatric Dentistry's (AAPDs) Periodicity Schedule. Dental preventive services that carry a limitation per year shall be limited to a 12-rolling month period.
- 4.7.3.6 The Contractor shall provide inter-periodic screens, which are screens that occur between the complete periodic screens and are Medically Necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes at a minimum vision and hearing services. An inter-periodic visit may be performed only for vision or hearing services.
- 4.7.3.7 The Contractor shall allow Referrals for further diagnostic and/or treatment services to correct or ameliorate defects, and physical and mental illnesses and Conditions discovered during the Health Check EPSDT preventive health visit. The PCP may make such Referrals and follow up pursuant to the PCP's contract with the Contractor, as appropriate.
- 4.7.3.8 The Contractor shall ensure an initial health and screening visit is performed, as appropriate, for all newly enrolled GF EPSDT eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth for all newborns. If the Member's PCP provides medical record evidence to the Contractor that the initial

health and screening visit have already taken place, this evidence will meet this Contract requirement. The Contractor should incorporate this evidence for this Member in its tracking system. The Contractor shall share EPSDT health check screening results with PCPs.

- 4.7.3.9 Minimum Contractor compliance with the Health Check screening requirements is an eighty percent (80%) screening ratio for the periodic preventive health visits, using the methodology prescribed by CMS to determine the screening ratio. This requirement and screening percentage is related to the CMS-416 Report requirements.

4.7.4 Diagnostic and Treatment Services

- 4.7.4.1 If a suspected problem is detected by a preventive health screening examination as described above, the Member shall be evaluated as necessary for further diagnosis. This diagnosis will be used to determine treatment needs.
- 4.7.4.2 EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a physical or mental illness or condition discovered or shown to have increased in severity during an EPSDT preventive health visit. Such Medically Necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-Covered Services as defined in Title XIX of the Social Security Act. The Contractor shall provide Medically Necessary, Medicaid-covered diagnostic and treatment services.
- 4.7.4.3 When a preventive health screening examination indicates the need for further evaluation of a Member's health, the Referral for diagnosis must be made without delay. Follow-up is required to ensure that the Member receives a complete diagnostic evaluation. If the Member is receiving care from a Continuing Care Provider, diagnosis may be part of the screening and examination process.
- 4.7.4.4 Continuing Care Providers may have to arrange for certain specialty services that are beyond the scope of their practice (e.g. cardiology or ophthalmology); and may agree, at their option, to make direct dental Referrals.
- 4.7.4.5 The Contractor must provide for EPSDT Diagnostic and Treatment Services, which must include:
 - 4.7.4.5.1 Vision Services: At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.
 - 4.7.4.5.2 Dental Services: At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health, at as early an age as necessary. Also included are emergency dental services, such as those services necessary to control bleeding, relieve pain, eliminate acute infection, etc. Dental services may not be limited to emergency services.

- 4.7.4.5.3 Hearing Services: At a minimum, include diagnosis and treatment for defects in hearing, and include hearing aids.
- 4.7.4.5.4 Developmental Assessment: Include structured tests and instruments administered by the professional to whom the Member has been referred after potential problems have been identified by the screening process.
- 4.7.4.5.5 Diagnosis, Treatment, and Follow-Up for Lead Toxicity: If a child is found to have blood lead levels equal to or greater than 10 ug/dL, Providers are to use their professional judgment regarding patient management and treatment.
- 4.7.4.5.6 Other Necessary Health Care: Provide other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

4.7.5 Tracking

- 4.7.5.1 The Contractor shall establish a tracking system that provides information on compliance with EPSDT requirements. This system shall track, at a minimum, the following areas:
 - 4.7.5.1.1 Initial newborn EPSDT visit occurring in the hospital;
 - 4.7.5.1.2 Periodic and preventive/well child screens and visits as prescribed by the periodicity schedule;
 - 4.7.5.1.3 Diagnosis and treatment services, including Referrals;
 - 4.7.5.1.4 Immunizations, lead, tuberculosis and dental services;
 - 4.7.5.1.5 Missed periodic and preventive/visits and Notification to Members of missed visits; and
 - 4.7.5.1.6 Activities listed in the CMS-416 Report. The Contractor must submit to DCH a report, using the CMS 416 Report's template that is specific to its Member population on a quarterly basis.
- 4.7.5.2 The Contractor shall establish a reminder/notification system that must be integrated with its tracking system allowing timely notifications of preventive visits coming due and missed appointments. The system must also interface with the Providers' notifications to the Contractor of the Members' missed appointments.
- 4.7.5.3 All information generated and maintained in the tracking system shall be consistent with Encounter Claims requirements as specified elsewhere herein.

4.7.6 Reporting Requirements

- 4.7.6.1 The Contractor shall submit all required EPSDT-related reports as described in the CMO Report Schedule. The Contractor must utilize the templates and specifications provided by DCH when submitting reports to DCH. From time to time, DCH may modify the reports' specifications and templates in response to federal and state needs. The reports' specifications and templates must not be altered by the CMO prior to submission to DCH. Each EPSDT report must include an analysis of the report's findings along with planned interventions to drive further improvements in the outcomes documented in the report. The report template along with the quality analysis report must be reviewed, approved, and signed by the Contractor's Chief Medical Officer prior to submission to DCH.

4.8 **GEORGIA FAMILIES PROVIDER NETWORK**

4.8.1 General Provisions

- 4.8.1.1 The Contractor shall develop and maintain a network of Providers and facilities adequate to deliver Covered Services as described in the RFP and this Contract while ensuring adequate and appropriate provision of services to Members in rural areas, and which may include the use of telemedicine when appropriate to the condition and needs of the Member. The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other health care Providers through whom it provides the items and services included in Covered Services.
- 4.8.1.2 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent, that maintain current license(s), and that have appropriate locations to provide the Covered Services.
- 4.8.1.3 The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.
- 4.8.1.4 The Contractor shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network enrollment for new Provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.
- 4.8.1.5 The Contractor shall not include any Providers who have been excluded from participation by the United States Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor shall check the exclusions list on a monthly basis and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.

4.8.2 Provider Selection and Retention Policies and Procedures

- 4.8.2.1 The Contractor shall have written Provider Selection and Retention Policies and Procedures to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter. In selecting and retaining Providers in its network the Contractor shall consider the following:
- 4.8.2.1.1 The anticipated GF Enrollment;
 - 4.8.2.1.2 The expected Utilization of services, taking into consideration the characteristics and Health Care needs of its Members;
 - 4.8.2.1.3 The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the Covered Services;
 - 4.8.2.1.4 The numbers of network Providers who are not accepting new GF patients; and
 - 4.8.2.1.5 The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.
- 4.8.2.2 If the Contractor declines to include individual Providers or groups of Providers in its network, the Contractor shall give the affected Providers written notice of the reason(s) for the decision. These provisions shall not be construed to:
- 4.8.2.2.1 Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members; and
 - 4.8.2.2.2 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs that are consistent with its responsibilities to Members.
- 4.8.2.3 The Contractor shall ensure that all network Providers have knowingly and willfully agreed to participate in the Contractor's network. The Contractor shall not acquire established networks without contacting each individual Provider to ensure knowledge of the requirements of this Contract and the Provider's complete understanding and agreement to fulfill all terms of the Provider Contract, as outlined in Section 4.10. DCH reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and on-site visits to network Providers, the existence of a direct relationship between the Contractor and the network Providers.
- 4.8.2.4 The Contractor shall send all newly contracted Providers a written network participation welcome letter that includes a contract effective date for which Providers are approved to begin providing medical services to Georgia Families Members.

4.8.2.5 The Contractor shall survey all Providers who chose to exit the network and use the results of Provider exit surveys to improve Provider retention and recruitment. The Contractor shall provide DCH with the Provider exit survey template initially and when updated thereafter. The Contractor shall provide DCH with results of the Provider exit surveys upon request.

4.8.3 Provider Network Compositions

4.8.3.1 The Contractor shall maintain an online Provider Directory and Network Listing.

4.8.3.2 The Contractor shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted Providers which shall include the use of access and availability audits described in Section 4.8.19.6. Failure to conduct quarterly Validation and provide a clean file after determining errors through Validation may result in liquidated damages up to \$5,000 per day against the Contractor.

4.8.3.3 The Contractor shall ensure that all Provider network data files are tested and validated for accuracy prior to Contractor deliverable submissions, which shall include the use of access and availability audits described in Section 4.8.19.6. The Contractor shall scrub data to identify inconsistencies such as duplicate addresses; mismatched cities, counties, and regions; and incorrect assigned specialties. The Contractor shall be responsible for submission of attestations for each network report. All reports are to be submitted in the established DCH format with all required data elements. Failure to submit all attestations and complete reports in the established DCH format with all required data elements may result in liquidated damages up to \$5,000 per day against the Contractor.

4.8.3.4 The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented in record. The Contractor will emphasize to Providers the need for a unique GA Medicaid number for each practice location unless DCH changes this requirement at a future date.

4.8.4 Primary Care Providers (PCPs)

4.8.4.1 The Contractor shall allow for PCPs to include not only traditional provider types that have historically served as PCPs but also alternative provider types such as specialists and patient-centered medical homes (PCMHs) with documented physician oversight and meaningful physician engagement.

4.8.4.2 The Contractor shall include in its network as PCPs the following:

4.8.4.2.1 Physicians who routinely provide Primary Care services in the areas of:

4.8.4.2.1.1 Family Practice;

4.8.4.2.1.2 General Practice;

- 4.8.4.2.1.3 Pediatrics;
 - 4.8.4.2.1.4 Internal Medicine; or
 - 4.8.4.2.1.5 Obstetrics and Gynecology.
- 4.8.4.2.2 Nurse Practitioners Certified (NP-C) specializing in:
- 4.8.4.2.2.1 Family Practice; or
 - 4.8.4.2.2.2 Pediatrics.
 - 4.8.4.2.2.3 NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who is a network Provider, who has hospital admitting privileges and oversees the provision of services furnished by NP-Cs.
- 4.8.4.2.3 Psychiatrists who agree to serve as PCPs for Members who have a primary diagnosis of a Severe Persistent Mental Illness.
- 4.8.4.2.4 Physicians who provide medical services at FQHCs and RHCs. The Contractor shall maintain an accurate list of all Providers rendering care at these facilities.
- 4.8.4.2.5 Providers who practice at Public Health Department clinics and Hospital Outpatient clinics may be included as PCPs if they agree to the requirements of the PCP role, including the following conditions:
- 4.8.4.2.5.1 The practice must routinely deliver Primary Care as defined by the majority of the practice devoted to providing continuing comprehensive and coordinated medical care to a population undifferentiated by disease or organ system. If deemed necessary, a Medical Record audit of the practice will be performed by the Contractor. Any exceptions to this requirement will be considered by DCH on a case-by-case basis.
 - 4.8.4.2.5.2 Any Referrals for specialty care to other Providers of the same practice may be reviewed for appropriateness.
 - 4.8.4.2.5.3 Members who have a primary diagnosis of a Severe Persistent Mental Illness may be permitted to have any physician including a psychiatrist as their PCP assuming the physician or psychiatrist agrees to serve in this role.
- 4.8.4.2.6 Physician's assistants (PAs); however, the physician should be listed as the Member's PCP.

- 4.8.4.3 The Contractor may allow Members with Chronic Conditions to select a specialist with whom he or she has an on-going relationship to serve as a PCP.
- 4.8.4.4 The Contractor is encouraged to promote and facilitate the capacity of all PCP practices to meet the recognition requirements of a NCQA PCMH™ as jointly defined by NCQA. The Contractor shall report to DCH those PCP practices that achieve recognition or meet the requirements of the NCQA for PCMH™ or TJC PCH Accreditation. The Contractor shall collaborate with other CMOs to coordinate efforts when PCPs are contracted with one or more plans so that efforts are not duplicated.
- 4.8.4.5 The Contractor will include Behavioral Health Homes in its Medical Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated. The number of Behavioral Health Homes proposed in the network should be responsive to the prevalence of members with severe and persistent mental illness or chronic behavioral health conditions. The proposed algorithm along with assignment of Behavioral Health Homes shall be included in a Medical Home implementation plan.
- 4.8.4.6 The Contractor shall provide a Medical Home implementation plan within ninety (90) days of the Operational Start Date for DCH review and approval that identifies the methodology for promoting and facilitating NCQA PCMH recognition and/or TJC PCH accreditation. The implementation plan shall include, but not be limited to:
 - 4.8.4.6.1 Payment methodology for payment to primary care practices;
 - 4.8.4.6.2 Provision of technical support, to assist in their transformation to PPC®-PCMH recognition or TJC PCH accreditation (e.g., education, training, tools, and provision of data relevant to patient clinical care management);
 - 4.8.4.6.3 Facilitation of specialty Provider Network access and coordination to support the PCMH; and
 - 4.8.4.6.4 Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other Providers.

4.8.5 Direct Access

- 4.8.5.1 The Contractor shall provide female Members with direct In-Network access to a women's health specialist for covered care necessary to provide her routine and preventive Health Care services. This access is in addition to the Member's designated source of Primary Care if that Provider is not a women's health specialist.
- 4.8.5.2 The Contractor shall have a process in place that ensures that Members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the Member's condition and identified needs. The Contractor's Medical Director shall be responsible for overseeing this process.

4.8.6 Pharmacies

4.8.6.1 The Contractor shall maintain a comprehensive Provider network of pharmacies that ensures pharmacies are available and geographically accessible to all Members.

4.8.7 Hospitals

4.8.7.1 The Contractor shall have a comprehensive Provider network of hospitals such that they are available and geographically accessible to all Members. This includes, but is not limited to tertiary care facilities and facilities with neo-natal, intensive care, burn, and trauma units.

4.8.7.2 The Contractor shall include in its network all Critical Access Hospitals (CAHs).

4.8.7.2.1 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include CAHs in its network. This documentation shall be provided to DCH upon request.

4.8.8 Laboratories

4.8.8.1 The Contractor shall maintain a comprehensive Provider network of laboratories that ensures laboratories are accessible to all Members. The Contractor shall ensure that all laboratory testing sites providing services under this contract have either a clinical laboratory (CLIA) certificate or a waiver of a certificate of registration, along with a CLIA number, pursuant to 42 CFR 493.3.

4.8.9 Mental Health/Substance Abuse

4.8.9.1 The Contractor shall include in its network the three tiers of community Behavioral Health Providers listed below that meet the requirements of the Department of Behavioral Health and Developmental Disabilities, provided they have been credentialed to participate in Medicaid for that provider type and agree to the Contractor's terms and conditions as well as rates. Additional information about these provider types and related policies and standards are available at <https://gadbhdd.policystat.com/policy/1038203/latest/>.

4.8.9.1.1 Tier 1: Comprehensive Community Providers (CCP)

4.8.9.1.1.1 CCPs function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The standards and requirements for CCPs are found in CCP Standards for Georgia's Tier 1 Behavioral Health Safety Net, 01-200.

4.8.9.1.2 Tier 2: Community Medicaid Providers (CMPs)

4.8.9.1.2.1 CMPs provide Behavioral Health services and supports identified in the Medicaid State Plan for Serious Emotional

Disturbance (SED) youth, young adults, Serious and Persistent Mental Illness (SPMI) Adults, and individuals with Substance Use Disorders (SUDs). CMPs must competently serve children, adolescents, emerging adults, and/or adults and have the capacity and infrastructure to provide all of the services in the core benefit package:

4.8.9.1.3 Tier 3: Specialty Providers (SPs)

4.8.9.1.3.1 SPs offer an array of specialty services including but not limited to:

4.8.9.1.3.1.1 Intensive Family Intervention providers for children who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.

4.8.9.1.3.1.2 Certified Peer Specialists (CPS) with lived experience for both young adults and adults to include CPS-Parents who are associated with a Family Support Organization (i.e. Federation of Families), CPS-Addiction and CPS Whole Health and Wellness.

4.8.9.1.3.1.3 Care Management Entities to provide intensive, customized, complex Care Coordination for children, youth, and young adults who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.

4.8.9.1.3.1.4 Assertive Community Treatment for adults with SPMI.

4.8.9.2 Additionally, the Contractor shall include in its Provider network Providers who are enrolled as psychologists under the State Plan.

4.8.9.3 The Contractor shall maintain copies of all letters and other correspondence related to the inclusion of Community Behavioral Health Providers in its network. This documentation shall be provided to DCH upon request.

4.8.10 Federally Qualified Health Centers (FQHCs)

4.8.10.1 The Contractor shall include in its Provider network all FQHCs and utilize the PPS rates for reimbursement.

- 4.8.10.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include FQHCs in its network. This documentation shall be provided to DCH upon request.
- 4.8.10.3 The FQHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for FQHC (the Manual). Services and supplies deemed necessary for the provision of a Core service as described in §901.2 of the Manual are considered part of the FQHC service. In addition, an FQHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:
 - 4.8.10.3.1 EPSDT [Health Check (COS 600)];
 - 4.8.10.3.2 Mental Health (COS 440);
 - 4.8.10.3.3 Dental Services (COS 450 and 460);
 - 4.8.10.3.4 Refractive Vision Care services (COS 470); and
 - 4.8.10.3.5 Podiatry (COS 550).

4.8.11 Rural Health Clinics (RHCs)

- 4.8.11.1 The Contractor shall include in its Provider network all RHCs in its Service Region based on PPS rates.
- 4.8.11.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include RHCs in its network. This documentation shall be provided to DCH upon request.
- 4.8.11.3 The RHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for RHC (the Manual). Services and supplies deemed necessary for the provision of a Core service as described in §901.2 of the Manual are considered part of the RHC service. In addition, an RHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:
 - 4.8.11.3.1 EPSDT [Health Check (COS 600)]
 - 4.8.11.3.2 Mental Health (COS 440);
 - 4.8.11.3.3 Dental Services (COS 450 and 460);
 - 4.8.11.3.4 Refractive Vision Care services (COS 470); and,
 - 4.8.11.3.5 Podiatry (COS 550).

4.8.12 Telemedicine

- 4.8.12.1 Telemedicine allows Provider-to-Provider and Provider-to-Member live interactions, and is especially useful in situations where Members do not have easy access to a Provider, such as for Members in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of treating Members. DCH does not currently recognize provider-to-provider live interactions without a Member present. Further, DCH does not currently recognize Store-and-Forward interactions of any kind. DCH reserves the right to modify this policy decision in the future, acknowledging that such a change would require a review of the appropriateness of the Capitation Rates. However, nothing in this Contract prevents Contractor from offering Store-and-Forward use of telemedicine or Provider-to-Provider interactions without a Member present as an additional service not subject to consideration in the Capitation Rate setting process.
- 4.8.12.2 The Contractor shall provide telemedicine services to increase access to primary and specialty care as appropriate. Telemedicine presentation sites shall receive a telemedicine presentation site facility fee consistent with the Georgia Medicaid FFS program unless otherwise negotiated. The Contractor must include in its Provider Directory information on Providers with telemedicine capabilities and telemedicine presentation sites. The Contractor must:
- 4.8.12.2.1 Promote and employ broad-based utilization for access to HIPAA-compliant Telemedicine service systems.
 - 4.8.12.2.2 Follow accepted HIPAA and 42 C.F.R. Part 2 regulations that affect Telemedicine transmission, including but not limited to staff and Provider training, room setup, security of transmission lines, etc. The Contractor shall have and implement policies and procedures that follow all federal and State security and procedure guidelines.
 - 4.8.12.2.3 Identify, develop, and implement training for accepted Telemedicine practices.
 - 4.8.12.2.4 Participate in the needs assessment of the organizational, developmental, and programmatic requirements of Telemedicine programs.
- 4.8.12.3 A health care facility that receives reimbursement under this Section for consultations provided by a Medicaid-participating provider who practices in that facility and a health professional who obtains a consultation under this section shall establish quality-of-care protocols and patient confidentiality guidelines to ensure that telehealth consultations meet all requirements and patient care standards as required by law.
- 4.8.12.4 The Contractor shall determine the exact number and locations of all telemedicine presentation sites and the number of Providers who will commit to providing telemedicine consultations.

4.8.13 Family Planning Clinics

- 4.8.13.1 The Contractor shall make a reasonable effort to subcontract with all family planning clinics, including those funded by Title X of the Public Health Services Act.
- 4.8.13.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include Title X Clinics in its network. This documentation shall be provided to DCH upon request.

4.8.14 Nurse Practitioners Certified (NP-Cs) and Certified Nurse Midwives (CNMs)

- 4.8.14.1 The Contractor shall ensure that Members have appropriate access to NP-Cs and CNMs, through either Provider contracts or Referrals. This provision shall in no way be interpreted as requiring the Contractor to provide any services that are not Covered Services.

4.8.15 Dental Practitioners

- 4.8.15.1 The Contractor shall not deny any dentist from participating in the Medicaid and PeachCare for Kids® dental program administered by the Contractor if the dentist meets the below criteria:
 - 4.8.15.1.1 Such dentist has obtained a license to practice in this State and is an enrolled Provider who has met all of the requirements of DCH for participation in the Medicaid and PeachCare for Kids® program;
 - 4.8.15.1.2 Licensed dentist will provide dental services to Members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, the Contractor shall be required to offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the service region who participate in the Contractor's Medicaid and PeachCare for Kids® dental programs; and
 - 4.8.12.1.3 The geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by DCH, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services.
- 4.8.15.2 The Contractor must establish a sufficient number of general dentists and specialists as specified by Geographic Access Requirements, specified in Section 4.8.17, to provide covered dental services to Members. The Contractor may cover certain dental services provided by a dental hygienist in a Public Health setting in accordance with all applicable laws and rules. The Contractor may also provide for services in a school environment by mobile dentistry providers.

4.8.15.3 Should the Contractor find that the Provider does not meet these provisions set forth in Section 4.8.15.1 and elects to deny participation, the Contractor's denial letter of a credentialed provider's request to contract must include specific information regarding the basis for denial and how to file an appeal.

4.8.15.4 The Contractor must report to DCH the number of dental application appeals, and appeal outcomes on a calendar month basis.

4.8.16 Dental Home

4.8.16.1 The Contractor shall provide all Members under age twenty-one (21) a Dentist who will serve as the Members' Dental Home. The Contractor shall have written Selection Policies and Procedures describing how Members select or are assigned to a Dental Home.

4.8.16.2 P4HB members are not eligible for a dental home.

4.8.17 Geographic Access Requirements

4.8.17.1 In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the following geographic access standards for all Members as outlined in Figure 1. The Contractor shall utilize the most recent Geo Access program versions available and update periodically as appropriate. The Contractor shall use GeoCoder software along with the Geo Access application package.

4.8.17.2 Beginning on the Operational Start Date, the Contractor's Geographic Access analysis must include the below data standards and reporting specifications. However, DCH reserves the right to modify the data standards and report specifications at any time in its discretion. The Contractor can submit recommendations for differing data standards and report specifications for DCH consideration and approval. With this submission, the Contractor must include its rationale for requesting the change. DCH's prior written approval of the change is required.

4.8.17.2.1 Data Standards:

4.8.17.2.1.1 The Contractor shall use the most recent eligibility files provided by DCH.

4.8.17.2.1.2 The Contractor shall use the most recent Member data to geocode each Member by street address. Identifying Members at zip code centroids or randomly within zip codes is not acceptable.

4.8.17.2.1.3 All Contractor's network Provider street addresses should be exactly geocoded. For any address that cannot be exactly geocoded, the address should be geocoded using a technique that takes into account population density.

Placing Providers at zip code centroids or randomly within zip codes is not acceptable.

- 4.8.17.2.1.4 If more than one Provider is located at the same address, all Providers at that address should have the same geographic coordinates.
- 4.8.17.2.1.5 Physicians should be classified based on their primary specialty only. For example, a pediatric cardiologist should be classified as cardiologist, not a pediatrician. The Provider file must include the capacity for each PCP and general dentist.
- 4.8.17.2.1.6 The Contractor shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider location. For purposes of this requirement, a Full-Time Provider location is defined as a location operating for sixteen (16) or more hours in an office location each week. For Providers who have more than one (1) office location, the Contractor must indicate each location by a separate record in the Provider file and divide the capacity of the Provider by the number of locations. For example, if the Provider capacity is one hundred fifty (150), and the Provider has two (2) offices, each office would have a capacity of seventy-five (75). The “individual capacity” option should be used when reporting PCPs.
- 4.8.17.2.1.7 For calculating distance (miles) the Contractor must use the maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider. DCH recognizes that transportation with NET vendors may not always follow direct routes due to multiple passengers.

4.8.17.2.2 Report Specifications

- 4.8.17.2.2.1 The Contractor must prepare separate Geographical Access reports for each county, addressing all Provider types included in Figure 1. Additionally, the Contractor shall prepare separate analyses for the following:
 - 4.8.17.2.2.1.1 Adult PCPs for ages twenty-one (21) and over
 - 4.8.17.2.2.1.2 Pediatric PCPs for children under the age of twenty-one (21)

4.8.17.2.2.1.3 General Dentist

4.8.17.2.2.1.4 Telemedicine Presentation Sites

4.8.17.2.2.1.5 Provider specialist shortages as identified by DCH or the Contractor including but not limited to OB Providers

4.8.17.2.2.2 The Contractor must prepare separate Geographical Access reports showing Providers with open panels only and showing all open and closed panels.

Figure 1. Geographic Access Standards by Provider Type

Provider Type	Urban	Rural
PCPs*	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Obstetric Providers	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

Provider Type	Urban	Rural
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles
Therapy : (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

*PCPs not including practitioners listed below in Table.

4.8.18 Other Reports

4.8.18.1 In addition to the Geographic Access data reports, the Contractor shall submit the following separate reports:

- 4.8.18.1.1 Providers and associated locations with closed panels (any Provider which the Contractor recognizes as no longer accepting new Members) and those Providers and associated locations with less than Full-Time Provider hours. The separate reports must include a listing of the Providers by name and location, Provider type and an analysis of the total number of Providers with closed panels or less than Full-Time Provider hours expressed as a percentage of the Contractor's total contracted Providers for the state and then for each Service Region.
- 4.8.18.1.2 The percent of Members who do not have Provider access as defined by Figure 1.
- 4.8.18.1.3 Plans or corrective actions to enhance access of the Providers included in these separate reports. If enhanced access is not possible (i.e., no Providers available for contracting or available Providers only practice part-time) the Contractor must describe the limitations to enhancing access. The Contractor may indicate whether a Provider's office is a primary, secondary, tertiary, etc. location.
- 4.8.18.1.4 Report monthly the total number of Provider requests to contract received, the total number of Providers referred to DCH or its Agent for

credentialing, the total number of contracts pending a determination, and the total of each of the approved and denied contract requests by Provider type and in aggregate.

4.8.18.2 The Contractor shall ensure that all executed Provider contracts are processed and loaded into all systems including but not limited to the Contractor’s Claims processing system, within thirty (30) Calendar Days of receipt by the Contractor or its designated subcontracted vendor.

4.8.19 Waiting Maximums and Appointment Requirements

4.8.19.1 The Contractor shall require that all network Providers offer hours of operation that are no less than the hours of operation offered to commercial and Fee-for-Service patients. The Contractor shall encourage its PCPs to offer After-Hours office care in the evenings and on weekends.

4.8.19.2 The Contractor shall have in its network the capacity to ensure that waiting times for appointments do not exceed those outlined in Figure 2.

Figure 2. Waiting Times by Provider Type

Provider Type	Waiting Time
PCPs (routine visits)	Not to exceed fourteen (14) calendar days
PCP (adult sick visit)	Not to exceed twenty-four (24) clock hours
PCP (pediatric sick visit)	Not to exceed twenty-four (24) clock hours
Maternity Care	First Trimester – Not to exceed fourteen (14) Calendar Days Second Trimester – Not to exceed seven (7) Calendar Days Third Trimester – Not to exceed three (3) Business Days
Specialists	Not to exceed thirty (30) Calendar Days
Therapy: Physical Therapists, Occupational Therapists, Speech Therapists, Aquatic Therapists	Not to exceed thirty (30) Calendar Days
Vision Providers	Not to exceed thirty (30) Calendar Days

Provider Type	Waiting Time
Dental Providers (routine visits)	Not to exceed twenty-one (21) Calendar Days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) Calendar Days
Mental health Providers	Fourteen (14) Calendar Days
Urgent Care Providers	Not to exceed twenty-four (24) clock hours
Emergency Providers	Immediately (twenty-four (24) clock hours a day, seven (7) days a week) and without prior authorization

4.8.19.3 The Contractor shall have in its network the capacity to ensure that waiting times in the Provider office does not exceed those outlined in Figure 3 for pediatrics and adults.

Figure 3. Waiting Times by Appointment Type

Appointment Type	Waiting Time
Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed ninety (90) minutes. After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

4.8.19.4 Providers shall track waiting times by appointment to be reviewed by DCH upon request.

4.8.19.5 The Contractor shall ensure that Provider response times for returning calls After-Hours do not exceed those outlined in Figure 4:

Figure 4. Returned Call Response Times

Call Type	Response Time
Urgent Calls	Shall not exceed twenty (20) minutes
Other Calls	Shall not exceed one (1) hour

4.8.19.6 The Contractor shall at least quarterly conduct access and availability audits to validate Provider network access (outreach phone calls, emails) of individual Providers within the Contractor’s primary care, specialty, dental, pediatric and obstetrical Provider Network. The Contractor may coordinate with other CMOs to conduct these audits to avoid duplicate contacts to Providers. The Contractor shall conduct a review of twenty-five percent (25%) of the combined network. Reviews shall include the use of “secret shopper” calls during which the caller pretends to be a Member to confirm specific information including but not limited to the following:

- 4.8.19.6.1 Contact information, such as address, phone, email, web site and fax numbers.
- 4.8.19.6.2 Provider is participating in the Network.
- 4.8.19.6.3 Open/Closed panel status.
- 4.8.19.6.4 Appointment availability and how far in advance the Member can schedule an appointment.

4.8.19.7 The Contractor shall provide DCH with results of all access and availability audits upon request. The Contractor shall take corrective action to remediate instances of identified non-compliance with the standards above and report all non-compliance to DCH within thirty (30) Calendar Days of the audit. Should DCH identify and notify the Contractor of non-compliance with the standards listed above, the Contractor shall provide to DCH a corrective action plan within thirty (30) Calendar Days of receipt of such notice.

4.8.20 Mainstreaming

- 4.8.20.1 The Contractor shall encourage that all In-Network Providers accept Members for treatment, unless they have a full panel and are accepting no new Georgia Families or commercial patients. The Contractor shall ensure that In-Network Providers do not intentionally segregate Members in any way from other persons receiving services.
- 4.8.20.2 The Contractor shall ensure that Members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.

4.8.21 Provider Credentialing

- 4.8.21.1 DCH is contracting with a single Credentialing Verification Organization (CVO) to conduct credentialing and re-credentialing of Providers for Medicaid and the contracted CMOs. Providers must enroll with Medicaid and/or Georgia Families or Georgia Families 360° by submitting an electronic application and supporting documentation through the CVO's web-based Provider Credentialing Portal. The Contractor will not conduct its own Credentialing processes and shall accept the CVO's credentialing and recredentialing determinations. The Contractor cannot appeal the CVO credentialing decision. The Contractor cannot require Providers to submit supplemental or additional information for purposes of conducting a second credentialing process by the Contractor. See **Attachment V, Provider Credentialing Process**.
- 4.8.21.2 The Contractor shall coordinate with DCH's contracted CVO to confirm the status of Providers who are requesting to enroll with the Contractor and to confirm recredentialing status. The Contractor shall report to DCH any instances of which it is informed a determination has not been made by the CVO within thirty (30) Calendar Days of application. See **Attachment W, Provider Credentialing Timelines**. DCH reserves the right to modify the credentialing timelines as needed.
- 4.8.21.3 The Contractor shall refer providers to the CVO website to complete the credentialing process prior to enrolling with a CMO. The Contractor shall also provide information about the re-credentialing process to all network Providers. The Contractor will refer all Providers to the CVO who are not Medicaid providers and requesting to enroll.
- 4.8.21.4 The CVO updates the Provider Credentialing Portal and notifies DCH of the Credentialing status. If Credentialing is successful, the application is sent to DCH for final disposition. For approved applications, the CVO sends a file with all of the Provider's enrollment data to the Fiscal Agent to update the MMIS to include the necessary Provider information. The Fiscal Agent will send the Provider a welcome letter, and notify any CMO in which the Provider has requested to also enroll.
- 4.8.21.5 In the event the State decides not to contract with a single CVO, the Contractor shall be responsible for all credentialing and re-credentialing of its network providers. The Contractor would be required to submit a credentialing and re-credentialing plan to DCH for review and approval prior to beginning these processes, and updates thereto.

4.8.22 Network Changes

- 4.8.22.1 The Contractor shall notify DCH within seven (7) Business Days of any significant changes to the Provider network or, if applicable, to any Subcontractors' Provider network. A significant change is defined as:
- 4.8.22.1.1 A decrease in the total number of PCPs by more than five percent (5%);
- 4.8.22.1.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within the geographic access standards as defined in Section 4.8.17;

- 4.8.22.1.3 A loss of specialty Providers in a Health Professional Shortage Area including but not limited to Obstetric Providers;
 - 4.8.22.1.4 A loss of a hospital in an area where another contracted hospital of equal service ability is not available the geographic access standards as defined in Section 4.8.17; or
 - 4.8.22.1.5 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to In-Network Providers including closed Provider panel.
- 4.8.22.2 The Contractor shall have procedures to address changes in the Contractor's Provider network that negatively affect the ability of Members to access services, including access to a culturally diverse Provider network. Failure to adequately address significant changes in network composition that negatively impact Member access to services may be grounds for Contract termination or State determined remedies.
- 4.8.22.3 If a PCP ceases participation in the Contractor's Provider network the Contractor shall send written notice to the Members who have chosen the Provider as their PCP. The notice shall encourage the Member to select a new PCP as soon as possible to limit disruption in care, and explain that the DCH Enrollment Broker will assign a new PCP if the Member does not choose a new PCP within thirty (30) Calendar Days. This notice must contain contact information to assist the Member in selecting a new PCP. This notice shall be issued no less than thirty (30) Calendar Days prior to the effective date of the termination and no more than ten (10) Calendar Days after receipt or issuance of the termination notice.
- 4.8.22.4 If a Member is in a prior authorized ongoing course of treatment with any other participating Provider who becomes unavailable to continue to provide services, the Contractor shall notify the Member in writing within ten (10) Calendar Days from the date the Contractor becomes aware of such unavailability.
- 4.8.22.5 These requirements to provide notice to the Member prior to the effective dates of Provider termination shall be waived in instances where a Provider becomes physically unable to care for Members due to illness, a Provider dies, the Provider moves from the Service Region and fails to notify the Contractor, or when a Provider fails Credentialing. Under these circumstances, notice shall be issued immediately upon the Contractor becoming aware of the circumstances, along with contact information to assist the Member in selecting a new PCP.
- 4.8.22.6 The Contractor shall submit a Continuity of Care plan to DCH sixty (60) Calendar Days prior to the anticipated mass Network changes, as defined in this section that will impact membership. DCH may require the Continuity of Care Plan drill down to the individually affected member level depending upon the situation.

4.8.23 Out-of-Network Providers

- 4.8.23.1 If the Contractor's network is unable to provide Medically Necessary Covered Services to a particular Member, the Contractor shall adequately and timely cover these services Out-of-Network for the Member. The Contractor must inform the Out-of Network Provider that the Member cannot be balance billed.
- 4.8.23.2 The Contractor shall coordinate with Out-of-Network Providers regarding payment. For payment to Out-of-Network, or non-participating Providers, the following guidelines apply:
 - 4.8.23.2.1 If the Contractor offers the service through an In-Network Provider(s), and the Member chooses to access the service (i.e., it is not an emergency) from an Out-of-Network Provider, the Contractor is not responsible for payment.
 - 4.8.23.2.2 If the service is not available from an In-Network Provider and the Member requires the service and is referred for treatment to an Out-of-Network Provider, the payment amount is a matter between the CMO and the Out-of-Network Provider.
 - 4.8.23.2.3 If the service is not available from an In-Network Provider, but the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
 - 4.8.23.2.4 If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition standard, and the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
 - 4.8.23.2.5 When paying out of state Providers in an emergency situation, the Contractor shall not allow a Member to be held accountable for payment.
- 4.8.23.3 In the event that needed services are not available from an In-Network Provider and the Member must receive services from an Out-of-Network Provider, the Contractor must reimburse the Provider. In this instance, Contractor is prohibited from billing the Member.

4.8.24 Shriners Hospitals for Children

- 4.8.24.1 The Contractor shall comply with the responsibilities outlined in the "Memorandum of Understanding for the PeachCare Partnership Program" executed on February 18, 2008, as amended from time to time, and attached to this Contract as **Attachment T** and expressly incorporated into this Contract as if completely restated herein.

- 4.8.24.2 The Contractor shall cooperate with DCH in making any updates or revisions to the Memorandum, as necessary.

4.8.25 Reporting Requirements

- 4.8.25.1 The Contractor shall submit to DCH quarterly Provider Network Adequacy and Capacity Reports (including Policies and Procedures) as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.
- 4.8.25.2 The Contractor shall submit to DCH quarterly Timely Access Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.9 **PROVIDER SERVICES**

The Contractor shall establish and maintain a Provider services function to act as the point of contact for its Providers. As such, the Contractor will provide educational material, operate a Provider services line, facilitate Provider complaints and timely address Provider contract and payment issues. The Contractor must staff its provider services department with personnel qualified to fulfill the requirements as described in this Section.

4.9.1 General Provisions

- 4.9.1.1 The Contractor shall provide information to all Providers about Georgia Families in order to operate in full compliance with the GF Contract and all applicable federal and State regulations.
- 4.9.1.2 The Contractor shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.
- 4.9.1.3 Within sixty (60) Calendar Days of the Contract Effective Date, the Contractor shall submit to DCH for initial review and approval all materials and information to be distributed and/or made available to Providers about Georgia Families. Any proposed revisions to such materials and information thereafter shall also be submitted to DCH for prior review and approval. DCH will attempt to complete its review of such materials within thirty (30) Calendar Days of its receipt of such materials.
- 4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.
- 4.9.1.5 Contractor must seek DCH's written approval of the Contractor's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider contracts or communications. DCH's review and response will be completed within sixty (60) Calendar Days of the Contractor's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Contractor misinterprets a Medicaid policy which is communicated to Providers, the Contractor must submit a

written corrective action plan to DCH within three (3) Business Days of notice from DCH. Contractor will be required to retroactively correct and adjust any previously adjudicated Claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) Calendar Days of approval of the corrective action plan.

4.9.2 Provider Handbooks

4.9.2.1 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding GF Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information:

- 4.9.2.1.1 Georgia Families Covered Services;
- 4.9.2.1.2 Member eligibility categories;
- 4.9.2.1.3 Medical Necessity standards and practice guidelines;
- 4.9.2.1.4 Role of the PCP;
- 4.9.2.1.5 Link to the NCQA and Joint Commission web sites;
- 4.9.2.1.5 Role of the Dental Home;
- 4.9.2.1.6 Emergency Service responsibilities;
- 4.9.2.1.7 Health Check/EPSTDT Benefit;
- 4.9.2.1.8 Prior Authorization, Pre-Certification, and Referral procedures;
- 4.9.2.1.9 Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
- 4.9.2.1.10 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers;
- 4.9.2.1.11 Provider Complaint System Policies and Procedures, including, but not be limited to, specific instructions for contacting the Contractor's Provider services to file a complaint and which individual(s) have the authority to review a complaint;
- 4.9.2.1.12 Policies and procedures for the Provider Grievance and Appeals process;

- 4.9.2.1.13 Information on the Member Grievance System, including the Member’s right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the right to request continuation of Benefits while utilizing the Grievance System;
- 4.9.2.1.14 The role of the CVO and link to the CVO web site;
- 4.9.2.1.15 Information about the GaHIN including how information will be used by the CMOs and DCH and an explanation of any service limitations or exclusions from coverage;
- 4.9.2.1.16 Link to the DCH web site;
- 4.9.2.1.17 Role of the DCH fiscal agent and link to the fiscal Agent’s web site;
- 4.9.2.1.18 Information about the Georgia Families Value-based Purchasing;
- 4.9.2.1.19 Transition of Care Planning;
- 4.9.2.1.20 Care Coordination Policies;
- 4.9.2.1.21 Protocol for Encounter Claims element reporting/records;
- 4.9.2.1.22 Medical Records standards;
- 4.9.2.1.23 Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;
- 4.9.2.1.24 Payment policies;
- 4.9.2.1.25 The Contractor’s Cultural Competency Plan;
- 4.9.2.1.26 Member rights and responsibilities;
- 4.9.2.1.27 Other Provider or Subcontractor responsibilities; and
- 4.9.2.1.28 Information about the 1115 Demonstration, Planning for Healthy Babies, including:
 - 4.9.2.1.28.1 Demonstration description;
 - 4.9.2.1.28.2 Covered Demonstration Services;
 - 4.9.2.1.28.3 Practice protocols;
 - 4.9.2.1.28.4 Other Provider responsibilities;

- 4.9.2.1.28.5 Coding requirements;
 - 4.9.2.1.28.6 Prior Authorization, Pre-Certification, and Referral procedures; and
 - 4.9.2.1.28.7 P4HB participants' rights and responsibilities.
- 4.9.2.2 The Contractor shall disseminate bulletins as needed to incorporate any needed changes to the Provider Handbook. These bulletins can be mailed hard copy or can be disseminated via email, provided hard copies are available and Providers are informed of how to request in hard copy.
- 4.9.2.3 The Contractor shall submit the Provider Handbook to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter. Any updates or revisions shall be submitted to DCH for review and approval at least thirty (30) Calendar Days prior to distribution.

4.9.3 Education and Training

- 4.9.3.1 The Contractor shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Contractor shall conduct initial training within thirty (30) Calendar Days of executing a contract with a newly contracted Provider. The Contractor shall also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Contractor or DCH in order to ensure compliance with program standards and the GF Contract and meet the needs of Providers.
- 4.9.3.2 The Contractor shall also provide Provider workshops, data, trainings and technical assistance, webinars and web-based tutorials about the emergence and ongoing operations of Medical Homes and other service delivery innovations, evidence-based and emergency best practices, delivering a person-centered approach to care and the System of Care approach to care delivery.
- 4.9.3.3 The Contractor shall provide training to all Demonstration Family Planning and IPC service Providers and their staffs regarding the requirements of the Demonstration and the Contract provisions related to the Demonstration and special needs of the P4HB participants. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or DCH in order to ensure compliance with the Demonstration's standards and the Contract.
- 4.9.3.4 The Contractor's Demonstration Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling available at <http://fpm.emory.edu/preventive/research/projects/index.html>.
- 4.9.3.5 The Contractor shall develop and submit the Provider Training Manual and Training Plan, including topics, schedule and languages spoken, to DCH for initial review and

approval at least thirty (30) Calendar Days prior to any scheduled trainings and as updated thereafter.

4.9.3.6 DCH may attend any training sessions specific to this Contract at its discretion.

4.9.4 Provider Relations

4.9.4.1 The Contractor shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. The Contractor shall implement policies addressing the compliance of Providers with the requirements included in this RFP and institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.

4.9.4.2 The Contractor shall provide for at least one (1) Provider Relations Liaison per Service Region to Conduct the Provider Relations functions.

4.9.5 Provider Services Call Center

4.9.5.1 The Contractor shall operate a toll-free call center to respond to Provider questions, comments and concerns.

4.9.5.2 The Contractor shall develop call center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.

4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment K.

4.9.5.5 Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays. The Contractor shall ensure that after regular business hours the non-Prior Authorization/ Pre-certification line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition. The call center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Contractor shall provide information to Providers on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.

- 4.9.5.6 The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the call center Quality Criteria and Protocols to DCH Provider Services for initial review and approval and as updated thereafter. At a minimum, the standards shall require that, on a Calendar month basis:
- 4.9.5.6.1 Average Speed of Answer: Eighty percent (80%) of calls shall be answered by a person within thirty (30) seconds. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative. The remaining twenty percent (20%) of calls shall be answered within one (1) minute of the call.
 - 4.9.5.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.
 - 4.9.5.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).
 - 4.9.5.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a live Call Center Representative.
 - 4.9.5.6.5 Timely Response to call center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.
 - 4.9.5.6.6 Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.
- 4.9.5.7 The Contractor shall set up remote phone monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer or phone, to monitor call Center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Contractor will facilitate bi-annual calibration sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.

4.9.6 Georgia Families Provider Web Site

- 4.9.6.1 The Contractor shall dedicate a section of its Web Site to Provider services and provide general up-to date information about the Contractor's program. At a minimum, the website must have the capability for Providers to make inquiries and receive responses through the Medicaid fiscal agent Web Site (www.mmis.georgia.gov) and must:

- 4.9.6.1.1 Include a searchable Provider Handbook.
- 4.9.6.1.2 Include a searchable Provider Directory that the Contractor updates within five (5) Business Days of a change.
- 4.9.6.1.3 Include Customer services, including the capability for Providers to submit questions and comments to the Contractor and receive responses. The Contractor shall respond to Provider inquiries within one (1) Business Day of receipt. The Contractor shall refer any inquiries to DCH that are not within the Contractor's scope of services (e.g., inquiries about the Fee-for-Service delivery system).
- 4.9.6.1.4 Include the capability for Providers to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate Claims electronically and consistent with the Contractor's policies and procedures for Provider Claims activities. To the extent a Provider has the capability; the Contractor shall submit payments to Providers electronically and submit remittance advices to Providers electronically within one (1) Business Day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.
- 4.9.6.1.5 Provide information about the following:
 - 4.9.6.1.5.1 Grievance and Appeals Systems
 - 4.9.6.1.5.2 Pharmacy Preferred Drug List
 - 4.9.6.1.5.3 Pharmacy Conditions for Coverage and Utilization Limits
 - 4.9.6.1.5.4 Member rights and responsibilities
 - 4.9.6.1.5.5 DCH's Value-based Purchasing
 - 4.9.6.1.5.6 Information about the HIE/GaHIN including how information will be used by the CMOs and DCH and procedures to opt out of the GaHIN
 - 4.9.6.1.5.7 PCP/Medical Home responsibilities;
 - 4.9.6.1.5.8 Dental Home responsibilities
 - 4.9.6.1.5.9 Planning for Healthy Babies 1115 Demonstration;
- 4.9.6.1.6 Link to the DCH CVO web site;
- 4.9.6.1.7 Link to the DCH Fiscal Agent web site;

- 4.9.6.1.8 Link to the NCQA accreditation recognition web site;
 - 4.9.6.1.9 Include What's New items;
 - 4.9.6.1.10 Include frequently asked questions and answers; and
 - 4.9.6.1.11 Links to the DCH Medicaid web site, DCH P4HB web site and the Enrollment Broker web site.
- 4.9.6.2 The Contractor must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Contractor must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades which support the ordinary operation, administration, and maintenance of the web site, the Contractor shall not modify the web site prior to receipt of DCH approval.
- 4.9.6.3 The Contractor's Web Site shall be functionally equivalent, with respect to functions described in this Contract, to the Web Site maintained by the State's Medicaid fiscal agent (<https://www.mmis.georgia.gov/portal/default.aspx/>) and consistent with the standards established by the Georgia Technology Authority (GTA) as published at <http://gta.georgia.gov/psg/> and amended periodically.
- 4.9.7 Provider Complaint System
- 4.9.7.1 The Contractor shall establish a Provider Complaint system that permits a Provider to dispute the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.
- 4.9.7.2 The Contractor shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and annually and as updated thereafter. The Contractor shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor's Provider services to file a Provider complaint and which individual(s) have the authority to review a Provider complaint.
- 4.9.7.3 The Contractor shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers with the remittance advice of the processed Claim. The Contractor may distribute a summary of these Policies and Procedures if the summary includes information on how the Provider may access the full Policies and Procedures on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.
- 4.9.7.4 As a part of the Provider Complaint System, the Contractor shall:
- 4.9.7.4.1 Allow Providers thirty (30) Calendar Days from the date of issue or incident to file a written complaint;

- 4.9.7.4.2 Allow Providers to consolidate complaints or appeals of multiple Claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment Claims included in the bundled complaint or appeal;
- 4.9.7.4.3 Require that Providers' complaints are clearly documented;
- 4.9.7.4.4 Allow a Provider that has exhausted the Contractor's internal appeals process related to a denied or underpaid Claim or group of Claims bundled for appeal the option either to pursue the administrative appeals process described in O.C.G.A. § 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A. § 33-21A-7. If the Contractor and the Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties;
- 4.9.7.4.5 For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from fifteen (15) Calendar Days after the date the Claim was submitted. The Contractor shall pay all interest required to be paid under this provision or Code Section O.C.G.A. 33-21A-7 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment;
- 4.9.7.4.6 Accurately identify all interest payments on the associated remittance advice submitted by the Contractor to the Provider;
- 4.9.7.4.7 Require that Providers exhaust the Contractor's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);
- 4.9.7.4.8 Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems;
- 4.9.7.4.9 Identify a staff person specifically designated to receive and process Provider Complaints;

- 4.9.7.4.10 Thoroughly investigate each GF Provider Complaint using applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and
- 4.9.7.4.11 Ensure that Contractor executives with the authority to require corrective action are involved in the Provider Complaint process.
- 4.9.7.5 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers may request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.
- 4.9.7.6 The Contractor shall notify the Providers that a request for an Administrative Law Hearing must include the following information:
 - 4.9.7.6.1 A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;
 - 4.9.7.6.2 Identification of the Action being appealed and the issues that will be addressed at the hearing;
 - 4.9.7.6.3 A specific statement of why the Provider believes the Contractor's Action is wrong; and
 - 4.9.7.6.4 A statement of the relief sought.
- 4.9.7.7 DCH has delegated its statutory authority to receive hearing requests to the Contractor. The Contractor shall include with the Notice of Adverse Action the Contractor's address where a Provider's request for an Administrative Law Hearing should be sent in accordance with O.C.G.A. § 49-4-153(e).

4.9.8 Claims Adjustment Requests/Claim Payment Disputes

- 4.9.8.1 If the amount reimbursed by the Contractor to an enrolled Provider is not correct, a positive or negative adjustment may be necessary. Such request for Claims adjustment shall be included in the Contractor's internal appeals process and shall not negate a Provider's right to appeal pursuant to O.C.G.A. §49-4-153(e). The Contractor shall develop a procedure to address Claims adjustment requests that meet the following minimum requirements:
 - 4.9.8.1.1 Contractor Positive Adjustments
 - 4.9.8.1.1.1 When a Provider can substantiate that additional reimbursement is appropriate, the Provider may adjust and resubmit a Claim. Provider shall be given the option to submit the written request, Explanation of Payment and all

Claims related documentation either electronically or by U.S. mail. All documentation must be received within three (3) months from the end of the month of payment. The adjustment request must include sufficient documentation to identify each Claim identified in the request. The Contractor may return incomplete requests without further action provided it notifies the Provider of the basis for the incomplete status and allows the Provider ten (10) calendar days to resubmit the adjustment request. The Provider shall be required to submit documentation that supports the requested Claims adjustment. If a positive adjustment is warranted, the Contractor shall make additional reimbursement upon processing of the request. If an adjustment is not warranted, the Provider will be notified via written correspondence from the Contractor.

4.9.8.1.2 Contractor Negative Adjustments

4.9.8.1.2.1 When a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim. Provider shall be given the option to submit the written request, Explanation of Payment and all claims related documentation either electronically or by U.S. mail. If a negative adjustment is warranted, Contractor may either deduct the payment from future reimbursement or request reimbursement from the Provider as required by the Provider's contract with the Contractor.

4.9.8.2 The Contractor shall respond to all adjustment requests within fifteen (15) Calendar Days of receipt.

4.9.8.3 Contractor shall maintain a website that allows Providers to submit, process, edit, rebill, and adjudicate claims electronically.

4.9.8.4 Contractor shall include recoupment information to be combined within the remittance where the recoupment occurs.

4.9.9 Reporting Requirements

4.9.9.1 The Contractor shall submit to DCH monthly Telephone and Internet Activity Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.9.9.2 The Contractor shall submit to DCH monthly Provider Complaints Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.10 PROVIDER CONTRACTS AND PAYMENTS

4.10.1 Provider Contracts

- 4.10.1.1 The Contractor shall submit to DCH for initial review and approval and as updated thereafter a model for each type of Provider Contract and shall comply with all DCH procedures for contract review and approval submission. Memoranda of Agreement (MOA) shall not be permitted.
- 4.10.1.2 Any significant changes to the model Provider Contract shall be submitted to DCH for review and approval no later than thirty (30) Calendar Days prior to use of the revised Provider Contract.
- 4.10.1.3 Upon request, the Contractor shall provide DCH with copies of all executed Provider Contracts at no cost.
- 4.10.1.4 In addition to addressing the CMO licensure requirements, the Contractor's Provider Contracts shall:
 - 4.10.1.4.1 Not require Providers to participate or accept other plans or products offered by the Contractor unrelated to providing Covered Services to Members. The Contractor shall be subject to a penalty of \$1,000.00 per violation if this prohibition is violated;
 - 4.10.1.4.2 Prohibit the Contractor from entering into any exclusive contracts agreements with providers that exclude other health care providers from contract agreements for network participation;
 - 4.10.1.4.3 Prohibit the Contractor from entering into a contract with or without the Provider's consent that prohibits the provider from Contracting with another Georgia Families CMO as a condition of the Contract;
 - 4.10.1.4.4 Prohibit the health care provider from, as a condition of contracting with the Contractor, requiring the Contractor to contract with or not contract with another health care provider;
 - 4.10.1.4.5 Prohibit the Provider from seeking payment from the Member for any Covered Services provided to the Member within the terms of the Contract and require the Provider to look solely to the Contractor for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Georgia Medicaid or CHIP State Plans, the Georgia State Medicaid Policies and Procedures Manuals, and this Contract;
 - 4.10.1.4.6 Require the Provider to cooperate with the Contractor's quality improvement and Utilization Review and management activities;

- 4.10.1.4.7 Include provisions for the immediate transfer to another PCP or Contractor if the Member or P4HB participant's health or safety is in jeopardy;
- 4.10.1.4.8 Not prohibit a Provider from discussing treatment or non-treatment options with Members that may not reflect the Contractor's position or may not be covered by the Contractor;
- 4.10.1.4.9 Not prohibit a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
- 4.10.1.4.10 Not prohibit a Provider from advocating on behalf of the Member in any Grievance System or Utilization Review process, or individual authorization process to obtain necessary Health Care services;
- 4.10.1.4.11 Require Providers to meet appointment waiting time standards pursuant to Section 4.8.19.2;
- 4.10.1.4.12 Provide for continuity of treatment in the event a Provider's participation terminates during the course of a Member's treatment by that Provider;
- 4.10.1.4.13 Prohibit discrimination with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely based on such license or certification. This provision should not be construed as any willing provider law, as it does not prohibit Contractors from limiting Provider participation to the extent necessary to meet the needs of the Members. Additionally, this provision shall not preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. This provision also does not interfere with measures established by the Contractor that are designed to maintain Quality and control costs;
- 4.10.1.4.14 Prohibit discrimination against Providers serving high-risk populations or those that specialize in Conditions requiring costly treatments;
- 4.10.1.4.15 Specify that CMS and DCH or its Agent will have the right to inspect, evaluate, and audit any pertinent books, financial records, documents, papers, and records of any Provider involving financial transactions related to this Contract;
- 4.10.1.4.16 Specify Covered Services and populations;
- 4.10.1.4.17 Require Provider submission of timely, complete and accurate Encounter Claims;

- 4.10.1.4.18 Include the definition and standards for Medical Necessity, pursuant to the definition in Sections 1.4 and 4.5.4;
- 4.10.1.4.19 Specify rates of payment. The Contractor ensures that Providers will accept such payment as payment in full for Covered Services provided to Members less any applicable Member cost sharing pursuant to this Contract;
- 4.10.1.4.20 Provide for timely payment to all Providers for Covered Services to Members. Pursuant to O.C.G.A. 33-24-59.5(b) (1) once a Clean Claim has been received, the CMO(s) will have fifteen (15) Business Days within which to process and either transmit funds for payment electronically for the Claim or mail a letter or notice denying it, in whole or in part giving the reasons for such denial;
- 4.10.1.4.21 Specify acceptable billing and coding requirements;
- 4.10.1.4.22 Require that Providers comply with the Contractor's Cultural Competency plan;
- 4.10.1.4.23 Require that any marketing materials developed and distributed by Providers to Members be submitted to the Contractor to submit to DCH for prior approval;
- 4.10.1.4.24 Specify that in the case of newborns the Contractor shall be responsible for any payment owed to Providers for services rendered prior to the newborn's Enrollment with the Contractor;
- 4.10.1.4.25 Specify that the Contractor shall not be responsible for any payments owed to Providers for services rendered prior to a Member's Enrollment with the Contractor, even if the services fell within the established period of retroactive eligibility;
- 4.10.1.4.26 Comply with 42 CFR 434 and 42 CFR 438.6;
- 4.10.1.4.27 Require Providers to attempt to collect Member Co-payments;
- 4.10.1.4.28 Prohibit Providers from refusing to treat a Member on the basis of inability to pay Co-payments;
- 4.10.1.4.29 Not employ or subcontract with individuals on the State or Federal Exclusions list;
- 4.10.1.4.30 Prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a member of the Provider's family has a Financial Relationship;

- 4.10.1.4.31 Require Providers of transitioning Members to cooperate in all respects with Providers of other CMOs to assure maximum health outcomes for Members;
- 4.10.1.4.32 Contain a provision stating that in the event DCH is due funds from a Provider who has exhausted or waived the Administrative Review process, if applicable, the Contractor shall reduce payment by one hundred percent (100%) to that Provider until such time as the amount owed to DCH is recovered;
- 4.10.1.4.33 Contain a provision giving notice that the Contractor's negotiated rates with Providers shall be adjusted in the event the Commissioner of DCH directs the Contractor to make such adjustments in order to reflect budgetary changes to the Medical Assistance program;
- 4.10.1.4.34 Require the Contractor to notify the Provider in writing no less than thirty (30) Calendar Days prior to any adjustments to the Provider's contracted reimbursement rates and receive written notification from the Provider of acceptance of the new reimbursement rates;
- 4.10.1.4.35 Allow for the Contractor to recoup or withhold reimbursement made or due to a Provider, as required by and upon receipt of notice by DCH that the Provider has an outstanding balance that is owed to DCH as the result of an identified overpayment for Fee-for-Service Claims. Contractor must transfer all funds withheld or recouped to DCH;
- 4.10.1.4.36 Prohibit Providers from requiring a pre-service consultation prior to providing care; and
- 4.10.1.4.37 Require that Providers participate in all DCH and CMO driven Quality improvement, performance measurement activities and Program Integrity operations.

4.10.2 Provider Termination

- 4.10.2.1 The Contractor shall comply with all State and federal laws regarding Provider termination. In its Provider Contracts the Contractor shall:
 - 4.10.2.1.1 Specify that in addition to any other right to terminate the Provider Contract, and notwithstanding any other provision of this Contract, DCH may require Provider termination immediately, or the Contractor may immediately terminate on its own, a Provider's participation under the Provider Contract if a Provider fails to abide by the terms and conditions of the Provider Contract, as determined by DCH, or, in the sole discretion of DCH, fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from the Contractor specifying such failure and requesting such Provider to abide by the terms and conditions hereof; and

4.10.2.1.2 Specify that any Provider whose participation is terminated under the Provider Contract for any reason shall utilize the applicable appeals procedures outlined in the Provider Contract. No additional or separate right of appeal to DCH or the Contractor is created as a result of the Contractor's act of terminating, or decision to terminate any Provider under this Contract. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, this Contract shall remain in full force and effect with respect to all other Providers.

4.10.2.2 The Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network. If the termination was "for cause", the Contractor may terminate, suspend, or withdraw the Provider immediately and shall notify DCH in writing within one (1) Business Day of the termination with the reasons for termination. If a Member is receiving ongoing care, the Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal.

4.10.3 Provider Insurance

4.10.3.1 The Contractor shall require each Provider (with the exception of Section 4.10.3.2, and FQHCs that are section 330 grantees) to maintain, throughout the terms of the Contract, at its own expense, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written Contract with the Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars (\$1,000,000) per occurrence, and three million dollars (\$3,000,000) annual aggregate. Providers may be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve. DCH reserves the right to waive the insurance requirement if necessary for business need.

4.10.3.2 The Contractor shall require allied mental health professionals to maintain, throughout the terms of the Contract, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written Contract with Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars (\$1,000,000) per occurrence, and one million dollars (\$1,000,000) annual aggregate. These Providers may also be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve.

4.10.3.3 In the event any such insurance is proposed to be reduced, terminated or canceled for any reason, the Contractor shall provide to DCH and Department of Insurance (DOI) at least thirty (30) Calendar Days prior written notice of such reduction, termination or cancellation. Prior to the reduction, expiration and/or cancellation of any insurance policy required hereunder, the Contractor shall require the Provider to secure replacement coverage upon the same terms and provisions so as to ensure no lapse in

coverage, and shall furnish DCH and DOI with a Certificate of Insurance indicating the receipt of the required coverage at the request of DCH or DOI.

- 4.10.3.4 The Contractor shall require Providers to maintain insurance coverage (including, if necessary, extended coverage or tail insurance) sufficient to insure against claims arising at any time during the term of this Contract, even though asserted after the termination of this Contract. DCH or DOI, at its discretion, may request that the Contractor immediately terminate the Provider from participation in the program upon the Provider's failure to abide by these provisions. The provisions of this Section shall survive the expiration or termination of this Contract for any reason.

4.10.4 Provider Payment

- 4.10.4.1 With the exceptions noted below, the Contractor shall negotiate rates with Providers and such rates shall be specified in the Provider Contract. The Contractor shall also develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The Contractor is required to submit to DCH timely, complete and accurate Encounter Claims for all services, including Claims from those Providers that may be paid a Capitation Payment by the Contractor. The Contractor must require all Providers to submit detailed Encounter data.

- 4.10.4.2 For services rendered within seventy-two (72) hours after the Provider verifies the eligibility of the patient with the Contractor, the Contractor shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Contractor made payment for a patient for whom it was not responsible, then the Contractor may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.

- 4.10.4.3 The Contractor shall be responsible for issuing an IRS Form (1099) in accordance with all federal laws, regulations and guidelines.

- 4.10.4.4 When the Contractor negotiates a contract with a Critical Access Hospital (CAH), the Contractor shall pay the CAH a payment rate based on one hundred and one percent (101%) allowable costs incurred by the CAH. DCH may require the Contractor to adjust the rate paid to CAHs if so directed by the State of Georgia's Appropriations Act.

4.10.4.4.1 A CAH must provide notice to the Contractor and DCH of any alleged breaches in its contract by the Contractor.

4.10.4.4.2 If a CAH satisfies the requirement of Title 33 of the Official Code of Georgia Annotated (Medicaid Care Management Organizations Act), and if DCH concludes, after notice and hearing, that the Contractor has substantively and repeatedly breached a term of its contract with a CAH, the DCH is authorized to require the Contractor to pay damages to the

CAH in an amount not to exceed three (3) times the amount owed. Notwithstanding the foregoing, nothing in said Act shall be interpreted to limit the authority of DCH to establish additional penalties or fines against a CMO for failure to comply with the contract between the Contractor and DCH.

- 4.10.4.5 When the Contractor negotiates a contract with a FQHC and/or a RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act, the Contractor shall pay the PPS rates for Core Services and other ambulatory services per Encounter. The rates are established as described in §1001.1 of the Manual. At Contractor's discretion, it may pay more than the PPS rates for these services. Payment Reports must consist of all covered service claim types each month, inclusive of all services provided by the Contractor.
- 4.10.4.6 Upon receipt of notice from DCH that it is due funds from a Provider, who has exhausted or waived the Administrative Review process, if applicable, the Contractor shall reduce payment to the Provider for all claims submitted by that Provider by one hundred percent (100%), or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered. The Contractor shall promptly remit any such funds recovered to DCH in the manner specified by DCH. To that end, the Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to DCH.
- 4.10.4.7 The Contractor shall adjust its negotiated rates with Providers to reflect budgetary changes to the Medical Assistance program, as directed by the Commissioner of DCH, to the extent such adjustments can be made within funds appropriated to DCH and available for payment to the Contractor. The Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to DCH. Change in the terms of the Provider's reimbursement rate methodology must be agreed to by the Provider. Contractors are not permitted to simply send a notice advising as to a reimbursement rate methodology change. This does not prevent routine and necessary adjustments to Maximum Allowable Charge rates.
- 4.10.4.8 The Contractor shall recognize and honor for payment consideration any Provider's claims with dates of service on or after the Provider credentialing date or the Provider contract effective date, whichever is later, irrespective of the date the Contractor loads the Provider into its claims processing system.

4.10.5 Administrative Review Process/Law Hearing

- 4.10.5.1 The Contractor shall offer the opportunity for Administrative Review to any Provider against whom it proposes to take an adverse action or denial of payment unless otherwise authorized to by law to take such action without Administrative Review. The Contractor shall develop policies and procedures which outline the Administrative Review process.

- 4.10.5.2 For a Provider to obtain an Administrative Review, a written request must be received at the address identified by the Contractor within thirty (30) Calendar Days of the date of the notification of the denial or reduction in payment, initial determination, or other adverse action. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation.
- 4.10.5.3 The Contractor shall issue an Administrative Review Response within thirty (30) Calendar Days of receipt of the request for Administrative Review. If the Contractor upholds the Proposed Action, the Contractor shall issue a Notice of Adverse Action which informs the Provider of their right to a hearing before an Administrative Law Judge at the Office of State Administrative Hearings (OSAH).
- 4.10.5.4 The Contractor shall offer Provider the opportunity for an Administrative Hearing after the Administrative Review has been completed and upon receipt of a written request from the Provider. The Request for an Administrative Hearing must be submitted within thirty (30) Calendar Days of the date of the Administrative Review response. The Request for Hearing must be accompanied by a copy of the Administrative Review Response.
- 4.10.5.5 All Provider Administrative Appeals shall be transmitted to the Office of State Administrative Hearings.

4.10.6 Reporting Requirements

- 4.10.6.1 The Contractor shall submit to DCH monthly FQHC and RHC Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.10.7 Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)).

- 4.10.7.1 The Contractor shall increase benefit payments to Providers in an amount consistent with the Provider rate increases included in the State of Georgia's fiscal year budget. This enhanced rate shall be effective for all dates of service for which the Hospital Medicaid Financing Program Act is in place or until or modified by legislative action or DCH policy changes.

- 4.10.7.2 The Contractor will provide reports as requested by DCH to enable DCH to determine the amount of the increase in benefit payments to Providers as referenced in Section 4.10.7.1. The report will include, but not be limited to monthly reports, by hospital, that provide the following data for each claim paid:

- 4.10.7.2.1 Claim Number;
- 4.10.7.2.2 Date of Service;
- 4.10.7.2.3 Date of Payment;

- 4.10.7.2.4 Base Paid Amount;
- 4.10.7.2.5 Add-on Paid Amount;
- 4.10.7.2.6 Interest Paid Amount; and
- 4.10.7.2.7 Total Paid Amount.

4.11 UTILIZATION MANAGEMENT AND COORDINATION AND CONTINUITY OF CARE RESPONSIBILITIES

4.11.1 Utilization Management

- 4.11.1.1 The Contractor shall implement innovative and effective Utilization Management processes to ensure a high quality, clinically appropriate yet highly efficient and cost-effective delivery system. The Contractor shall continually evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Contractor must apply objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account when determining the medical appropriateness of Health Care services.
- 4.11.1.2 The Contractor shall enable Pre-Certification of service requests when required and direct providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Contractor must evaluate all review requests for Medical Necessity and make recommendations that are more appropriate and more cost-effective. The Contractor should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.
- 4.11.1.3 The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:
 - 4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.
 - 4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.
 - 4.11.1.3.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.

- 4.11.1.3.4 Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Sections 1.4 and 4.5.4.
- 4.11.1.3.5 Provide for the appeal by Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.
- 4.11.1.4 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval annually and as changed. Nothing in this Section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures insofar as that decision is accompanied by the clinical rationale for such a decision.
- 4.11.1.5 Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.
 - 4.11.1.5.1 Utilization Management Committee
 - 4.11.1.5.1.1 The Contractor shall establish a Utilization Management Committee. The Utilization Management Committee is accountable to the Medical Director and governing body of the Contractor. The Utilization Management Committee shall meet no less frequently than a quarterly basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.
 - 4.11.1.5.2 Emergency Room (ER) Diversion Pilot
 - 4.11.1.5.2.1 The Contractor shall develop and implement an ER diversion pilot program with hospital(s) that agree to participate to reduce inappropriate utilization of ERs for non-emergent conditions. The Contractor shall submit to DCH ninety (90) Calendar Days prior to beginning the ER Diversion Pilot program a detailed plan describing how the Contractor will work with providers to reduce inappropriate utilization of ERs for non-emergent conditions. The diversion pilot shall not prohibit or delay a Member's access to ER services.
- 4.11.1.6 The Contractor, and any delegated Utilization Review agent, shall not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

4.11.1.6.1 Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or

4.11.1.6.2 Any other method that encourages the rendering of a Proposed Action.

4.11.2 Prior Authorization and Pre-Certification

4.11.2.1 The Contractor shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services, as described in Section 4.6.1, 4.6.2, and 4.6.3, Special Coverage Provisions.

4.11.2.2 The Contractor shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.

4.11.2.3 The Contractor may require Prior Authorization and/or Pre-Certification for all non-emergent, Out-of-Network services.

4.11.2.4 Prior Authorization and Pre-Certification shall be conducted by a currently Georgia licensed, registered or certified Health Care Professional who is appropriately trained in the principles, procedures and standards of Utilization Review.

4.11.2.5 The Contractor and its network Providers (except Pharmacy Providers) shall use DCH's central Prior Authorization Portal for communicating Prior Authorization and Pre-Certification requests and their disposition. The Contractor shall establish an interface with the Prior Authorization Portal that allows the Contractor to receive and submit required data. The Prior Authorization and Pre-Certification process shall be one hundred percent (100%) paperless. The Contractor shall conduct outreach to and educate network Providers about use of the Portal and submission of all required documentation through the Portal.

4.11.2.6 The Contractor will retain authority for reviewing requests and making Prior Authorization and Pre-Certification determinations. The Contractor shall implement policies and procedures that incorporate how the Contractor will conduct the following activities:

4.11.2.6.1 Accept Prior Authorization and Pre-Certification requests that Providers submit on a standardized form developed by DCH through the Prior Authorization Portal.

4.11.2.6.2 Communicate requests for additional information from the Provider through the Prior Authorization Portal. The Contractor may directly contact the Provider with questions, but the Contractor shall communicate the same information through the Prior Authorization Portal.

4.11.2.6.3 Review requests when a Member has an outstanding Prior Authorization and transitions enrollment to the Contractor. The Contractor may not require the requesting Provider to re-submit the Prior Authorization

request. The Contractor may make its own determination regarding approval of the request.

4.11.2.7 The Contractor shall notify the Provider of Prior Authorization determinations via the Prior Authorization Portal in accordance with the following timeframes.

4.11.2.7.1 Standard Service Authorizations. Prior Authorization decisions for non-urgent services shall be made within three (3) Business Days, or other established timeframe, of the request (generally submitted one week prior to the service or procedure). An extension may be granted for an additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's best interest.

4.11.2.7.2 Expedited Service Authorizations. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision with twenty-four (24) clock hours and provide notice as expeditiously as the Member's health condition requires and no later than three (3) Business Days after receipt of the request for service. The Contractor may extend the twenty-four (24) clock hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's best interest.

4.11.2.7.3 Authorization for Services that have been Delivered. Determinations for authorization involving health care services that have been delivered shall be made within thirty (30) Calendar Days of receipt of the necessary information.

4.11.2.8 The Contractor's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.

4.11.3 Referral Requirements

4.11.3.1 The Contractor may require that Members obtain a Referral from their PCP prior to accessing non-emergency specialized services.

4.11.3.2 In the Utilization Management Policies and Procedures discussed in Section 4.11.1, the Contractor shall address:

4.11.3.2.1 When a Referral from the Member's PCP is required;

4.11.3.2.2 How a Member obtains a Referral to an In-Network Provider or an Out-of-Network Provider when there is no Provider within the Contractor's network that has the appropriate training or expertise to meet the particular health needs of the Member;

- 4.11.3.2.3 How a Member with a Condition which requires on-going care from a specialist may request a standing Referral; and
 - 4.11.3.2.4 How a Member with a life-threatening Condition or disease, which requires specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.
 - 4.11.3.3 The Contractor shall prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a member of the Provider's family has a Financial Relationship.
 - 4.11.3.4 The Contractor shall develop electronic, web-based Referral processes and systems. In the event a Referral is made via the telephone, the Contractor shall ensure that the Contractor, the Provider and DCH maintain Referral data, including the final decision, in a data file that can be accessed electronically.
 - 4.11.3.5 In conjunction with the other Utilization Management policies, the Contractor shall submit the Referral processes to DCH for review and approval.
- 4.11.4 Transition of Members
- 4.11.4.1 The Contractor shall coordinate the transfer of information when Members transition from one CMO to another, to the fee-for-service system, or to private insurance.
 - 4.11.4.2 Inpatient Acute Coverage Responsibility
 - 4.11.4.2.1 Members enrolled in a CMO that are hospitalized in an acute inpatient hospital facility will remain the responsibility of that CMO until they are discharged from the facility, even if they change to a different CMO, or they become eligible for coverage under FFS Medicaid during their inpatient stay. Members enrolled in a CMO that are hospitalized in an acute inpatient hospital facility and are placed in Foster Care during the inpatient stay will be disenrolled from the CMO and enrolled in the Georgia Families 360° Program on the date the Member's 834 file is transferred to the Georgia Families 360° CMO. The CMO is not required to cover services for an individual that has no Medicaid benefits, if the individual remains an acute inpatient and loses Medicaid eligibility during the stay; the CMO is only responsible for payment until the last day of Medicaid eligibility.
 - 4.11.4.2.2 A P4HB Participant that is hospitalized in an acute inpatient hospital facility will remain the responsibility of that P4HB Participant's original CMO until she is discharged from the facility, even if she changes to a different CMO or becomes eligible for other coverage during her inpatient stay. The CMO is not required to cover Demonstration related Services for a P4HB Participant that has no Demonstration benefits. If the P4HB Participant remains an acute inpatient and loses Demonstration eligibility

during the stay, the CMO is only responsible for payment until the last day of Demonstration eligibility.

- 4.11.4.2.3 Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned CMO.
- 4.11.4.2.4 The Contractor shall remain responsible for Members that become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization until they are discharged from inpatient acute hospital care. These Members will remain the responsibility of the Contractor for all Covered Services, even if the start date for SSI eligibility is made retroactive to a date prior to the inpatient acute hospitalization.
- 4.11.4.2.5 Upon notification that a hospitalized Member will be transitioning to a new CMO, or to Fee-for-Service Medicaid, the current CMO will work with the new CMO or Fee-for-Service Medicaid or private insurance to ensure that Coordination of Care and appropriate Discharge Planning occurs.

4.11.4.3 Relinquishment of Members

- 4.11.4.3.1 When relinquishing Members, the Contractor shall cooperate with the receiving CMO, Fee-for-Service Medicaid or private insurance regarding the course of ongoing care with a specialist or other Provider. Contractor must identify and facilitate Coordination of Care for all Members during changes or transitions between Contractors, as well as transitions to Fee-for-Service Medicaid or private insurance. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations. Special circumstances include Members designated as having "special Health Care needs", as well as Members who have medical conditions or circumstances such as:
 - 4.11.4.3.1.1 Pregnancy (especially women who are high risk and in third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date)
 - 4.11.4.3.1.2 Major organ or tissue transplantation services which are in process, or have been authorized
 - 4.11.4.3.1.3 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing or other facilities
 - 4.11.4.3.1.4 Significant medical conditions, (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments

- 4.11.4.3.1.5 Members who are in treatment such as:
 - 4.11.4.3.1.5.1 Chemotherapy, and/or radiation therapy; or
 - 4.11.4.3.1.5.2 Dialysis.
- 4.11.4.3.1.6 Members with ongoing needs such as:
 - 4.11.4.3.1.6.1 Durable medical equipment including ventilators and other respiratory assistance equipment;
 - 4.11.4.3.1.6.2 Home health services;
 - 4.11.4.3.1.6.3 Medically Necessary transportation on a scheduled basis; or
 - 4.11.4.3.1.6.4 Prescription medications.
- 4.11.4.3.1.7 Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible Members
- 4.11.4.3.1.8 Members who are currently hospitalized.

4.11.4.4 Long-Term Care Coverage Responsibility

- 4.11.4.4.1 Members enrolled in a CMO that are receiving services in a long-term care facility will remain the responsibility of the admitting CMO until disenrolled from the CMO by DCH.
- 4.11.4.4.2 For the purposes of this requirement, long-term care facilities include Nursing Homes, Skilled Nursing Facilities, Psychiatric Residential Treatment Facilities and other facilities that provide long-term non-acute care.
- 4.11.4.4.3 Upon disenrollment from the CMO, the financial responsibility for services provided to the Member transitions to the Member's new CMO or Fee for Service Medicaid.
- 4.11.4.4.4 Members that are in ongoing non acute treatment in an inpatient facility that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary Transition of Care. The CMO will not be obligated to cover services

beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days.

4.11.5 Back Transfers

- 4.11.5.1 The Contractor shall permit transfers from a higher level of care, back to a lower level (referred to as a back transfer). The transfer is subject to Medical Necessity review and the payment policies outlined in the contract with the payer.
- 4.11.5.2 Each request will be reviewed on an individual basis to determine if the transfer is appropriate. The length of stay for the transferring hospital and for the return to the originating hospital will also be evaluated to determine if the transfer is appropriate.
- 4.11.5.3 If a transfer back to a hospital that provides a lower level of care does occur, the facility receiving the back-transfer will be eligible for reimbursement if Prior Authorization is obtained from the applicable payer and according to the payment agreement of that payer.
- 4.11.5.4 The Contractor shall make available Provider education and clear policies regarding the “back transfer” Pre-Certification requirements along with the billing procedures.

4.11.6 Court-Ordered Evaluations and Services

- 4.11.6.1 In the event a Member requires Medicaid-Covered Services ordered by a State or federal court, the Contractor shall fully comply with all court orders while maintaining appropriate Utilization Management practices.

4.11.7 Second Opinions

- 4.11.7.1 The Contractor shall provide for a second opinion in any situation when there is a question concerning a diagnosis or the options for surgery or other treatment of a health Condition when requested by any Member of the Health Care team, a Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.
- 4.11.7.2 The second opinion must be provided by a qualified Health Care Professional within the network, or the Contractor shall arrange for the Member to obtain one outside the Provider network, if an appropriate Provider is unavailable in the Contractor’s network.
- 4.11.7.3 The second opinion shall be provided at no cost to the Member.

4.11.8 Coordination and Continuity of Care Responsibilities

- 4.11.8.1 The Contractor is responsible for employing a System of Care approach to Care Coordination and Continuity of Care. Care Coordination is a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely, and cost effective manner. Care Coordination includes Case Management, Disease Management, Transition of Care and Discharge Planning.

- 4.11.8.2 The Contractor must develop and implement Care Coordination and Continuity of Care. Policies and procedures are designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and include, at a minimum, the following elements:
- 4.11.8.2.1 The provision of an individual needs assessment and diagnostic assessment; the development of an individualized treatment plan, as necessary, based on the needs assessment; the establishment of treatment objectives; the monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary;
 - 4.11.8.2.2 Includes a patient-centered approach to meet the needs of Members, addressing both developmental and chronic conditions;
 - 4.11.8.2.3 Ensure that Members who are determined to need a course of treatment or regular care monitoring have a treatment plan. This treatment plan shall be developed by the Member's PCP with Member participation, and in consultation with any specialists caring for the Member. The Contractor will develop a care plan for all members with a treatment plan who are actively enrolled in case management. The Contractor's medical officer responsible for oversight of the care management function shall follow up with the treating physician when the actively case managed member is not achieving his/her care plan goals that align with the treating physician's treatment plan;
 - 4.11.8.2.4 A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning or regular care management;
 - 4.11.8.2.5 A strategy to ensure the timely provision of services;
 - 4.11.8.2.6 A strategy to ensure that the Contractor works with Members and Providers to implement an integrated approach to meeting physical health and Behavioral Health needs of the Member;
 - 4.11.8.2.7 Use of data analytics to identify patterns of care. DCH encourages the use of predictive modeling to identify high risk Members;
 - 4.11.8.2.8 Procedures and criteria for making Referrals to specialists and sub-specialists;
 - 4.11.8.2.9 Procedures and criteria for maintaining treatment plans and Referral Services when the Member changes PCPs;
 - 4.11.8.2.10 Capacity to implement, when indicated, Case Management functions such as individual needs assessment, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plan;

- 4.11.8.2.11 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and
- 4.11.8.2.12 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP.
- 4.11.8.3 The Contractor shall submit Care Coordination and Continuity of Care Policies and Procedures to DCH for review and approval within ninety (90) Calendar Days of Contract Award and as updated thereafter.
- 4.11.8.4 The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities. This includes: Transition of Care, Discharge Planning; Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management.
- 4.11.8.5 Transition of Care
 - 4.11.8.5.1 Contractors shall identify and facilitate transitions for Members that are moving from one CMO to another or from a CMO to a Fee-for-Service provider or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing Members, the Contractor shall cooperate with the receiving CMO or FFS Medicaid regarding the course of on-going care with a specialist or other Provider. Priority will be given to Members who have medical conditions or circumstances such as:
 - 4.11.8.5.1.1 Members who are currently hospitalized;
 - 4.11.8.5.1.2 Pregnant women who are high risk and in their third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date;
 - 4.11.8.5.1.3 Major organ or tissue transplantation services which are in process, or have been authorized;
 - 4.11.8.5.1.4 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities;
 - 4.11.8.5.1.5 Members who are in treatment such as Chemotherapy, radiation therapy, or Dialysis;
 - 4.11.8.5.1.6 Members with ongoing needs such as Specialized Durable medical equipment, including ventilators and other respiratory assistance equipment;

- 4.11.8.5.1.7 Current Home health services;
- 4.11.8.5.1.8 Medically Necessary transportation on a scheduled basis;
- 4.11.8.5.1.9 Prescription medications requiring Prior Authorizations;
- 4.11.8.5.1.10 The Contractor will monitor Providers to ensure Transition of Care from one entity to another to include Discharge Planning as appropriate. Members with procedures that are scheduled to occur after their new CMO effective date, but that have been authorized by either DCH or the Member's original CMO prior to their new CMO effective date will be covered by the Member's new CMO for thirty (30) Calendar Days; and
- 4.11.8.5.1.11 Members that are in ongoing outpatient treatment or that are receiving medication that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary Transition of Care. The Contractor will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days.

4.11.8.6 Discharge Planning

- 4.11.8.6.1 The Contractor shall maintain and operate a formalized Discharge Planning program that includes a comprehensive evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following Discharge from an institutional clinical setting.
- 4.11.8.6.2 The Contractor shall implement a Discharge Planning pilot program with hospital(s) that agree to participate to improve coordination for Members when being discharged from the hospital. The intent of this program is to improve Quality of care and outcomes, as well as to reduce readmissions. The Contractor will place a nurse onsite in the hospital to serve as an onsite resource for Members and to provide support to Members, such as patient education and care planning, reviewing medications and how to take those medications, identifying community resources that may be beneficial to the Member, assuring follow-up care is arranged for when Members leave the hospital and regularly contacting Members after Discharge to confirm they have received follow up care.
- 4.11.8.6.3 The Contractor shall submit its plan for a Discharge Planning pilot program to DCH for initial review and approval prior to implementation and any updates thereto. The plan shall include, for example, information

about the hospital(s) that will participate, Member eligibility for the program, services that will be provided, and approach to coordinating with hospital staff to supplement the care and education they are providing. The Contractor shall submit monthly reports to DCH that provide information that will track results to help identify initiatives that improve quality of care and outcomes.

4.11.8.7 Care Coordination

- 4.11.8.7.1 The Contractor shall provide Care Coordination services which shall:
 - 4.11.8.7.1.1 Be comprehensive: All services a Member receives are to be coordinated;
 - 4.11.8.7.1.2 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and
 - 4.11.8.7.1.3 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP.

4.11.8.8 Coordination with Other Entities

- 4.11.8.8.1 The Contractor shall coordinate and work collaboratively with all divisions within DCH, as well as with other State agencies, and with other CMOs for administration of the Georgia Families program.
- 4.11.8.8.2 The Contractor shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children's Intervention School Services provided by the LEAs to ensure Medical Necessity and prevent duplication of services.
- 4.11.8.8.3 The Contractor shall coordinate the services furnished to its Members with the service the Member receives outside the CMO, including services received through any other managed care entity.
- 4.11.8.8.4 The Contractor shall coordinate with all DCH-contracted entities involved in providing care to the Member or administering program services that also impact the CMO's services. Coordination with other contracted-entities includes, but is not limited to, the following:
 - 4.11.8.8.4.1 NET vendors to ensure Members are able to access Medically Necessary services in a timely manner.

- 4.11.8.8.4.2 DCH's Pharmacy Rebate Services Vendor for the purposes of processing pharmacy rebates. The Contractor shall regularly submit data, such as Omnibus Budget Reconciliation Act (OBRA) and J-Code claims feed to the Fee-for-Service Pharmacy Rebate Services Vendor. Prior to program launch, the Contractor will accept the Fee-for-Service Pharmacy Rebate Services Vendor's file format for data feeds and for testing interface capabilities. The Contractor shall respond to and resolve all inquiries and requests from the Pharmacy Rebate Vendor within thirty (30) Calendar Days of receipt of such inquiry or request.
- 4.11.8.8.4.3 DCH's CVO as set forth in Section 4.8.21.
- 4.11.8.8.4.4 DCH's Fiscal Agent Contractor.
- 4.11.8.8.4.5 The State Health Benefit Plan
- 4.11.8.8.4.6 Vendors identified by DCH to complete DCH required audits, reviews and special projects.
- 4.11.8.8.4.7 Other DCH vendors, including other Georgia Families CMOs to complete statewide initiatives.
- 4.11.8.8.4.8 Private insurance and Fee-for-Service providers
- 4.11.8.8.5 The Contractor shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 45 CFR 164.
- 4.11.8.9 Integration of Physical and Behavioral Health Services
 - 4.11.8.9.1 The Contractor shall develop an innovative approach to encourage PCPs, Behavioral Health Providers, and dental Providers to effectively and efficiently share behavioral and physical health clinical Member information, including how the Contractor will notify Behavioral Health Providers and PCPs after an inpatient mental health stay.
 - 4.11.8.9.2 The Contractor must require Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks.
 - 4.11.8.9.3 The Contractor shall submit an annual Health Coordination and Integration Report to the Department due June 30th of each calendar year for the prior calendar year beginning 2017. This report is subject to approval by the Department. At a minimum, this report shall include:

- 4.11.8.9.3.1 Program Goals and Objectives
- 4.11.8.9.3.2 Summary of activities and efforts to integrate and coordinate behavioral and physical health;
- 4.11.8.9.3.3 Successes (e.g., exceeding performance targets) and opportunities for improvement;
- 4.11.8.9.3.4 Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and
- 4.11.8.9.3.5 Roadmap of activities planned for the next reporting

4.11.9 Disease Management

- 4.11.9.1 The Contractor shall develop a minimum of three (3) disease management programs for Members with Chronic Conditions. These programs must target the prevalent chronic diseases within the Contractor's population, as specified by DCH.
- 4.11.9.2 Disease Management functions include, but are not limited to:
 - 4.11.9.2.1 Incorporating evidence-based guidelines or standards of care in program development.
 - 4.11.9.2.2 Utilizing clinical data to stratify Members for Enrollment based on levels of service intensity.
 - 4.11.9.2.3 Encouraging the Member's active participation and adherence to interventions.
 - 4.11.9.2.4 Educating the Member on their disease or condition to facilitate self-management.
 - 4.11.9.2.5 Consistently informing the Member on progress in the achievement of goals and about the areas that require further improvement.
 - 4.11.9.2.6 Promoting Coordination of Care by collaborating and communicating with Providers and other health care resources to improve Member outcomes.
- 4.11.9.3 The Contractor must notify DCH of the disease management programs it initiates and terminates and provide evidence, on an annual basis of the effectiveness of such programs for its enrolled Members. The Contractor is encouraged to align disease management programs with quality initiatives.

- 4.11.9.4 The Contractor must submit Quarterly status reports to DCH which include specified Disease Management Program data as listed in Section 5.71 in addition to the annual report.

4.11.10 Case Management

- 4.11.10.1 The Contractor's Case Management program shall emphasize prevention, Continuity of Care, and Coordination of Care and integration of care. The program shall link Members to services.

- 4.11.10.2 Case Management functions include, but are not limited to:

- 4.11.10.2.1 Early identification of Members who have or may potentially have special needs by receiving referrals, reviewing medical records, claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An Initial Assessment of pregnant women may be performed by a local public health agency at the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO;

- 4.11.10.2.2 Assessment of a Member's risk factors such as an over- or under-utilization of services, inappropriate use of services, non-adherence to established plan of care or lack thereof, lack of education or understanding of current condition, lack of support system, financial barriers that impede adherence to plan of care, compromised patient safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities;

- 4.11.10.2.3 Development of a personalized, patient-centered plan of care which is consistent with evidence-based guidelines and includes established goals that are specific and measurable, with emphasis on Member education of disease or condition to facilitate shared decision making and self-management;

- 4.11.10.2.4 Coordination of Care, as previously described;

- 4.11.10.2.5 Monitoring to ensure the plan of care and interventions continue to be appropriate or revised as needed based on changes in the Member's condition or lack of positive response to the plan of care;

- 4.11.10.2.6 Continuity of care which includes collaboration and communication with other Providers involved in the Member's transition to another level of care to optimize outcomes and resources while eliminating fragmentation of care;

- 4.11.10.2.7 Follow up which includes assessing the achievement of established goals and identifying the overall impact of the plan of care;

- 4.11.10.2.8 Documentation which includes adherence to Member privacy and confidentiality standards, evidence of Member's progress and effectiveness of the plan of care, evaluation of Member satisfaction ; and
 - 4.11.10.2.9 When appropriate, Disenrollment from Case Management when the goals have been achieved and the Member is able to self-manage, or the needs and desires of the Member change.
- 4.11.10.3 Case Management functions for the IPC component of the P4HB Demonstration include:
- 4.11.10.3.1 Early identification of P4HB IPC Participants who have or may have special needs;
 - 4.11.10.3.2 Assessment of a P4HB IPC Participant's risk factors;
 - 4.11.10.3.3 Development of a plan of care;
 - 4.11.10.3.4 Referrals and assistance to ensure timely access to Providers included and external to the Contractor's network;
 - 4.11.10.3.5 Coordination of Care actively linking the P4HB IPC Participant to In-Network and Out of Network Providers, physical and Behavioral Health Services, residential social and other support services where needed;
 - 4.11.10.3.6 Resource Mothers Outreach;
 - 4.11.10.3.7 Monitoring;
 - 4.11.10.3.8 Continuity of care;
 - 4.11.10.3.9 Follow up; and
 - 4.11.10.3.10 Documentation
- 4.11.10.4 Details pertaining to Resource Mothers Outreach are incorporated in **Attachment N** to this Contract. The Contractor must utilize the Resource Mothers Training Manual specified by DCH as the training manual for the Resource Mothers Outreach.
- 4.11.10.5 The Contractor must monitor the effectiveness of the Resource Mothers Outreach and ensure such Outreach activities comply with the Resource Mothers Training Manual.
- 4.11.10.6 Levels of Case Management for the GF Program include:
- 4.11.10.6.1 Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment

related to their health problem, and a plan of care that has been developed which provides for health and social problem follow-up as indicated.

4.11.10.6.2 Level II - Services that ensure necessary Member services are available. Case managers will arrange for appointments and transportation to the Member's appointments and referrals and verify that the referral site is available and appropriate for the Member's needs.

4.11.10.6.3 Level III - Services defined in Level I and Level II plus assisting the Member to complete forms, accompanying the Member to their appointments to provide introductions and support as well as contacting the Member to schedule additional appointments. Visits to the Member's residence are included in Level III Case Management. This level of Case Management services ensures the Member successfully negotiates any transitions in care. Level III Case Management may be reserved for certain high risk Members who require special assistance to negotiate complex or highly structured health or social systems.

4.11.10.7 The Contractor shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have catastrophic or other high-cost or high-risk Conditions including pregnant women under twenty-one (21) years of age, high risk pregnancies and infants and toddlers with established risk for developmental delays.

4.11.10.8 The Contractor must notify DCH of the specific Case Management programs it initiates (i.e. OB Case Management, Behavioral Health case management, etc.) and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members.

4.11.10.9 The Contractor will submit quarterly reports to DCH which include specified Case Management Program data as listed in Section 5.71 in addition to the annual report.

4.11.11 Reporting Requirements

4.11.11.1 The Contractor shall submit to DCH quarterly Case Management and Disease Management Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.1.1.11.2 The Contractor shall submit to DCH quarterly Prior Authorization and Pre-Certification Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.11.11.3 The Contractor shall submit to DCH all reports as outlined in the Demonstration Quality Strategy identified in **Attachment M** of this Contract in addition to the annual report.

4.12 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

4.12.1 General Provisions

4.12.1.1 The Contractor shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).

4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers, community resources and agencies to actively improve the Quality of care provided to Members.

4.12.1.3 National Committee for Quality Assurance (NCQA) Accreditation

4.12.1.3.1 The Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date. Contractors shall apply for NCQA accreditation, or at other times as required by DCH as follows:

4.12.1.3.1.1 July 1, 2016: Apply for NCQA Interim Status

4.12.1.3.1.2 July 1, 2017: Apply for provisional status (first survey)

4.12.1.3.1.3 December 31, 2017: Notify NCQA of intent to submit data

4.12.1.3.1.4 June 15, 2018: Submit CY 2017 data

4.12.1.3.2 The Contractor shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.

4.12.1.4 Quality Oversight Committee

4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following:

4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director;

4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization;

4.12.1.4.1.3 A senior executive who is responsible for program implementation;

4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and

4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

4.12.1.4.2 The Quality Management Committee must:

4.12.1.4.2.1 Maintain Records that document the committee's activities, findings, recommendations, actions, and results; and

4.12.1.4.2.2 Obtain DCH's approval of membership of the Quality Oversight Committee.

4.12.2 DCH Quality Strategic Plan Requirements

4.12.2.1 The Contractor shall support and comply with the Georgia Families DCH Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to Georgia Families and Georgia Families 360 Members (as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).

4.12.2.2 The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to enrolled Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit is responsible for oversight of the Contractor's Quality program including:

4.12.2.2.1 Monitoring and evaluating the Contractor's service delivery system and Provider network, as well as its own processes for Quality management and performance improvement;

4.12.2.2.2 Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members;

4.12.2.2.3 Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, Provider profiling, Utilization Management reviews, etc.;

4.12.2.2.4 Monitoring compliance with Federal, State and DCH requirements;

- 4.12.2.2.5 Ensuring the Contractor's coordination with State registries;
- 4.12.2.2.6 Ensuring Contractor executive and management staff participation in the quality management and performance improvement processes;
- 4.12.2.2.7 Ensuring that the development and implementation of Quality management and performance improvement activities include Provider participation and information provided by Members, their families and guardians; and
- 4.12.2.2.8 Identifying the Contractor's best practices, lessons learned and other findings for performance and Quality improvement.

4.12.3 Performance Measures

- 4.12.3.1 The Contractor shall comply with the GF DCH Quality Strategic Plan requirements to improve the health outcomes for all GF Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS[®]) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measure and incent Contractor improvement through the Value-based Purchasing program.
- 4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS[®] measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirement for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure.
- 4.12.3.3 DCH establishes Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at <http://dch.georgia.gov/medicaid-quality-reporting>. Performance targets are based on national Medicaid Managed Care HEDIS[®] percentiles as reported by NCQA or other benchmarks as established by DCH.
- 4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.

- 4.12.3.5 The performance measures apply to the Member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.
- 4.12.3.6 The Contractor must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.

4.12.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

- 4.12.4.1 The Contractor shall deliver to DCH the results of CAHPS Surveys conducted by an NCQA certified CAHPS survey vendor. The survey report must include but not limited be to the following items:
 - 4.12.4.1.1 An Executive Summary with the description of the survey process conducted according to the CAHPS Health Plan Survey guidelines of the HEDIS protocol;
 - 4.12.4.1.2 Protocols for the administration of the survey via mail, telephone or mixed mode;
 - 4.12.4.1.3 Definition of the sample size, number of completed surveys and response rates achieved. Response rates should, at a minimum, be no less than the NCQA average Medicaid response rates for the period; and
 - 4.12.4.1.4 Detailed survey results and trend analysis.
- 4.12.4.2 The Contractor shall submit, on an annual basis to DCH, Adult and Child CAHPS Survey reports as stated in Section 4.12.16.

4.12.5 Member and Provider Incentives

- 4.12.5.1 The Contractor shall implement Member and Provider incentives to increase Member and Provider participation in reaching program goals. The Contractor may provide:
 - 4.12.5.1.1 Incentives to Members and/or Providers to encourage compliance with periodicity schedules. Such incentives shall be established in accordance with all applicable State and federal laws, rules and regulations. Member incentives must be of nominal value (\$10.00 or less per item and \$50.00 in the aggregate on an annual basis per Member) and may include gift cards so long as such gift cards are not redeemable for cash or Co-payments. The Contractor shall submit the proposed incentive methods to DCH for review and receive DCH approval prior to implementation. Upon request by DCH, the Contractor shall provide DCH with reports detailing incentives provided to Members and/or Providers and illustrating efficacy of incentive programs. In accordance with 42 CFR 1003.101, the Nominal Value requirement stated herein is not applicable

where the incentive is offered to promote the delivery of preventive care services, provided:

- 4.12.5.1.1.1 The delivery of the preventive services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or Medicaid;
 - 4.12.5.1.1.2 The incentive is not cash or an instrument convertible to cash; and
 - 4.12.5.1.1.3 The value of the incentive is not disproportionately large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care).
- 4.12.5.1.2 Provider incentives for the specific purpose of supporting necessary costs to transform and sustain NCQA PCMH recognition or TJC PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters.
 - 4.12.5.1.3 Provider incentive strategies to improve Provider compliance with clinical practice guidelines and ensure consistent application of the guidelines.

4.12.6 Quality Assessment Performance Improvement (QAPI) Program

- 4.12.6.1 The Contractor shall have in place an ongoing QAPI program consistent with 42 CFR 438.240. The program must be established utilizing strategic planning principles with defined goals, objectives, strategies and measures of effectiveness for the strategies implemented to achieve the defined goals. The Contractor's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include:
 - 4.12.6.1.1 A method of monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over Utilization of services), including those with special Health Care needs;
 - 4.12.6.1.2 Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy;
 - 4.12.6.1.3 A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data;
 - 4.12.6.1.4 Designated staff with expertise in Quality assessment, Utilization Management and Care Coordination;

- 4.12.6.1.5 Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to Providers and Members;
 - 4.12.6.1.6 A methodology and process for conducting and maintaining Provider profiling;
 - 4.12.6.1.7 Ad-Hoc Reports to the Contractor's multi-disciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations and implemented system changes; and annual Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas;
 - 4.12.6.1.8 Integration of the results from annual Performance Improvement Projects (PIPs), performance measure rate monitoring, and compliance with federal and state standards;
 - 4.12.6.1.9 The impact of the Contractor's Member demographics on their ability to improve health outcomes; and
 - 4.12.6.1.10 A process for evaluation of the impact and assessment of the Contractor's QAPI program.
- 4.12.6.2 The Contractor shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCPs or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.
- 4.12.6.3 The Contractor's QAPI Program Plan must be submitted to DCH for initial review and approval and as updated thereafter.
- 4.12.6.4 The Contractor shall submit any changes to its QAPI Program Plan to DCH for review and prior approval sixty (60) Calendar Days prior to implementation of the change.
- 4.12.6.5 Upon the request of DCH, the Contractor shall provide any information and documents related to the implementation of the QAPI program.
- 4.12.6.6 Annually, the Contractor shall submit to DCH a comprehensive QAPI Report, utilizing the report template that integrates all aspects of the QAPI Plan and tells the story of the effectiveness of the Contractor's QAPI Plan in meeting defined goals and objectives and achieving improved health outcomes for the Contractor's Members. DCH may require interim reports more frequently than annually to demonstrate progress.

4.12.7 Performance Improvement Projects

- 4.12.7.1 As part of its QAPI program, the Contractor shall conduct clinical and non-clinical Performance Improvement Projects in accordance with DCH and federal protocols. In designing its performance improvement projects, the Contractor shall:

- 4.12.7.1.1 Show that the selected area of study is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale);
 - 4.12.7.1.2 Establish clear, defined and measurable goals and objectives that the Contractor shall achieve in each year of the project;
 - 4.12.7.1.3 Utilize Rapid Cycle Process Improvement and Plan Do Study Act (PDSA) processes;
 - 4.12.7.1.4 Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;
 - 4.12.7.1.5 Implement interventions designed to achieve Quality improvements;
 - 4.12.7.1.6 Evaluate the effectiveness of the interventions;
 - 4.12.7.1.7 Establish standardized performance measures (such as HEDIS® or another similarly standardized product);
 - 4.12.7.1.8 Plan and initiate activities for increasing or sustaining improvement; and
 - 4.12.7.1.9 Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.
- 4.12.7.2 Each performance improvement project must be completed in a period determined by DCH, to allow information on the success of the project in the aggregate to produce new information on Quality of care each year.
- 4.12.7.3 The Contractor shall perform the required performance improvement projects (PIPs), as specified by DCH and agreed upon by the Parties, on an annual basis. Plan Do Study Act cycles must be incorporated into each PIP process.
- 4.12.7.4 Each PIP will use a study period approved by DCH.
- 4.12.7.5 Each PIP must include AIM statements and Driver Diagrams and align with the EQRO prepared PIP template. PIP components will be included as agreed upon by DCH and the CMOs.
- 4.12.7.6 The Contractor shall submit the designated PIPs to the EQRO Contractor using the DCH specified template and format as defined in the PIP protocol approved by DCH.
- 4.12.7.7 The EQRO will evaluate the CMOs' PIPs performance, using CMS approved Rapid Cycle PIP and/or other EQRO protocols. DCH reserves the right to request modification of the PIPs based on this evaluation. Modifications will be discussed with each CMO prior to implementation.

- 4.12.7.8 The Contractor shall submit PIP documentation to DCH and/or the EQRO using the DCH specified template and format as specified in the CMS approved Rapid Cycle PIP and/or other EQRO protocols.
- 4.12.7.9 The Contractor shall submit a PIP Annual Improvement Strategy Plan to DCH and/or the EQRO using the DCH specified template and format by October 31st of each contract year. This Plan will describe the improvement strategies to be implemented in the upcoming plan year (January 1st – December 31st).

4.12.8 Clinical Practice Guidelines (CPGs)

- 4.12.8.1 The Contractor shall adopt a minimum of three (3) evidence-based clinical practice guidelines. Such guidelines shall:
 - 4.12.8.1.1 Be based on the health needs and opportunities for improvement identified as part of the QAPI program;
 - 4.12.8.1.2 Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;
 - 4.12.8.1.3 Consider the needs of the Members;
 - 4.12.8.1.4 Be adopted in consultation with network Providers; and
 - 4.12.8.1.5 Be reviewed and updated periodically as appropriate.
- 4.12.8.2 The Contractor shall submit to DCH for review and prior approval and as updated thereafter all Clinical Practice Guidelines in use, which shall include a methodology for measuring and assessing compliance as part of the QAPI program plan.
- 4.12.8.3 The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members.
- 4.12.8.4 The Contractor shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
- 4.12.9.5 To ensure consistent application of the guidelines, the Contractor shall require Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Contractor will conduct this review on a quarterly basis. The Contractor may use Provider incentive strategies to improve Provider compliance with guidelines.
- 4.12.9.6 To further ensure consistent application of the Clinical Practice Guidelines, the Contractor shall perform a review of a minimum random sample of fifty (50) Members' medical records per evidence-based CPG, each quarter.

4.12.9 Focused Studies

- 4.12.9.1 Focused Studies examine a specific aspect of health care (such as prenatal care) for a defined point in time. These studies are usually based on information extracted from medical records or Contractor administrative data such as Enrollment files and Encounter/claims data. Steps that may be taken by the Contractor when conducting focused studies are:
 - 4.12.9.1.1 Selecting the Study Topic(s)
 - 4.12.9.1.2 Defining the Study Questions or Aim Statement
 - 4.12.9.1.3 Selecting the Study Indicator(s)
 - 4.12.9.1.4 Identifying a representative and generalizable study population
 - 4.12.9.1.5 Documenting sound sampling techniques utilized (if applicable)
 - 4.12.9.1.6 Collecting reliable data
 - 4.12.9.1.7 Analyzing data and interpreting study results
- 4.12.9.2 The Contractor may perform, at DCH discretion, a Focused Study to examine a specific aspect of health care (such as prenatal care) for a defined point in time. The Focused Study will have a calendar year study period and the results will be reported to DCH by June 30th following the year of the study. DCH shall retain the right to approve or disapprove all proposed Focus Studies.

4.12.10 Patient Safety Plan

- 4.12.10.1 The Contractor shall have a structured Patient Safety Plan, Report, and Analysis to address incidents and concerns regarding clinical care. This plan must include written policies and procedures for processing Member complaints regarding the care received and addressing incidents and concerns with clinical care. Such policies and procedures shall include:
 - 4.12.10.1.1 A system of classifying incidents, concerns, and complaints according to severity;
 - 4.12.10.1.2 A review by the Medical Director and a mechanism for determining which incidents will be forwarded to Peer Review; and
 - 4.12.10.1.3 A summary of incident(s), including the final disposition, included in the Provider profile.
- 4.12.10.2 At a minimum, the Patient Safety Program process shall:

- 4.12.10.1.4.1 Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals;
- 4.12.10.1.4.2 Report and analyze Medication recalls;
- 4.12.10.1.4.3 Report and analyze Medication errors;
- 4.12.10.1.4.4 Describe the results of site Inspections; and
- 4.12.10.1.4.5 Report and analyze Patient Quality of Care Concerns, including those arising from patient grievances.

4.12.10.3 The Contractor shall submit the Patient Safety Plan to DCH for initial review and approval and as updated and submit to DCH on an annual basis no later than June 30 of the Contract year a Patient Safety Program Report inclusive of the program components described in 4.12.10.1 and 4.12.10.2.

4.12.11 External Quality Review

4.12.11.1 DCH will contract with an External Quality Review Organization (EQRO) to conduct independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Contractor shall collaborate with DCH and its EQRO to develop studies, surveys and other analytic activities to assess the Quality of care and services provided to Members and to identify opportunities for CMO improvement. To facilitate this process the Contractor shall supply data, as requested by DCH or its EQRO, to the EQRO.

4.12.12 Value-Based Purchasing (VBP) Program

4.12.12.1 The Contractor shall collaborate with DCH to implement a Value-Based Purchasing (VBP) model. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, Contractors and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.

4.12.12.2 Prior to the Operational Start Date, DCH will establish a VBP performance management team ("VBP Performance Management Team"). The VBP Performance Management Team will have responsibility for planning, implementing, and executing the VBP initiative. The Team will work collaboratively with the Contractor to review the Contractor's progress on a monthly, quarterly and/or annual basis, determine incentive payments, and determine the need to modify priority areas, measures and targets.

4.12.12.3 In addition to DCH staff, key leadership from the Contractor such as the Medical Director, Chief Operating Officer, or other designee approved by DCH will provide input and feedback on planned priorities and initiatives. As appropriate, DCH will engage operational-level Contractor staff.

- 4.12.12.4 Through the VBP Performance Management Team, the Contractor and DCH shall meet at least quarterly to discuss progress on initiatives. Rapid cycle feedback is key to the success of a VBP model. The Contractor shall regularly review and provide real-time information focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis to DCH. The Contractor shall provide ongoing and ad hoc reports to DCH to highlight status and progress of initiatives, as well as successes and challenges. Regularly reviewing data is necessary for DCH and the Contractor to identify where initiatives are not resulting in improvements necessitating adjustments to the implemented approach. When adjustments are necessary, the Contractor shall report to DCH changes the Contractor will make to continually work towards improvements.
- 4.12.12.5 **Attachment U** outlines the performance measures and related targets that the Contractor must achieve under the VBP model. The Contractor must establish in collaboration with DCH initiatives that it will undertake to achieve the specified targets. Such initiatives may differ from or include other required initiatives, such as Performance Improvement Projects (PIPs) and Focused Studies. Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold") from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.
- 4.12.12.6 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the fourteen (14) performance measures. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold.

Contractor Payout Amount = (Number of Performance Targets Achieved/Total Number of Performance Targets) x Total VBP Withhold

- 4.12.12.7 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to a methodology for quantifying the Contractor's success in achieving targets and payments for each measure.
- 4.12.12.8 The Contractor shall incentivize Providers to participate in VBP and may also incentivize Members. The Contractor shall develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize Providers on a more frequent schedule than DCH's schedule for payment to the Contractor). Contractors are encouraged to collaborate to develop and implement interventions and solutions. The Contractor shall submit the plan to DCH for prior approval. The

Contractor shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date. The plan shall include details of how the Contractor will collaborate with Providers to determine the frequency of incentive payments to Providers and how the Contractor will encourage participation in the program.

4.12.12.9 The Contractor shall comply with the requirements set forth in the VBP Operations Manual.

4.12.13 Monitoring and Oversight Committee

4.12.13.1 The Contractor shall participate in the Georgia Families Monitoring and Oversight Committee (“GFMOOC”) and associated subcommittees as requested by DCH. The GFMOOC and associated subcommittees will assist DCH in assessing the performance of the Contractor and developing improvements and new initiatives specific to the Georgia Families program. The GFMOOC will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration between State agencies, the Contractor and external stakeholders. Members of the GFMOOC will be appointed by the DCH Commissioner or his designee. The GFMOOC meetings must be attended by Contractor decision makers defined as one or more of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position; and Chief Medical Officer.

4.12.14 Member Advisory Committee

4.12.14.1 The Contractor shall establish and maintain a Member Advisory Committee consisting of persons served by the Contractor including current and past Members and/or Authorized Representatives, and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The Committee shall meet at least quarterly, and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct on-site reviews of the membership of the Committee to ensure:

4.12.14.1.1 The Committee is discussing issues pertinent to the Member population;

4.12.14.1.2 The Committee is meeting as scheduled; and

4.12.14.1.3 The Committee members are in attendance.

4.12.15 Provider Advisory Committee

4.12.15.1 The Contractor shall establish and maintain a Provider Advisory Committee consisting of Providers contracted with the Contractor to serve Members. At least two (2) Providers on the Committee shall maintain health care practices that predominantly serve Medicaid beneficiaries. The Committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor Quality

management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct onsite reviews of the Committee meetings to ensure:

4.12.15.1.1 The Committee is discussing issues pertinent to the Member population;

4.12.15.1.2 The Committee is meeting as scheduled; and

4.12.15.1.3 The Committee members are in attendance.

4.12.16 Reporting Requirements

4.12.16.1 Contractors must submit the following data reports as indicated.

REPORT	DUE DATE	REPORTS DIRECTED TO:
Performance Improvement Project Proposal(s)	Annually October 31	DCH PQO Unit
Quality Assurance Performance Improvement Plan	Annually June 30	DCH PQO Unit
Quality Assessment Performance Improvement Program Evaluation	Annually June 30	DCH PQO Unit
Performance Improvement Project Report	Annually June 30	EQRO vendor
Performance Measures Report	Annually June 30	DCH PQO Unit
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	Annually July 31	DCH PQO Unit

4.12.16.2 If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the DCH PQO Unit.

4.12.16.3 The Contractor’s Quality Oversight Committee shall submit to DCH Quality Oversight Committee Reports - Ad Hoc as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.12.16.4 The Contractor shall submit to DCH Performance Improvement Project Reports no later than June 30 of the Contract year or per protocol described in Section 4.12.7.

4.12.16.5 The Contractor shall submit to DCH Focused Studies Reports no later than June 30 of the Contract year as described in Section 4.12.9.

4.12.16.6 The Contractor shall submit to DCH annual Patient Safety Plan Reports no later than June 30 of the Contract year as described in Section 4.12.10.

4.13 FRAUD, WASTE AND ABUSE

4.13.1 Program Integrity

- 4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services under this Contract.
- 4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below.
- 4.13.1.3 The Contractor shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and Provider type within seven (7) Business Days of the settlement.

4.13.2 Compliance Plan

- 4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following:
 - 4.13.2.1.1 The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed.
 - 4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud , Waste and Abuse violations, including specific methodologies for such monitoring and auditing;
 - 4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;
 - 4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;
 - 4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;
 - 4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;
 - 4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;

- 4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following:
 - 4.13.2.1.8.1 Prepayment review of claims;
 - 4.13.2.1.8.2 Claims edits;
 - 4.13.2.1.8.3 Post-processing review of Claims;
 - 4.13.2.1.8.4 Provider profiling;
 - 4.13.2.1.8.5 Quality Control; and
 - 4.13.2.1.8.6 Utilization Management.
- 4.13.2.1.9 Written standards for organizational conduct;
- 4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;
- 4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;
- 4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;
- 4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified; and
- 4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Georgia Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.
- 4.13.2.2 As part of the Program Integrity Program, the Contractor may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures described in Section 4.13.1. The pharmacy lock-in program shall:
 - 4.13.2.2.1 Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;

- 4.13.2.2.2 Provide Case Management and education reinforcement of appropriate medication use;
- 4.13.2.2.3 Annually assess the need for lock in for each Member;
- 4.13.2.2.4 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH; and
- 4.13.2.2.5 Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.

4.13.3 Coordination with DCH and Other Agencies

- 4.13.3.1 The Contractor shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.
- 4.13.3.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.
- 4.13.3.3 The Contractor shall inform DCH immediately about known or suspected fraud cases and it shall not investigate or resolve the suspicion without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.

4.13.4 Reporting Requirements

- 4.13.4.1 The Contractor shall submit to DCH a quarterly Fraud and Abuse Report, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.20.

4.14 INTERNAL GRIEVANCE/APPEALS SYSTEM

4.14.1 General Requirements

- 4.14.1.1 The Contractor's Grievance System shall include a process to receive, track, resolve and report on Grievances from its Members. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing. See O.C.G.A. §49-4-153.

- 4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.
- 4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal laws and regulations, the provisions of this Contract, and the Contractor's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.
- 4.14.1.4 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.
- 4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.
- 4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision-making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:
 - 4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;
 - 4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and
 - 4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.

4.14.2 Member Medical Review Process for PeachCare for Kids®

- 4.14.2.1 DCH also allows a state review on behalf of PeachCare for Kids® Members. If the Member, parent or other authorized representative of the Member believes that a denied service should be covered, the parent or such representative must send a written request for review to the CMO in which the affected child is enrolled.
- 4.14.2.2 If the decision of the Contractor review maintains the denial of service, a letter will be sent to the parent or representative detailing the reason for denial. If the parent or representative elects to dispute the decision, the parent or representative will have the option of having the decision reviewed by the Formal Grievance Committee. The request should be sent to:

Department of Community Health
PeachCare for Kids®
Administrative Review Request
2 Peachtree Street, NW, 37th floor
Atlanta, GA 30303-3159

- 4.14.2.3 The decision of the Formal Grievance Committee will be the final recourse available to the Member. In reference to the Formal Grievance level, the State assures:
- 4.14.2.3.1 Enrollees receive timely written notice of any documentation that includes the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which Enrollment may continue, pending review.
 - 4.14.2.3.2 Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, or termination of health services, or failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Grievance level.
 - 4.14.2.3.3 Decisions are written when reviewed by DCH and the Formal Grievance Committee.
 - 4.14.2.3.4 Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.
 - 4.14.2.3.5 Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, Members will be notified of the timeframes for the appeals process once an appeal is filed with the Formal Grievance Committee.
 - 4.14.2.3.6 Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.
 - 4.14.2.3.7 Reviews that are not expedited due to an enrollee's medical condition will be completed within ninety (90) Calendar Days of the date of a request is made.
 - 4.14.2.3.8 Reviews that are expedited due to an enrollee's medical condition shall be completed within seventy-two (72) clock hours of the receipt of the request.

4.14.3 Grievance Process

- 4.14.3.1 A Member or Member's Authorized Representative may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.

- 4.14.3.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director, who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making.
- 4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.
- 4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.

4.14.4 Proposed Action

- 4.14.4.1 All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member's Condition or disease.
- 4.14.4.2 In the event of a Proposed Action, the Contractor shall notify the Member in writing. The Contractor shall also provide written notice of a Proposed Action to the Provider. This notice must meet the language and format requirements in accordance with Section 4.3.2 of this Contract and be sent in accordance with the timeframes described in Section 4.14.3.4.
- 4.14.4.3 The notice of Proposed Action must contain the following:
 - 4.14.4.3.1 The Action the Contractor has taken or intends to take, including the service or procedure that is subject to the Action;
 - 4.14.4.3.2 Additional information, if any, that could alter the decision;
 - 4.14.4.3.3 The specific reason used as the basis of the Action;
 - 4.14.4.4 The reasons for the Action must have a factual basis and legal/policy basis;
 - 4.14.4.3.5 The Member's right to file an Administrative Review through the Contractor's internal Grievance System;
 - 4.14.4.3.6 The Provider's right to file a Provider Complaint as described in Section 4.9.7;
 - 4.14.4.3.7 The requirement that a Member exhaust the Contractor's internal Administrative Review Process;
 - 4.14.4.3.8 The procedures for exercising the rights outlined in this Section;

- 4.14.4.3.9 The circumstances under which expedited review is available and how to request it; and
 - 4.14.4.3.10 The Member's right to have Benefits continue pending resolution of the Administrative Review with the Contractor, Member instructions on how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.
- 4.14.4.4 The Contractor shall mail the notice of Proposed Action within the following timeframes:
- 4.14.4.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of one of the following exceptions:
 - 4.14.4.4.1.1 The Contractor has factual information confirming the death of a Member.
 - 4.14.4.4.1.2 The Contractor receives a clear written statement signed by the Member that
 - 4.14.4.4.1.2.1 he or she no longer wishes services; or
 - 4.14.4.4.1.2.2 gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
 - 4.14.4.4.1.3 The Contractor establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
 - 4.14.4.4.1.4 The Member has been admitted to an institution where he is ineligible under the plan for further services.
 - 4.14.4.4.1.5 The post office returns Contractor mail directed to the Member indicating no forwarding address and the Member's whereabouts are unknown (refer to 42 CFR 431.231(d) for procedures if the Member's whereabouts become known).
 - 4.14.4.4.1.6 The Member's Provider prescribes an immediate change in the level of medical care.
 - 4.14.4.4.1.7 The date of Action will occur in less than ten (10) Calendar days, in accordance with 42 C.F.R. §483.12(a) (5) (ii),

which provides exceptions to the thirty (30) Calendar days' notice requirements of 42 C.F.R. § 483.12(a) (5) (i).

- 4.14.4.4.2 For an adverse determination with regard to preadmission screening requirements, not later than the date of Proposed Action in accordance with 42 CFR 431.213.
- 4.14.4.4.3 For Standard Service Authorization decisions that deny or limit services, within the timeframes required in Section 4.11.2.7.1.
- 4.14.4.4.4 If the Contractor extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.7, the Contractor shall give the Member written notice of the reasons for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.
- 4.14.4.4.5 For authorization decisions not reached within the timeframes required in Section 4.11.2.7 for either standard or expedited Service Authorizations (which constitutes a denial and is thus an adverse action), notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.

4.14.4.5 Notice in Case of Probable Fraud

- 4.14.4.5.1 The Contractor may shorten the period of advance notice to five (5) Calendar Days before date of Action if the Contractor has facts indicating that Action should be taken because of probable Member Fraud and the facts have been verified, if possible, through secondary sources.

4.14.5 Administrative Review Process

- 4.14.5.1 An Administrative Review is the request for review of a "Proposed Action". The Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review either orally or in writing. Unless the Member or Provider requests expedited review, the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's or written consent, must follow an oral filing with a written, signed, request for Administrative Review. An Administrative Review must be filed within thirty (30) Calendar Days of the notice of Proposed Action.
- 4.14.5.2 Administrative Reviews shall be filed directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Administrative Review committee, but the delegation must be in writing.
- 4.14.5.3 The Contractor shall ensure that the individuals who make decisions on Administrative Reviews are individuals who were not involved in any previous level of review or

decision-making and who are Health Care Professionals who have the appropriate clinical expertise in treating the Member's Condition or disease if deciding any of the following:

- 4.14.5.3.1 An Administrative Review of a denial that is based on lack of Medical Necessity.
- 4.14.5.3.2 An Administrative Review that involves clinical issues.
- 4.14.5.4 The Administrative Review process shall provide the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing, and to examine the Member's case file, including Medical Records, and any other documents and records considered during the Administrative Review process. The Contractor shall inform the Member of the limited time available to provide this in case of expedited review.
- 4.14.5.5 The Administrative Review process must include as parties to the Administrative Review the Member, the Member's Authorized Representative, the Provider acting on behalf of the Member with the Member's written consent, or the legal representative of a deceased Member's estate.
- 4.14.5.6 The Contractor shall resolve each Administrative Review and provide written notice of the resolution, as expeditiously as the Member's health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Contractor receives the Administrative Review. For expedited reviews and notice to affected parties, the Contractor has no longer than three (3) Working Days or as expeditiously as the Member's physical or mental health condition requires, whichever is sooner. If the Contractor denies a Member's request for expedited review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) Calendar Days with a written notice. The Contractor shall also make reasonable efforts to provide oral notice for resolution of an expedited review of an Administrative Review.
- 4.14.5.7 The Contractor may extend the timeframe for standard or expedited resolution of the Administrative Review by up to fourteen (14) Calendar Days if the Member, Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, requests the extension or the Contractor demonstrates (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the Member's interest. If the Contractor extends the timeframe, it must, for any extension not requested by the Member, give the Member written notice of the reason for the delay.

4.14.6 Notice of Adverse Action

- 4.14.6.1 If the Contractor upholds the Proposed Action in response to an Administrative Review filed by the Member the Contractor shall issue a Notice of Adverse Action within the timeframes described in Sections 4.14.5.6 and 4.14.5.7.
- 4.14.6.2 The Notice of Adverse Action shall meet the language and format requirements as specified in 4.3.2 and include the following:
 - 4.14.6.2.1 The results and date of the Adverse Action including the service or procedure that is subject to the Action.
 - 4.14.6.2.2 Additional information, if any, that could alter the decision.
 - 4.14.6.2.3 The specific reason used as the basis of the Action.
 - 4.14.6.2.4 The right to request a State Administrative Law Hearing within thirty (30) Calendar Days from the date of the Notice of Adverse Action. The time for filing will begin when the filing is date stamped.
 - 4.14.6.2.5 The right to continue to receive Benefits pending a State Administrative Law Hearing.
 - 4.14.6.2.6 How to request the continuation of Benefits.
 - 4.14.6.2.7 Information explaining that the Member may be liable for the cost of any continued Benefits if the Contractor's Action is upheld in a State Administrative Law Hearing.
 - 4.14.6.2.8 Circumstances under which expedited resolution is available and how to request it.

4.14.7 Administrative Law Hearing

- 4.14.7.1 The State will maintain an independent Administrative Law Hearing process as defined in O.C.G.A. §49-4-153 and as required by federal law, 42 CFR 431.200. The Administrative Law Hearing process shall provide Members an opportunity for a hearing before an impartial Administrative Law Judge. The Contractor shall comply with decisions reached as a result of the Administrative Law Hearing process.
- 4.14.7.2 The Contractor is responsible for providing counsel to represent its interests. DCH is not a party to the case and will only provide counsel to represent its own interests.
- 4.14.7.3 A Member, or Member's Authorized Representative may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by the Contractor. The parties to the Administrative Law Hearing shall include the Contractor as well as the Member, Member's Authorized Representative, or authorized representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member. DCH reserves the right to intervene on behalf of the interest of either party.

- 4.14.7.4 The hearing request and a copy of the adverse action letter must be received by the Contractor within thirty (30) Calendar Days or less from the date that the notice of Action was mailed.
- 4.14.7.5 A Member may request a Continuation of Benefits as described in Section 4.14.7 while an Administrative Law Hearing is pending.
- 4.14.7.6 The Contractor shall make available any records and any witnesses at its own expense in conjunction with a request pursuant to an Administrative Law Hearing.
- 4.14.8 Continuation of Benefits while the Contractor Appeal and Administrative Law Hearing are Pending
 - 4.14.8.1 As used in this Section, “timely” filing means filing on or before the later of the following:
 - 4.14.8.1.1 Within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Action.
 - 4.14.8.1.2 The intended effective date of the Contractor’s Proposed Action.
 - 4.14.8.2 The Contractor shall continue the Member’s Benefits if the Member, or the Member’s Authorized Representative files the Appeal timely; the Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized Provider; the original period covered by the original authorization has not expired; and the Member requests extension of the Benefits.
 - 4.14.8.3 If, at the Member’s request, the Contractor continues or reinstates the Member’s Benefits while the Appeal or Administrative Law Hearing is pending, the Benefits must be continued until one of the following occurs:
 - 4.14.8.3.1 The Member withdraws the Appeal or request for the Administrative Law Hearing.
 - 4.14.8.3.2 Ten (10) Calendar Day pass after the Contractor mails the Notice of Adverse Action, unless the Member, within the ten (10) Calendar Day timeframe, has requested an Administrative Law Hearing with continuation of Benefits until an Administrative Law Hearing decision is reached.
 - 4.14.8.3.3 An Administrative Law Judge issues a hearing decision adverse to the Member.
 - 4.14.8.3.4 The time period or service limits of a previously authorized service has been met.
 - 4.14.8.4 If the final resolution of Appeal is adverse to the Member, that is upholds the Contractor’s Action, the Contractor may recover from the Member the cost of the

services furnished to the Member while the Appeal is pending, to the extent that they were furnished solely because of the requirements of this Section.

4.14.8.5 If the Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires.

4.14.8.6 If the Contractor or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Contractor shall pay for those services.

4.15 ADMINISTRATION AND MANAGEMENT

4.15.1 General Provisions

4.15.1.1 The Contractor shall be responsible for the administration and management of all requirements of this Contract. All costs related to the administration and management of this Contract shall be the responsibility of the Contractor.

4.15.2 Place of Business and Hours of Operation

4.15.2.1 The Contractor shall maintain a place of business in the metropolitan Atlanta Area within thirty-five (35) miles of 2 Peachtree Street, NW Atlanta, GA 30303. The Contractor must have at least one (1) satellite office serving no less than two (2) contiguous Service Regions. The central business office must be accessible for foot and vehicle traffic. All documentation must reflect the address of the location identified as the legal, duly licensed, central business office. This business office must be open at least between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday with the exception of State holidays. The Contractor shall ensure that the office(s) are adequately staffed to ensure that Members and Providers receive prompt and accurate responses to inquiries.

4.15.2.2 The Contractor shall provide access twenty-four (24) clock hours a day, seven (7) days per week to its web site. The Contractor shall provide seventy-two (72) clock hours advance notice of web site upgrades, servicing and updates.

4.15.3 Training

4.15.3.1 The Contractor shall conduct on-going training for its entire staff, in all departments, to ensure appropriate functioning in all areas and to ensure that staff is aware of all programmatic changes. The Contractor must train its staff using a curriculum specific to their areas of responsibility. The training program must include, for example, training about the Georgia Medicaid program, Medicaid regulations, issues specific to the enrolled populations and managed care operations. Staff must receive training about the functionality of Information Systems so that they are fully capable of using the systems to complete their job functions. The Contractor shall also ensure that staff have the necessary qualifications and education to perform their assigned jobs. The

Contractor and its staff shall attest that staff have received required trainings and have necessary qualifications and education.

- 4.15.3.2 The Contractor shall submit a staff-training plan to DCH for initial review and approval and as updated thereafter.
- 4.15.3.3 The Contractor designated staff are required to attend DCH in-service training on an ad-hoc basis. DCH will determine the type and scope of the training.
- 4.15.3.4 DCH may attend any training sessions conducted by or on behalf of the Contractor specific to this Contract at its discretion.

4.15.4 Data and Report Certification

4.15.4.1 The Contractor shall certify all data pursuant to 42 CFR 438.606. The data that must be certified include, but are not limited to, Enrollment information, Encounter Data, Contractual Reports, inclusive of all Quality management reports, and other information required by the State and contained in Contracts, proposals and related documents. The data must be certified by one of the following: the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for and who Reports directly to the Contractor's Chief Executive Officer or Chief Financial Officer. Specific to the Quality management reports, the Chief Medical Officer or other delegated physician must review and attest to the accuracy of all Quality management reports submitted to DCH. The signature of the Chief Medical Officer or other delegated physician is required on all Quality management reports.

4.15.4.1.1 By virtue of submission, the Contractor attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.

4.15.4.1.2 Inaccurate data, reports, and other documents provided to the State by the Contractor are subject to applicable Liquidated Damages.

4.15.4.2 The Contractor shall submit the certification concurrently with the certified data.

4.15.5 Transition Planning

4.15.5.1 The Contractor must include a transition plan as part of its implementation CMO Project Plan. The transition plan must outline specific goals and objectives that articulate how the Contractor will coordinate with DCH and DCH sister agencies to assume responsibility for Members transitioning from another CMO and other scope of work activities. An impact statement should be produced outlining the potential impact of the transition of Members, the existing infrastructure and operations and support staff. Specifically, the Contractor must:

4.15.5.1.1 Work to ensure Members will be served in a timely and appropriate manner to maintain continuity of care for the Members;

- 4.15.5.1.2 Detail how activities will differ for existing Medicaid Members upon the Operational Start Date versus new Members coming into the program after the Operational Start Date; and
- 4.15.5.1.3 Accept and recognize existing Pre-Certifications and Prior Authorizations.
- 4.15.5.2 The transition plan must also identify the tools, techniques, and methodologies that are needed to perform an efficient and effective transition.

4.15.6 Turnover Planning

- 4.15.6.1 No later than thirty (30) Calendar Days after the Contract Effective Date, the Contractor must submit a detailed turnover plan (“Turnover Plan”) to DCH. The Turnover Plan must:
 - 4.15.6.1.1 Specify how the Contractor will turn over any and all records, files, methodologies, data and any supplemental documentation which DCH would require for DCH or another contractor to take over operation of the Georgia Families programs in the event of Contract expiration or termination for any reason;
 - 4.15.6.1.2 Include all elements of turnover phases, including specific schedule;
 - 4.15.6.1.3 Include a statement of resources and training that would be necessary to facilitate and efficiently turnover the Georgia Families programs to the State or another contractor;
 - 4.15.6.1.4 Include a statement commitment to maintain the level of resources dedicated to full-program operations through the contract termination; and
 - 4.15.6.1.5 Any Turnover Plan revisions required by DCH must be finalized within five (5) Calendar Days of DCH’s feedback.

4.16 **CLAIMS MANAGEMENT**

The Contractor shall have adequate systems and staff in place to ensure that the provision of Health Care services under this Contract is properly documented, accounted for, and reported.

4.16.1 General Provisions

- 4.16.1.1 The Contractor shall adhere to the time frames and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid Claims outlined in the DCH Policy Manuals. The Contractor shall administer an effective, accurate and efficient claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by DCH (see Part I.

Policy and Procedures for Medicaid/PeachCare for Kids® Manual) and in compliance with all applicable State and federal laws, rules and regulations. Any claims processing issues caused by the Contractor will be resolved within a forty-five (45) Calendar Day limit. The Contractor shall contact Providers within fifteen (15) Calendar Days to resolve claims processing issues. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum, calculated from fifteen (15) Calendar Days after the date the Claim was submitted.

- 4.16.1.2 The Contractor shall maintain a Claims management system that can identify date of receipt (the date the Contractor receives the Claim as indicated by the date-stamp), real-time-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, Appealed, etc.), and date of payment (the date of the check or other form of payment).
- 4.16.1.3 At a minimum, the Contractor shall run one (1) Provider payment cycle per week, on the same day each week, as determined by DCH.
- 4.16.1.4 The Contractor shall support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of Claims payments.
- 4.16.1.5 The Contractor shall encourage its Providers, as an alternative to the filing of paper-based Claims, to submit and receive Claims information through electronic data interchange (EDI), i.e. electronic Claims. Electronic Claims must be processed in adherence to information exchange and data management requirements specified in the Information Management and Systems section of this Contract, Section 4.17. As part of this Electronic Claims Management (ECM) function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status information.
- 4.16.1.6 The Contractor shall generate explanation of Benefits and remittance advices in accordance with State standards for formatting, content and timeliness and will verify that Members have received the services indicated on the explanation of Benefits and the remittance advices.
- 4.16.1.7 The Contractor shall issue a formal tracking number for claims inquiries and shall tie any recoupment to the original payment on the remittance advice. The Contractor shall provide the ability to separate provider remittance advice by location identified through the location-specific provider number.
- 4.16.1.8 The Contractor shall not pay any Claim submitted by a Provider who is excluded or suspended from the Medicare, Medicaid or CHIP programs for Fraud, Waste or Abuse or otherwise included on the U.S. Department of Health and Human Services Office of Inspector General exclusions list, or who employs someone on this list. The Contractor shall not pay any Claim submitted by a Provider that is on payment hold under the authority of DCH or its Agent(s).

- 4.16.1.9 Not later than the fifteenth (15) Business Day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO web site/Provider Portal or an interim explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO shall complete processing of the Claim within fifteen (15) Business Days.
- 4.16.1.10 For services rendered within seventy-two (72) hours after the Provider verifies the eligibility of the patient with the Contractor, the Contractor shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Contractor made payment for a patient for whom it was not responsible, then the Contractor may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.
- 4.16.1.11 The Contractor shall not apply any penalty for failure to file Claims in a timely manner, for failure to obtain Prior Authorization, or for the Provider not being a participating Provider in the Contractor's network. The amount of reimbursement shall be that Provider's applicable rate for the service provided by an In Network or Out of Network Provider.
- 4.16.1.12 The Contractor shall inform all network Providers about the information required to submit a Clean Claim as a provision within the Contractor/Provider Contract. The Contractor shall make available to network Providers Claims coding and processing guidelines for the applicable Provider type. The Contractor shall notify Providers ninety (90) Calendar Days before implementing significant changes to Claims coding and processing guidelines. DCH's definition of 'significant' shall be binding.
- 4.16.1.13 The Contractor shall perform and submit to DCH Quarterly scheduled Global Claims Analyses to ensure an effective, accurate, and efficient claims processing function that adjudicates and settles Provider Claims. In addition, the Contractor shall assume all costs associated with Claims processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor's Span of Control. If, based on its review of such analysis, DCH finds the Contractor's claims management system and/or processes to be insufficient, DCH may require from the Contractor a Corrective Action Plan outlining how it will address the identified issues.
- 4.16.1.14 The Contractor's web site shall be functionally equivalent to the web site maintained by the State's Medicaid Fiscal Agent Contractor.

4.16.2 Other Considerations

- 4.16.2.1 An adjustment to a paid Claim shall not be counted as a Claim for the purposes of reporting.

4.16.2.2 Electronic Claims shall be treated as identical to paper-based Claims for the purposes of reporting.

4.16.3 Encounter Claims Submission Requirements

4.16.3.1 The GF program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor to provide timely, complete and accurate information. Encounter data from the Contractor also allows DCH to budget available resources, set Contractor Capitation Rates, monitor Utilization, follow public health trends and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes.

4.16.3.2 The Contractor shall work with all contracted Providers to implement standardized billing requirements to enhance the Quality and accuracy of the billing data submitted to the health plan.

4.16.3.3 The Contractor shall instruct contracted Providers that the State of Georgia Medicaid ID number is mandatory, until such time as otherwise determined by DCH. The Contractor will emphasize to Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.

4.16.3.4 The Contractor shall submit to DCH's Fiscal Agent Contractor and Data Warehouse vendor weekly cycles of data files. All identified errors shall be submitted to the Contractor from the Fiscal Agent Contractor each Week. The Contractor shall address identified issues and resubmit the corrected file to the Fiscal Agent Contractor within seven (7) Business Days of receipt. Data files to the DCH Data Warehouse vendor may lag a week based on corrected file re-submissions identified by DCH's Fiscal Agent Supplier.

4.16.3.5 The Contractor is required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, Member Name, and DOB. These items must match the State's eligibility and Provider file.

4.16.3.6 The Contractor's submitted Claims must consistently include valid values for the below list of fields and any other fields identified by DCH:

4.16.3.6.1 Patient name

4.16.3.6.2 Date of birth

4.16.3.6.3 Place of service

4.16.3.6.3 Date of service

- 4.16.3.6.4 Type of service
 - 4.16.3.6.5 Units of service
 - 4.16.3.6.7 Diagnostic related groupings (DRGs)
 - 4.16.3.6.8 Treating Provider
 - 4.16.3.6.9 NPI number of rendering Provider
 - 4.16.3.6.10 NPI number of OPR Provider
 - 4.16.3.6.11 Tax Identification Number
 - 4.16.3.6.12 Facility code
 - 4.16.3.6.13 A unique Transaction Control Number (TCN)
 - 4.16.3.6.14 All additionally required CMS 1500 or UB 04 codes
 - 4.16.3.6.15 CMO Paid Amount
 - 4.16.3.6.16. DRG version
 - 4.16.3.6.17. Specify units (by adding allowed units; billed units and paid units of service
 - 4.16.3.6.18 Mandatory Identification of any claim that is a 340B claim.
- 4.16.3.7 For each submission of Claims as described in this section, the Contractor must provide via DCH's required electronic format the following Cash Disbursements data elements:
- 4.16.3.7.1 Provider/Payee Number
 - 4.16.3.7.2 Name
 - 4.16.3.7.3 Address
 - 4.16.3.7.4 City
 - 4.16.3.7.5 State
 - 4.16.3.7.6 Zip
 - 4.16.3.7.8 Check date
 - 4.16.3.7.9 Check number

4.16.3.7.10 Check amount

4.16.3.7.11 Check code (i.e. EFT, paper check, etc.).

4.16.3.8 The Contractor will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.

4.16.3.9 The Contractor shall submit ninety-nine percent (99%) of Encounter Claims within thirty (30) Calendar Days of Claims payment both for the original Claim and any adjustment. DCH will validate Encounter Claims submission according to the cash disbursement journal of the Contractor and any of its applicable Subcontractors.

4.16.3.10 The Contractor shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the Fiscal Agent Contractor and DCH. The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim counts as an error for that encounter (this is regardless of how many other errors are detected in the TCN.)

4.16.3.11 The Contractor's failure to comply with the defined standard(s) will be subject to a Corrective Action Plan and the Contractor may be liable for Liquidated Damages.

4.16.3.12 Within thirty Calendar Days of Contract Award, the Contractor must submit to DCH a data model of the Supplier's reporting repository, the proposed data layout for weekly data file submissions and a corresponding data dictionary. As these documents are part of DCH's advancement in MITA maturity, such information will not be considered final without DCH approval. Please note that DCH uses the ERwin Data Modeling tool. A sample data dictionary is included in the Suppliers' Library. The sample data dictionary is a guide to provide Suppliers with an understanding of DCH's expectations as it relates to the elements to be included in a dictionary and the format which will be most useful to the DCH. Alternate dictionaries may be accepted if they, at the least, provide the listed elements in a format with similar functionality.

4.16.4 RESERVED

4.16.5 Emergency Services

4.16.5.1 The Contractor shall not deny or inappropriately reduce payment to a Provider of Emergency Services for any evaluation, diagnostic testing, or treatment provided to a Member for an emergency condition.

4.16.5.2 The Contractor shall not make payment for Emergency Services contingent on the Member or Provider of Emergency Services providing any notification, either before or after receiving Emergency Services.

4.16.5.3 In processing claims for Emergency Services, the Contractor shall consider, at the time that a claim is submitted, at least the following criteria:

4.16.5.3.1 The age of the patient;

- 4.16.5.3.2 The time and day of the week the patient presented for services;
 - 4.16.5.3.3 The severity and nature of the presenting symptoms;
 - 4.16.5.3.4 The patient's initial and final diagnosis; and
 - 4.16.5.3.5 Any other criteria prescribed by DCH, including criteria specific to patient less than eighteen (18) years of age.
- 4.16.5.4 The Contractor shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for Claims presented for Emergency Services.
- 4.16.5.5 If a provider that has not entered into a contract with the Contractor provides Emergency Services or post-stabilization services to the Contractor's Member, the Contractor shall reimburse the non-contracted provider for such Emergency Services and post-stabilization services at a rate equal to the rate paid by DCH for Medicaid claims that it reimburses directly.

4.16.6 Reporting Requirements

- 4.16.6.1 The Contractor shall submit to DCH monthly Claims Processing Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.17 **INFORMATION MANAGEMENT AND SYSTEMS**

The Contractor shall develop, maintain and update, at no cost to DCH or Providers, an information management system for the purpose of integrating all components of the delivery of care to its Members. The system shall have the capability to securely store and transmit information, interface with other relevant systems and report data in a format specified by DCH. The Contractor shall ensure the system is available and accessible to users at times and in a format that encourages meaningful use by stakeholders.

4.17.1 General Provisions

- 4.17.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GF requirements, State and federal reporting requirements, all other Contract requirements and any other applicable State and federal laws, rules and regulations, as amended, including HIPAA.
 - 4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.
- 4.17.1.2 The Contractor is responsible for maintaining Systems that shall possess capacity sufficient to handle the workload projected for the start of the program and will be

scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.

- 4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.
- 4.17.1.4 The Contractor shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its Agents and every Contractor.
- 4.17.1.5 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with the State. This system shall be:
 - 4.17.1.5.1 Available from the workstations of the designated Contractor contacts; and
 - 4.17.1.5.2 Capable of attaching and sending documents created using software products other than Contractor systems, including the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.
- 4.17.1.6 By no later than the 30th of April of each year, the Contractor will provide DCH with an annual progress/status report of the Contractor's Systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Contractor's Span of Control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The Systems refresh plan will also indicate how the Contractor will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the Systems' components.
- 4.17.1.7 The Contractor is responsible for all costs associated with the Contractor's Systems refresh plan.

4.17.2 Health Information Technology and Exchange

- 4.17.2.1 The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased information on cost and Quality of care through health information technology.

- 4.17.2.2 The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the Quality and cost of health care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Contractor shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers.
- 4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).
 - 4.17.2.3.1 If not already participating in the GaHIN, the Contractor shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Contract Effective Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process;
 - 4.17.2.3.2 The Contractor shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;
 - 4.17.2.3.3 DCH and/or its designee shall provide detailed on-boarding information for use by the Contractor to establish interoperability with the GaHIN; and
 - 4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.
- 4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.
 - 4.17.2.4.1 Through their system and interoperability with the GaHIN, the Contractor shall provide the following types of patient health information on Members including, but not limited to:
 - 4.17.2.4.1.1 Member-specific information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic information, as appropriate;
 - 4.17.2.4.1.2 Name and address of each Member's PCP;
 - 4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;
 - 4.17.2.4.1.4 Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;

- 4.17.2.4.1.5 Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnoses, and treatment given, including drugs prescribed;
 - 4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;
 - 4.17.2.4.1.7 Complete record of all immunizations;
 - 4.17.2.4.1.8 Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the claims or "visits" module of the VHR; and
 - 4.17.2.4.1.9 Any utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description.
- 4.17.2.5 The Contractor shall access the GaHIN to display Member health information within their system for the purpose of Care Coordination and management of the Members.
- 4.17.2.6 The Contractor shall provide DCH with a list of Authorized Users who may access patient health data from the Contractor's Systems. DCH shall review and approve the list, including revisions thereto, of the Contractor's Authorized Users who may access patient health data from the Contractor's systems. The Contractor shall be permitted to access the GaHIN for purposes associated with this Contract only.
- 4.17.2.8 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.

4.17.3 Global System Architecture and Design Requirements

- 4.17.3.1 The Contractor shall comply with federal and State policies, standards and regulations in the design, development and/or modification of the Systems it will employ to meet the aforementioned requirements and in the management of Information contained in those Systems. Additionally, the Contractor shall adhere to DCH and State-specific system and data architecture preferences as indicated in this Contract.
- 4.17.3.2 The Contractor's Systems shall:
 - 4.17.3.2.1 Employ a relational data model in the architecture of its databases and relational database management system (RDBMS) to operate and maintain them;
 - 4.17.3.2.2 Be SQL and ODBC compliant;

- 4.17.3.2.3 Adhere to Internet Engineering Task Force/Internet Engineering Standards Group standards for data communications, including TCP and IP for data transport;
 - 4.17.3.2.4 Conform to standard code sets detailed in Attachment K;
 - 4.17.3.2.5 Contain industry standard controls to maintain information integrity applicable to privacy and security, especially PHI. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly and mutually agreed upon by the Contractor and DCH; and
 - 4.17.3.2.6 Partner with the State in the development of future standard code sets, not specific to HIPAA or other federal effort and will conform to such standards as stipulated by DCH.
- 4.17.3.3 Where Web services are used in the engineering of applications, the Contractor's Systems shall conform to World Wide Web Consortium (W3C) standards such as XML, UDDI, WSDL and SOAP so as to facilitate integration of these Systems with DCH and other State systems that adhere to a service-oriented architecture.
- 4.17.3.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the Information is finally recorded. The audit trails shall:
- 4.17.3.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;
 - 4.17.3.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;
 - 4.17.3.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;
 - 4.17.3.4.4 Be supported by listings, transaction Reports, update Reports, transaction logs, or error logs;
 - 4.17.3.4.5 Facilitate auditing of individual Claim records as well as batch audits; and
 - 4.17.3.4.6 Be maintained for seven (7) years in either live and/or archival Systems, as applicable. The duration of the retention period may be extended at the discretion of and as indicated to the Contractor by the State as needed for ongoing audits or other purposes.
- 4.17.3.5 The Contractor shall house indexed images of documents used by Members and Providers to transact with the Contractor in the appropriate database(s) and document

management systems to maintain the logical relationships between certain documents and certain data.

- 4.17.3.6 The Contractor shall institute processes to ensure the validity and completeness of the data it submits to DCH. At its discretion, DCH will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Member ID, date of service, Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of Claim processing, and date of Claim payment.
- 4.17.3.7 Where Systems are herein required to, or otherwise supports, the applicable batch or on-line transaction type, the Systems shall comply with HIPAA-standard transaction code sets as specified in **Attachment K**, and as updated thereafter.
- 4.17.3.8 The Contractor System(s) shall conform to HIPAA standards for information exchange, and as updated thereafter.
- 4.17.3.9 The layout and other applicable characteristics of the pages of Contractor Web sites shall be compliant with Federal “section 508 standards” and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.
- 4.17.3.10 Contractor Systems shall conform to any applicable Application, Information and Data, Middleware and Integration, Computing Environment and Platform, Network and Transport, and Security and Privacy policy and standard issued by GTA as stipulated in the appropriate policy/standard, and as updated thereafter. These policies and standards can be accessed at:
http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.html

4.17.4 Data and Document Management Requirements By Major Information Type

- 4.17.4.1 In order to meet programmatic, reporting and management requirements, the Contractor’s Systems shall serve as either the Authoritative Host of key data and documents or the host of valid, replicated data and documents from other systems. **Attachment K** lays out the requirements for managing (capturing, storing and maintaining) data and documents for the major information types and subtypes associated with the aforementioned programmatic, reporting and management requirements.

4.17.5 System and Data Integration Requirements

- 4.17.5.1 All of the Contractor’s applications, operating software, middleware, and networking hardware and software shall be able to interface with the State’s systems DCH vendors systems and will conform to standards and specifications set by the Georgia Technology Authority and the agency that owns the systems. These standards and specifications are detailed in **Attachment K**.

- 4.17.5.2 The Contractor's System(s) shall be able to transmit and receive transaction data to and from the MMIS as required for the appropriate processing of Claims and any other transaction that may be performed by either system.
- 4.17.5.3 The Contractor shall generate Encounter data files no less than weekly (or at a frequency defined by DCH) from its claims management system(s) and/or other sources. The files will contain settled Claims and Claim adjustments and encounters from Providers with whom the Contractor has a capitation arrangement for the most recent month for which all such transactions were completed. The Contractor will provide these files electronically to DCH and/or its designated Agent in adherence to the procedure and format indicated in **Attachment K**, and as updated thereafter.
- 4.17.5.4 The Contractor's System(s) shall be capable of generating all required files in the prescribed formats (as referenced in **Attachment K**, including any updates thereto) for upload into state systems used specifically for program integrity and compliance purposes.
- 4.17.5.5 The Contractor's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

4.17.6 Systems Access Management and Information Accessibility Requirements

- 4.17.6.1 The Contractor's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and Information. The access management function shall:
 - 4.17.6.1.1 Restrict access to Information on a "need to know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;
 - 4.17.6.1.2 Restrict access to specific Systems' functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by DCH and the Contractor;
 - 4.17.6.1.3 Restrict attempts to access Systems' functions (both internal and external) to three (3), with a system function that automatically prevents further access attempts and records these occurrences; and
 - 4.17.6.1.4 At a minimum, follow the GTA Security Standard and Access Management protocols, and updates thereto.
- 4.17.6.2 The Contractor shall make System Information available to duly Authorized Representatives of DCH and other State and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

- 4.17.6.3 The Contractor shall have procedures to provide for prompt electronic transfer of System Information upon request to In-Network or Out-of-Network Providers for the medical management of the Member in adherence to HIPAA and other applicable requirements.

4.17.7 Systems Availability and Performance Requirements

- 4.17.7.1 The Contractor will ensure that Member and Provider portal and/or phone-based functions and information, such as confirmation of CMO Enrollment (CCE) and electronic claims management (ECM), Member services and Provider services, are available to the applicable System users twenty-four (24) hours a day, seven (7) Days a week, except during periods of scheduled System Unavailability agreed upon by DCH and the Contractor. Unavailability caused by events outside of a Contractor's Span of Control is outside of the scope of this requirement.

- 4.17.7.2 The Contractor shall ensure that at a minimum, all other Systems' functions and Information are available to the applicable Systems' users between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday with the exception of State holidays.

- 4.17.7.3 The Contractor shall ensure that the average response time that is controllable by the Contractor is no greater than the requirements set forth below, between 7:00 am and 7:00 pm EST, Monday through Friday for all applicable system functions except: a) during periods of scheduled downtime, b) during periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Contractor's Span of Control, or c) for Member and Provider portal and phone-based functions such as CCE and ECM that are expected to be available twenty-four (24) hours a day, **seven (7) days a week:**

- 4.17.7.3.1 **Record Search Time** – The response time shall be within three (3) seconds for ninety-eight percent (98%) of the record searches as measured from a representative sample of DCH System Access Devices, as monitored by the Contractor;

- 4.17.7.3.2 **Record Retrieval Time** – The response time will be within three (3) seconds for ninety-eight percent (98%) of the records retrieved as measured from a representative sample of DCH System Access Devices;

- 4.17.7.3.3 **On-line Adjudication Response Time** – The response time will be within five (5) seconds ninety-nine percent (99%) of the time as measured from a representative sample of user System Access Devices.

- 4.17.7.3.4 **Screen Display Time** – The system Screen Display Time must be within 2 seconds for 95% of the time. Screen Display Time is the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor;

- 4.17.7.3.5 **New Screen Page Time** – must be within 2 seconds for 95% of the time. New Screen/Page Time is the time elapsed from the time a new screen is

requested until the data from the screen appears or loads to completion on the monitor; and

- 4.17.7.3.6 Print Initiation Time – must be within 2 seconds for 95% of the time. Print Initiation Time is the time elapsed from the command to print a screen or report until it appears in the appropriate queue.
- 4.17.7.4 The Contractor shall develop an automated method of monitoring the CCE and ECM functions on at least a thirty (30) minute basis twenty-four (24) hours a day, seven (7) Days per week. The monitoring method shall separately monitor for availability and performance/response time each component of the CCE and ECM systems, such as the voice response system, the PC software response, direct line use, the swipe box method and ECM on-line pharmacy system.
- 4.17.7.5 Upon discovery of any problem within its Span of Control that may jeopardize System availability and performance as defined in this Section of the Contract, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, in person, via phone and electronic mail, followed by surface mail notification.
- 4.17.7.6 The Contractor shall deliver notification as soon as possible but no later than 7:00 pm EST if the problem occurs during the Business Day and no later than 9:00 am EST the following Business Day if the problem occurs after 7:00 pm.
- 4.17.7.7 Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on System Unavailability protocols.
- 4.17.7.8 The Contractor shall provide to the DCH Director, Contract Compliance and Resolution, information on System Unavailability events, as well as status updates on problem resolution. These up-dates shall be provided on an hourly basis and made available via electronic mail, telephone and the Contractor's Web Site/DCH Portal.
- 4.17.7.9 Unscheduled System Unavailability of CCE and ECM functions, caused by the failure of systems and telecommunications technologies within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the Contractor's discovery of System Unavailability. Unavailability to all other Contractor System functions caused by systems and telecommunications technologies within the Contractor's Span of Control shall be resolved, and the restoration of services implemented, within four (4) hours of the Contractor's discovery of System Unavailability.
- 4.17.7.10 Cumulative System Unavailability caused by systems and telecommunications technologies within the Contractor's Span of Control shall not exceed one (1) hour during any continuous five (5) Calendar Day period.

- 4.17.7.11 The Contractor shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Contractor's Span of Control. The Contractor is obligated to work with identified vendors to resolve and report system availability and performance issues.
- 4.17.7.12 Full written documentation that includes a Corrective Action or Remedial Action response that describes what caused the problem, how the problem will be prevented from occurring again, and within a set time frame for resolution must be submitted to DCH within the DCH required timeframe of the problem's occurrence.
- 4.17.7.13 Regardless of the architecture of its Systems, the Contractor shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that at a minimum addresses the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e. causes unscheduled System Unavailability.
- 4.17.7.14 The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore System functions per the standards outlined elsewhere in this Contract. The Contractor will prepare a report of the results of these tests and present to DCH staff within five (5) business days of test completion. DCH or its designee, federal auditors, or the State Auditor, reserves the right to conduct a site visit of the Contractor's disaster recovery location with one (1) day prior notice.
- 4.17.7.15 In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall be required to submit to the State a CAPA that describes how the failure will be resolved. The CAPA will be delivered within five (5) Business Days of the conclusion of the test.
- 4.17.7.16 The Contractor shall submit monthly System Availability and Performance Reports to DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.17.8 System User and Technical Support Requirements

- 4.17.8.1 The Contractor shall provide Systems Help Desk (SHD) services to all DCH staff and the other agencies that may have direct access to Contractor Systems.
- 4.17.8.2 The SHD shall be available via local and toll free telephone service and via e-mail from 7:00 a.m. to 7:00 p.m. EST Monday through Friday, with the exception of State

holidays. Upon State request, the Contractor shall staff the SHD on a State holiday, Saturday, or Sunday at the Contractor's expense.

- 4.17.8.3 SHD staff shall answer user questions regarding Contractor Systems' functions and capabilities; report recurring programmatic and operational problems to appropriate Contractor or DCH staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate State login account administrator.
- 4.17.8.4 The Contractor shall submit to DCH for review and approval its SHD Standards. At a minimum, these standards shall require that between the hours of 7:00 a.m. and 7:00 p.m. EST ninety percent (90%) of calls are answered by the fourth (4th) ring, the call abandonment rate is five percent (5%) or less, the average hold time is two (2) minutes or less, and the Blocked Call rate does not exceed one percent (1%).
- 4.17.8.5 Individuals who place calls to the SHD between the hours of 7:00 p.m. and 7:00 a.m. EST shall be able to leave a message. The Contractor's SHD shall respond to messages by noon EST the following Business Day.
- 4.17.8.6 Recurring problems not specific to System Unavailability identified by the SHD shall be documented and reported to Contractor management within one (1) Business Day of recognition so that deficiencies are promptly corrected in accordance with this Contract.
- 4.17.8.7 Additionally, the Contractor shall have an IT service management system that provides an automated method to record, track, and report on all questions and/or problems reported to the SHD. The service management system shall:
 - 4.17.8.7.1 Assign a unique number to each recorded incident;
 - 4.17.8.7.2 Create State defined extract files that contain summary information on all problems/issues received during a specified time frame;
 - 4.17.8.7.3 Escalate problems based on their priority and the length of time they have been outstanding;
 - 4.17.8.7.4 Perform key word searches that are not limited to certain fields and allow for searches on all fields in the database;
 - 4.17.8.7.5 Notify support personnel when a problem is assigned to them and re-notify support personnel when an assigned problem has escalated to a higher priority;
 - 4.17.8.7.6 Generate a list of all problems assigned to a support person or group;
 - 4.17.8.7.7 Perform searches for duplicate problems when a new problem is entered;

- 4.17.8.7.8 Allow for entry of at least five hundred (500) characters of free form text to describe problems and resolutions; and
- 4.17.8.7.9 Generate Reports that identify categories of problems encountered, length of time for resolution, and any other State-defined criteria.
- 4.17.8.8 The Contractor's call center systems shall have the capability to track call management metrics identified in **Attachment K** and updates thereto.

4.17.9 System Change Management Requirements

- 4.17.9.1 The Contractor shall absorb the cost of routine maintenance, inclusive of defect correction, Systems changes required to effect changes in State and federal statute and regulations, and production control activities, of all Systems within its Span of Control.
- 4.17.9.2 The Contractor shall provide DCH prior written notice of non-routine System changes excluding changes prompted by events described in the Systems Access management and Information Accessibility Requirements section above and including proposed corrections to known system defects, within ten (10) Calendar Days of the projected date of the change. As directed by the State, the Contractor shall discuss the proposed change in the Systems Work Group.
- 4.17.9.3 The Contractor shall respond to State reports of System problems not resulting in Systems Unavailability and shall perform the needed changes according to the following timeframes:
 - 4.17.9.3.1 Within five (5) Calendar Days of receipt, the Contractor shall respond via phone and in writing via email to notices of system problems.
 - 4.17.9.3.2 Within fifteen (15) Calendar Days, the correction will be made and confirmed to the State or a Requirements Analysis and Specifications document will be due.
- 4.17.9.4 The Contractor will correct the deficiency by an effective date to be determined by DCH.
- 4.17.9.5 Contractor Systems will have a system-inherent mechanism for recording any change to a software module or subsystem.
- 4.17.9.6 The Contractor shall put in place procedures and measures for safeguarding the State from unauthorized modifications to Contractor Systems.
- 4.17.9.7 Unless otherwise agreed to in advance by DCH as part of the activities described in the System User and Technical Support Requirements section above, scheduled System Unavailability to perform System maintenance, repair and/or upgrade activities shall take place between 11:00 p.m. EST on a Saturday and 6:00 a.m. EST on the following Sunday.

4.17.10 System Security and Information Confidentiality and Privacy Requirements

- 4.17.10.1 The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide DCH with access to data facilities upon DCH request. The physical security provisions shall be in effect for the life of this Contract and thereafter.
- 4.17.10.2 The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.
- 4.17.10.3 The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.
- 4.17.10.4 The Contractor shall ensure that the operation of all of its Systems is performed in accordance with State and federal regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations.
- 4.17.10.5 The Contractor will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a Contractor's Span of Control.
- 4.17.10.6 The Contractor shall ensure compliance with:
 - 4.17.10.6.1 42 CFR Part 431 Subpart F (confidentiality of information concerning applicants and Members of public medical assistance programs);
 - 4.17.10.6.2 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and
 - 4.17.10.6.3 Special confidentiality provisions related to people with HIV/AIDS and mental illness.
- 4.17.10.7 The Contractor shall provide its Members with a privacy notice as required by HIPAA. The Contractor shall provide the State with a copy of its Privacy Notice for its filing.

4.17.11 Information Management Process and Information Systems Documentation Requirements

- 4.17.11.1 The Contractor shall ensure that written System Process and Procedure Manuals, and updates thereto, document and describe all manual and automated system procedures for its information management processes and information systems in accordance to CMS seven conditions and standards, and amendments thereto. Available at: http://www.acs-inc.com/wp_state_self_assessment.aspx
- 4.17.11.2 The Contractor shall develop, prepare, print, maintain, produce, and distribute distinct System Design and Management Manuals, User Manuals and Quick/Reference Guides, and any updates thereafter, for DCH and other agency staff that use the DCH Portal.

- 4.17.11.3 The Systems User Manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system's data.
- 4.17.11.4 When Systems change are subject to State approval, the Contractor shall draft revisions to all appropriate manuals impacted by the system change, i.e. user manuals, technical specifications etc., prior to State approval of the change.
- 4.17.11.5 All of the aforementioned manuals and reference guides shall be available in printed form and on-line via the DCH Portal. The manuals will be published in accordance to the applicable DCH and/or Georgia Technology Authority (GTA) standard.
- 4.17.11.6 Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) Business Days of the update taking effect.

4.17.12 Reporting Requirements

- 4.17.12.1 The Contractor shall submit to DCH a monthly Systems Availability and Performance Report as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.18 MONITORING AND REPORTING

4.18.1 General Procedures

- 4.18.1.1 The Contractor shall support DCH in its program monitoring and reporting efforts for program performance and trending analyses through submission of ongoing, dashboard and ad hoc reports to DCH for all activities described in the Contract. The Contractor shall provide ad hoc reports to DCH upon request and within timeframes agreed to by DCH and the Contractor.
- 4.18.1.2 The Contractor shall meet with DCH Business Owners during implementation to discuss all data requirements and the Contractor's recommended reports. The Contractor shall accommodate DCH's requests for data and reporting based on implementation decisions as well as for ongoing requests during operations.

4.18.2 Ongoing Reporting

- 4.18.2.1 The Contractor shall collect, validate and report required program data to DCH in an accurate and timely manner. The Contractor's Chief Executive or Financial Officer, or a designee vested with their authority, shall attest to the accuracy and completeness of all submitted reports, in accordance with 42 CFR §438.604. In addition, the Contractor shall comply with all state and federal requirements set forth in this Section and throughout this Contract.
- 4.18.2.2 The Contractor shall comply with all the reporting requirements established by this Contract and shall submit all Reports included in this Contract. The Contractor shall

create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. **DCH may modify reports, specifications, templates, or timetables as necessary during the Contract year.** Contractor changes to the format must be approved by DCH prior to implementation. The Contractor shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 23.2. The Contractor's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 25.0.

4.18.2.2.1 The Contractor shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, **unless otherwise indicated.**

4.18.2.2.1.1 Weekly Reports shall be submitted on the same day of each week as determined by DCH;

4.18.2.2.1.2 Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month;

4.18.2.2.1.3 Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;

4.18.2.2.1.4 Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12th) month of the contract year ending June 30th;

4.18.2.2.1.5 Ad-Hoc, as determined by DCH; and

4.18.2.2.1.6 Other Reports (bi-annual, according to the due date of the respective report).

4.18.2.2.2 For reports required by DOI and DCH, the Contractor shall submit such reports according to the DOI schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in this Contract, should the DOI schedule of due dates be amended at a future date, the due dates in this Contract shall automatically change to the new DOI due dates.

4.18.2.2.3 The Contractor shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Contractor's responsibility shall be limited to data in its possession.

4.18.3 Public Reporting

4.18.3.1 DCH will periodically publish information or receive requests from audiences such as legislators that may require data from the Contractor. DCH will provide the Contractor with information about the data DCH would like to publish or must produce, and the Contractor shall produce all reports or summary data for DCH to incorporate into a

larger report. The Contractor shall develop these reports considering the audience to be targeted.

- 4.18.3.2 The Contractor shall not publish reports on its website or any other forum without prior consent from DCH.

4.18.4 Ongoing Reporting and Monitoring Meetings

- 4.18.4.1 The Contractor must be prepared to participate in regularly scheduled meetings with DCH staff to review decisions, resolve issues and define operational enhancements. These meeting schedules will be determined by DCH.

- 4.18.4.2 The Contractor and its various levels of staff as determined by DCH must also attend an onsite meeting at DCH to report on all activities, trends, opportunities for improvement and recommendations for programmatic and policy changes at the frequency determined by DCH. Contractors must provide best practices and lessons learned to reach GF program goals.

5.0 **DELIVERABLES**

5.1 **CONFIDENTIALITY**

The Contractor shall ensure that any Deliverables that contain information about individuals that is protected by confidentiality and privacy laws shall be prominently marked as “CONFIDENTIAL” and submitted to DCH in a manner that ensures that unauthorized individuals do not have access to the information. The Contractor shall not make public such reports. Failure to ensure confidentiality may result in sanctions and liquidated damages as described in Section 25.

5.2 **NOTICE OF APPROVAL/DISAPPROVAL**

- 5.2.1 All Deliverables are subject to approval from DCH.
- 5.2.2 DCH will provide written notice of disapproval of a Deliverable to the Contractor within fourteen (14) Calendar Days of submission if it is disapproved. DCH may, at its sole discretion, elect to review a deliverable longer than fourteen (14) Calendar Days.
- 5.2.3 The notice of disapproval shall state the reasons for disapproval as specifically as is reasonably necessary and the nature and extent of the corrections required for meeting the Contract requirements.

5.3 **RESUBMISSION WITH CORRECTIONS**

Within fourteen (14) Calendar Days of receipt of a notice of disapproval, the Contractor shall make the corrections and resubmit the Deliverable.

5.4 NOTICE OF APPROVAL/DISAPPROVAL OF RESUBMISSION

Within thirty (30) Calendar Days following resubmission of any disapproved Deliverable, DCH will give written notice to the Contractor of approval, Conditional approval or disapproval.

5.5 DCH FAILS TO RESPOND

In the event that DCH fails to respond to a Contractor’s submission or resubmission within the applicable time period, the Contractor should notify DCH of the outstanding request. DCH’s failure to respond within the applicable time period does not constitute approval of the submission.

5.6 REPRESENTATIONS

5.6.1 By submitting a Deliverable or report, the Contractor represents that to the best of its knowledge, it has performed the associated tasks in a manner that will, in concert with other tasks, meet the objectives stated or referred to in the Contract.

5.6.2 By approving a Deliverable or report, DCH represents only that it has reviewed the Deliverable or report and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the Withholding or denial of payment for the work completed. DCH’s acceptance of a Deliverable or report does not discharge any of the Contractor’s contractual obligations with respect to that Deliverable or report.

5.7 CONTRACTOR DELIVERABLES

Contractor must consider the timeframes for receiving such DCH approval in meeting the specific deadlines for each deliverable. Any dates that fall on a weekend or State holiday shall have a deliverable date of the next Business Day. All deliverables must be complete and comprehensive.

5.7.1 Reports

Contractor shall deliver the following reports to DCH in the format(s) required by DCH or as set forth in this Contract:

<u>Report</u>	<u>Frequency</u>
Pharmacy Rebate File	Weekly
Claims Processing Report	Monthly
Cost Avoidance Report	Monthly
Dental Participation Denial Report	Monthly
Disenrollment Activity Notification Report	Monthly
Eligibility and Enrollment Reconciliation Report	Monthly
FQHC and RHC Report	Monthly
Medical Loss Ratio Report	Monthly
Member Data Conflict Report	Monthly

Provider Complaints Report	Monthly
System Availability and Performance Report	Monthly
Telephone and Internet Activity Report	Monthly
Third Party Liability and Coordination of Benefits Report	Monthly
Case Management Report	Quarterly
CMS 416 Report	Quarterly
Clinical Practice Guidelines (CPGs)	Quarterly
Contractor Notification	Quarterly
Dental Utilization Report	Quarterly
Disease Management Report	Quarterly
EPSDT Informing Activity Report	Quarterly
EPSDT Initial Screening Report	Quarterly
EPSDT Medical Health Check Record Review Report	Quarterly
EPSDT Referrals Report	Quarterly
Fraud and Abuse Report	Quarterly
Grievance System Report	Quarterly
Hospital Statistical and Reimbursement Report	Quarterly
Neonatal Intensive Care Supplement Payment Report	Quarterly
Performance Improvement Projects (PIPs) Reports	Quarterly
Pharmacy Audit Reports	Quarterly
Pharmacy Cost Reports	
Prior Authorization and Pre-Certification Report	Quarterly
Provider Network Adequacy and Capacity Report	Quarterly
Timely Access Report	Quarterly
Utilization Management Report	Quarterly
Disclosure of Information on Annual Business Transactions	Annually
EPSDT Reports	Annually
Independent Audit and Income Statement	Annually
Patient Safety Reports and Analysis	Annually
Performance Improvement Projects Reports	Annually
Performance Measures	Annually
Quality Assessment Performance Improvement (QAPI)	Annually
Systems Refresh Plan	Annually
“SSAE 16” Reports	Annually

Unclaimed Payments Report	Annually
Unclaimed Property Report	Annually
72 Hour Eligibility Rule Report	Ad Hoc
Focused Studies Report	Ad Hoc
Provider Rep Field Visit Report	Ad Hoc
Quality Oversight Committee Report	Ad Hoc
State Quality Monitoring Reports	Ad Hoc
Subcontractor Agreement and Monitoring Information Report	B-Annually

5.7.2 Other Miscellaneous Deliverables

Contractor shall deliver the following deliverables to DCH in the format(s) required by DCH or as set forth in this Contract:

Deliverable	Contract Section
PCP Auto assignment Policies	2.3.3
Member Handbook	4.3.3
Provider Directory	4.3.5
Sample Member ID card	4.3.6
Telephone Hotline Policies and Procedures (Member and Provider)	4.3.7 4.9.5
Call Center Quality Criteria and Protocols	4.3.7.9 4.9.5.8
Web site Screenshots	4.3.8 4.9.6
Cultural Competency Plan	4.3.9.3
Marketing Plan and Materials	4.4
Provider Marketing Materials	4.4.4
MH/SA Policies and Procedures	4.6.11
EPSDT Policies and Procedures	4.7
Provider Selection and Retention Policies and Procedures	4.8.1.6
Provider Network Listing spreadsheet for all requested Provider types and Provider Letters of Intent or executed Signature Pages of Provider Contracts not previously submitted as part of the RFP response	4.8
Final Provider Network Listing spreadsheet for all requested Provider types, Signature Pages for all Providers, and written acknowledgements from all	4.8.1.8

Providers part of a PPO, IPO, or other network stating they know they are in the Contractor's network, know they are accepting Medicaid patients, and are accepting the terms and conditions of the Provider Contract	
PCP Selection Policies and Procedures	4.8.2.2
Provider Handbook	4.9.2
Provider Training Manuals	4.9.3.2
Provider Complaint System Policies and Procedures	4.9.7
Utilization Management Policies and Procedures	4.11
Care Coordination and Case Management Policies and Procedures	4.11
Quality Assessment and Performance Improvement Program	4.12.7 4.12.8
Focused Studies	4.12.10
Patient Safety Plan	4.12.11
Program Integrity Policies and Procedures	4.13
Grievance System Policies and Procedures	4.14
Staff Training Plan	4.15.3
Claims Management	4.16
Business Continuity Plan	4.17.7.13
System Users Manuals and Guides	4.17.11
Information Management Policies and Procedures	4.17
Subcontractor Agreements	18.0

6.0 TERM OF CONTRACT

6.1 This Contract shall begin on the Contract Effective Date and shall continue until June 30, 2017 unless terminated earlier pursuant to **Section 24, *Termination of Contract***. The Parties agree that DCH has five (5) options to renew this Contract for additional terms of up to one (1) State fiscal year each, which shall begin on July 1, and end at midnight on June 30 of the following year as follows:

Initial Term: Contract Effective Date - June 30, 2017
Renewal Option 1: July 1, 2017 - June 30, 2018
Renewal Option 2: July 1, 2018 - June 30, 2019
Renewal Option 3: July 1, 2019 - June 30, 2020
Renewal Option 4: July 1, 2020 - June 30, 2021
Renewal Option 5: July 1, 2021 - June 30, 2022

6.2 Pursuant to O.C.G.A. § 50-5-64(a)(2), each renewal option shall be exercisable solely and exclusively by DCH. The terms, conditions and pricing in effect at the time of renewal shall apply for each renewal option term. DCH will send Contractor written notice of its intent to exercise a renewal option under this Contract. As to each term, the Contract shall be terminated absolutely at the close of the then current state fiscal year without further obligation by DCH. Notwithstanding any language to the contrary, DCH reserves the right to terminate this Contract prior to the close of the fiscal year pursuant to Section 24 of this Contract.

7.0 PAYMENT FOR SERVICES

7.1 GENERAL PROVISIONS

7.1.1 DCH will compensate the Contractor on a Per Member Per Month basis for each Member enrolled in the Contractor's plan as detailed in **Attachment G** ("Capitation Payments") which is incorporated by this reference as if fully written herein. In the event that the contracted rates for July 1, 2016 through June 30, 2017 have not been approved by CMS prior to July 1, 2016, the Department shall make payment to Contractor utilizing the CMS approved rates in effect on June 30, 2016. Upon CMS approval of the July 1, 2016 through June 30, 2017 rates, the Department shall cease making payment using the June 30, 2016 rates, begin making payment under the July 1, 2016 through June 30, 2017 rates, and reprocess any payments made prior to the CMS approval date utilizing the July 1, 2016 through June 30, 2017 payment rates.

For the first partial month of a Member's enrollment in the Contractor's plan, DCH will prorate the Member's Capitation Payment on a per Calendar Day basis for the remainder of the calendar month. The Capitation Payment will be prorated on a per Calendar Day basis for any partial month of a Member's enrollment in the CMO. The number of enrolled Members will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's Fiscal Agent Contractor. The Capitation Payment will be multiplied by the number of enrolled Members. The Contractor must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, and notwithstanding any other withheld amounts allowed under this Contract, such amount shall be withheld from the prepaid, monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

7.1.1.1 DCH will compensate the Contractor on a per member per month basis for each P4HB participant enrolled in the Contractor's plan (See **Attachment O**). The number of enrolled P4HB participants in each rate cell category will be determined by the records maintained in the MMIS maintained by DCH's Fiscal Agent Contractor. The monthly compensation will be the final negotiated rate for each rate cell multiplied by the number of enrolled P4HB participants in each rate cell category. The Contractor must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, and notwithstanding any other withheld amounts allowed by

this Contract, such amount shall be withheld from the monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

- 7.1.2 The relevant Deliverables concerning payment under this Contract shall be mailed to the Project Leader named in the Notice provision of this Contract.
- 7.1.3 The total of all payments made by DCH to Contractor under this Contract shall not exceed the per Member per month Capitation payments agreed to under **Attachment G**, which has been provided for through the use of State or federal grants or other funds. With the exception of payments provided to the Contractor in accordance with Section 7.2 on Performance Incentives, DCH will have no responsibility for payment beyond that amount. Also, the total of all payments to the Contractor will not exceed one hundred and five percent (105%) of the Capitation payment pursuant to 42 CFR 438.6 (hereinafter the “Maximum Funds”). It is expressly understood that the total amount of payment to the Contractor will not exceed the maximum funds provided above, unless Contractor has obtained prior written approval, in the form of a Contract amendment, authorizing an increase in the total payment. Additionally, the Contractor agrees that DCH will not pay or otherwise compensate the Contractor for any work that it performs in excess of the Maximum Funds.

7.2 PERFORMANCE INCENTIVES

- 7.2.1 Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Contractor’s Capitation Rates (“VBP withhold”) from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.
- 7.2.2 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor’s performance relative to the targets for the fourteen (14) performance measures outlined in **Attachment U**. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold.
 - 7.2.2.1 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to a methodology for quantifying the Contractor’s success in achieving targets and payments for each measure.
- 7.2.3 The Contractor shall develop a plan for distributing to Providers fifty percent (50%) of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize providers on a more frequent schedule than DCH’s schedule for payment to the Contractor). The Contractor shall submit the plan to DCH for prior approval. The Contractor

shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date.

8.0 FINANCIAL MANAGEMENT

8.1 GENERAL PROVISIONS

8.1.1 The Contractor shall be responsible for the sound financial management of the CMO.

8.2 SOLVENCY AND RESERVES STANDARDS

8.2.1 The Contractor shall establish and maintain such net worth, working capital and financial reserves as required pursuant to O.C.G.A. § 33-21-1 *et seq.*

8.2.2 The Contractor shall provide assurances to the State that its provision against the risk of insolvency is adequate such that its Members shall never be liable for its debts in the event of insolvency.

8.2.3 As part of its accounting and budgeting function, the Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. As part of its reserving process, the Contractor shall conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

8.3 REINSURANCE

8.3.1 DCH will not administer a Reinsurance program funded from capitation payment withholding.

8.3.2 In addition to basic financial measures required by State law and discussed in section 8.2.1 and Section 28, the Contractor shall meet financial viability standards. The Contractor shall maintain net equity (assets minus liability) equal to at least one (1) month's capitation payments under this Contract. In addition, the Contractor shall maintain a current ratio (current assets/current liabilities) of greater than or equal to 1.0.

8.3.3 In the event the Contractor does not meet the minimum financial viability standards outlined in 8.3.2, the Contractor shall obtain Reinsurance that meets all DOI requirements. While commercial Reinsurance is not required, DCH recommends that Contractors obtain commercial Reinsurance rather than self-insuring. The Contractor may not obtain a reinsurance policy from an offshore company; the insurance carrier, the insurance carrier's agents and the insurance carrier's subsidiaries must be domestic.

8.4 THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.

- 8.4.1.1 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Contractor as its Agent to identify and cost avoid Claims for all CMO Members, including PeachCare for Kids® Members.
- 8.4.1.2 The Contractor shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO Members. To the extent permitted by State and federal law, the Contractor shall use Cost Avoidance processes to ensure that primary payments from the liable third party are identified, as specified below in Section 8.4.2.
- 8.4.1.3 If the Contractor is unsuccessful in obtaining necessary cooperation from a Member to identify potential Third Party Resources after sixty (60) Calendar Days of such efforts, the Contractor may inform DCH, in a format to be determined by DCH, that efforts have been unsuccessful.
- 8.4.1.4 For situations other than Medicare payments where payment is already made to the Provider by the CMO, the CMO shall coordinate with the other responsible payer and shall not recoup funds directly from the Provider and cause the Provider to have to resubmit claims to the other responsible payer.

8.4.2 Cost Avoidance

- 8.4.2.1 The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier, and may deny a service to a Member if the Contractor is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below in Section 8.4.2.2. However, if a third party health insurance carrier requires the Member to pay any cost-sharing amounts (e.g., co-payment, coinsurance, deductible), the Contractor shall pay the cost sharing amounts. The Contractor's liability for such cost sharing amounts shall not exceed the amount the Contractor would have paid under the Contractor's payment schedule for the service.
- 8.4.2.2 Further, the Contractor shall not withhold payment for services provided to a Member if third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) Calendar Days.
- 8.4.2.3 The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services, the Contractor shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Contractor shall then coordinate with DCH or its Agent to enable DCH to recover payment from the potentially liable third party.
- 8.4.2.4 If the Contractor determines that third party liability exists for part or all of the services rendered, the Contractor may:

- 8.4.2.4.1 Pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider; and
- 8.4.2.4.2 Pay the Provider only the amount, if any, by which the Provider's allowable Claim exceeds the amount of third party liability.
- 8.4.2.5 If the provider determines that a person other than the Contractor to which it has submitted a Claim is responsible for coverage of the Member at the time the service was rendered, the provider may submit the claim to the person that is responsible and that person shall reimburse all Medically Necessary Services without application of any penalty for failure to file claims in a time manner, for failure to obtain Prior Authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by the DCH for the same type of claim that it pays directly if the provider is not under contract with that person.

8.4.3 Compliance

- 8.4.3.1 DCH may determine whether the Contractor complies with this Section by inspecting source documents for timeliness of billing and accounting for third party payments.

8.5 PHYSICIAN INCENTIVE PLAN

- 8.5.1 The Contractor may establish physician incentive plans pursuant to federal and State regulations, including 42 CFR 422.208 and 422.210, and 42 CFR 438.6.
- 8.5.2 The Contractor shall disclose any and all such arrangements to DCH, and upon request, to Members. Such disclosure shall include:
 - 8.5.2.1 Whether services not furnished by the physician or group are covered by the incentive plan;
 - 8.5.2.2 The type of Incentive Arrangement;
 - 8.5.2.3 The percent of withhold or bonus; and
 - 8.5.2.4 The panel size and if patients are pooled, the method used.
- 8.5.3 Upon request, the Contractor shall report adequate information specified by the regulations to DCH in order that DCH will adequately monitor the CMO.
- 8.5.4 If the Contractor's physician incentive plan includes services not furnished by the physician/group, the Contractor shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to DCH proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual Member surveys, with results disclosed to DCH, and to Members, upon request.

- 8.5.5 Such physician incentive plans may not provide for payment, directly or indirectly, to either a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.

8.6 REPORTING REQUIREMENTS

- 8.6.1 The Contractor shall submit to DCH the Cost Avoidance Reports within twenty (20) Calendar Days of a written request from DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein
- 8.6.2 The Contractor shall submit to DCH monthly Medical Loss Ratio Reports that detail direct medical expenditures for Members and premiums paid by the Contractor, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.
- 8.6.3 The Contractor shall submit to DCH Third Party Liability and Coordination of Benefits Reports within ten (10) Business Days of verification of available Third Party Resources to a Member, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. The Contractor shall report any known changes to such resources in the same manner.
- 8.6.4 The Contractor, at its sole expense, shall submit by May 15 (or a later date if approved by DCH) of each year a “Reporting on Controls at a Service Organization”, meeting all standards and requirements of the American Institute of Certified Public Accountants’ (AICPA) SSAE 16 “type 2” report, for the Contractor’s operations performed for DCH under this Contract. Such initial report shall cover a period of no less than nine (9) months, ending March 31 of that year. Subsequent reports shall cover 12 months ending on March 31 of that year.
- 8.6.4.1 Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization, is an attestation standard developed by the AICPA which is required for such auditors’ reports for periods ending on or after June 15th of each year.
- 8.6.4.2 For more information on the AICPA’s “Statement on Standards for Attestation Engagements No. 16, Reporting on Controls at a Service Organization,” Contractor may refer to this AICPA website:
<http://www.aicpa.org/News/FeaturedNews/Pages/SASNo70Transformed%E2%80%933ChangesAheadforStandardonServiceOrganizations.aspx>.
- 8.6.4.3 The audit shall be conducted by an independent auditing firm, which has SSAE No. 16 audit experience. The auditor must meet all AICPA standards for independence. The selection of, and contract with, the independent auditor shall be subject to the approval of DCH and the State Auditor. Since such audits are not intended to fully satisfy all auditing requirements of DCH, the State Auditor reserves the right to fully and completely audit at their discretion the Contractor’s operations, including all aspects, which will have effect upon the DCH account, either on an interim audit basis or at the end of the State’s fiscal year. DCH also reserves the right to designate other auditors

or reviewers to examine the Contractor's operations and records for monitoring and/or stewardship purposes.

- 8.6.4.4 The independent auditing firm shall simultaneously deliver identical reports of its findings and recommendations to the Contractor and DCH within forty-five (45) Calendar Days after the close of each review period. The audit shall be conducted and the report shall be prepared in accordance with generally accepted auditing standards for such audits as defined in the publications of the AICPA, entitled Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization.
- 8.6.4.5 The Contractor shall respond to the audit findings and recommendations within thirty (30) Calendar Days of receipt of the audit and shall submit an acceptable proposed corrective action to DCH. The Contractor shall implement the Corrective Action Plan within forty (40) Calendar Days of its approval by DCH. Such response shall address, at minimum, any opinion other than a clean opinion; any testing exception; and any other exception, deficiency, weakness, opportunity for improvement, or recommendation reported by the independent auditor.
- 8.6.5 The Contractor shall submit to DCH and the US Department of Health and Human Services a "Disclosure of Ownership and Control Interest Statement"
 - 8.6.5.1 The Contractor shall disclose to DCH full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including 42 CFR §455.104.
 - 8.6.5.2 The Contractor (including its Subcontractors) shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The Contractor shall screen their employees and contractors initially and on an ongoing quarterly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to the DCH on a monthly basis. The word "contractors" in this Section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.
 - 8.6.5.3 Definition of A Party in Interest – As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:
 - 8.6.5.3.1 Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of

the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or Member of such corporation under applicable State corporation law;

- 8.6.5.3.2 Any organization in which a person as described in the above Section is a director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
 - 8.6.5.3.3 Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
 - 8.6.5.3.4 Any spouse, child, or parent of an individual as described in section 8.6.5.1.
- 8.6.5.4 The Contractor shall disclose the name and address of each person with an ownership or control interest in the disclosing entity or in any Provider, Subcontractor or Contractor's Fiscal Agent in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. In the case of an individual it shall include date of birth and Social Security Number.
- 8.6.5.5 The Contractor shall disclose the identity including the name, address, date of birth, and Social Security Number of any Provider or Subcontractor with whom the Contractor has had significant business transactions, defined as those totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the Contractor, any wholly owned supplier, or between the Contractor and any Provider or Subcontractor, during the five (5) year period ending on the date of the disclosure.
- 8.6.5.6 The Contractor shall disclose the identity including the name, address, date of birth, and Social Security Number of any person who has an ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs.
- 8.6.5.7 Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:
- 8.6.5.7.1 Any sale, exchange or lease of any property between the Contractor and a party in interest;

- 8.6.5.7.2 Any lending of money or other extension of credit between the Contractor and a party in interest; and
- 8.6.5.7.3 Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
- 8.6.5.8 The information which must be disclosed in the transactions listed in Section 8.6.5.7 between the Contractor and a party of interest includes:
 - 8.6.5.8.1 The name of the party in interest for each transaction;
 - 8.6.5.8.2 A description of each transaction and the quantity or units involved;
 - 8.6.5.8.3 The accrued dollar value of each transaction during the fiscal year; and
 - 8.6.5.8.4 Justification of the reasonableness of each transaction.
- 8.6.5.9 All information regarding ownership and financial transactions which must be disclosed by the Contractor pursuant to Section 8.6.5 is due at any of the following times:
 - 8.6.5.9.1 Upon the Contractor submitting the Contractor Proposal in accordance with the State's procurement process;
 - 8.6.5.9.2 Upon the Contractor executing this Contract with the State;
 - 8.6.5.9.3 Upon renewal or extension of this Contract;
 - 8.6.5.9.3 Within thirty (35) Calendar Days after any change in ownership; and
 - 8.6.5.9.4 At least once every quarter, if so requested by DCH.
- 8.6.6 The Contractor shall submit all necessary reports, documentation, to DOI as required by State law, which may include, but is not limited to the following:
 - 8.6.6.1 Pursuant to State law and regulations, an annual report on the form prescribed by the National Association of Insurance Commissioners (NAIC) for HMOs, on or before March 1 of each calendar year.
 - 8.6.6.2 An annual income statement detailing the Contractor's fourth quarter and year to date earned revenue and incurred expenses as a result of this Contract on or before March 1 of each year. This annual income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and a reconciliation of the Medical Loss Ratio report to the annual NAIC filing on an accrual basis.

- 8.6.6.3 Pursuant to state law and regulations, a quarterly report on the form prescribed by the NAIC for HMOs filed on or before May 15 for the first quarter of the year, August 15 for the second quarter of the year, and November 15, for the third quarter of the year.
 - 8.6.6.4 A quarterly income statement detailing the Contractor's quarterly and year to date earned revenue and incurred expenses because of this Contract filed on or before May 15, for the first quarter of the year, August 15, for the second quarter of the year, and November 15, for the third quarter of the year. Each quarterly income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and reconciliation of the Medical Loss Ratio report to the quarterly NAIC filing on an accrual basis.
 - 8.6.6.5 An annual independent audit of its business transactions to be performed by a licensed and certified public accountant, in accordance with NAIC Annual Statement Instructions regarding the Annual Audited Financial Report, including but not limited to the financial transactions made under this Contract.
- 8.6.7 The Contractor shall submit all necessary reports, documentation, to the Department of Revenue as required by State law, which may include, but is not limited to the following for Unclaimed Property Reports:
- 8.6.7.1 Pursuant to State law and regulations, an annual report on the form prescribed by the Georgia Department of Revenue for Unclaimed Property Reports for all Insurance Companies is due on or before May 1 of each calendar year.

9.0 FUNDING

Notwithstanding any other provision of this Contract, the Parties acknowledge that institutions of the State of Georgia are prohibited from pledging the credit of the State. At the sole discretion of DCH, this Contract shall immediately terminate without further obligation of the State if the source of payment for DCH's obligation, including but not limited to state appropriations and/or federal grant funding, no longer exists or is insufficient. The certification by DCH of the events stated above shall be conclusive and not subject to appeal.

10.0 PAYMENT OF TAXES

- 10.1 Contractor will forthwith pay all taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. DCH makes no representation whatsoever as to the liability or exemption from liability of Contractor to any tax imposed by any governmental entity.
- 10.2 Furthermore, Contractor shall be responsible for payment of all expenses related to, based on, or arising from salaries, benefits, employment taxes (whether State or Federal) and insurance (whether health, disability, personal, or retirement) for its employees, designees, or assignees.

11.0 RELATIONSHIP OF PARTIES

Neither Party is an agent, employee, assignee or servant of the other. It is expressly agreed that Contractor and any Subcontractors and agents, officers, and employees of Contractor or Subcontractor, or agent in

the performance of this Contract, shall act as independent contractors and not as officers or employees of DCH. DCH shall not be responsible for withholding taxes with respect to the Contractor's compensation hereunder. The Parties acknowledge, and agree, that the Contractor, its agents, Subcontractors, employees, and servants shall in no way hold themselves out as agents, employees, or servants of DCH. The parties also agree that the Contractor, its agents, Subcontractors, employees, and servants shall have no claim against DCH hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and DCH.

12.0 INSPECTION OF WORK

12.1 DCH, the State Department of Audits and Accounts, the U.S. Department of Health and Human Services, the General Accounting Office and the Comptroller General of the United States, if applicable, or their authorized representatives, shall have the right to enter into the premises of Contractor and/or all Subcontractors, or such other places where duties under this Contract are being performed for DCH in order to inspect, monitor or otherwise evaluate the services or any work performed pursuant to this Contract. Contractor shall bear all costs associated with inspections and evaluations of work. All inspections and evaluations of work being performed shall be conducted with prior notice and during normal business hours and performed in such a manner as will not unduly delay work.

12.2 Contractor agrees to sign and comply with **Attachment C, *Non-Profit Organization Disclosure Form***.

13.0 STATE PROPERTY

13.1 Contractor agrees that any materials, reports, analyses, compilations of data or other Deliverables that are furnished to DCH in accordance with the terms of this Contract, shall be the property of DCH upon submission of such materials to DCH, for whatever use that DCH deems appropriate. Contractor further agrees to execute any and all documents, or to take any additional actions that may be necessary in the future to effectuate this provision fully. In particular, if the work product or services include the taking of photographs or videotapes of individuals, Contractor must obtain the written consent from such individuals authorizing the use by DCH of such photographs, videotapes, and names in conjunction with such use. Contractor shall also obtain necessary written releases from such individuals, releasing DCH from any and all damages, claims or demands arising from such use.

13.2 All information received by DCH and prepared or maintained on behalf of DCH, including but not limited to all handwritten and electronic documents, papers, letters, emails, maps, books, tapes, photographs, policies, procedures, notes, computer based or generated information, or similar material, is subject to the Open Records Act of Georgia (O.C.G.A. § 50-18-70 et seq.) (hereinafter "ORA") and open to public inspection. If Contractor claims that any portion of its material submitted to DCH at any time and for any purpose is a proprietary trade secret, Contractor must clearly identify at the time of submission those portions of the material. In addition, Contractor is required to submit an affidavit which meets the requirements of O.C.G.A. § 50-18-72(a)(34) setting forth any and all trade secret claims. Material submitted to DCH that is not designated as a trade secret is subject to disclosure under the ORA. Information that is designated as a trade

secret will not be disclosed under the ORA without (1) a determination by DCH's Office of General Counsel that the information is not a trade secret; and (2) prior notification of Contractor that DCH intends to disclose the information, which notification will enable Contractor to seek legal protection of the information. If DCH determines that information submitted by Contractor is a trade secret and must not be disclosed by DCH as required herein, DCH shall use commercially reasonable efforts to hold such information in confidence.

- 13.3 The Contractor shall be responsible for the proper custody and care of any State-owned property furnished for the Contractor's use in connection with the performance of this Contract. The Contractor will also reimburse DCH for its loss or damage, normal wear and tear excepted, while such property is in the Contractor's custody or use.

14.0 OWNERSHIP AND USE OF DATA; RELATED MATTERS

14.1 OWNERSHIP AND USE OF DATA

14.1.1 All data created from information, documents, messages (verbal or electronic), reports, or meetings involving or arising out of this Contract is owned by DCH (hereafter referred to as "DCH Data"). The Contractor is expressly prohibited from sharing or publishing DCH Data or any information relating to Medicaid, PeachCare for Kids®, or P4HB data without the prior written consent of DCH. In the event of a dispute regarding what is or is not DCH Data, DCH's decision on this matter shall be final and not subject to Appeal.

14.1.2 If DCH consents to the publication of its Data by Contractor, Contractor shall display the following statement within the publication in a clear and conspicuous manner:

"This publication is made possible by the Georgia Department of Community Health (DCH) through a contract managed by (Contractor's name). Neither DCH or (Contractor's name) is responsible for any misuse or copyright infringement with respect to the publication."

14.1.3 The statement shall not be considered clear and conspicuous if it is difficult to read or hear, or if the placement is easily overlooked.

14.2 SOFTWARE AND OTHER UPGRADES

14.2.1 The Parties also understand and agree that any upgrades or enhancements to software programs, hardware, or other equipment, whether electronic or physical, shall be made at the Contractor's expense only, unless the upgrade or enhancement is made at the Department's request and solely for the Department's use exclusive of the deliverables contemplated by this Contract. Any upgrades or enhancements requested by and made for the Department's sole use shall become the Department's property without exception or limitation. The Contractor agrees that it will facilitate the Department's use of such upgrade or enhancement and cooperate in the transfer of ownership, installation, and operation by the Department.

14.3 INFRINGEMENT AND MISAPPROPRIATION

14.3.1 The Contractor warrants that all Deliverables provided by the Contractor do not and will not infringe or misappropriate any right of any third party based on copyright, patent, trade secret, or

other intellectual property rights. In case the Deliverables or any one or part thereof is held or alleged to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to the Contractor to be likely to be brought, the Contractor will, at its own expense, either:

14.3.1.1 Procure for the Department the right to continue using the Deliverables; or

14.3.1.2 Modify or replace the Deliverables to comply with the Specifications so that no violation of any intellectual property right occurs.

14.3.2 If Contractor fails to comply with the terms and conditions set forth in this Section, DCH shall have the option to terminate the Contract.

14.4 CUSTOMIZATION

14.4.1 If the Department requests specific customization of software programs, hardware, or other equipment, whether electronic or physical after the initial term of this Contract begins, the Contractor shall promptly make the requested change or modification at no cost to the Department.

14.5 SYSTEM CHANGES

14.5.1 All system changes required to comply, enable, and operate data transfers pursuant to this Contract shall be enabled, completed, and operated at no cost to DCH.

14.5.2 The Parties agree that the required system changes are not complete until they are fully implemented, tested and approved by DCH prior to the live date. In any event, DCH's determination on whether the system changes are complete and satisfactory shall be conclusive and final, subject to Section 30.

14.6 BUSINESS CONTINUITY AND DISASTER RECOVERY

14.6.1 Contractor shall provide and maintain for the life of the Contract a detailed Business Continuity and Disaster Recovery (BC-DR) Plan that will be implemented in the event that Contractor's facility experiences a disaster (for example, power outages, computer virus infections, natural disaster, etc.) that impacts fulfilling the requirements of this Contract. The BC-DR Plan shall include the following:

14.6.1.1 Notification process;

14.6.1.2 Identification of the Contractor's disaster recovery location and equipment;

14.6.1.3 Testing frequency of the plan; and

14.6.1.4 Step-by-step explanation of the backup and recovery procedures of services, which must include the number of hours to complete each step within a twelve (12) hour period.

14.6.2 Contractor shall submit an updated BC-DR Plan within thirty (30) Calendar Days of notification of Contract renewal.

14.6.3 DCH, federal auditors, or the State Auditor, reserves the right to conduct a site visit of the Contractor's disaster recovery location with one (1) day prior notice.

14.6.4 Contractor shall conduct an annual Disaster Recovery Plan Review and exercise/drill at the Contractor's own expense. The review must test all components of the Contractor's operation, including services provided by any third parties. A written report of the findings must be delivered to DCH within fifteen (15) Calendar Days of the date that the test is conducted. The Contractor must develop a written CAP for any deficiencies noted in the test and must thoroughly re-test until satisfactory results are achieved and maintained.

14.6.5 This Section shall survive termination of this Contract for any reason.

14.7 DISCHARGE OF LIENS

14.7.1 The Contractor shall immediately discharge or cause to be discharged any lien or right in lien of any kind, other than in favor of DCH, which at any time exists or arises in connection with work done or equipment or other instrumentality furnished under this Contract. If any such lien or right in lien is not immediately discharged, DCH may discharge or cause to be discharged such lien or right at the expense of the Contractor.

15.0 OWNERSHIP AND USE OF INTELLECTUAL PROPERTY

15.1 OWNERSHIP OF INVENTIONS AND WORKS OF AUTHORSHIP

15.1.1 DCH shall own any Inventions or Works of Authorship that may be (i) made by Contractor personnel in the course of performance of this Contract and relate to Contractor's Technology or (ii) made by DCH personnel.

15.2 SOFTWARE AND OWNERSHIP RIGHTS

15.2.1 The Parties specifically agree that the rights to any Proprietary Software licensed or developed by Contractor pursuant to this Contract shall rest and remain with Contractor, subject to the License. During the term of this Contract, Contractor hereby grants DCH a nonexclusive, term license to use any Proprietary Software owned or sublicensed to DCH by Contractor. In the event of termination of this Contract, a nonexclusive and irrevocable license to use any Proprietary Software necessary and appropriate to DCH business continuity shall be issued to DCH by Contractor at a cost equivalent to the cost paid by DCH during the term of the Contract for the License.

16.0 CONTRACTOR STAFFING

The Contractor shall demonstrate to DCH's satisfaction that it has the necessary staffing, by function and qualifications, to fulfill its obligations as described in this Scope of Work. In addition, the Contractor shall have adequate infrastructure, organization, management and systems in place to carry out the requirements of the GF Program. The Contractor shall provide a detailed listing of contact information for

all of its Material Subcontractors, including a description of the Subcontractor's organization and the responsibilities that are delegated to the Subcontractor. The Contractor will not contract with or permit the performance of any work or services by Material Subcontractors without prior written consent of DCH.

16.1 STAFFING ASSIGNMENT AND CREDENTIALS

16.1.1 The Contractor warrants and represents that all persons, including Subcontractors, independent contractors and consultants assigned by it to perform this Contract, shall be employees or formal agents of the Contractor and shall have the credentials necessary (i.e., licensed, and bonded, as required) to perform the work required herein; failure to notify DCH of replacement of Subcontractors will be considered breach of contract. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work hereunder. The Contractor also agrees that DCH may approve or disapprove the Contractor's Subcontractors or its staff assigned to this Contract prior to the proposed staff assignment. DCH's decision on this matter shall not be subject to Appeal.

16.1.2 The Contractor shall ensure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice. On at least an annual basis, the CMO and its Subcontractors will verify that staff has a current license that is in good standing and will provide a list to DCH of licensed staff and current licensure status.

16.1.3 In addition, the Contractor warrants that all persons assigned by it to perform work under this Contract shall be employees or authorized Subcontractors of the Contractor and shall be fully qualified, as required in the RFP and specified in the Contractor's Proposal and in this Contract, to perform the services required herein. Personnel commitments made in the Contractor's Proposal shall not be changed unless approved by DCH in writing. Staffing will include the named individuals at the levels of effort proposed.

16.1.4 The Contractor shall provide and maintain sufficient qualified personnel and staffing to enable the Deliverables to be provided in accordance with the RFP, the Contractor's Proposal and this Contract. The Contractor shall submit to DCH a detailed staffing plan, within thirty (30) Calendar Days of the Contract Effective Date which includes plans to fill any staffing needs to have a sufficient level of support during the Implementation Phase and after the Operational Start Date. Such staffing plan must include a timetable for filling all staffing position(s) after the Contract Effective Date. The Contractor must provide DCH with resumes of Key Staff, reporting responsibilities, Contractor staff to Member ratios and an organizational chart during the Implementation Phase with updates provided to DCH within two (2) Business Days of any changes or vacancies. The staffing must include the employees and management for all CMO functions.

16.1.5 At a minimum, the Contractor shall provide the following Key Staff:

16.1.5.1 A dedicated project manager to lead program implementation and facilitate ongoing operations. The CMO Project Manager must be stationed at the CMO's metropolitan Atlanta headquarters. The Project Manager must also be onsite at the DCH offices in Atlanta, Georgia at times specified by DCH during the planning, implementation and deployment phases of the Contract.

- 16.1.5.2 An Executive Administrator who is a full-time administrator with clear authority over the general administration and implementation of the requirements detailed in this Contract.
- 16.1.5.3 A Medical Director who is a licensed physician in the State of Georgia. The Medical Director shall be actively involved in all major clinical program components of the CMO, shall be responsible for the sufficiency and supervision of the Provider network, and shall ensure compliance with federal, State and local reporting laws on communicable diseases, child abuse, neglect, etc.
- 16.1.5.4 A Quality Improvement Director with appropriate education, training and licensure, if applicable. The Quality Improvement Director shall possess or obtain within six (6) months of hire, training in one or more of the following areas:
 - 16.1.5.4.1 Strategic planning
 - 16.1.5.4.2 Six Sigma Certification
 - 16.1.5.4.3 Lean Six Sigma Certification
 - 16.1.5.4.4 Plan-Do-Study-Act Cycle
 - 16.1.5.4.5 Rapid Cycle Improvement
- 16.1.5.5 A Chief Financial Officer who oversees all budget and accounting systems.
- 16.1.5.6 A Strategic Planner to support clinical quality improvement.
- 16.1.5.7 Utilization Management Director.
- 16.1.5.8 An Information Management and Systems Director and a complement of technical analysts and business analysts as needed to maintain the operations of Contractor Systems and to address System issues in accordance with the terms of this Contract.
- 16.1.5.9 Pharmacist who is licensed in the State of Georgia.
- 16.1.5.10 A Dental Consultant who is a licensed dentist in the State of Georgia.
- 16.1.5.11 Mental Health Coordinator who is a licensed mental health professional in the State of Georgia.
- 16.1.5.12 A Member Services Director.
- 16.1.5.13 A Provider Services Director.
- 16.1.5.14 A Provider Relations Liaison.
- 16.1.5.15 A Grievance/Complaint Coordinator.

- 16.1.5.16 Compliance Officer.
 - 16.1.5.17 A Prior Authorization/Pre-Certification Coordinator who is a physician, registered nurse, or physician's assistant licensed in the State of Georgia.
 - 16.1.5.18 Sufficient staff in all departments, including but not limited to, Member services, Provider services, and Prior Authorization and concurrent review services to ensure appropriate functioning in all areas.
 - 16.1.5.19 Hospital-based care managers whose responsibilities include visiting with patients and interacting with hospital staff to ensure proper utilization and Discharge Planning.
 - 16.1.5.20 Staff trained in the System of Care approach to service delivery.
 - 16.1.5.21 Ombudsman Staff including Ombudsman Coordinator and Ombudsman Liaison. The Contractor must consider and monitor current Enrollment levels when evaluating the number of Ombudsman Liaisons necessary to meet Member needs. The Ombudsmen staff is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to health care services, and communication and education Members and Providers.
- 16.1.6 The Contractor shall comply with all staffing/personnel obligations set out in the RFP and this Contract, including but not limited to those pertaining to security, health, and safety issues.
- 16.1.7 The Contractor shall provide the DCH Project Leader with a staff roster every ninety (90) days during the Term of the Contract. This roster shall set forth the names, titles, and physical location of all members of Contractor's staff (including Subcontractor and Contractor affiliates), their areas of assignment and the number of hours they are required to work.

16.2 STAFFING CHANGES

- 16.2.1 DCH may reject any proposed changes in key staff and may require the removal or reassignment of any Contractor employee or Subcontractor employee that the Department deems to be unacceptable in the exercise of its reasonable judgment. The Department's decision on this matter shall be final.
- 16.2.2 Notwithstanding the above provisions, the Parties acknowledge and agree that the Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law. In the event of Contractor termination of any key staff, Contractor will provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee with a person of equivalent training, experience, and talent within ten (10) Calendar Days of the termination.
- 16.2.3 The Contractor shall notify DCH within five (5) Business Days, via written communication, prior to any changes to key staff, including the Executive Administrator, Medical Director, Quality Improvement Director, Utilization Management Director, Management Information Systems Director, and Chief Financial Officer. The Contractor shall replace any of the key staff with a

person of equivalent experience, knowledge and talent. Within ten (10) Calendar Days of the termination, Contractor shall provide the DCH Project Leader with the resume of the proposed replacement and offer the DCH Project Leader, and/or his authorized representatives, the opportunity to interview that person. If the DCH Project Leader is not reasonably satisfied with the apparent skill and qualifications of the proposed replacement, he or she shall notify Contractor within ten (10) Calendar Days after receiving the resume or conducting the interview (whichever occurs last). Once that has occurred, the Contractor shall propose another replacement and the DCH Project Leader shall have the same right of approval. Such process shall be repeated until a proposed replacement is approved by the DCH Project Leader. If, after sixty (60) Calendar Days from the notice of termination, a qualified replacement is not approved, liquidated damages may be assessed against and imposed on Contractor.

16.2.4 DCH also may require the removal or reassignment of any Contractor employee or Subcontractor employee that DCH deems to be unacceptable. DCH's decision on this matter shall not be subject to Appeal. Notwithstanding the above provisions, the Parties acknowledge and agree that the Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law. In the event of Contractor termination of any key staff the Contractor shall provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee.

16.2.5 The Contractor must submit to DCH quarterly the Contractor Information Report that includes but is not limited to the changes to Contractor's local staff information as well as local and corporate organizational charts.

16.3 CONTRACTOR'S FAILURE TO COMPLY

16.3.1 If DCH, in its sole discretion, determines that the Contractor's services and/or performance under the terms, conditions, and requirements of this Contract are insufficient, unacceptable, or unsatisfactory, the Contractor, after notice from DCH, agrees that it will make every attempt to remedy the deficiency within two (2) Business Days.

16.3.2 Should the Contractor at any time: 1) refuse or neglect to supply adequate and competent supervision; 2) refuse or fail to provide sufficient and properly skilled personnel, equipment, or materials of the proper quality or quantity; 3) fail to provide the services in accordance with the timeframes, schedule or dates set forth in this Contract; 4) fail in the performance of any term or condition contained in this Contract, 5) knowingly or unknowingly accept payment from DCH of an amount in excess of what it is owed at the time of the payment under the terms of this Contract, DCH may (in addition to any other contractual, legal or equitable remedies) proceed to take any one or more of the following actions after five (5) Calendar Days' written notice to the Contractor:

16.3.2.1 Withhold any monies then or next due to the Contractor;

16.3.2.2 Obtain the services or their equivalent from a third party, pay the third party for same, and withhold the amount so paid to third party from any money then or thereafter due to the Contractor;

16.3.2.3 Withhold monies in the amount of any damage caused by any deficiency or delay in the services; or

16.3.2.4 Any combination of the above.

16.3.3 In addition to the consequences indicated above, if it is determined that Contractor knowingly submitted any false statement, invoice or other document to DCH, Contractor shall also be subject to the sanctions imposed by O.C.G.A. §16-10-20.

17.0 CRIMINAL BACKGROUND, EXCLUSIONS, AND DEBARMENT

17.1 The Contractor agrees that it will not permit any of its employees or its Subcontractor's employees, (which in this section includes temporary and contract employees) to perform the services under this Contract unless and until they pass a background check as outlined below.

17.2 Minimum background check requirements

17.2.1 Contractor shall conduct criminal background checks on all employees assigned to or proposed to be assigned to any aspect of the performance of this Contract, who have direct contact with members or who have access to PHI as defined by HIPAA and those individuals designated as Key Staff.

17.2.2 Contractor shall verify that the individual has a satisfactory criminal record. Satisfactory criminal record means that, at minimum, the individual has no history of convictions for the following crimes in his/her record:

- 17.2.2.1 Aggravated Assault;
- 17.2.2.2 Aggravated Battery;
- 17.2.2.3 Armed Robbery;
- 17.2.2.4 Arson;
- 17.2.2.5 Attempted Murder;
- 17.2.2.6 Financial-related crimes, including but not limited to fraud and identity theft;
- 17.2.2.7 Forgery;
- 17.2.2.8 Kidnapping;
- 17.2.2.9 Murder or Felony Murder;
- 17.2.2.10 Rape;
- 17.2.2.11 Sexual Offenses; and
- 17.2.2.12 Theft by taking, by deception or by conversion.

A conviction shall not include treatment under the Georgia First Offender Act.

17.2.3 The background checks must be conducted prior to the performance of any services under this Contract and on an annual basis.

17.2.4 Contractor shall develop and implement policies and procedures to ensure that employees, at all times during their employment while this Contract is in effect, maintain a satisfactory criminal record as defined in Section 17.2.2.

- 17.2.5 Contractor shall, on an annual basis, submit to DCH a report which demonstrates compliance with the minimum background check requirements. The report shall include, but need not be limited to, the results of a random sampling of at least 25% of those employees subject to background checks.
- 17.2.6 Contractor shall have defined oversight procedures to ensure that its subcontractors meet or exceed all minimum background check requirements.
- 17.2.7 Notwithstanding any language to the contrary, the Parties understand that the requirements set forth in Section 17 are minimum requirements and Contractor may establish additional criteria, as appropriate.
- 17.3 The Contractor shall not employ or use any company, entity, or individual that is on the Federal Exclusions List or any company, entity, or individual subject to 42 USCS § 1320a-7.
- 17.4 By signing or executing this Contract, the Contractor states and certifies that it is in compliance with and that it will continue to comply with the Anti-Kickback Act of 1986, 41 USCS § 51-58, and Federal Acquisition Regulation 52.203-7.
- 17.5 Contractor agrees to sign and comply with **Attachment B, *Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters***.

18.0 SUBCONTRACTS

18.1 USE OF SUBCONTRACTORS

- 18.1.1 The Contractor will not subcontract or permit anyone other than Contractor personnel to perform any of the work, services, or other performance required of the Contractor under this Contract, or assign any of its rights or obligations hereunder, without the prior written consent of DCH. Prior to hiring or entering into an agreement with any Subcontractor, any and all Subcontractors and Subcontracts shall be approved by DCH. DCH must also approve any replacement Subcontractors in the same manner. Upon request from DCH, the Contractor shall provide in writing the names of all proposed or actual Subcontractors. DCH reserves the right to reject any or all Subcontractors that, in the judgment of DCH, lack the skill, experience, or record of satisfactory performance to perform the work specified herein.
- 18.1.2 Contractor is solely responsible for all work contemplated and required by this Contract, whether Contractor performs the work directly or through a Subcontractor. No subcontract will be approved which would relieve Contractor or its sureties of their responsibilities under this Contract. In addition, DCH reserves the right to terminate this Contract if Contractor fails to notify DCH in accordance with the terms of this paragraph.
- 18.1.3 All contracts between the Contractor and Subcontractors must be in writing and must specify the activities and responsibilities delegated to the Subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. DCH reserves the right to inspect all subcontract agreements at any time during the Contract period.

- 18.1.4 All contracts entered into between Contractor and any Subcontractor related to this Contract must contain provisions which require Contractor to monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to formal review according to a schedule established by DCH and consistent with industry standards or State laws and regulations. Contractor shall identify any deficiencies or areas for improvement related to any Subcontractor's performance related to this Contract, and upon request from DCH, provide evidence that corrective action has been taken to address the deficiency.
- 18.1.5 For any subcontract, there must be a designated project manager who is a member of the Subcontractor's staff that is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The subcontract agreement must contain a provision which requires the Contractor and its Subcontractors to seek binding arbitration to resolve any dispute between those parties and to provide DCH with written notice of the dispute.
- 18.1.6 Contractor shall give DCH immediate notice in writing by registered mail or certified mail of any action or suit filed by any Subcontractor and prompt notice of any Claim made against the Contractor by any Subcontractor or vendor that, in the opinion of Contractor, may result in litigation related in any way to this Contract.
- 18.1.7 All Subcontractors must fulfill the requirements of 42 CFR 438.6 as appropriate.
- 18.1.8 All Provider contracts shall comply with the requirements and provisions as set forth in Section 4.10 of this Contract.
- 18.1.9 The Contractor shall submit a Subcontractor Information and Monitoring Report to include, but is not limited to: Subcontractor name, services provided, effective date of the subcontracted agreement.
- 18.1.10 The Contractor shall submit to DCH a written notification of any subcontractor terminations at least ninety (90) days prior to the effective date of the termination.

18.2 COST OR PRICING BY SUBCONTRACTORS

- 18.2.1 Contractor shall submit, or shall require any Subcontractors hereunder to submit, cost or pricing data for any subcontract to this Contract prior to Contract Award. The Contractor shall also certify that the information submitted by the Subcontractor is, to the best of their knowledge and belief, accurate, complete and current as of the date of agreement, or the date of the negotiated price of the subcontract to the Contract or amendment to the Contract. The Contractor shall insert the substance of this Section in each subcontract hereunder.
- 18.2.2 If DCH determines that any price, including profit or fee negotiated in connection with this Contract, or any cost reimbursable under this Contract was increased by any significant sum because of the inaccurate cost or pricing data, then such price and cost shall be reduced accordingly and this Contract and the subcontract shall be modified in writing to reflect such reduction.

19.0 LICENSE, CERTIFICATE AND PERMIT REQUIREMENT

- 19.1 Contractor shall have, obtain, and maintain in good standing any licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits that may be necessary, upon DCH's request.
- 19.2 The Contractor warrants that it is qualified to do business in the State and is not prohibited by its articles of incorporation, bylaws, or other controlling documents relevant to Contractor's entity type, or any law of the State under which it is incorporated from performing the services under this Contract. The Contractor shall have and maintain a Certificate of Authority pursuant to O.C.G.A. §33-21-1 et seq., and shall obtain and maintain in good standing any Georgia-licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Loss of the licenses, certificates, permits, or Certificate of Authority for health maintenance organizations shall be cause for termination of the Contract pursuant to Section 24 of this Contract. In the event the Certificate of Authority, or any other license or permit is canceled, revoked, suspended or expires during the term of this Contract, the Contractor shall inform the State immediately and cease all activities under this Contract, until further instruction from DCH. The Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits necessary upon request.
- 19.3 The Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) for MCO, URAC (Health Plan accreditation), Accreditation Association for Ambulatory Health Care (AAAHC) for MCO, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for MCO, or shall be actively seeking and working towards such accreditation. The Contractor shall provide to DCH upon request any and all documents related to achieving such accreditation and DCH shall monitor the Contractor's progress towards accreditation. DCH may require that the Contractor achieve such accreditation by year three of this Contract.
- 19.4 The Contractor shall notify DCH within fifteen (15) Calendar Days of any accrediting organization noted deficiencies as well as any accreditations that have been rescinded by a recognized accrediting organization.
- 19.5 The Contractor warrants that there is no claim, legal action, counterclaim, suit, arbitration, governmental investigation or other legal, administrative, or tax proceeding, or any order, decree or judgment of any court, governmental agency, or arbitration tribunal that is in progress, pending, or threatened against or relating to Contractor or the assets of Contractor that would individually or in the aggregate have a material adverse effect on Contractor's ability to perform the obligations contemplated by this Contract. Without limiting the generality of the representation of the immediately preceding sentence, Contractor is not currently the subject of a voluntary or involuntary petition in bankruptcy, does not presently contemplate filing any such voluntary petition, and is not aware of any intention on the part of any other person, or entity, to file such an involuntary petition against it.

20.0 RISK OF LOSS AND REPRESENTATIONS

- 20.1 DCH takes no title to any of the Contractor's goods used in providing the services and/or Deliverables hereunder and the Contractor shall bear all risk of loss for any goods used in performing work pursuant to this Contract.
- 20.2 The Parties agree that DCH may reasonably rely upon the representations and certifications made by the Contractor, including those made by the Contractor in the Contractor's Proposal in response to the RFP and this Contract, without first making an independent investigation or verification.
- 20.3 The Parties also agree that DCH may reasonably rely upon any audit report, summary, analysis, certification, review, or work product that the Contractor produces in accordance with its duties under this Contract, without first making an independent investigation or verification.
- 20.4 By submitting a Deliverable, the Contractor represents that, to the best of its knowledge, it has performed the associated tasks in a manner, which will, in concert with other tasks, meet the objectives states or referred to in the Contract.
- 20.5 By unconditionally approving a Deliverable, DCH represents only that it has reviewed the Deliverable and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the withholding or denial of payment for the work completed. DCH's approval of a Deliverable does not discharge any of the Contractor's contractual obligations with respect to that Deliverable.

21.0 PROHIBITION OF GRATUITIES AND LOBBYIST DISCLOSURES

- 21.1 The Contractor, in the performance of this Contract, shall not offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of this Contract, and shall comply with the disclosure requirements set forth in O.C.G.A. § 45-1-6.
- 21.2 The Contractor also states and warrants that it has complied with all disclosure and registration requirements for vendor lobbyists as set forth in O.C.G.A. § 21-5-1, et seq. and all other applicable law, including but not limited to registering with the Georgia Government Transparency and Campaign Finance Commission. For the purposes of this Contract, vendor lobbyists are those who lobby State officials on behalf of businesses that seek a contract to sell goods or services to the State or oppose such contract.
- 21.3 As required by applicable Federal law, Contractor states and warrants that no federal money has been used for any lobbying of State officials, as required under applicable federal law.
- 21.4 Contractor agrees to sign and comply with **Attachment E, *Vendor Lobbyist Disclosure and Registration Certification Form***.

22.0 RECORDS REQUIREMENTS

The Contractor agrees to maintain books, records, documents, invoices, and any other evidence pertaining to the costs and expenses of this Contract and/or any document that is a part of this Contract by reference or

inclusion. This includes, but is not limited to, Contractor's balance sheets, income statements and invoices from Subcontractors, Contractor's affiliates or other vendors. The Contractor's accounting procedures and practices shall conform to generally accepted accounting principles, and the costs properly applicable to the Contract shall be readily ascertainable therefrom. This includes, but is not limited to, payment (with respect to salary), overhead and Subcontractors.

22.1 RECORDS RETENTION REQUIREMENTS

22.1.1 The Contractor shall preserve and make available all of its records pertaining to the performance under this Contract for a period of seven (7) years from the date of final payment under this Contract, and for such period, if any, as is required by applicable statute or by any other section of this Contract. If the Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of seven (7) years from the date of termination or of any resulting final settlement. Records that relate to Appeals, litigation, or the settlements of Claims arising out of the performance of this Contract, or costs and expenses of any such agreements as to which exception has been taken by the Contractor or any of its duly Authorized Representatives, shall be retained by Contractor until such Appeals, litigation, Claims or exceptions have been disposed of.

22.2 ACCESS TO RECORDS

22.2.1 The State and federal standards for audits of DCH agents, contractors, and programs are applicable to this section and are incorporated by reference into this Contract as though fully set out herein.

22.2.2 Pursuant to the requirements of 42 CFR 434.6(a) (5), the Contractor shall make all of its books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases available for examination and audit by DCH, the State Attorney General, the State Health Care Fraud Control Unit, the State Department of Audits and Accounts, and/or authorized State or federal personnel. Any records requested hereunder shall be produced immediately for review at DCH or sent to the requesting authority by mail within fourteen (14) Calendar Days following a request. All records shall be provided at the sole cost and expense of the Contractor. DCH shall have unlimited rights to access, use, disclose, and duplicate all information and data in any way relating to this Contract in accordance with applicable State and federal laws and regulations. DCH shall not be restricted in the number of times it may audit, visit, inspect, review or otherwise monitor Contractor and any Subcontractors during the term of this Contract. DCH will only conduct audits as determined reasonably necessary by the Department.

22.3 SUBPOENAS FOR RECORDS OR OTHER DOCUMENTS

The Department may issue subpoenas to Contractor, which require the Contractor or its agents (e.g. employees, subcontractors) to: produce and permit inspection and copying of designated books, papers, documents, or other tangible items; and/or attend and give testimony at a deposition or hearing. The Contractor agrees to comply with all subpoenas issued by the Department or parties acting on behalf of the Department. The Contractor understands that it is ultimately responsible for its agents' compliance with the subpoenas described herein.

22.4 FINANCIAL RECORDS

During the entire life of the Contract, the Contractor and all Subcontractors shall provide DCH with copies of its annual report and all disclosure or reporting statements or forms filed with the State of Georgia and/or the Securities and Exchange Commission (SEC) as soon as they are prepared in final form and are otherwise available for distribution or filing. In the event that the Contractor is not required to or does not prepare either an annual report or SEC disclosure or reporting statements or forms by virtue of being a subsidiary of another corporation, it shall fulfill the requirements of this section, with respect to all such documents for any parent corporation, which reflect, report or include any of its operations on any basis. In addition, upon the written request of the Program Manager, the Contractor and all Subcontractors shall furnish DCH with the most recent un-audited and audited copies of its current balance sheet within fourteen (14) Calendar Days of its receipt of such request.

22.5 INDEPENDENT SERVICE AUDITOR'S REPORT

At its discretion, DCH may request a third party be engaged to prepare an Independent Service Auditor's Report. This report would meet the standards articulated by the American Institute of Certified Public Accountants including, but not limited to, the Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization. Contractor shall bear the cost of obtaining the report. In addition, Contractor shall provide the Auditor with complete access to the records described in this Section.

22.6 MEDICAL RECORD REQUESTS

22.6.1 The Contractor shall ensure a copy of the Member's Medical Record is made available, without charge, upon the written request of the Member or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request.

22.6.2 The Contractor shall ensure that Medical Records are furnished at no cost to a new PCP, Out-of-Network Provider or other specialist, upon Member's request, no later than fourteen (14) Calendar Days following the written request.

23.0 CONFIDENTIALITY REQUIREMENTS

23.1 GENERAL CONFIDENTIALITY REQUIREMENTS

23.1.1 The Contractor shall treat all individually identifiable health information, including PHI and PII, that is obtained or viewed by its employees, agents, or authorized Subcontractors in the performance of this Contract as confidential information and shall not use any information so obtained, in any manner, except as may be necessary for the proper discharge of its obligations. Employees or authorized Subcontractors of the Contractor who have a reasonable need to know such information for purposes of performing their duties under this Contract shall use personal or patient information, provided such employees and/or Subcontractors have first signed an appropriate non-disclosure agreement that has been approved and maintained by DCH. The Contractor shall remove any person from performance of services hereunder upon notice that DCH reasonably believes that such person has failed to comply with the confidentiality obligations of this Contract. In such cases, Contractor shall replace such removed personnel in accordance with the staffing requirements of this Contract. DCH, the State Attorney General, federal officials as

authorized by federal law or regulations, or the Authorized Representatives of these parties shall have access to all confidential information in accordance with the requirements of State and federal laws and regulations.

23.2 HIPAA COMPLIANCE

23.2.1 Contractor warrants to DCH that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the HITECH Act, and all implementing regulations (together, the “HIPAA Privacy and Security Rules”). Upon the execution of this Contract and upon any material change in the HIPAA Privacy and Security Rules, Contractor must provide DCH with a written description of the policies and procedures used by it to achieve and maintain compliance with the HIPAA Privacy and Security Rules. These policies and procedures are subject to DCH approval.

23.2.2 The Contractor also agrees to assist DCH in its efforts to comply with the HIPAA Privacy and Security Rules, as amended from time to time. To that end, the Contractor will abide by any requirements mandated by the HIPAA Privacy and Security Rules or any other applicable laws in the course of this Contract. Contractor warrants that it will cooperate with DCH, including cooperation with DCH privacy officials and other compliance officers required by the HIPAA Privacy and Security Rules and all implementing regulations, in the course of performance of this Contract so that both parties will be in compliance with HIPAA. The Contractor also acknowledges that the HIPAA Privacy and Security Rules may require the Contractor and DCH to sign documents for compliance purposes, including but not limited to a Business Associate Agreement. Contractor further agrees to sign any other documents that may be required for compliance with the HIPAA Privacy and Security Rules and to abide by their terms and conditions. Contractor also agrees to abide by the terms and conditions of current DCH policies and procedures.

23.3 HIPAA PERFORMANCE GUARANTEE

23.3.1 Failure to achieve or maintain compliance with the requirements of the HIPAA Privacy and Security Rules, as amended from time to time, and with the DCH Business Associate Agreement will constitute failure to substantially perform and will result in the assessment of liquidated damages. These liquidated damages will be assessed in the amount of \$2,000.00 for each day the Contractor fails to achieve or maintain compliance. If DCH incurs penalties and/or fines as a result of Contractor’s non-compliance with the HIPAA Privacy and Security Rules, as amended from time to time, and Contractor indemnifies DCH as required by Section 26 of this Contract with respect to such penalties and/or fines, any liquidated damages due and payable at the time will be offset by the amount that the Contractor paid to indemnify the Department.

23.4 ENHANCED PRIVACY AND SECURITY PROVISIONS OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (“ARRA”)

23.4.1 The Contractor warrants that it will comply with all requirements of the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”), specifically related to improved privacy and security provisions. Contractor is subject to the provisions in effect as of the signing of the Act, and any provisions made effective during the term of this Contract, including increased penalties for HIPAA violations as contemplated in 42 U.S.C. §1320d et seq.

24.0 TERMINATION OF CONTRACT

24.1 GENERAL PROVISIONS

24.1.1 This Contract may terminate, or may be terminated in whole or in part by DCH for any or all of the following reasons:

- 24.1.1.1 Default by the Contractor, upon thirty (30) Calendar Days' notice;
- 24.1.1.2 Convenience of DCH, upon thirty (30) Calendar Days' notice;
- 24.1.1.3 Immediately, in the event of insolvency, Contract breach, or declaration of bankruptcy by the Contractor;
- 24.1.1.4 Determination by DCH that the instability of the Contractor's financial condition threatens delivery of services and continued performance of Contractor's responsibilities, upon five (5) Calendar Days' notice; or
- 24.1.1.5 Immediately, when sufficient appropriated funds no longer exist for the payment of DCH's obligation under this Contract.

24.2 TERMINATION BY DEFAULT

24.2.1 In the event DCH determines that the Contractor has defaulted by failing to carry out the substantive terms of this Contract or failing to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act, DCH may terminate the Contract in addition to or in lieu of any other remedies set out in this Contract or available by law.

24.2.2 Prior to the termination of this Contract, DCH will:

- 24.2.2.1 Provide written notice of the intent to terminate at least thirty (30) Calendar Days prior to the termination date, the reason for the termination, and the time and place of a hearing to give the Contractor an opportunity to Appeal the determination and/or cure the default;
- 24.2.2.2 Provide written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of the termination; and
- 24.2.2.3 For an affirming decision, give Members or the Contractor notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

24.3 TERMINATION FOR CONVENIENCE

DCH may terminate this Contract for convenience and without cause upon thirty (30) Calendar Days written notice. Termination for convenience shall not be a breach of the Contract by DCH. The Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory

authorized work performed as of the termination date. Availability of funds shall be determined solely by DCH.

24.4 TERMINATION FOR INSOLVENCY OR BANKRUPTCY

The Contractor's insolvency, or the Contractor's filing of a petition in bankruptcy, shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy, the Contractor shall immediately advise DCH. If DCH reasonably determines that the Contractor's financial condition is not sufficient to allow the Contractor to provide the services as described herein in the manner required by DCH, DCH may terminate this Contract in whole or in part, immediately or in stages. The Contractor's financial condition shall be presumed not sufficient to allow the Contractor to provide the services described herein, in the manner required by DCH if the Contractor cannot demonstrate to DCH's satisfaction that the Contractor has risk reserves and a minimum net worth sufficient to meet the statutory standards for licensed health care plans. The Contractor shall cover continuation of services to Members for the duration of period for which payment has been made, as well as for inpatient admissions up to Discharge.

24.5 TERMINATION FOR INSUFFICIENT FUNDING

In the event that federal and/or State funds to finance this Contract are insufficient or otherwise unavailable, DCH, at its sole discretion, may terminate the Contract immediately. DCH shall provide prompt written notice of such termination. Subject to the availability of funds, the Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the terminate date. The certification by DCH of the events stated above shall be conclusive and not subject to appeal.

24.6 TERMINATION PROCEDURES

24.6.1 DCH will issue a written notice of termination to the Contractor by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall cite the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective. Termination shall be effective at 11:59 p.m. EST on the termination date.

24.6.2 Upon receipt of notice of termination or on the date specified in the notice of termination and as directed by DCH, the Contractor shall:

24.6.2.1 Stop work under the Contract on the date and to the extent specified in the notice of termination;

24.6.2.2 Place no further orders or Subcontract for materials, services, or facilities, except as may be necessary for completion of such portion of the work under the Contract as is not terminated;

24.6.2.3 Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;

- 24.6.2.4 Assign to DCH, in the manner and to the extent directed by the DCH Contract Administrator, all of the right, title, and interest of Contractor under the orders or subcontracts so terminated, in which case DCH will have the right, at its discretion, to settle or pay any or all Claims arising out of the termination of such orders and Subcontracts;
- 24.6.2.5 With the approval of the DCH Contract Administrator, settle all outstanding liabilities and all Claims arising out of such termination or orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of the Contract;
- 24.6.2.6 Complete the performance of such part of the work as shall not have been terminated by the notice of termination;
- 24.6.2.7 Take such action as may be necessary, or as the DCH Contract Administrator may direct, for the protection and preservation of any and all property or information related to the Contract that is in the possession of Contractor and in which DCH has or may acquire an interest;
- 24.6.2.8 Promptly make available to DCH, or another CMO acting on behalf of DCH, any and all records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this Contract in the format required by DCH. Such records shall be provided at no expense to DCH;
- 24.6.2.9 Promptly supply all information necessary to DCH, or another CMO acting on behalf of DCH, for reimbursement of any outstanding Claims at the time of termination; and
- 24.6.2.10 Submit a termination plan to DCH for review and approval that includes the following terms:
 - 24.6.2.10.1 Maintain Claims processing functions as necessary for ten (10) consecutive months in order to complete adjudication of all Claims;
 - 24.6.2.10.2 Comply with all duties and/or obligations incurred prior to the actual termination date of the Contract, including but not limited to, the Appeal process as described in Section 4.14;
 - 24.6.2.10.3 File all Reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;
 - 24.6.2.10.4 Ensure the efficient and orderly transition of Members from coverage under this Contract to coverage under any new arrangement developed by DCH in accordance with procedures set forth in Section 4.11.8;
 - 24.6.2.10.5 Maintain the financial requirements, and insurance set forth in this Contract until DCH provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled; and

24.6.2.10.6 Submit Reports to DCH every thirty (30) Calendar Days detailing the Contractor's progress in completing its continuing obligations under this Contract until completion.

24.6.3 Upon completion of these continuing obligations, the Contractor shall submit a final report to DCH describing how the Contractor has completed its continuing obligations. DCH will advise, within twenty (20) Calendar Days of receipt of this report, if all of the Contractor's obligations are discharged. If DCH finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, then DCH will require the Contractor to submit a revised final report to DCH for approval.

24.7 TERMINATION CLAIMS

24.7.1 After receipt of a notice of termination, the Contractor shall submit to the DCH Contract Administrator any termination claim in the form, and with the certification prescribed by, the DCH Contract Administrator. Such claim shall be submitted promptly but in no event later than ten (10) months from the effective date of termination. Upon failure of the Contractor to submit its termination claim within the time allowed, the DCH Contract Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the Contract, determine, on the basis of information available, the amount, if any, due to the Contractor by reason of the termination and shall thereupon cause to be paid to the Contractor the amount so determined.

24.7.2 Upon receipt of notice of termination, the Contractor shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this Contract or any other contract. Upon termination, the Contractor shall be paid in accordance with the following:

24.7.2.1 At the Contract price(s) for completed Deliverables and/or services delivered to and accepted by DCH; and/or

24.7.2.2 At a price mutually agreed upon by the Contractor and DCH for partially completed Deliverables and/or services.

24.7.3 In the event the Contractor and DCH fail to agree in whole or in part as to the amounts with respect to costs to be paid to the Contractor in connection with the total or partial termination of work pursuant to this article, the provisions of Section 30 shall control.

25.0 DAMAGES/PERFORMANCE GUARANTEES

25.1 GENERAL PROVISIONS

25.1.1 The Contractor shall, at all times, comply with all terms, conditions, and performance requirements and expectations specified in the RFP, Contractor's Proposal, and this Contract. In the event that Contractor fails to meet the terms, conditions, or requirements of this Contract and said failure results in damages that can be measured in actual cost, DCH will assess the actual damages warranted by said failure.

- 25.1.2 Contractor acknowledges that its failure to: complete the tasks, activities, and responsibilities set forth in Sections 25.2, 25.3, 25.4, 25.5, and 25.6, and submit Deliverables specified by the deadlines required therein, will cause the DCH substantial damages of types and in amounts which are difficult or impossible to ascertain exactly. The Parties further acknowledge and agree that the specified liquidated damages in Sections 25.2, 25.3, 25.4, 25.5, and 25.6 are the result of a good faith effort by the Parties to estimate the actual harm caused by the Contractor's failure to meet the Performance Guarantees. Accordingly, Contractor agrees that DCH may assess liquidated damages against the Contractor for its failure to meet the Performance Guarantees outlined in Sections 25.2, 25.3, 25.4, 25.5, and 25.6.
- 25.1.3 The Parties further acknowledge and agree that the liquidated damages referenced in Sections 25.2, 25.3, 25.4, 25.5, and 25.6 are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of DCH's projected financial loss and damage resulting from: the Contractor's nonperformance, including financial loss as a result of project delays, of the activities and responsibilities described in Sections 25.2, 25.3, 25.4, 25.5 and 25.6; or Contractor's failure to timely submit the deliverables described therein. Accordingly, Contractor agrees that DCH may assess liquidated damages against the Contractor for its failure to meet the Performance Guarantees outlined in Sections 25.2, 25.3, 25.4, 25.5, and 25.6.
- 25.1.4 Contractor acknowledges, affirms, ratifies, and agrees that the damage provisions set forth herein meet the criteria for enforceable damages that are reasonable, appropriate, and necessary. Liquidated damages shall be in addition to any other remedies that DCH may have. Accordingly, DCH reserves the right to seek all other reasonable and appropriate remedies available at law and in equity.
- 25.1.5 If the Contractor commits any of the violations or fails to meet the requirements set forth in Sections 25.2, 25.3, 25.4, 25.5, and 25.6, the Contractor shall submit a written CAP to DCH for review and approval prior to implementing the corrective action. All Corrective Action Plans must be submitted within the timeframe outlined in the Contract.
- 25.1.6 Contractor must agree to or provide evidence acceptable to DCH to challenge the reimbursement to the State for actual damages or the amounts set forth as liquidated damages within thirty (30) Calendar Days as further discussed in Section 25.1.7 below.
- 25.1.7 DCH will notify Contractor in writing of the proposed damage assessment. The amounts due to DCH as actual or liquidated damages may be deducted from any fees or other compensation payable to the Contractor or DCH may require the Contractor to remit the actual or liquidated damages within thirty (30) Calendar Days following the notice of assessment or resolution of any dispute at DCH's sole discretion. At DCH's option, DCH may obtain payment of assessed actual or liquidated damages through one (1) or more claims upon any irrevocable letter of credit furnished by the Contractor.
- 25.1.8 The Parties agree that disputes arising under this Section shall be handled through negotiations with DCH Vendor Management. The Contractor shall be allowed to appeal the decision of DCH Vendor Management to the Commissioner of DCH or his or her designee. Pending final determination of any dispute, the Contractor shall proceed diligently with performance of the Contract and in accordance with the direction of DCH.

25.1.9 Imposition of liquidated damages will not relieve the Contractor from submitting the CAP and implementing the associated corrective action as determined by DCH.

25.1.10 Notwithstanding any sanction or liquidated damages imposed upon the Contractor other than Contract termination, the Contractor shall continue to administer all the provisions of the State's Medicaid Managed Care Program, Georgia Families and the Section 1115 Family Planning Waiver, Planning for Healthy Babies Program.

25.1.11 The venue for any formal legal proceedings shall lie in Fulton County, Georgia.

25.2 CATEGORY 1

25.2.1 Liquidated damages up to \$100,000.00 per day may be imposed for Category 1 events. For Category 1 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 1 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.2.1.1 Failure to "go live" by the Operational Start Date; and

25.2.1.2 Failure to meet the readiness and/or annual review requirements, as specified in Section 2.13.

25.3 CATEGORY 2

25.3.1 Liquidated damages up to \$100,000 per violation may be imposed for Category 2 events. For Category 2 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 2 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.3.1.1 Acts that discriminate among Members on the basis of their health status or need for health care services;

25.3.1.2 Misrepresentation of information or false statements furnished to CMS or the State;

25.3.1.3 Failure to implement requirements stated in the Contractor's Proposal, the RFP, this Contract, or other material failures in the Contractor's duties;

25.3.1.4 Failure to provide an adequate provider network of physicians, pharmacies, hospitals, and other specified health care Providers in order to assure member access to all Covered Services;

25.3.1.5 Failure to achieve the Performance Target for each Quality Performance Measure as described in Section 4.12.3;

25.3.1.6 Failure to comply with the eighty percent (80%) screening ratio for periodic visits on the Contractor's CMS-416 EPSDT as described Section 4.7.3.9;

- 25.3.1.7 Failure to deliver effective Demonstration services as evidenced by lack of achievement of annual targeted LBW and VLBW reduction targets as identified in **Attachment M**;
- 25.3.1.8 Failure to achieve annual targeted reductions in the Pregnancy Rate as identified in **Attachment M**; and
- 25.3.1.9 Failure to fulfill duties to report Member abuse, neglect, or exploitation as a State Mandated Reported as defined by the Official Code of Georgia Annotated, as may be amended from time to time.

25.4 CATEGORY 3

- 25.4.1 Liquidated damages up to \$25,000 per violation may be imposed for Category 3 events. For Category 3 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 3 events are monitored by DCH to determine compliance and include the following:
- 25.4.1.1 Substantial failure to provide Medically Necessary Services that the Contractor is required to provide under law, or under this Contract, to a Member covered under this Contract;
 - 25.4.1.2 Misrepresentation of information or false statements furnished to a Member, Potential Member, or health care Provider;
 - 25.4.1.3 Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;
 - 25.4.1.4 Distribution directly, or indirectly, through any Agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;
 - 25.4.1.5 Violation of any other applicable requirements of Section 1903(m) or 1932 of the Social Security Act and any implementing regulations;
 - 25.4.1.6 Failure of the Contractor to assume full operation of its duties under this Contract in accordance with the transition timeframes specified herein;
 - 25.4.1.7 Imposition of premiums or charges on Members that are in excess of the premiums or charges permitted under the Medicaid program (the State will deduct the amount of the overcharge and return it to the affected Member);
 - 25.4.1.8 Failure to resolve Member Appeals and Grievances within the timeframes specified in this Contract;
 - 25.4.1.9 Failure to ensure client confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of noncompliance will be assessed as per member and/or per HIPAA regulatory violation;

25.4.1.10 Violation of a subcontracting requirement in the Contract; and

25.4.1.11 Failure to provide notice of any known or suspected conflicts of interest, as prescribed in Section 31, **Attachment P**, **Attachment Q** and **Attachment R**.

25.5 CATEGORY 4

25.5.1 Liquidated damages up to \$5,000.00 per day may be imposed for Category 4 events. For Category 4 events, a written Corrective Action Plan may be required and corrective action must be taken. In the case of Category 4 events, if corrective action is taken within four (4) Business Days, then liquidated damages may be waived at the discretion of DCH. Category 4 events are monitored by DCH to determine compliance and shall include the following:

25.5.1.1 Failure to submit required Reports and Deliverables in the timeframes prescribed in Section 4.18 and Section 5.7;

25.5.1.2 Submission of incorrect or deficient Deliverables or Reports as determined by DCH, including the submission of Deliverables or Reports in a format unacceptable to DCH;

25.5.1.3 Failure to comply with the Claims processing standards as follows:

25.5.1.3.1 Failure to process and finalize to a paid or denied status ninety-seven percent (97%) of all Clean Claims within fifteen (15) Business Days during a fiscal year; and

25.5.1.3.2 Failure to pay Providers interest at a twelve percent (12%) annual rate, calculated daily for the full period during which a clean, unduplicated Claim is not adjudicated within the claims processing deadlines. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from 15 calendar days after the date the claim was submitted. A Contractor shall pay all interest required to be paid under this provision or O.C.G.A. Section 33-24-59.5 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the Contractor to the Provider. A Contractor shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic claims, a CMS Form 1500 for non-electronic claims, or any claim prescribed by DCH.

25.5.1.4 Failure to provide an initial visit within fourteen (14) Calendar Days for all newly enrolled women who are pregnant in accordance with Sections 4.6.9.1;

- 25.5.1.5 Failure to comply with the Notice of Proposed Action and Notice of Adverse Action requirements as described in Sections 4.14.3 and 4.14.5;
- 25.5.1.6 Failure to comply with any Corrective Action Plan as required by DCH;
- 25.5.1.7 Failure to seek, collect and/or report third party information as described in Section 8.4;
- 25.5.1.8 Failure to comply with the Contractor staffing requirements and/or any other conditions described in Sections 16.1 and 16.2;
- 25.5.1.9 Failure of Contractor to issue written notice to Members upon Provider's notice of termination in the Contractor's plan as described in Section 4.3.1.1.8;
- 25.5.1.10 Failure to comply with federal law regarding sterilizations, hysterectomies, and abortions and as described in Section 4.6.5;
- 25.5.1.11 Failure to submit acceptable Member and Provider directed materials or documents in a timely manner, i.e., member, handbooks, policies and procedures;
- 25.5.1.12 Failure to comply with the required Demonstration Reports and Deliverables as prescribed in Attachments L and M;
- 25.5.1.13 Failure to conduct quarterly Validation of Provider demographic data and provide DCH with current and accurate data for all contracted Providers as described in Section 4.8.3.2; and
- 25.5.1.14 Failure to submit attestations for each Provider network report in the established DCH format with all required data elements as described in Section 4.8.3.3.

25.6 CATEGORY 5

25.6.1 Liquidated damages as specified below may be imposed for Category 5 events. Imposition of liquidated damages will not relieve the Contractor from submitting and implementing the Corrective Action Plan or corrective action as determined by DCH. Category 5 events are monitored by DCH to determine compliance and include the following:

- 25.6.1.1 Failure to implement the business continuity-disaster recovery (BC-DR) plan as follows:
 - 25.6.1.1.1 Implementation of the (BC-DR) plan exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars (\$5,000) per day up to day 2;
 - 25.6.1.1.2 Implementation of the (BC-DR) plan exceeds the proposed time by more than (2) and up to five (5) Calendar Days: ten thousand dollars (\$10,000) per each day beginning with Day 3 and up to Day 5;

- 25.6.1.1.3 Implementation of the (BC-DR) plan exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days, twenty-five thousand dollars (\$25,000) per day beginning with Day 6 and up to Day 10; and
- 25.6.1.1.4 Implementation of the (BC-DR) plan exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars (\$50,000) per each day beginning with Day 11.
- 25.6.1.2 **Unscheduled System Unavailability (other than CCE and ECM functions described below) occurring during a continuous five (5) Calendar Day period, may be assessed as follows:**
 - 25.6.1.2.1 Greater than or equal to two (2) and less than twelve (12) clock hours cumulative: up to one hundred twenty-five dollars (\$125) for each thirty (30) minutes or portions thereof;
 - 25.6.1.2.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to two hundred fifty dollars (\$250) for each thirty (30) minutes or portions thereof; and
 - 25.6.1.2.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to five hundred dollars (\$500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars (\$25,000) per occurrence.
- 25.6.1.3 **Confirmation of CMO Enrollment (CCE) or Electronic Claims Management (ECM) system downtime. In any calendar week, penalties may be assessed as follows for downtime outside the State's control of any component of the CCE and ECM systems, such as the voice response system and PC software response system:**
 - 25.6.1.3.1 Less than twelve (12) clock hours cumulative: up to two hundred fifty dollars (\$250) for each thirty (30) minutes or portions thereof;
 - 25.6.1.3.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to five hundred (\$500) for each thirty (30) minutes or portions thereof; and
 - 25.6.1.3.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to one thousand dollars (\$1,000) for each thirty (30) minutes or portions thereof up to a maximum of fifty thousand dollars (\$50,000) per occurrence.
- 25.6.1.4 **Failure to make available to the State and/or its agent readable, valid extracts of Encounter Information for a specific month within fifteen (15) Calendar Days of the close of the month: five hundred dollars (\$500) per day. After fifteen (15) Calendar Days of the close of the month: two thousand dollars (\$2000) per day.**

- 25.6.1.5 Failure to correct a system problem not resulting in System Unavailability within the allowed timeframe, where failure to complete was not due to the action or inaction on the part of DCH as documented in writing by the Contractor:
 - 25.6.1.5.1 One (1) to fifteen (15) Calendar Days late: two hundred and fifty dollars (\$250) per Calendar Day for Days 1 through 15;
 - 25.6.1.5.2 Sixteen (16) to thirty (30) Calendar Days late: five hundred dollars (\$500) per Calendar Day for Days 16 through 30; and
 - 25.6.1.5.3 More than thirty (30) Calendar Days late: one thousand dollars (\$1,000) per Calendar Day for Days 31 and beyond.
- 25.6.1.6 Failure to meet the Telephone Hotline performance standards:
 - 25.6.1.6.1 One thousand dollars (\$1,000) for each percentage point that is below the target answer rate of eighty percent (80%) in thirty (30) seconds;
 - 25.6.1.6.2 One thousand (\$1,000) for each percentage point that is above the target of a one percent (1%) Blocked Call rate; and
 - 25.6.1.6.3 One thousand (\$1,000) for each percentage point that is above the target of a five percent (5%) Abandoned Call rate.
- 25.6.1.7 Failure to make available to the State and/or its agent readable valid neonatal intensive care supplement payment reports for a specific month within fifteen (15) Calendar Days of the close of the month:
 - 25.6.1.7.1 Five hundred dollars (\$500) per Calendar Day; and
 - 25.6.1.7.2 Two thousand dollars (\$2,000) per Calendar Day after fifteen (15) Calendar Days of the close of the month.
- 25.6.1.8 Failure to have office space procured and operational by the Operational Start Date:
 - 25.6.1.8.1 One thousand dollars (\$1,000) per Calendar Day
- 25.6.1.9 Failure to be in full compliance with geographic access standards and submit electronic provider network reporting demonstrating its full compliance with the Provider network requirements within ten (10) Calendar Days after receiving the initial Member file. [The initial Member file will be delivered to the Contractor prior to the Operational Start Date.]
 - 25.6.1.9.1 0.25% of the monthly Capitation Payment for Provider types not meeting the geographic access standards per Service Area until the deficiency is fully corrected.

25.6.1.10 Failure to test and ensure the Information Systems are fully operational and meet all RFP and Contract requirements prior to the Operational Start Date:

25.6.1.10.1 Ten thousand dollars (\$10,000) per Calendar Day

25.7 OTHER REMEDIES

25.7.1 In addition to other liquidated damages described above for Category 1-5 events, DCH may impose the following other remedies in addition to other remedies available at law or equity:

25.7.1.1 Appointment of temporary management of the Contractor as provided in 42 CFR 438.706, if DCH finds that the Contractor has repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Social Security Act;

25.7.1.2 Granting Members the right to terminate Enrollment without cause and notifying the affected Members of their right to disenroll;

25.7.1.3 Suspension of all new Enrollment, including default Enrollment, after the effective date of remedies;

25.7.1.4 Suspension of payment to the Contractor for Members enrolled after the effective date of the remedies and until CMS or DCH is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur;

25.7.1.5 Termination of the Contract if the Contractor fails to carry out the substantive terms of the Contract or fails to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act;

25.7.1.6 Civil Monetary Fines in accordance with 42 CFR 438.704;

25.7.1.7 Additional remedies allowed under State statute or State regulation that address areas of non-compliance specified in 42 CFR 438.700;

25.7.1.8 Referral to appropriate state licensing agency for investigation; and

25.7.1.9 Referral to the Office of the Attorney General for investigation.

25.8 NOTICE OF REMEDIES

25.8.1 Prior to the imposition of either liquidated damages or other remedies, DCH will issue a written notice of remedies that will include the following:

25.8.1.1 A citation to the law, regulation or Contract provision that has been violated;

25.8.1.2 The remedies to be applied and the date the remedies will be imposed;

25.8.1.3 The basis for DCH's determination that the remedies should be imposed;

- 25.8.1.4 Request for a Corrective Action Plan, if applicable; and
- 25.8.1.5 The time frame and procedure for the Contractor to dispute DCH's determination. A Contractor's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damage or remedies.

26.0 INDEMNIFICATION

- 26.1 Contractor hereby releases and agrees to indemnify and hold harmless DCH, the State of Georgia, its departments, agencies and instrumentalities (including but not limited to the State Tort Claims Trust Fund, the State Authority Liability Trust Fund, The State Employee Broad Form Liability Funds, the State Insurance and Hazard Reserve Fund, and other self-insured funds, all such funds hereinafter collectively referred to as the "Funds"), and each of its current or former officers, directors, and employees, in individual and official capacities from and against any and all claims, demands, liabilities, losses, costs or expenses, and attorneys' fees, caused by, growing out of, or arising from this Contract, due to any act or omission on the part of Contractor, its agents, employees, customers, invitees, licensees or others working at the direction of Contractor or on its behalf, or due to any breach of this Contract by Contractor, or due to the insolvency or declaration of bankruptcy by Contractor, or due to the application or violation of any pertinent federal, state or local law, rule or regulation. This indemnification extends to the successors and assigns of Contractor, and this indemnification survives the termination of the Contract and the dissolution or, to the extent allowed by law, the bankruptcy of Contractor.
- 26.2 The Parties who shall be entitled to enforce this indemnity of the Contractor shall be DCH, the State of Georgia, its officials, agents, employees, and representatives, including attorneys or the Office of the Attorney General, other public officials, any successor in office to any of the foregoing individuals, and their respective legal representatives, heirs, and beneficiaries.

27.0 INSURANCE

- 27.1 Contractor shall, at a minimum, prior to the commencement of work, procure and maintain the insurance policies identified below at Contractor's own cost and expense and shall furnish DCH with an insurance certificate evidencing proof of coverage at least in the amounts indicated, which shall list DCH as certificate holder and as an additional insured. The insurance certificate must document that the Commercial General Liability insurance coverage purchased by Contractor includes contractual liability coverage applicable to this Contract.
- 27.2 In addition, the insurance certificate must provide the following information: the name and address of the insured; name, address, telephone number and signature of the authorized agent; name of the insurance company (authorized to operate in Georgia); a description of coverage in detailed standard terminology [including policy period, policy number, limits of liability, exclusions, endorsements, and policy notification requirements for claims (to whom, address and time limits)]; and an acknowledgment of notice of cancellation to DCH.
- 27.3 It shall be the responsibility of Contractor to require any Subcontractor to secure the same insurance coverage as prescribed herein for Contractor, and to obtain a certificate evidencing that such insurance is in effect. Upon request, Contractor shall provide evidence of such insurance to DCH. In addition, Contractor shall indemnify and hold harmless DCH and the State from any

liability arising out of Contractor's or Subcontractor's untimely failure in securing adequate insurance coverage as prescribed herein:

27.3.1 Workers' Compensation Insurance

Contractor shall maintain Workers' Compensation Insurance in accordance with the statutory limits established by the General Assembly of the State of Georgia. The Workers' Compensation Policy must include Coverage B – Employer's Liability Limits of:

Bodily Injury by Accident	\$100,000.00 per employee
Bodily Injury by Disease	\$100,000.00 per employee
Policy Limits	\$500,000.00 policy limits

27.3.2 Commercial General Liability

Contractor shall maintain Commercial General Liability Policy(ies), which shall include, but need not be limited to, coverage for bodily injury and property damage arising from premises and operations liability, personal injury liability and contractual liability. The Commercial General Liability Insurance shall provide at least the following limits (per occurrence) for each type of coverage with a \$3,000,000.00 aggregate:

Premises and Operations	\$1,000,000.00
Personal Injury	\$1,000,000.00
Contractual Liability	\$1,000,000.00

27.3.3 Automobile Liability

27.3.3.1 Contractor shall procure and maintain Commercial Automobile Liability Insurance, which shall include coverage for bodily injury and property damage arising from the operation of any owned, non-owned or hired automobile with limits of at least:

Automobile Liability Combined Singled Limit	\$1,000,000.00
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27.3.3.2 To achieve the appropriate coverage levels, a combination of a specific policy written with an umbrella policy covering liabilities above stated limits is acceptable.

27.3.4 Professional Liability Insurance

Professional Liability Insurance	\$1,000,000.00
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27.4 Each of the insurance policies required pursuant to this section shall be issued by a company licensed to transact the business of insurance in the State of Georgia by the Insurance Commissioner for the applicable line of insurance and, unless waived or modified in writing by DCH, shall be an insurer with a Best Policyholders Rating of "A" or better and with a financial

size rating of Class IX or larger. Each such policy shall also contain the following provisions, or the substance thereof, made a part of the insurance policy:

27.4.1 The Contractor agrees that this policy shall not be canceled, changed, allowed to lapse, or allowed to expire until thirty (30) Calendar Days after DCH and the Department of Administrative Services, Risk Management Division, has received written notice thereof as evidenced by return receipt of registered letter or until such time as other valid and effective insurance coverage acceptable in every respect to DCH and providing protection equal to protection called for in the policy shown above shall have been received, accepted, and acknowledged by DCH. It is also agreed that said notice shall be valid only as to such project as shall have been designated by name in said notice.

28.0 IRREVOCABLE LETTER OF CREDIT

28.1 Within five (5) Business Days of the Contract Effective Date, or a later date as determined by DCH, Contractor shall obtain and maintain in force and effect an irrevocable letter of credit. For SFY 2017 and thereafter, on or before July 2 each following year, Contractor shall modify the amount of the irrevocable letter of credit in force and effect as of June 30 to equal 37.5% of the average of the incurred Capitation Payments calculated by the Department for the Contractor for the months of January, February and March. For each fiscal year, the irrevocable letter of credit shall be for the duration of that fiscal year.

28.2 If at any time during the year, the actual GF lives enrolled in Contractor's plan increases or decreases by more than twenty-five percent, DCH, at its sole discretion, may increase or decrease the amount required for the irrevocable letter of credit.

28.3 With regard to the irrevocable letter of credit, DCH may recoup payments from the Contractor for liabilities or obligations arising from any act, event, omission or condition which occurred or existed subsequent to the Contract Effective Date of the Contract and which is identified in a survey, review, or audit conducted or assigned by DCH.

28.4 DCH may also, at its discretion, redeem Contractor's irrevocable letter of credit in the amount(s) of actual damages suffered by DCH if DCH determines that the Contractor is (1) unable to perform any of the terms and conditions of the Contract or if (2) the Contract is terminated by default or bankruptcy or material breach that is not cured within the time specified by DCH, or under both conditions described at one (1) and two (2).

29.0 COMPLIANCE WITH ALL LAWS

29.1 NON-DISCRIMINATION

The Contractor agrees to comply with applicable federal and State laws, rules and regulations, and the State's policy relative to nondiscrimination in employment practices because of political affiliation, religion, race, color, sex, physical handicap, age, or national origin including, but not limited to, Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972 as amended; the Age Discrimination Act of 1975, as amended; Equal Employment Opportunity (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375) and the Americans with Disability Act of 1993 (including but

not limited to 28 C.F.R. § 35.100 *et seq.*). Nondiscrimination in employment practices is applicable to employees for employment, promotions, dismissal and other elements affecting employment.

29.2 DELIVERY OF SERVICE AND OTHER FEDERAL LAWS

29.2.1 Contractor agrees that all work performed pursuant to this Contract shall comply fully with all applicable laws, statutes, case law, codes, rules, regulations, and procedures (whether administrative or otherwise) whether federal or State. Specifically, the Contractor agrees to comply with laws, regulations, and guidelines, including but not limited to §1902(a)(7) of the Social Security Act, DCH Policies and Procedures, HIPAA and the Health Insurance Title XIII of the American Recovery and Reinvestment Act of 2009 (the Health Information Technology for Economic and Clinical Health Act, or “HITECH”), and in the implementing regulations of HIPAA and HITECH. Implementing regulations are published as the Standards for Privacy and Security of Individually Identifiable Health Information in 45 C.F.R. Parts 160 and 164. Together, HIPAA, HITECH and their implementing regulations are referred to in this Contract as the “Privacy Rule and Security Rule”. The Contractor assumes responsibility for full compliance with all such applicable laws, regulations, and guidelines, and agrees to fully reimburse DCH for any loss of funds or resources or overpayment resulting from non-compliance by Contractor, its staff, agents or subcontractors, as revealed in audits conducted by or on behalf of DCH.

29.2.2 The provisions of the Fair Labor Standards Act of 1938 (29 U.S.C. § 201 *et seq.*) and the rules and regulations as promulgated by the United States Department of Labor in Title XXIX of the Code of Federal Regulations are applicable to this Contract. Contractor shall agree to conform with such federal laws as affect the delivery of services under this Contract including but not limited to the Titles VI, VII, XIX, XXI of the Social Security Act, the Federal Rehabilitation Act of 1973, the Davis Bacon Act (40 U.S.C. § 276a *et seq.*), the Copeland Anti-Kickback Act (40 U.S.C. § 276c), the Americans with Disabilities Act of 1990 (including but not limited to 28 C.F.R. § 35.100 *et seq.*), the Clean Air Act (42 U.S.C. 7401 *et seq.*) and the Federal Water Pollution Control Act as Amended (33 U.S.C. 1251 *et seq.*); the Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); and Debarment and Suspension (45 CFR 74 Appendix A (8) and Executive Order 12549 and 12689). Contractor will agree to conform to such requirements or regulations as the United States Department of Health and Human Services may issue from time to time. Authority to implement federal requirements or regulations will be given to the Contractor by DCH in the form of a Contract amendment.

29.2.3 The Contractor shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

29.2.4 The Contractor shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

29.3 COST OF COMPLIANCE WITH APPLICABLE LAWS

The Contractor agrees that it will bear any and all costs (including but not limited to attorneys' fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not limited to federal and State statutes, case law, precedent, regulations, policies, and procedures which exist at the time of the execution of this Contract. The Contractor further agrees that it will bear any and all costs (including but not limited to attorneys' fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not limited to federal and state statutes, case law, precedent, regulations, policies, and procedures which become effective or are amended throughout the life of the Contract. In the event of a disagreement on this matter, DCH's determination on this matter shall be conclusive and not subject to Appeal.

29.4 GENERAL COMPLIANCE

Additionally, the Contractor agrees to comply and abide by all laws, rules, regulations, statutes, policies, or procedures that may govern the Contract, the deliverables in the Contract, or either Party's responsibilities. To the extent that applicable laws, rules, regulations, statutes, policies, or procedures – either those in effect at the time of the execution of this Contract, or those which become effective or are amended during the life of the Contract – require the Contractor to take action or inaction, any costs, expenses, or fees associated with that action or inaction shall be borne and paid by the Contractor solely.

30.0 CONFLICT RESOLUTION

30.1 GOOD FAITH EFFORTS

Except for the right of either Party to apply to a court of competent jurisdiction for a temporary restraining order or other provisional remedy to preserve the status quo or prevent irreparable harm, the Parties agree to attempt in good faith to promptly resolve any dispute, controversy or claim arising out of or relating to this Contract, including but not limited to payment disputes, through negotiations between senior management of the Parties.

30.2 RESOLUTION

If the dispute cannot be resolved within thirty (30) Calendar Days of initiating such negotiations, the dispute shall be decided by the DCH Director of Contracts Administration, who shall reduce his or her decision to writing and mail or otherwise furnish a copy to the Contractor.

30.3 APPEAL

The written decision of the DCH Director of Contracts Administration shall be final and conclusive, unless the Contractor mails or otherwise furnishes a written appeal to the Commissioner of DCH within ten (10) Calendar Days from the date of receipt of such decision. The decision of the Commissioner or his duly authorized representative for the determination of such appeal shall be final and conclusive.

30.4 OTHER REMEDIES

If either Party is dissatisfied, after exhausting the administrative process described above, that Party may pursue its available legal and equitable remedies.

30.5 CONTINUATION OF WORK

Contractor and DCH agree that, the existence of a dispute notwithstanding, they will continue without delay to carry out all their respective responsibilities under this Contract.

31.0 CONFLICT OF INTEREST AND CONTRACTOR INDEPENDENCE

31.1 No official or employee of the State of Georgia or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the GF program shall, prior to the termination of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract.

31.2 The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any material manner or degree with, or have a material adverse effect on the performance of its services hereunder. The Contractor further covenants that in the performance of this Contract no person having any such interest shall be employed.

31.3 All of the parties hereby certify that the provisions of O.C.G.A. §45-10-20 through §45-10-28, which prohibit and regulate certain transactions between State officials and employees and the State of Georgia, have not been violated and will not be violated in any respect throughout the duration of this Contract.

31.4 In addition, it shall be the responsibility of the Contractor to maintain independence and to establish necessary policies and procedures to assist the Contractor in determining if any Contractors or Subcontractors performing work under this Contract have any impairment to their independence. To that end, the Contractor shall submit a written plan to DCH within five (5) Business Days of Contract Award in which it outlines its Impartiality and Independence Policies and Procedures relating to how it monitors and enforces Contractor and Subcontractor impartiality and independence. The Contractor further agrees to take all necessary actions to eliminate threats to impartiality and independence, including but not limited to reassigning, removing, or terminating Contractors or Subcontractors.

32.0 NOTICE

32.1 All notices under this Contract shall be deemed duly given upon delivery, if delivered by hand, or three (3) Calendar Days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the addresses set forth below or to such other address as a party may designate by notice pursuant hereto.

For DCH:

Contracts Administration:

Director of Contracts Administration
Office of General Counsel
Georgia Department of Community Health
2 Peachtree, NW – 40th Floor
Atlanta, Georgia 30303

Project Leader:

[contact info to be placed here]

For [CONTRACTOR]:

[contact info to be placed here]

- 32.2 It shall be the responsibility of the Contractor to inform the Contract Administrator of any change in address in writing no later than five (5) Business Days after the change.
- 32.3 Within two (2) Business Days of receipt of notice, the Contractor shall inform DCH of any legal action, whether the action is formal, informal, administrative, mediation, arbitration, actual litigation, or proposed litigation, which is instituted against the Contractor by a Subcontractor, sub-subcontractor, vendor, supplier, or manufacturer.
- 32.4 The Contractor shall inform DCH immediately of any legal action, whether the action is formal, informal, administrative, mediation, arbitration, actual litigation, or proposed litigation, that it knows, knew, or should have known would be instituted or brought against the Contractor by a Subcontractor, sub-subcontractor, vendor, supplier, or manufacturer for work based on, arising from, or related to this Contract.

33.0 MISCELLANEOUS

33.1 ASSESSMENT OF FEES

The Contractor and DCH agree that DCH may elect to deduct any assessed fees from payments due or owing to the Contractor or direct the Contractor to make payment directly to DCH for any and all overpayments previously made to Contractor by DCH or any fees or penalties assessed against DCH as a result of Contractor's negligence, acts or omissions. The method of collection of assessed fees is solely and strictly at DCH's discretion.

33.2 ATTORNEY'S FEES

In the event that either party deems it necessary to take legal action to enforce any provision of this Contract, and in the event DCH prevails, the Contractor agrees to pay all expenses of such action including reasonable attorney's fees and costs at all stages of litigation as awarded by the court, a lawful tribunal, hearing officer or administrative law judge. If the Contractor prevails in any such action, the court or hearing officer, at its discretion, may award costs and reasonable attorney's fees to the Contractor. The

term “legal action” shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

33.3 AUTHORITY

DCH has full power and authority to enter into this Contract, the person acting on behalf of and signing for the Contractor has full authority to enter into this Contract, and the person signing on behalf of the Contractor has been properly authorized and empowered to enter into this Contract on behalf of the Contractor and to bind the Contractor to the terms of this Contract. Each party further acknowledges that it has had the opportunity to consult with and/or retain legal counsel of its choice, read this Contract, understands this Contract, and agrees to be bound by it.

33.4 BINDING

This Contract and all of its terms, conditions, requirements, and amendments shall be binding on DCH, the Contractor, and their respective successors and permitted assigns.

33.5 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT AND OTHER MATTERS

The Contractor certifies that it is not presently debarred, suspended, proposed for debarment or declared ineligible for award of contracts by any federal or State agency or department.

33.6 CHOICE OF LAW OR VENUE

This Contract shall be governed in all respects by the laws of the State of Georgia. Any lawsuit or other action brought against DCH or the State based upon, or arising from this Contract shall be brought in a court or other forum of competent jurisdiction in Fulton County in the State of Georgia.

33.7 CONTRACT DRAFTING

The Parties agree that each Party had an opportunity to have the legal counsel of its choice review, revise, edit, negotiate, and modify this Contract as needed or desired.

33.8 CONTRACT LANGUAGE INTERPRETATION

The Contractor and DCH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DCH’s interpretation of the Contract language in dispute shall control and govern. DCH’s interpretation of the Contract language in dispute shall not be subject to Appeal under any circumstance.

33.9 COOPERATION WITH AUDITS

33.9.1 The Contractor agrees to assist and cooperate with the Department in any and all matters and activities related to or arising out of any audit or review, whether federal, private, or internal in nature, at no cost to the Department.

33.9.2 The Parties also agree that the Contractor shall be solely responsible for any costs it incurs for any audit related inquiries or matters. Moreover, the Contractor may not charge or collect any fees or compensation from DCH for any matter, activity, or inquiry related to, arising out of, or based on an audit or review.

33.10 COOPERATION WITH OTHER CONTRACTORS

33.10.1 In the event that DCH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, the Contractor agrees to cooperate fully with such other contractors. The Contractor shall not commit any act that will interfere with the performance of work by any other contractor.

33.10.2 Additionally, if DCH eventually awards this Contract to another contractor, the Contractor agrees that it will not engage in any behavior or inaction that prevents or hinders the other Contractor's work related thereto. The Contractor agrees to submit a written turnover plan and/or transition plan to DCH within thirty (30) Calendar Days of receiving the Department's intent to terminate notice. The Parties agree that the Contractor has not successfully met this obligation until the Department accepts its turnover plan and/or transition plan.

33.10.3 The Contractor's failure to cooperate and comply with this provision, shall be sufficient grounds for DCH to halt all payments due or owing to the Contractor until it becomes compliant with this or any other contract provision. DCH's determination on the matter shall be conclusive and not subject to Appeal.

33.11 DRUG-FREE WORKPLACE

The Contractor must certify to DCH that a drug-free workplace will be provided for the Contractor's employees during the performance of this Contract as required by the "Drug-Free Workplace Act", O.C.G.A. § 50-24-1, et seq. and certify compliance with applicable federal law as set forth in **Attachment A**. Contractor agrees to sign and comply with **Attachment A**. The Contractor will secure from any Subcontractor hired to perform services under this Contract such similar certification. Any false certification by the Contractor or violation of such certification, or failure to carry out the requirements set forth in the State of Georgia or federal statutes, rules, regulations, policies, or guidelines relating to a drug-free workplace may result in the Contractor being suspended, terminated or debarred from the performance of this Contract.

33.12 ENFORCEABILITY

If, for any reason, a court of competent jurisdiction finds any provision of this Contract, or portion thereof, to be unenforceable, that provision shall be enforced to the maximum extent permissible so as to effect the intent of the Parties, and the remainder of this Contract shall continue in full force and effect.

33.13 ETHICS IN PUBLIC CONTRACTING

33.13.1 Contractor understands, states, and certifies that it made its proposal to the RFP without collusion or fraud and that it did not offer or receive any kickbacks or other inducements from any other Contractor, supplier, manufacturer, or Subcontractor in connection with its proposal to the RFP.

33.13.2 Contractor agrees to sign and comply with **Attachment P, *Statement of Ethics*, Attachment Q, *DCH Ethics in Procurement Policy***, and **Attachment R, *Code of Ethics and Conflict of Interest Policy***.

33.14 FORCE MAJEURE

Neither party to this Contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party. Such acts shall include, but not be limited to, acts of God, strikes, riots, lockouts, and acts of war, epidemics, fire, earthquakes, or other disasters.

33.15 HOMELAND SECURITY CONSIDERATIONS

33.15.1 The Contractor shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the Contractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

33.15.2 If the Contractor performs services, or uses services, in violation of the foregoing paragraph, the Contractor shall be in material breach of this Contract and shall be liable to the Department for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Contractor shall be required to hold harmless and indemnify DCH pursuant to the indemnification provisions of this Contract.

33.15.3 The prohibitions in this Section shall also apply to any and all agents and Subcontractors used by the Contractor to perform any services under this Contract.

33.16 LEGAL CONSIDERATIONS

The Contractor agrees to be bound by the laws of the State of Georgia. The solicitation and this Contract shall be construed and interpreted in accordance with Georgia law, regardless of where services are performed, in the event a choice of law situation arises. The Contractor further acknowledges that nothing contained in this Contract, shall be construed as a waiver of the immunity from liability, which would otherwise be available to the State of Georgia under the principles of sovereign immunity. In particular, the Contractor agrees that the sole and exclusive means for the presentation of any claim against the State arising out of this Contract, shall be in accordance with all applicable Georgia statutes and the Contractor further covenants not to initiate legal proceedings in any State or Federal court in addition to, or in lieu of, any proceedings available under Georgia statutes.

33.17 LIMITATIONS OF LIABILITY/EXCEPTIONS

Nothing in this Contract shall limit the Contractor's indemnification liability or civil liability arising from, based on, or related to claims brought by DCH or any third party or any claims brought against DCH or the State by a third party or the Contractor.

33.18 OPEN RECORDS

- 33.18.1 In the event Contractor receives a public records request pursuant to any independent Freedom of Information legislation (including but not limited to the Freedom of Information Act (“FOIA”), 5 U.S.C. § 552 and/or the Georgia Open Records Act, O.C.G.A. § 50-18-71, et. seq.) while this Contract is in effect or after the termination of this Contract for any information relating to this Contract, Contractor shall provide a copy of the request to DCH’s Open Records Officer at openrecordsrequest@dch.ga.gov and to the DCH HIPAA Privacy and Security Specialist specified in **Attachment D, Business Associate Agreement**, on the same business day.
- 33.18.2 Upon notifying DCH of the request, Contractor agrees to comply with the response requirements, restrictions, and exceptions in the applicable statute(s) under which the request is made. Contractor will cooperate with DCH to ensure that DCH’s interests are represented and that the confidentiality of the information is not compromised by any actions or omissions of Contractor in relation to the public records request or responses thereto. If DCH objects and Contractor is still required by law to disclose the information, Contractor shall do so only to the minimum extent necessary to comply with the operation of the law, and shall provide DCH a copy of the information disclosed.

33.19 ORDER OF PRECEDENCE

- 33.19.1 This Contract shall include (1) The body of this Contract contained at pages x-y and **Attachments A-W**, (2) The Request for Proposal (**Exhibit 1**), and (3) The Contractor’s Proposal (**Exhibit 2**).
- 33.19.2 In the event of any conflict in language between or among the provisions and documents incorporated into, referenced, or contained in the Contract, the order of precedence shall be as enumerated above, except that the terms of **Attachment D**, shall govern, for the express and agreed upon purpose of compliance with the more stringent protections of confidentiality, privacy, and security. Any other conflicts shall be clarified or decided by DCH.

33.20 OWNERSHIP AND FINANCIAL DISCLOSURE

- 33.20.1 The Contractor shall disclose each person or corporation with an ownership or control interest of five percent (5%) or more in the Contractor’s entity for the prior twelve (12) month period as required in Section 8.6.5 of this Contract.
- 33.20.2 In the event Contractor is, or becomes during the course of this Contract, the wholly owned subsidiary of a publicly owned company, in lieu of the requirements set forth above, Contractor shall disclose financial statements of its immediate parent organization and identify each person, corporation, or entity with an ownership or control interest of five percent (5%) or more in the Contractor’s entity for the prior twelve (12) consecutive calendar month period.
- 33.20.3 For the purposes of this Section, a person, corporation, or entity with an ownership or control interest shall mean a person, corporation, or entity that:

- 33.20.3.1 Owns directly or indirectly five percent (5%) or more of the Contractor's capital or stock or received five percent (5%) or more of its profits;
 - 33.20.3.2 Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, and that interest is equal to or exceeds five percent (5%) of the total property and assets of the Contractor; and
 - 33.20.3.3 Is an officer or director of the Contractor (if it is organized as a corporation), is a Member or manager in the Contractor's organization (if it is organized as a limited liability company) or is a partner in the Contractor's organization (if it is organized as a partnership).
- 33.20.4 All ownership and financial disclosures shall be submitted to DCH when the Contractor's Proposal is submitted and updated or amended at least once every quarter, unless otherwise requested by DCH.

33.21 PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED AND SUSPENDED

- 33.21.1 The Contractor shall not knowingly have a relationship with an individual, or an affiliate of an individual, who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. For the purposes of this Section, a "relationship" is described as follows:
- 33.21.1.1 A director, officer or partner of the Contractor;
 - 33.21.1.2 A person with beneficial ownership of five percent (5%) or more of the Contractor entity; and
 - 33.21.1.3 A person with an employment, consulting or other arrangement with the Contractor's obligations under its Contract with the State.
- 33.21.2 The Contractor shall submit a quarterly Program Integrity Exception List report that identifies Providers, owners, agents, employees, Subcontractors and contractors (as defined in Section 8.6.5.2) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities). (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp) and/or the CMS MED (Medicare Exclusion Database).
- 33.21.3 All disclosures required under this Section shall be included in the Contractor's quarterly Fraud and Abuse Report (See Sections 4.13.4 and 5.7.1).

33.22 SECTION TITLES NOT CONTROLLING

The Section titles used in this Contract are for reference purposes only and shall not be deemed a part of this Contract.

33.23 SURVIVABILITY

The terms, provisions, representations and warranties contained in this Contract shall survive the delivery or provision of all services or Deliverables hereunder.

33.24 TIME IS OF THE ESSENCE

Time is of the essence in this Contract. Any reference to “Days” shall be deemed Calendar Days unless otherwise specifically stated.

33.25 WAIVER

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written consent of the parties. Forbearance or indulgence in any form or manner by either party, in any regard whatsoever, shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any remedy available under the Contract.

34.0 AMENDMENT IN WRITING

- 34.1 No amendment, waiver, termination or discharge of this Contract, or any of the terms or provisions hereof, shall be binding upon either party unless confirmed in writing. Nothing may be modified or amended, except by writing executed by both parties.
- 34.2 If the Contractor desires an amendment or modification to any provision, condition, or obligation contained in this Contract, it must deliver a timely and written change order request to the Department that includes a detailed explanation of the proposed change, justification, and any and all potential cost implications, if any, for the proposed change.
- 34.3 Additionally, the Contractor understands and agrees that CMS and the Georgia Department of Administrative Services approval may be required before any such amendment or proposed amendment can become effective. DCH shall determine, in its sole discretion, when such approval is required.
- 34.4 Any agreement of the Parties to amend, modify, eliminate or otherwise change any part of this Contract shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be of full force and effect as set out herein.

35.0 CONTRACT ASSIGNMENT

- 35.1 Unless otherwise authorized by an act of the legislature, the rights of DCH under this Contract may be assigned to any other agency of the State of Georgia, with ten (10) Calendar Days’ prior notice to Contractor.
- 35.2 Contractor shall not assign this Contract, in whole or in part, without the prior written consent of DCH, and any attempted assignment not in accordance herewith shall be null and void and of no

force or effect. Any assignment or transfer of any interest under the Contract, by Contractor, shall be made explicitly subject to all rights, defenses, set-offs, or counterclaims, which would have been available to DCH against the Contractor in the absence of such assignment or transfer of interest. This provision includes reassignment of Contract due to change of ownership of Contractor.

36.0 PROHIBITION OF CERTAIN CONTRACT PROVISIONS

Contractor acknowledges that pursuant to Georgia Constitution Article 3, Section 6, Paragraph 6, the Department is prohibited from entering into any contract that grants any donation or gratuity or forgives any debt or obligation owing to the public.

37.0 SEVERABILITY

Any section, subsection, paragraph, term, condition, provision, or other part of this Contract that is judged, held, found or declared to be voidable, void, invalid, illegal or otherwise not fully enforceable shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be of full force and effect as set out herein. The Contract shall not be interpreted for or against any party on the basis that such party or its legal representatives caused part of or the entire Contract to be drafted.

38.0 COMPLIANCE WITH AUDITING AND REPORTING REQUIREMENTS FOR NONPROFIT ORGANIZATIONS (O.C.G.A. § 50-20-1 ET SEQ.)

The Contractor agrees to comply at all times with the provisions of the Federal Single Audit Act (hereinafter called the Act) as amended from time to time, all applicable implementing regulations, including but not limited to any disclosure requirements imposed upon non-profit organizations by the Georgia Department of Audits as a result of the Act, and to make complete restitution to DCH of any payments found to be improper under the provisions of the Act by the Georgia Department of Audits, the Georgia Attorney General’s Office or any of their respective employees, agents, or assigns.

39.0 COUNTERPARTS/ELECTRONIC SIGNATURE

This Contract may be signed in any number of counterparts, each of which shall be an original, with the same effect as if the signatures thereto were upon the same instrument. Any signature below that is transmitted by facsimile or other electronic means shall be binding and effective as the original.

40.0 ENTIRE AGREEMENT

This Contract constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, representations or contracts. No written or oral agreements, representatives, statements, negotiations, understandings, or discussions that are not set out, referenced, or specifically incorporated in this Contract shall in any way be binding or of effect between the Parties.

(Signatures on following page)

[THIS SPACE LEFT BLANK INTENTIONALLY]

SIGNATURE PAGE

IN WITNESS WHEREOF, the parties state and affirm that, they are duly authorized to bind the respected entities designated below as of the day and year indicated.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Commissioner

Date

Chief
Division of Medical Assistance Plans

Date

[CONTRACTOR]

BY: _____
Signature

Date

Print/Type Name

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized by Corporate Resolution to Execute on Behalf of and Bind the Corporation to a Contract



State of Georgia

State Entity: Georgia Department of Community Health

Electronic Request for Proposals (“eRFP”)

Event Name: GA Families & GA Families 360° Care Management Organization

eRFP (Event) Number: DCH0000100

1. Introduction

1.1. Purpose of Procurement

Pursuant to the State Purchasing Act §§50-5-50 et seq.), this Request for Proposals (“RFP”) is being issued on behalf of the Department of Community Health (DCH) to establish a Contract with up to four (4) qualified Care Management Organizations (CMOs), or “Suppliers”, for the provision of Benefits and Services for Georgia Families, the State’s managed care program for Medicaid, PeachCare for Kids® Members and Planning for Healthy Babies (P4HB) participants. PeachCare for Kids® is the State Children’s Health Insurance Program (CHIP), and the P4HB program is Georgia’s Section 1115 Family Planning Waiver program. The State also intends to contract with one (1) of the selected Georgia Families CMOs for the provision of Benefits and Services for the State’s Medicaid managed care program, Georgia Families 360°, for children, youth and young adults in Foster Care (FC) or receiving Adoption Assistance and select youth involved with the Department of Juvenile Justice (DJJ).

This RFP is subsequent to an electronic Request for Qualified Contractors (eRFQC), ES-RFQC-40199-465 issued in November 2014. Only Suppliers that responded to the eRFQC, and who were determined to meet the qualifications specified in the eRFQC, are eligible to respond to this RFP.

The selected Supplier may use one or more Subcontractors to deliver services described throughout this RFP. However, DCH intends to sign one Contract with each selected Georgia Families Supplier and two Contracts with the selected Georgia Families 360° Supplier.

1.1.1. Georgia Families and Georgia Families 360° Background

The DCH Division of Managed Care and Quality submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) in 2004 to implement the program now known as Georgia Families, a full-risk mandatory Medicaid managed care program. DCH believed that managed care could continuously and incrementally improve the Quality of Health Care and services provided to patients and improve efficiency by utilizing both human and material resources more effectively and efficiently. After successful implementation and growth, the Georgia Families program, now includes the following Members: Recipients of Medicaid and PeachCare for Kids® and P4HB. Additional information regarding the Georgia Families program can be found in RFP Attachment C.

In August 2011, DCH initiated an effort to analyze redesign options for managing the financing and care of populations enrolled in Medicaid and PeachCare for Kids®. As a result of the analysis, DCH identified a need for enhanced Care Coordination and service integration for children in Foster Care, Adoption Assistance, and those youth in DJJ custody while residing in community residential facilities. DCH, in collaboration with sister agencies and other stakeholders developed the Georgia Families 360° program to specifically meet the unique needs of these Members. Additional information regarding the Georgia Families 360° program can be found in RFP Attachment C.

DCH’s goals for enrolling children in Foster Care, Adoption Assistance, and those youth in DJJ with one (1) CMO are to:

- a. Enhance the Coordination of Care and access to services;

- b. Improve health outcomes;
- c. Develop and utilize meaningful and complete electronic Medical Records; and
- d. Comply fully with regulatory reporting requirements.

The Georgia Families 360° Program is also designed to support Georgia’s efforts towards achieving and sustaining outcomes defined in the Kenny A. Consent Decree (See Attachment J of the RFP) for Georgia Families 360° Foster Care Members in custody of Fulton or DeKalb Counties.

1.1.2. Eligibility for Participation in Georgia Families or Georgia Families 360°

Most Medicaid and PeachCare for Kids® Members are eligible for the Georgia Families program. The following Figure 1 outlines eligibility categories for individuals who are required to enroll in Georgia Families.

Figure 1: Georgia Families Eligibility Categories

Populations	Description
Georgia Families	
Low Income Families	Adults and children who meet the standards of the former Aid to Families with Dependent Children (AFDC) program.
Transitional Medicaid	Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit.
Pregnant Women (Right from the Start Medicaid – RSM)	Pregnant women with family income at or below two hundred twenty percent (220%) of the Federal Poverty Level (FPL) who receive Medicaid through the RSM program.
Children (Right from the Start Medicaid – RSM)	Children less than nineteen (19) years of age whose family income is at or below the appropriate percentage of the FPL for their age and family.
Children (newborn)	A child born to a woman who is eligible for Medicaid on the day the child is born.
Women Eligible Due to Breast or Cervical Cancer	Women less than sixty-five (65) years of age who have been screened through Title XV Center for Disease Control (CDC) screening and have been diagnosed with breast or cervical cancer.
Refugees	Individuals, as defined under O.C.G.A. § 38-3-3, including but not limited to those who have the required Immigration and Naturalization Service (INS) documentation showing they meet a status of asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims.
<i>The following Medicaid Categories of Eligibility are required to receive Resource Mother Outreach through Georgia Families.</i>	

Populations	Description
Women ages eighteen (18) through forty-four (44)	Eligible if qualify under one of the following: <ol style="list-style-type: none"> a. The LIM Category of Eligibility under the Georgia Medicaid State Plan, are already enrolled in Georgia Families and deliver a Very Low Birth Weight (VLBW) baby on or after January 1, 2011. b. The Aged, Blind or Disabled (ABD) Category of Eligibility under the Georgia Medicaid State Plan and deliver a VLBW baby on or after January 1, 2011.
Planning for Health Babies Participants	
Eligible for Family Planning Only Services: Women ages eighteen (18) through forty-four (44) who are otherwise uninsured	Family income at or below two hundred percent (200%) of the FPL.
Eligible for Family Planning Services and Interpregnancy Care Services: Women ages eighteen (18) through forty-four (44) who are otherwise uninsured	Family income at or below two hundred percent (200%) of the FPL who have delivered a VLBW infant.
Women ages eighteen (18) through forty-four (44)	Current Medicaid recipients delivered a VLBW infant and are eligible for Resource Mother services only.
PeachCare for Kids®	
Children less than nineteen (19) years of age	Family income less than two hundred forty-seven percent (247%) of the FPL, are not eligible for Medicaid or any other health insurance program, and cannot be covered by the State Health Benefit Plan.

Georgia Families 360° provides managed care services for youth in Foster Care, children and youth receiving Adoption Assistance, and select youth involved in the juvenile justice system. Figure 2 outlines Medicaid Categories of Eligibility for individuals who are enrolled in Georgia Families 360°. Children and youth receiving Adoption Assistance may elect to be served through the Fee-for-Service delivery system. Some Categories of Eligibility may include the following children or youth who are in joint custody of Division of Family and Children Services (DFCS) and DJJ.

Figure 2: Georgia Families 360° Eligibility Categories

Populations	Description
Georgia Families 360°	

Populations	Description
<i>Children in Foster Care or Receiving Adoption Assistance</i>	
Children and young adults less than twenty-six (26) years of age	Eligible if receiving Foster Care under one of the following scenarios: <ul style="list-style-type: none"> a. Title IV-B or Title IV-E of the Social Security Act b. Title IV-B or Title IV-E of the Social Security Act, and eligible for Supplemental Security Income c. Title IV-B or Title IV-E of the Social Security Act, and enrolled in PeachCare for Kids®
Children less than twenty-one (21) years of age	Eligible if receiving Adoption Assistance under one of the following scenarios: <ul style="list-style-type: none"> a. Title IV-B or Title IV-E of the Social Security Act b. Title IV-B or Title IV-E of the Social Security Act and enrolled in PeachCare for Kids®
Children and young adults less than twenty-six (26) years of age who are in Foster Care or less than twenty-six (26) and receiving Adoption Assistance under Title IV-B or Title IV-E of the Social Security Act and are enrolled in a Home- and Community-Based Services (HCBS) 1915(c) waiver program	Waiver programs are as follows: <ul style="list-style-type: none"> a. Elderly and Disabled Waiver Program: Provides services to people who are functionally impaired or disabled, helping members to remain in their own homes, the homes of caregivers or in other community-based settings as long as possible. b. New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP): Offers HCBS services for people with intellectual or developmental disabilities. c. Community-Based Alternatives for Youth (CBAY): Provides intensive Behavioral Health supports to children who have been diagnosed with a serious emotional disturbance. d. Young adults less than twenty-six (26) who are in Foster Care or receiving Adoption Assistance under Title IV-E of the Social Security Act and are enrolled in the Independent Care Waiver Program (ICWP). ICWP provides services for people with physical disabilities who remain in their own homes or in the community instead of in a hospital or nursing home.
Children eighteen (18) years of age and under	Eligible pursuant to the Interstate Compact for the Placement of Children (ICPC).

Populations	Description
Children and youth subject to age limitations, as specified	Eligible pursuant to the Interstate Compact for Adoption and Medical Assistance (ICAMA). Age limitations are based on the DFCS eligibility requirements for members in Adoption Assistance. In ICAMA cases where Georgia is the receiving state and the child is receiving Adoption Assistance from another state, Georgia can provide Medicaid coverage under ICAMA for the period of time that the sending state continues to provide Adoption Assistance under the Adoption Assistance agreement. Age limitations and eligibility criteria vary by state and are based on the sending state's criteria instead of DFCS' eligibility requirements.
<i>Children Involved with the Department of Juvenile Justice (DJJ)</i>	
Children and youth less than nineteen (19) years of age	Eligible for Right from the Start Medicaid and one of the following: <ul style="list-style-type: none"> a. Placement in community (non-secure) residential care as a result of their involvement with the DJJ. b. Eligible for Supplemental Security Income and are placed in community (non-secure) residential care as a result of their involvement with the DJJ.

1.1.3. Georgia Families, Georgia Families 360° and P4HB Exclusions

The following Medicaid recipients are excluded or exempted from enrolling in Georgia Families and Georgia Families 360°, even if the recipient is otherwise eligible for Georgia Families per the above outlined eligibility requirements.

- a. Recipients eligible for Medicare.
- b. Recipients who are members of a Federally Recognized Indian Tribe (Note: Georgia has no Federally Recognized Indian Tribes).
- c. Recipients who are enrolled in Fee-for-Service Medicaid through Supplemental Security Income. Members who are already enrolled in Georgia Families will remain in Georgia Families until the Disenrollment is completed through the normal monthly process.
- d. Recipients enrolled in the Children's Medical Services program administered by the Georgia Department of Public Health.
- e. Children enrolled in the Georgia Pediatric Program (GAPP).
- f. Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.
- g. Individuals enrolled in a hospice Category of Eligibility.
- h. Individuals enrolled in a nursing home Category of Eligibility.

- i. Individuals enrolled in a Community Based Alternative for Youths (CBAY) (exclusion does not apply to Georgia Families 360° Members).
- j. Children less than twenty-one (21) years of age who are in Foster Care or receiving Adoption Assistance under Title IV-E of the Social Security Act and are enrolled in the Georgia Pediatric Program (GAPP).

The following Members are excluded from the P4HB Program:

- a. Women who become pregnant while enrolled in the Demonstration.
- b. Women determined to be infertile (sterile) or who are sterilized while enrolled in the Demonstration.
- c. Women who become eligible for any other Medicaid or commercial insurance program.
- d. Women who no longer meet the Demonstration's eligibility requirements.
- e. Women who are or become incarcerated.

1.1.4 Service Regions

The selected Supplier will provide services to Members statewide. For the purposes of coordination and planning, DCH has divided the State, by county, into six (6) Service Regions. See the Suppliers' Library for a listing of the counties in each Service Region. In the Suppliers' Library, DCH has also provided Member counts with related age bands for each Service Region and county.

1.1.5 Transition Planning

DCH has developed the following open Enrollment and Auto-Assignment processes to enroll all Georgia Families Members with the selected CMOs.

Figure 3 below provides DCH's plans for initial Enrollment of Georgia Families Members based on the Supplier selections resulting from this RFP. These plans account for incumbent CMOs returning and/or DCH selecting new CMO/CMO(s). Should DCH select one (1) or more new CMO(s), DCH's plan will:

- a. Allow for an open Enrollment period for all Georgia Families Members prior to the Operational Start Date. Georgia Families Members who do not select a CMO during open Enrollment will be auto-assigned to a CMO/CMOs.
- b. Assume Enrollment of at least two hundred thousand (200,000) Georgia Families Members with each CMO.
- c. Suspend the current Quality-based Auto-Assignment process until 2019 when DCH will return to a Quality based Auto-Assignment process. DCH has submitted a Section 1932(a) State Plan Amendment to CMS for approval to suspend the Quality based Auto-Assignment process until 2019.

Figure 3: Potential Georgia Families Selection Scenarios and Enrollment Processes

No.	Procurement Scenario	Open Enrollment and Auto-Assignment Process
1.	<p>No CMO Turnover</p> <ul style="list-style-type: none"> • Incumbent CMOs are 	<ul style="list-style-type: none"> • DCH will not conduct an open Enrollment period • Members will be able to change CMOs based on

No.	Procurement Scenario	Open Enrollment and Auto-Assignment Process
	<p>selected as a result of the RFP process</p>	<p>current change period schedule</p> <ul style="list-style-type: none"> • DCH will maintain the current Quality-based Auto-Assignment algorithm
2.	<p>Addition of One (1) or More New CMOs to Serve the Georgia Families Program</p> <ul style="list-style-type: none"> • 2 or 3 incumbent CMOs and 1 new CMO • 1 or 2 incumbent CMOs and 2, or 3 new CMOs • 0 incumbent CMOs and 3 or 4 new CMOs 	<ul style="list-style-type: none"> • All Members will have a thirty (30) day open Enrollment period prior to the Operation Effective Date • DCH will Auto-Assign Members who do not select a CMO during the open Enrollment period using the following Auto-Assignment algorithm: <ul style="list-style-type: none"> – If a Member is enrolled in a returning CMO, assign the Member to that CMO. – If the Member is not enrolled in a returning CMO, and a family member of the Member is already enrolled in one CMO, assign the Member to that CMO – If no family members are enrolled and the Member has a prior or existing Provider relationship, assign the Member to the CMO in which the Provider is in the Provider network. – If the Provider is in the Provider network of more than one CMO, randomly assign the Member to one of those CMOs. – If the Member does not have a Provider participating with a CMO, assign the Member to a CMO using alphabetical order logic. The assignments may be batched so that one third of the total pool of unassigned Members will be assigned to each CMO if three (3) CMOs are participating or one-fourth of the total pool of unassigned Members will be assigned to each CMO if four (4) CMOs are participating. • Members will have ninety (90) days after the Operational Start Date to change their CMO assignments.

For all scenarios, DCH will collaborate with the selected Suppliers to conduct an extensive multi-phase Member, Provider, and stakeholder outreach campaign. The process described above in Figure 3 does not apply to Georgia Families 360° Members. Georgia Families 360° Members will all be assigned to the one (1) selected Georgia Families 360° Supplier.

1.1.6 Supplier's Library

A resource library is available electronically for potential Suppliers to review material relevant to the RFP. Information on how to obtain access to the electronic resource library will be available via the Additional Resources hyperlink located on the DCH Web Site. The library may be found at:
<https://dch.georgia.gov/care-management-organization-procurement-georgia-families-and-georgia-families-360-programs>.

The library includes but is not limited to documents and web access links such as the following:

- a. Medicaid Service Regions
- b. Georgia Families and Georgia Families 360° Enrollment
- c. Stakeholder Feedback:
 - i. CMO Procurement Suggestions
 - ii. Amerigroup Contract Revision Recommendations
 - iii. Georgia Dental Association Comments
 - iv. Georgia Occupational Therapy Association, Georgia Speech Language-Hearing Association and Physical Therapy Association of Georgia – Comments
 - v. Recommendations for Preventive Pediatric Health Care
- d. 2014 Bright Futures
- e. Readiness Review Tool (draft)
- f. Georgia Quality Strategy
- g. 2014 External Quality Review Annual Report
- h. Georgia Department of Public Health Billing Resources Manual
- i. Georgia Public Health Services for Medicaid Members
- j. 2014 National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements
- k. Georgia Families Fraud and Abuse Monitoring Analysis
- l. Georgia Families Medicaid Primary Care Accessibility Analysis
- m. GAMMIS_5010_Encounter_837D_Companion_Guide_v2.3 (Dental encounters)
- n. GAMMIS_5010_Encounter_837I_Companion_Guide_v2.3 (Institutional encounters)
- o. GAMMIS_5010_Encounter_837P_Companion_Guide_v2.3 (Professional encounters)
- p. Rebate Vendor Data Feeds and Interface Capabilities
- q. 2014 CMO Medical Loss Ratio Summary
- r. Georgia Rate Certification Planning for Healthy Babies FY13 and FY14
- s. Georgia Rate Certification for Planning for Healthy Babies FY15

- t. Georgia Families 360° Rate Certification March 2014 – June 2015
- u. Georgia Families 360° Rate Certification CY14
- v. Georgia Families Rate Certification FY14
- w. Georgia Families Rate Certification FY15
- x. The library also includes but is not limited to web access links such as the following:
 - i. Vaccines for Children Program Resources: <http://dph.georgia.gov/vaccines-children-program>
 - ii. Planning for Healthy Babies Resources: <http://dch.georgia.gov/planning-healthy-babies>
 - iii. Georgia Medicaid State Plan: <http://dch.georgia.gov/medicaid-state-plan>
 - iv. Medicaid Redesign Strategy Report: <https://dch.georgia.gov/medicaid-chip-redesign>
 - v. NCQA Patient Centered Medical Home Resources: <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>

It is the Supplier's responsibility to review Suppliers' Library materials in addition to other publicly available sources for relevance to this RFP's Scope of Work. Several data files are included with the RFP to aid in the development of the Suppliers' submissions.

1.2. eRFP Certification

Pursuant to the provisions of the Official Code of Georgia Annotated §50-5-67(a), the State Entity certifies the use of competitive sealed bidding will not be practicable or advantageous to the State of Georgia in completing the acquisition described in this eRFP. Thus, competitive sealed proposals will be submitted in response to this eRFP. This eRFP is being sourced through an electronic sourcing tool approved by the Department of Administrative Services ("DOAS") and all suppliers' responses must be submitted electronically in accordance with the instructions contained in Section 2 "Instructions to Suppliers" of this eRFP. Electronic competitive sealed proposals will be administered pursuant to the Georgia Electronic Records and Signature Act. Please note electronic competitive sealed proposals meet the sealed proposal requirements of the State of Georgia, an electronic record meets any requirements for writing, and an electronic signature meets any requirements for an original signature.

1.3. Overview of the eRFP Process

The objective of the eRFP is to select a qualified supplier to provide the goods and/or services outlined in this eRFP to the State Entity. This eRFP process will be conducted to gather and evaluate responses from suppliers for potential award. All qualified suppliers are invited to participate by submitting responses, as further defined below. After evaluating all suppliers' responses received prior to the closing date of this eRFP and following negotiations (if any) and resolution of any contract exceptions, the preliminary results of the eRFP process will be publicly announced, including the names of all participating suppliers and the evaluation results. Subject to the protest process, final contract award(s) will be publicly announced thereafter.

NOTE TO SUPPLIERS: The general instructions and provisions of this document have been drafted with the expectation that the State Entity will make a single award; however, please refer to Section 6.7 "Selection and Award" of this eRFP for information concerning the State Entity's actual award strategy (single, multiple, split awards, etc).

1.4. Schedule of Events

The schedule of events set out herein represents the State Entity's best estimate of the schedule that will be followed. However, delays to the procurement process may occur which may necessitate adjustments to the proposed schedule. If a component of this schedule, such as the close date, is delayed, the rest of the schedule may be shifted as appropriate. Any changes to the dates up to the closing date of the eRFP will be publicly posted prior to the closing date of this eRFP. After the close of the eRFP, the State Entity reserves the right to adjust the remainder of the proposed dates, including the dates for evaluation, negotiations, award and the contract term on an as needed basis with or without notice.

Description	Date	Time
Release of eRFP	As Published on the Georgia Procurement Registry ("GPR")	N/A
Deadline for Round 1 written questions sent via email to the Issuing Officer referenced in Section 1.5.	02/25/2015	4:00 p.m. ET
Responses to Round 1 Written Questions	03/09/2015	5:00 p.m. ET
Deadline for Round 2 written questions sent via email to the Issuing Officer referenced in Section 1.5.	03/31/2015	4:00 p.m. ET
Responses to Round 2 Written Questions	04/10/2015	5:00 p.m. ET
Proposals Due/Close Date and Time	As Published on the GPR	See GPR
Proposal Evaluation Completed (on or about)	3 to 4 Weeks after Closing	N/A
Negotiations Invitation Issued (emailed) (on or about); discretionary process	4 to 5 Weeks after Closing	TBD
Negotiations with Identified suppliers (on or about); discretionary process	5 to 7 Weeks after Closing	TBD
Final Evaluation (on or about)	7 to 8 Weeks after Closing	N/A
Finalize Contract Terms	8 to 9 Weeks after closing or Nine calendar days	N/A
Notice of Intent to Award [NOIA] and Certificate of Authority [COA] (on or about)	9 to 10 Weeks after Closing	N/A
Notice of Award [NOA] (on or about)	10 calendar days after NOIA	N/A

1.5. Official Issuing Officer (Buyer)

Dana M. Harris
Dana.Harris@Doas.Ga.Gov

1.6. Definition of Terms

Please review the following terms:

Supplier(s) – companies desiring to do business with the State of Georgia.

State Entity – the governmental entity identified in Section 1.1 "Purpose of Procurement" of this eRFP.

Any special terms or words which are not identified in this State Entity eRFP Document are identified separately in Attachment B: Definitions of Terms at the end of this eRFP. Please download, save and carefully review all documents in accordance with the instructions provided in Section 2 "Instructions to Suppliers" of this eRFP.

1.7. Contract Term

The initial term of the Contract(s) shall be from the date of award until the end of the State's current fiscal year. The State's fiscal year is from July 1st through June 30th. DCH shall possess five (5) one (1) year option(s) to renew, which options shall be exercisable at the sole discretion of DCH. Renewal will be accomplished through the issuance of Notice of Award Amendment. In the event that the Contract(s), if any, resulting from the award of this eRFP shall terminate or be likely to terminate prior to the making of an award for a new Contract for the identified products and/or services, DCH may, with the written consent of the awarded Supplier(s), extend the Contract(s) for such period of time as may be necessary to permit the DCH's continued supply of the identified products and/or services. The Contract(s) may be amended in writing from time to time by mutual consent of the parties. Unless this eRFP states otherwise, the resulting award of the Contract(s) does not guarantee volume or a commitment of funds.

2. Instructions to Suppliers

By submitting a response to the eRFP, the supplier is acknowledging that the supplier:

1. Has read the information and instructions,
2. Agrees to comply with the information and instructions contained herein.

2.1. General Information and Instructions

2.1.1. Team Georgia Marketplace™ Registration System

DOAS requires all companies and/or individuals interested in conducting business with the State of Georgia to register in the State's web-based registration system, through Team Georgia Marketplace™. Registration is free and enables the registering company to gain access to certain information, services and/or materials maintained in Team Georgia Marketplace™ at no charge to the registering company. All registering companies must agree to be bound by the applicable terms and conditions governing the supplier's use of Team Georgia Marketplace™. In the event DOAS elects to offer certain optional or premium services to registered companies on a fee basis, the registered company will be given the opportunity to either accept or reject the service before incurring any costs and still maintain its registration. Companies may register at <https://saofn.state.ga.us/psp/sao/SUPPLIER/ERP/?cmd=login>

2.1.2. Restrictions on Communicating with Staff

From the issue date of this eRFP until the final award is announced (or the eRFP is officially cancelled), suppliers are not allowed to communicate for any reason with any State staff except through the Issuing Officer named herein, or during the Bidders/Offerors' conference (if any), or as defined in this eRFP or as provided by existing work agreement(s). Prohibited communication includes all contact or interaction, including but not limited to telephonic communications, emails, faxes, letters, or personal meetings, such as lunch, entertainment, or otherwise. The State Entity reserves the right to reject the response of any supplier violating this provision.

2.1.3. Submitting Questions

All questions concerning this eRFP must be submitted in writing via email to the Issuing Officer identified in Section 1.5 "Issuing Officer" of this eRFP. No questions other than written will be accepted. No response other than written will be binding upon the State. All suppliers must submit questions by the deadline identified in the Schedule of Events for submitting questions. Suppliers are cautioned that the State Entity may or may not elect to entertain late questions or questions submitted by any other method than as directed by this section. All questions about this eRFP must be submitted in the following format:

Company Name

Question #1 Question, *Citation of relevant section of the eRFP*

Do not use the comments section of the Sourcing Event to submit questions to the issuing officer.

2.1.4. State's Right to Request Additional Information – Supplier's Responsibility

Prior to contract award, the State Entity must be assured that the selected supplier has all of the resources to successfully perform under the contract. This includes, but is not limited to, adequate number of personnel with required skills, availability of appropriate equipment in sufficient quantity to meet the on-going needs of the State Entity, financial resources sufficient to complete performance under the contract, and experience in similar endeavors. If, during the evaluation process, the State Entity is unable to assure itself of the supplier's ability to perform, if awarded, the State Entity has the option of requesting from the supplier any information deemed necessary to determine the supplier's responsibility. If such information is required, the supplier will be so notified and will be permitted approximately seven business days to submit the information requested.

2.1.5. Failing to Comply with Submission Instructions

Responses received after the identified due date and time or submitted by any other means than those expressly permitted by the eRFP will not be considered. Suppliers' responses must be complete in all respects, as required in each section of this eRFP.

2.1.6. Rejection of Proposals; State's Right to Waive Immaterial Deviation

The State Entity reserves the right to reject any or all responses, to waive any irregularity or informality in a supplier's response, and to accept or reject any item or combination of items, when to do so would be to the advantage of the State of Georgia. It is also within the right of the State Entity to reject responses **that do not contain all elements and information requested in this eRFP**. A supplier's response will be rejected if the response contains any defect or irregularity and such defect or irregularity constitutes a material deviation from the eRFP requirements, which determination will be made by the State Entity on a case-by-case basis.

2.1.7. State's Right to Amend and/or Cancel the eRFP

The State Entity reserves the right to amend this eRFP. Any revisions must be made in writing prior to the eRFP closing date and time. By submitting a response, the supplier shall be deemed to have accepted all terms and agreed to all requirements of the eRFP (including any revisions/additions made in writing prior to the close of the eRFP whether or not such revision occurred prior to the time the supplier submitted its response) unless expressly stated otherwise in the supplier's response. **THEREFORE, EACH SUPPLIER IS INDIVIDUALLY RESPONSIBLE FOR REVIEWING THE REVISED eRFP AND MAKING ANY NECESSARY OR APPROPRIATE CHANGES AND/OR ADDITIONS TO THE SUPPLIER'S RESPONSE PRIOR TO THE CLOSE OF THE eRFP.** Suppliers are encouraged to frequently check the eRFP for additional information. Finally, the State Entity reserves the right to cancel this eRFP at any time.

2.1.8. Protest Process

Suppliers should familiarize themselves with the procedures set forth in Chapter 6 of the *Georgia Procurement Manual*.

2.1.9. Costs for Preparing Responses

Each supplier's response should be prepared simply and economically, avoiding the use of elaborate promotional materials beyond those sufficient to provide a complete presentation. The cost for developing the response and participating in the procurement process (including the protest process) is the sole responsibility of the supplier. The State will not provide reimbursement for such costs.

2.1.10. ADA Guidelines

The State of Georgia adheres to the guidelines set forth in the Americans with Disabilities Act. Suppliers should contact the Issuing Officer at least one day in advance if they require special arrangements when attending the Bidders/Offerors' Conference (if any). The Georgia Relay Center at 1-800-255-0056 (TDD Only) or 1-800-255-0135 (Voice) will relay messages, in strict confidence, for the speech and hearing impaired.

2.1.11. Public Access to Procurement Records

Solicitation opportunities will be publicly advertised as required by law and the provisions of the Georgia Procurement Manual. The State Purchasing Act delays the release of certain procurement records in the event the public disclosure of those records prior to the State Entity's public announcements of the results of a solicitation would undermine the public purpose of obtaining the best value for the State such as cost estimates, proposals/bids, evaluation criteria, supplier evaluations, negotiation documents, offers and counter-offers, and certain records revealing preparation for the procurement. The State Purchasing Act requires bids and proposals to be available for public inspection, upon request, within one business day of the State Entity's posting of the Notice of Intent to Award (or the Notice of Award in the event the State Entity does not issue the Notice of Intent to Award). Audited financial statements not otherwise publicly available but required to be submitted as part of the supplier's response shall not be subject to public disclosure. The State Entity is allowed to assess a reasonable charge to defray the cost of reproducing documents. A state employee should be present during the time of onsite inspection of documents. PLEASE NOTE: Even though information (financial or other information) submitted by a supplier may be marked as "confidential", "proprietary", etc., the State will make its own determination regarding what information may or may not be withheld from disclosure.

2.1.12. Registered Lobbyists

By submitting a response to this eRFP, the supplier hereby certifies that the supplier and its lobbyists are in compliance with the Lobbyist Registration Requirements in accordance with the *Georgia Procurement Manual*.

2.2. Submittal Instructions

Submittal Instructions for Team Georgia Marketplace™

Listed below are key action items related to this eRFP. The Schedule of Events in Section 1.4 identifies the dates and time for these key action items. This portion of the eRFP provides high-level instructions regarding the process for reviewing the eRFP, preparing a response to the eRFP and submitting a response to the eRFP. Suppliers are required to access, print and utilize the training materials identified in Section 2.2.1 of this eRFP to ensure the supplier successfully submit a response to this eRFP.

2.2.1. eRFP Released

The release of the eRFP is formally communicated through the posting of this eRFP as an event in Team Georgia Marketplace™ and by a public announcement posted to the Georgia Procurement Registry, which is accessible online as follows: http://ssl.doas.state.ga.us/PRSapp/PR_index.jsp

This eRFP is being conducted through Team Georgia Marketplace™, an online, electronic tool, which allows a supplier to register, logon, select answers and type text in response to questions, and upload any necessary documents. Team Georgia Marketplace™ permits a supplier to build and save a response over time until the supplier is ready to submit the completed response. Each supplier interested in competing to win a contract award must complete and submit a response to this eRFP using Team Georgia Marketplace™. Therefore, each supplier MUST carefully review the instructions and training information from the following link for a comprehensive overview of the functionality of Team Georgia Marketplace™:

<http://doas.ga.gov/Training/Pages/SupplierTraining.aspx>

2.2.2. eRFP Review

The eRFP (or “Sourcing Event”) consists of the following: this document, entitled “The State Entity eRFP Document”, and any and all information included in the Sourcing Event, as posted online on Team Georgia Marketplace™, including any and all documents provided by the State Entity as attachments to the Sourcing Event or links contained within the Sourcing Event or its attached documents.

Please carefully review all information contained in the Event, including all documents available as attachments or available through links. Any difficulty accessing the Event or opening provided links or documents should be reported immediately to the Issuing Officer (See Section 1.5) and/or the Help Desk (Section 2.2.8). Attached documents may be found as follows:

1. First, the State Entity will provide documents at the “header” level of the Event. Please select “View/Add General Comments & Attachments”, which appears at the top of the screen of the Event under the “Event Details” Section. Next, by selecting “View Event Attachments”, the supplier may open and save all of the available documents. In this location, the supplier is most likely to find this document (The State Entity eRFP Document) as well as the worksheets referenced in Section 4 “eRFP Proposal Factors”, such as the Mandatory Response Worksheet, the Mandatory Scored Requirements, and the Additional Scored Responses. Please thoroughly review all provided attachments.
2. Second, the State Entity may also provide documents at the “**line detail**” level of the Event.

Each category of service for this solicitation is referenced at the line level i.e.:

1. GA Families
2. GA Families 360°

For the purposes of entering a proposal submission, please place the amount of \$1.00 for each line.

3. Please navigate to “Step 2: Enter Line Bid Responses”, which appears towards the bottom of the screen of the Event. Please access any provided documents as follows:
 - a. First Method:
 - i. To the right of each line appearing under Step 2, the Event contains a “Bid” link. By selecting the “Bid” link, the supplier will navigate to a new page of the Event.
 - ii. On this new page, the supplier can select “View/Add Question Comments and Attachments” to locate attached documents.
 - b. Second Method:
 - i. To the right of each line appearing under Step 2, the Event contains a “Line Comments/Files” icon (appears as a bubble with text). By selecting the “Line Comments/Files” icon, the supplier will navigate to a new page of the Event.
 - ii. On this new page, the supplier can locate attached documents.

2.2.3. Preparing a Response

As noted earlier, Team Georgia Marketplace™ allows the supplier to answer questions by entering text and numeric responses. In addition, as noted in Section 2.2.4 “Uploading Forms”, the supplier may also provide information by uploading electronic files. When preparing a response, the supplier must consider the following instructions:

1. Use the provided worksheets to prepare your response. Enter your responses directly into the worksheet. Unless otherwise directed, do not insert “see attached file” (or similar statements) in the worksheet to reference separate documents.
2. Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response.
3. Proofread your response and make sure it is accurate and readily understandable.
4. Label any and all uploaded files using the corresponding section numbers of the eRFP or any other logical name so that the State Entity can easily organize and navigate the supplier’s response.
5. Use caution in creating electronic files to be uploaded. If the State Entity is unable to open an electronic file due to a virus or because the file has become corrupted, the supplier’s response may be considered incomplete and disqualified from further consideration.
6. Use commonly accepted software programs to create electronic files. The State Entity has the capability of viewing documents submitted in the following format: Microsoft Word or WordPad, Microsoft Excel, portable document format file (PDF), and plain text files with the file extension noted in parentheses (.txt). Unless the eRFP specifically requests the use of another type of software or file format than those listed above, please contact the Issuing Officer prior to utilizing another type of software and/or file format. In the event the State Entity is unable to open an electronic file because the State Entity does not have ready access to the software utilized by the supplier, the supplier’s response may be considered incomplete and disqualified from further consideration.
7. Continue to save your response until the response is ready to be submitted. Select the “Save for Later” button at the top of the page under “Event Details” of the Event.

2.2.4. Uploading Forms

Once the supplier is ready to upload electronic files (completed forms or worksheets, product sheets, etc.), please following the directions within the eRFP to upload these documents in the proper location. There are three places to upload completed documents:

1. First, the “View/Add General Comments & Attachments” link contains a place for the supplier to upload all of the documents and worksheets which were provided by the State Entity under the “View Event Attachments” link. Once the supplier has completed the Event Attachments, the supplier can then select “Add New Attachments” to upload the completed documents. The supplier can upload as many documents as necessary in this section of the Event.
2. Second, the supplier can also upload documents in response to each question or bid factor which appears on the main page of the Event, which appears below the “View/Add General Comments & Attachments” link of the Event. To the right of each question or bid factor, the supplier can select the “Add Comments or Attachments” link to either enter a written response or upload an electronic document in response to the question or bid factor. After selecting “Add Comments or Attachments”, the supplier should select “Upload” under the “Add New Attachments” section to browse and upload an electronic file.
3. Third, the supplier can also upload documents in the bottom portion of the Event where pricing is requested. After selecting the comment bubble icon, the Event allows the supplier to select “Upload” in order to include an attachment as part of the supplier’s response. In the alternative, the supplier can also select the link “Bid”, which also appears to the right of any line items provided in the “Enter Line Bid Responses” portion of the Event. After selecting the “Bid” link, the supplier can select “View/Add Question Comments and Attachments” to upload a document.

2.2.5. Reviewing the Response Prior to Submission

Each supplier is responsible for ensuring all questions have been answered appropriately and that all necessary documents have been uploaded. Prior to final submission of your response, please review the following checklist:

1. Please review and confirm that the supplier has answered all questions appropriately. Many questions require a “yes” or “no” response. Please ensure that the correct response has been selected.
2. Please review and confirm that the most competitive response has been provided.
3. Please confirm that all necessary files have been uploaded.
4. Please select the “Validate Entries” button under “Event Details” at the top portion of the Event. While the “Validate Entries” feature cannot verify whether the supplier has attached files, attached the correct files, or entered the correct responses, the “Validate Entries” feature will alert the supplier if one or more questions in the “Event Questions” section of the Event have not been answered. The “Validate Entries” feature is a useful tool; however, it is no substitute for careful preparation and review by the supplier. The State Entity will not consider the supplier’s use of the “Validate Entries” feature as an excuse for an error committed by the supplier in the preparation of its response.

2.2.6. Submitting the Completed Response/Bid

Once the completed response has been reviewed by the supplier, click the "Submit Bid" button at the top of the page under the “Event Details” section of the Event. Any information entered by a supplier into Team Georgia Marketplace™ but not submitted prior to the submission deadline will not be released to the State Entity and will not be considered for award. Only after the supplier selects the “Submit Bid” button, will the response to the eRFP be sent electronically, time stamping the supplier’s response and sending a confirmation email to the email address of the supplier. Please note that submission is not instantaneous; therefore, each supplier must **allow ample time for its response to be submitted prior to the deadline.**

2.2.7. Reviewing, Revising or Canceling a Submitted Response

After the response has been submitted, the supplier may view and/or revise its response by logging into Team Georgia Marketplace™ and selecting the eRFP event number and the “View/Edit” feature for the supplier’s previous response. Please take note of the following:

1. REVIEW ONLY. In the event the supplier only wishes to view a submitted response, the supplier may select “View/Edit”. Once the supplier has finished viewing the response, the supplier may simply exit the screen. **DO NOT SELECT “Save for Later.”** Team Georgia Marketplace™ recognizes any response placed in the “Save for Later” status as a work in progress and withdraws the originally submitted bid. As a result, unless the supplier selects “Submit” prior to the closing date and time, no response will be transmitted to the State Entity.
2. REVIEW AND REVISE. In the event the supplier desires to revise a previously submitted response, the supplier may select “View/Edit” and then revise the response. If the revisions cannot be completed in a single work session, the supplier should save its progress by selecting “Save for Later.” Once revisions are complete, the supplier **MUST** select “Submit” to submit its corrected response. Please permit adequate time to revise and then resubmit the response. Please note submission is not instantaneous and may be affected by several events, such as the supplier temporarily losing a connection to the Internet.

AS EACH SUPPLIER IS SOLELY RESPONSIBLE FOR RESUBMITTING ITS RESPONSE PRIOR TO THE eRFP END DATE AND TIME TO ENSURE THE RESPONSE MAY BE CONSIDERED BY THE STATE ENTITY, PLEASE USE CAUTION IN DECIDING WHETHER OR NOT TO MAKE REVISIONS. The State will assume no responsibility for a supplier’s inability to correct errors or otherwise make revisions to the submitted response or the supplier’s inability to resubmit a response prior to the eRFP end date and time.

3. WITHDRAW/CANCEL. In the event the supplier desires to revise a previously submitted response, the supplier may select “View/Edit” and then select “Save for Later”. Team

Georgia Marketplace™ recognizes any response placed in the “Save for Later” status as a work in progress and **withdraws the originally submitted bid**. As a result, unless the supplier selects “Submit” prior to the closing date and time, no response will be transmitted to the State Entity. In the event a supplier desires to withdraw its response after the closing date and time, the supplier must submit a request in writing to the Issuing Officer.

2.2.8. Help Desk Support

For technical questions related to the use of Team Georgia Marketplace™, suppliers have access to phone support through the DOAS Customer Service Help Desk at 404-657-6000, Monday through Friday 8:00 AM to 5:00 PM excluding State Holidays or any other day state offices are closed such as furlough days or closings in response to inclement weather. Suppliers can also email questions to: ProcurementHelp@doas.ga.gov.

3. General Business Requirements

This section contains general business requirements. By submitting a response, the supplier is certifying its agreement to comply with all of the identified requirements of this section in the Scope of Work, Attachment D.

3.1. Standard Insurance Requirements

If awarded a contract, the supplier shall procure and maintain insurance which shall protect the supplier, the State Entity and the State of Georgia (as an additional insured) from any claims for bodily injury, property damage, or personal injury covered by the indemnification obligations set forth in the contract attached to this solicitation throughout the duration of the contract. The supplier shall procure and maintain the insurance policies described below at the supplier’s own expense and shall furnish the State Entity an insurance certificate listing the State of Georgia as certificate holder and as an additional insured. The insurance certificate must document that the Commercial General Liability insurance coverage purchased by the supplier includes contractual liability coverage applicable to the contract. In addition, the insurance certificate must provide the following information: the name and address of the insured; name, address, telephone number and signature of the authorized agent; name of the insurance company (authorized to operate in Georgia); a description of coverage in detailed standard terminology (including policy period, policy number, limits of liability, exclusions and endorsements); and an acknowledgment of notice of cancellation to the State Entity.

The supplier is required to maintain the following insurance coverage’s during the term of the contract:

- 1) Workers Compensation Insurance (Occurrence) in the amounts of the statutory limits established by the General Assembly of the State of Georgia (A self-insurer must submit a certificate from the Georgia Board of Workers Compensation stating that the supplier qualifies to pay its own workers compensation claims.) In addition, the supplier shall require all subcontractors occupying the premises or performing work under the contract to obtain an insurance certificate showing proof of Workers Compensation Coverage with the following minimum coverage:

Bodily injury by accident - per employee	\$100,000;
Bodily injury by disease - per employee	\$100,000;
Bodily injury by disease – policy limit	\$500,000.
- 2) Commercial General Liability Policy with the following minimum coverage:

Each Occurrence Limit	\$1,000,000
Personal & Advertising Injury Limit	\$1,000,000
General Aggregate Limit	\$ 3,000,000
Products/Completed Ops. Aggregate Limit	\$ 3,000,000
- 3) Automobile Liability

Combined Single Limit	\$1,000,000
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The foregoing policies shall contain a provision that coverage afforded under the policies will not be

canceled, or not renewed or allowed to lapse for any reason until at least thirty (30) days prior written notice has been given to the State Entity. Certificates of Insurance showing such coverage to be in force shall be filed with the State Entity prior to commencement of any work under the contract. The foregoing policies shall be obtained from insurance companies licensed to do business in Georgia and shall be with companies acceptable to the State Entity, which must have a minimum A.M. Best rating of A-. All such coverage shall remain in full force and effect during the term and any renewal or extension thereof.

Within ten (10) business days of award, the awarded supplier must procure the required insurance and provide the State Entity with two (2) Certificates of Insurance. Certificates must reference the contract number. The supplier's submitted pricing must include the cost of the required insurance. No contract performance shall occur unless and until the required insurance certificates are provided.

3.2. Letter of Credit

The awarded Supplier(s) shall be required to furnish an irrevocable letter of credit to DCH for the faithful performance on the Contract in an amount equal to ten percent (10%) of the annual value of the Contract for each State fiscal year for all work that may be undertaken pursuant to the Contract. The letter of credit shall be issued by a FDIC insured financial institution authorized to do business with the State of Georgia; and shall list DCH (Georgia Department of Community Health) as the beneficiary. The letter of credit must be submitted to DCH prior to the beginning of any Contract performance by the awarded Supplier. **Please refer to eRFP Attachments I and J: State Contract (Irrevocable Letter of Credit) for details surrounding the requirements of the letter of credit.**

3.3. Proposal Certification

By responding to this solicitation, the supplier understands and agrees to the following:

1. That this electronically submitted proposal constitutes an offer, which when accepted in writing by the State Entity, and subject to the terms and conditions of such acceptance, will constitute a valid and binding contract between the supplier and the State Entity; and
2. That the supplier guarantees and certifies that all items included in the supplier's response meet or exceed any and all of the solicitation's identified specifications and requirements except as expressly stated otherwise in the supplier's response; and
3. That the response submitted by the supplier shall be valid and held open for a period of **one hundred and twenty (120) days** from the final solicitation closing date and that the supplier's offer may be held open for a lengthier period of time subject to the supplier's consent; and
4. That the supplier's response is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a response for the same materials, supplies, equipment, or services and is in all respects fair and without collusion or fraud. Supplier understands and agrees that collusive bidding is a violation of state and federal law and can result in fines, prison sentences, and civil damage awards; and
5. That the provisions of the Official Code of Georgia Annotated, Sections 45-10-20 et seq. have not been violated and will not be violated in any respect.

4. eRFP Proposal (Bid) Factors

This section contains the detailed technical requirements and related services for this Sourcing Event. Suppliers are required to download, complete and then upload the Worksheets titled "Supplier General Information", "Mandatory Response Worksheet", "Mandatory Scored Requirement Worksheet" and "Additional Scored Response Worksheet" found as attachments in the Sourcing Event. Although many solicitations will contain all of the worksheets noted above, it is possible that a solicitation will not contain all of the worksheets. In the event all four worksheets are not available as downloadable forms to this eRFP, please confirm with the Issuing Officer that all four worksheets are not required.

Unless requested otherwise, all responses must be provided within the Excel worksheets and not as a separately attached document. Except as otherwise indicated, all requested forms and documents must be submitted electronically via the sourcing tool as an uploaded document to the supplier's response. These worksheets

together with any and all other documents submitted in response to Section 4 of this eRFP will be considered the supplier's technical proposal.

The State Entity has determined that it is best to define its own needs, desired operating objectives, and desired operating environment. The State Entity will not tailor these needs to fit particular solutions suppliers may have available; rather, the suppliers shall propose to meet the State Entity's needs as defined in this eRFP. All claims shall be subject to demonstration. Suppliers are cautioned that conditional proposals, based upon assumptions, may be deemed non-responsive.

4.1. Technical Proposal Introduction

All of the items described in this section are service levels and/or terms and conditions that the State Entity expects to be satisfied by the selected supplier. Each supplier must indicate its willingness and ability to satisfy these requirements in the appropriate worksheets.

4.2. Supplier General Information

Each supplier must complete all of the requested information in the attached file entitled **Supplier's General Information Worksheet**.

DO NOT INCLUDE ANY COST/PRICING INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

4.3. Mandatory Requirements

As specified with each requirement listed in the **Mandatory Response Worksheet**, the supplier must indicate whether its proposal meets the individual requirements by marking either a "YES" or "NO" in the response block provided. A Pass/Fail evaluation will be utilized for all mandatory requirements. Ordinarily, to be considered responsive, responsible and eligible for award, all questions identified as mandatory must be marked "YES" to pass. There may be rare instances in which a response of "NO" is the correct and logical response in order to meet the mandatory requirement (e.g. responding "NO" that the supplier does not possess any conflicts of interest). Otherwise, any mandatory questions marked "NO" will fail the technical requirements and will result in disqualification of the proposal.

DO NOT INCLUDE ANY COST/PRICING INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

4.4. Mandatory Scored Response

As specified with each requirement listed in the **Mandatory Scored Response Worksheet**, the supplier must indicate whether it will meet the individual requirement (if any) and provide a supporting narrative in the space provided. To be considered responsive, responsible and eligible for award, any and all requirements identified in the Mandatory Scored Response Worksheet must be met. There may be rare instances in which an item within the Mandatory Scored Response Worksheet does not create an individual requirement which must be met, but, instead, merely requires a response. All requirements labeled "Mandatory Scored" must be met by the supplier. Failure to meet any mandatory scored requirements may result in disqualification of the proposals. The narrative description, along with any required supporting materials, will be evaluated and awarded points in accordance with Section 6 "Proposal Evaluation, Negotiations and Award" of this eRFP.

DO NOT INCLUDE ANY COST INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

4.5. Additional Scored Responses

All items labeled "Additional Scored Responses" represent information that is requested by the State Entity. **Additional Scored Information must be submitted for eligibility and evaluation of the Georgia 360° Contract award.** Answers along with any requested supporting materials will be evaluated and awarded points in accordance with Section 6 "Proposal Evaluation, Negotiations and Award" of this eRFP.

DO NOT INCLUDE ANY COST INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

4.6. Additional Information

As noted in Section 2.2.2 “eRFP Review”, please access and review all of the attachments provided by the State Entity within the Event. If supplemental materials are requested by the State Entity to be submitted by the supplier as part of the technical proposal, the supplier should upload these additional materials as noted in Section 2.2.4 “Uploading Forms”.

5. Capitation Rate Methodology

5.1. General Description of Capitation Rate Methodology

Supplier must agree to provide all services and fulfill all requirements of this RFP in exchange for the Capitation Rates as determined under the terms of the Contract. Based on the Supplier’s own experience and projections, the Supplier must determine its expected costs under the Contract, evaluate the Capitation Rate methodology (“Capitation Rate Methodology”) and related information presented within this RFP, and assess whether the rates determined using the described Capitation Rate Methodology will be adequate. The Supplier must agree to accept the Capitation Rates as determined by DCH using the described Capitation Rate Methodology as a mandatory condition for selection under this RFP. Instead, Suppliers must differentiate themselves based on Quality, network access, efficiency and value-added services for Members as demonstrated through the Technical Proposal and resulting score.

The first rate period of the Contract for the CMOs approved through this RFP process will be State fiscal year (FY) 17 (July 1, 2016 through June 30, 2017). The rate setting process for that period is expected to be completed on or around June 2016 to ensure that the best and most recent program information and data is reflected in the rate development. The same process will be used for all future rate periods covered under this RFP.

5.2. Overview of Georgia Families and Georgia Families 360° Capitation Rate Methodology

Capitation Rates for the Georgia Families program are determined on an annual basis, on a July 1st to June 30th fiscal period. Separate Capitation Rates are paid by Service Region, age, gender, and Category of Eligibility. In addition, separate payments are currently made as follows:

- a. Obstetrical Delivery Payments
- b. Neonatal Intensive Care Unit (NICU) Supplemental Payments
- c. Capitation Payments for Members enrolled in the Breast and Cervical Cancer Program.

Capitation Rates are based on the actual Claims cost experience of the incumbent CMOs, with adjustments for missing Encounter Claim data, incurred but unpaid Claims, population changes, non-Covered Services, trend, Provider reimbursement changes, Benefits changes and other relevant items, with a managed care impact projection divided by Member months of Enrollment in the Georgia Families program.

Capitation Rates for the Georgia Families 360° program were initially established from program inception, March 3, 2014 through December 31, 2014. A separate blended Capitation Rate was established for Foster Care and Juvenile Justice Members on a statewide basis, and Capitation Rates for Adoption Assistance Members were established by Service Region and age group.

Because Georgia Families 360° is a new program, Fee-for-Service historical Enrollment and Claims data were used as the base data to develop the Capitation Rate ranges, as described in the Rate Certification Report found in the Suppliers’ Library. Capitation Rates established by DCH for this initial rate period, including a 5% Withhold for Value Based Purchasing, were near the midpoint of the Capitation Rate range. Capitation Rates are now in the process of being extended through June 30, 2015. The Rate Certification Report for this extension is included in the Suppliers’ Library. For the Contract period covered by this RFP,

the base data to be used is expected to incorporate actual Encounter Claims data from the incumbent Georgia Families 360° CMO once that data becomes available.

The Capitation Rate Methodology reflects CMS requirements that full-risk Capitated payment rates to CMOs be actuarially sound. This means that each Capitation Payment for each rate cell (e.g., Atlanta Region, PeachCare for Kids®, age 1-5, etc.) must fall within the actuarially sound Capitation Rate range developed and certified by the State's actuaries and approved by CMS. Rate ranges developed by DCH's actuary include a low end of the range to ensure adequate access for Members as well as an upper end of the range to ensure cost effective and efficient programs.

New Capitation Rate ranges will be established by DCH annually for each Contract year based on the above methodology that has been used historically and approved by CMS, which incorporates new and updated program information, data and CMO experience for each Capitation Rate period. Historically, DCH has generally established rates at the low end of the rate range for Georgia Families, resulting in Capitation Payments acceptable to CMS and ensuring adequate Member access and Quality. The lower end of the rate range is indicative of the current Capitation Rate Methodology for Georgia Families. For Georgia Families 360°, DCH selected a Capitation Payment rate near the midpoint of the rate range in 2014. The Capitation Payment rate is then adjusted for a 5% Value Based Purchasing Withhold. Georgia Families 360° is a new program, and future rate periods are also expected to reflect rates, prior to adjusting for the Value Based Purchasing Withhold, near the midpoint of the Capitation Rate range.

To assist Suppliers' assessment of the adequacy of the Capitation Rate Methodology, DCH has provided the detailed data book for the Georgia Families Rate Range Development for the Contract periods July 1, 2013 through June 30, 2014 and July 1, 2014 through June 30, 2015, along with the actuarial certification and report that describes the development of the base period data used in the Suppliers' Library. The Georgia Families 360° Program- Foster Care and Adoptive Assistance Rate Range Development for the Contract period March 3, 2014 through December 31, 2014 is also included in the Suppliers' Library. These documents provide a step-by-step build-up of the Capitation Rates for both periods.

5.3 Health Insurance Providers Fee

DCH also reimburses the CMOs for the amount of the Federal Health Insurance Providers Fee (Section 9010 of the Affordable Care Act), including an actuarially sound adjustment for the estimated impact of the non-deductibility of the fee for federal and State tax purposes, specifically attributable to the Georgia Families, Georgia Families 360° and Planning for Healthy Babies membership.

Payment for the Health Insurance Providers Fee shall be made once the amount attributable to each CMO's membership is known. The amount attributable is based on each CMO's final United States Internal Revenue Service (IRS) Form 8963 filing, the final notification of the Health Insurance Providers Fee amount owed by the CMO as received from the IRS, and supporting documentation from the CMOs as requested by DCH. CMOs are reimbursed for the twelve (12) month cost of the annual Health Insurance Providers Fee in a single month using adjusted Capitation Payments.

5.4 Overview of Planning for Healthy Babies (P4HB) Capitation Rate Methodology

The P4HB Program expands the provision of Family Planning Services to uninsured women, ages 18 through 44. For the P4HB Program, the Capitation Rate ranges reflect all P4HB services provided to P4HB participants. The Per Member Per Month (PMPM) rate structure is split for those eligible for Family Planning Services, those eligible for Interpregnancy Care Services (IPC) and those eligible for Resource Mother only services. The P4HB Capitation Rates also include an administrative cost allowance. The Capitation Rate ranges were developed based on detailed Enrollment, and medical and prescription drug Encounter Data received from the incumbent CMOs. Using the Encounter Data and Enrollment data, base period Per Member Per Month costs were developed and adjustments and trending applied as described in the P4HB Rate Certification Report for the Contract Period July 1, 2014 through June 30, 2015, which is included in

the Suppliers' Library. For the P4HB initiative, it has been DCH's practice to pay Capitation Rates at the low end of the rate range. The lower bound of the rate range is indicative of the current Capitation Rate Methodology for P4HB.

5.5 Future Capitation Rate Methodology

All Capitation Rates for the first year Contract under this RFP will be developed by DCH's actuary in a similar actuarially sound manner as described above, taking into account relevant factors for the rate period. For example, the FY 2015 rate certification for Georgia Families includes an adjustment for the Affordable Care Act (ACA) Primary Care Provider (PCP) Rate Increase, which expired December 31, 2014. That rate adjustment would be removed from the rates for subsequent periods. Other potential adjustments include incorporating costs related to the NICU Supplemental Payment into the newborn premium rate, and conversion to a risk-adjusted Capitation Payment approach.

DCH intends to implement a Value Based Purchasing (VBP) model similar to the current Georgia Families 360° for the Georgia Families program. When implemented, Georgia Families Capitation Rates would be revised so that the Georgia Families Capitation Rates are actuarially sound given the VBP Withhold. Therefore, the Georgia Families Capitation Rates will be actuarially sound even if the Supplier does not achieve the VBP performance criteria.

Other changes may be reflected based on future programmatic changes. The totality of such potential changes cannot be contemplated or enumerated at this time. However, such future changes could include: future Provider fee and rate changes, changes in the eligible population or services covered, the Health Insurance Providers Fee methodology, and other marketplace or State /Federal policy changes. For such changes, DCH will have its independent actuary review the proposed change and determine whether the change would materially impact the actuarial soundness of the Capitation Rates. If the actuary determines that the change would materially impact the actuarial soundness of one or more of the Capitation Rates, the actuary will determine the appropriate adjustment to the impacted rate(s).

5.6 Partial Month Capitation Rate Methodology

DCH will compensate the selected Supplier on a Per Member Per Month basis for each Member enrolled in the selected Supplier's plan as detailed in Attachment I and Attachment J, if applicable, of this RFP which is incorporated by this reference as if fully written herein. For the first partial month of a Member's enrollment in the selected Supplier's plan, DCH will prorate the Member's Capitation Payment on a per Calendar Day basis for the remainder of the calendar month. The Capitation Payment will be prorated on a per Calendar Day basis for any partial month of a Member's enrollment in the CMO. The number of enrolled Members will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's Fiscal Agent Contractor. The Capitation Payment will be multiplied by the number of enrolled Members. The selected Supplier must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, and notwithstanding any other withheld amounts allowed under this Contract, such amount shall be withheld from the prepaid, monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

6. Proposal Evaluation, Negotiations and Award

All timely proposals will be evaluated in accordance with the following steps. The objective of the evaluation process is to identify the proposal which represents the best value to the State Entity based on a combination of technical and cost factors. Based on the results of the initial evaluation, the State Entity may or may not elect to negotiate technical and/or cost factors as further described in the eRFP. In the event negotiations of the technical and/or cost factors occur, the revised proposals will be reevaluated in accordance with the provisions of Section 6.4 "Scoring Criteria" of this eRFP. Once the evaluation process has been completed (and any negotiations the

State Entity desires to conduct have occurred), the apparent successful supplier(s) will be required to enter into discussions with the State Entity to resolve any exceptions to the State Entity's contract. The State Entity will announce the results of the eRFP as described further in Section 6.9 "Public Award Announcement" of this eRFP.

6.1. Administrative/Preliminary Review

First, the proposals will be reviewed by the Issuing Officer to determine the proposal's compliance with the following requirements:

1. Proposal was submitted by deadline in accordance with Section 2
2. Proposal is complete and contains all required documents
3. Technical Proposal does not include any pricing from the Cost Proposal

6.2. Evaluating Proposal Factors (Section 4)

If the supplier's proposal passes the Administrative/Preliminary Review, the supplier's responses to Section 4 "eRFP Proposal Factors" will be submitted to the Evaluation Team for evaluation.

6.2.1. Review of Mandatory and Mandatory Scored Questions

The Evaluation Team will review each proposal in detail to determine its compliance with mandatory eRFP requirements. Responses to both "Mandatory" and "Mandatory Scored" Questions will be evaluated on a pass/fail basis. If a proposal fails to meet a mandatory and/or mandatory scored eRFP requirement, the State Entity will determine if the deviation is material. A material deviation will be cause for rejection of the proposal. An immaterial deviation will be processed as if no deviation had occurred. All proposals which meet the requirements of the "Mandatory" and "Mandatory Scored" Questions are considered "Responsive Proposals" at this point in time and will be scored in accordance with the point allocation in Section 6.4 "Scoring Criteria" of this eRFP. The Supplier will receive a total technical score at the conclusion of the mandatory scored evaluation of the eRFP Proposal Factors.

6.2.2. Review of Additional Scored Information Questions

For all proposals determined to be "Responsive Proposals" for Georgia 360°, the Evaluation Team will review and score the responses to the Additional Scored Information (if any) in accordance with the point allocation in Section 6.4 "Scoring Criteria" of this eRFP.

The Georgia 360° Contract award is intended to be offered to the highest scoring proposal resulting from the combined score of Suppliers within the competitive range of mandatory score and Additional Scored results. Only those Suppliers ranking within the competitive range using mandatory scored responses will receive a combined mandatory scored and additional score result.

The supplier will receive a total technical score at the conclusion of the evaluation of the eRFP Proposal Factors.

6.3. Georgia Enterprises for Products and Services (GEPS)

In the event the issuing officer has received a response from GEPS, the issuing officer must factor in a price preference of 8% for purposes of cost evaluation. The price preference of 8% has been approved by DOAS in accordance with the State Use Law set forth at O.C.G.A. 50-5-135 et seq., which is intended to create opportunities for disabled persons employed by community-based rehabilitation programs and training centers that are certified by the State Use Council. To implement the price preference, the issuing officer must lower GEPS' price by 8% when comparing GEPS' price with any other supplier's response. However, in the event GEPS wins the contract award, GEPS must be paid at its actual bid price.

6. 4. Scoring Criteria

The evaluation is comprised of the following:

Category	Criteria	Points
Technical/Proposal Factors	1. "Mandatory" Requirements	Pass/Fail
Technical/Proposal Factors	2. "Mandatory Scored" and/or "Additional Scored" Responses	1000 points
Total	N/A	1000 points

6.5. Georgia Based Business/Reciprocal Preference Law O.C.G.A. §50-5-60(b)

For the purposes of evaluation only, suppliers resident in the State of Georgia will be granted the same preference over suppliers resident in another state in the same manner, on the same basis, and to the same extent that preference is granted in awarding bids for the same goods or services by such other state to suppliers resident therein over suppliers resident in the State of Georgia. NOTE: For the purposes of this law, the definition of a resident supplier is a supplier who is domiciled in the State of Georgia.

6.6. Negotiations of Proposals and/or Cost Factors

DOAS possesses discretionary authority to conduct one or more rounds of negotiations of technical proposal and/or cost factors as permitted by Georgia law and DOAS' established procurement policy. This section of the eRFP describes DOAS' process for utilizing its discretionary negotiation authority as defined by O.C.G.A. Section 50-5-67(a)(6). No state entity is permitted to conduct negotiations of proposal and/or cost factors without DOAS' supervision unless DOAS has expressly authorized the state entity to conduct negotiations on its own. Although this section addresses DOAS' right to negotiate in accordance with O.C.G.A. §50-5-67(a)(6), DOAS/State Entity reserves the right to conduct any other negotiations authorized by law.

The objective of negotiations is to obtain the supplier's best terms. PLEASE NOTE: NEGOTIATIONS ARE DISCRETIONARY; THEREFORE, THE STATE ENTITY URGES THE SUPPLIER (1) TO SUBMIT ITS BEST RESPONSE AND (2) NOT TO ASSUME THE SUPPLIER WILL BE GRANTED AN OPPORTUNITY TO NEGOTIATE.

6.6.1. Overview of Negotiations

After the Evaluation Team has scored the suppliers' proposals, the State Entity may elect to enter into one or more rounds of negotiations with all responsive and responsible suppliers or only those suppliers identified by the Evaluation Team as being in the competitive range. The competitive range will not be selected arbitrarily and those suppliers included in the competitive range must have highly scored proposals.

After each round of negotiations (if any), the supplier will submit revisions to its proposal factors and/or cost proposal, which revisions will be scored by the Evaluation Team in accordance with the same criteria used to evaluate the initial responses from the suppliers. Suppliers may be removed from further participation in the negotiation process in the event the Evaluation Team determines

the supplier cannot be considered responsive and responsible or based on the competitive range as defined in Section 6.6.3 "Competitive Range."

The State Entity reserves the right to proceed to award without further discussions after receipt of the initial proposals, in which case, negotiations and Proposal Revisions will not be required.

6.6.2. Negotiation Instructions

Listed below are the key action items related to negotiations. The State's Negotiation Committee may consist of the State's Evaluation Committee or may be comprised of different people. However, evaluation of proposals or revised proposals shall be completed only by the State's Evaluation Committee.

- 1. Negotiation Invitation:** Those suppliers identified by the Evaluation Committee to negotiate will be notified and invited to attend negotiations. Suppliers will be notified in writing: (i) the general purpose and scope of the negotiations; (ii) the anticipated schedule for the negotiations; and (iii) the procedures to be followed for negotiations.
- 2. Confirmation of Attendance:** Suppliers who have been invited to participate in negotiations must confirm attendance.
- 3. Negotiations Round(s):** One or more rounds of negotiations may be conducted with those suppliers identified by the State's Evaluation Team.

6.6.3. Competitive Range

If the State Entity elects to negotiate pursuant to Section 6.6, the State Entity may either (1) elect to negotiate with all responsive and responsible suppliers, (2) limit negotiations to those suppliers identified within the competitive range, or (3) limit negotiations to the number of suppliers with whom the State Entity may reasonably negotiate as defined below. In the event the State Entity elects to limit negotiations to those suppliers identified within the competitive range, the State Entity will identify the competitive range by (1) ranking suppliers' proposals from highest to lowest based on each supplier's Total Combined Score and (2) then looking for breaks in the scores such that natural groupings of similar scores may be identified. In the event the State Entity determines the number of responsive and responsible suppliers is so great that the State Entity cannot reasonably conduct negotiations (which determination shall be solely at the State Entity's discretion and shall be conclusive), the State Entity may elect to limit negotiations to the top three (3) ranked suppliers as determined by the Total Combined Score.

6.6.4. Negotiation Round Completion

As part of each round of negotiation, the State Entity may or may not engage in verbal discussions with the suppliers. However, whether or not the State Entity engages in verbal discussions, any revisions the supplier elects to make to its response must be submitted in writing via email by the end date and time identified by the Issuing Officer. All revisions received by the due date and time will be evaluated and re-scored by the Evaluation Team in accordance with the same criteria used to evaluate the initial responses from the suppliers. Revisions which are not received prior to the due date and time cannot be considered; however, any supplier failing to submit timely revisions will not be disqualified from consideration for award based on its final proposal as accepted by the State Entity.

6.7. Selection and Award

The State Entity desires to make an award to the top ranking responsive and responsible supplier(s) receiving the highest Total Combined Score and with whom the State Entity is able to reach agreement as to contract terms will be selected for award.

6.8. Site Visits and Oral Presentations

The State Entity reserves the right to conduct site visits or to invite suppliers to present their proposal factors/technical solutions to the Evaluation Team. Cost proposals and related cost information must not be discussed during the oral presentation of the supplier's technical solution. Nothing in this section shall prohibit the Negotiation Team from discussing both proposal factors and cost information during the negotiation process.

6.9. Public Award Announcement

The preliminary results of the evaluation will be announced through the public posting of a Notice of Intent to Award (in the event the value of the contract(s) is estimated to be \$100,000 or more in the first year) to the Georgia Procurement Registry. The Notice of Intent to Award ("NOIA") is not notice of an actual contract award; instead, the NOIA is notice of the State Entity's expected contract award(s) pending resolution of the protest process. The NOIA (if any) will identify the apparent successful supplier(s), unsuccessful supplier(s), and the reasons why any unsuccessful suppliers were not selected for contract award. **NO SUPPLIER SHOULD ASSUME PERSONAL NOTICE OF THE NOTICE OF INTENT TO AWARD ("NOIA") WILL BE PROVIDED BY THE STATE ENTITY. INSTEAD, ALL SUPPLIERS SHOULD FREQUENTLY CHECK THE GEORGIA PROCUREMENT REGISTRY FOR NOTICE OF THE NOIA.**

The Notice of Award ("NOA") is the State Entity's public notice of actual contract award(s). The NOA will be publicly posted to the Georgia Procurement Registry.

7. Contract Terms and Conditions

The contract that the State Entity expects to award as a result of this eRFP will be based upon the eRFP, the successful supplier's final response as accepted by the State Entity and the contract terms and conditions, which terms and conditions can be downloaded from the Sourcing Event. The "successful supplier's final response as accepted by the State Entity" shall mean: the final cost and technical proposals submitted by the awarded supplier and any subsequent revisions to the awarded supplier's cost and technical proposals and the contract terms and conditions due to negotiations, written clarifications or changes made in accordance with the provisions of the eRFP, and any other terms deemed necessary by the State Entity, except that no objection or amendment by the supplier to the eRFP requirements or the contract terms and conditions shall be incorporated by reference into the contract unless the State Entity has explicitly accepted the supplier's objection or amendment in writing.

Please review the State Entity's contract terms and conditions prior to submitting a response to this eRFP. Suppliers should plan on the contract terms and conditions contained in this eRFP being included in any award as a result of this eRFP. The Contract terms and conditions may be supplemented or revised before Contract Execution.

7.1 Exception to Contract

By submitting a proposal, each supplier acknowledges its acceptance of the eRFP specifications and the contract terms and conditions without change except as otherwise expressly stated in the submitted proposal. If a supplier takes exception to a contract provision, the supplier must state the reason for the exception and state the specific contract language it proposes to include in place of the provision. Any exceptions to the contract must be uploaded and submitted as an attachment to the supplier's response. Proposed exceptions must not conflict with or attempt to preempt mandatory requirements specified in the eRFP.

In the event the supplier is selected for potential award, the supplier will be required to enter into discussions with the State Entity to resolve any contractual differences before an award is made. These discussions are to be finalized and all exceptions resolved within the period of time identified in the schedule of events. Failure to resolve any contractual issues will lead to rejection of the supplier. The State Entity reserves the right to proceed to discussions with the next best ranked supplier.

The State Entity reserves the right to modify the contract to be consistent with the apparent successful offer, and to negotiate other modifications with the apparent successful supplier. Exceptions that materially change the terms or the requirements of the eRFP may be deemed non-responsive by the State Entity, in its sole discretion, and rejected. Contract exceptions which grant the supplier an impermissible competitive advantage, as determined by the State Entity, in its sole discretion, will be rejected. If there is any question whether a particular contract exception would be permissible, the supplier is strongly encouraged to inquire via written question submitted to the Issuing Officer prior to the deadline for submitting written questions as defined by the Schedule of Events.

8. List of eRFP Attachments

The following documents make up this eRFP. Please see Section 2.2.2 “eRFP Review” for instructions about how to access the following documents. Any difficulty locating or accessing the following documents should be immediately reported to the Issuing Officer.

- A. State Entity eRFP (this document)
- B. Term Definitions from Section 1.9 “Definition of Terms” of this eRFP
- C. Additional Background Information of this eRFP
- D. Requirements and Scope of Work
- E. Supplier’s General Information Worksheet from Section 4.2 of this eRFP
- F. Mandatory Response Worksheet from Section 4.3 of this eRFP
- G. Mandatory Scored Response Worksheet from Section 4.4 of this eRFP
- H. Additional Scored Response Worksheet from Section 4.5 of this eRFP
- I. Georgia Families Contract from Section 7 “Contract Terms and Conditions” of this eRFP
- J. Georgia Families 360° Contract from Section 7 “Contract Terms and Conditions” of this eRFP
- K. DCH Liquidated Damages
- L. SPD-SP054 Immigration and Security Form
- M. Georgia Families Supplier Reference Form
- N. Georgia Families Material Subcontractor Reference Form
- O. Georgia Families 360° Supplier Reference Form
- P. Georgia Families 360° Material Reference Form

Definition of Terms

Whenever capitalized, the following terms have the respective meaning set forth below, unless the context clearly requires otherwise.

Abandoned Call: A call in which the caller elects a valid option and is either not permitted access to that option or disconnects from the system.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for Health Care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the Care Management Organization (CMO) to act within the time-frames provided in 42 CFR 438.408(b).

Activities of Daily Living (ADL): Daily self-care activities including bathing, dressing, feeding, toileting, grooming, and transferring (walking, transferring from bed to wheelchair or wheelchair to toilet, etc.) and continence.

Administrative Claiming for Education (ACE): The Georgia Medicaid Administrative Claiming for Education (ACE) program allows reimbursement to Local Education Agencies (LEA) for approved administrative activities that support the Medicaid program. Reimbursement is available through a quarterly claiming process.

Administrative Law Hearing: The Appeal process administered by the State in accordance with Official Code of Georgia Annotated (O.C.G.A.) § 49-4-153 and as required by federal law available to Members and Providers after they exhaust the Supplier's Appeals Process.

Administrative Review: The formal reconsideration of a Proposed Action, as a result of the proper and timely submission of a Provider's request, Member's request, or a request by the Department of Community Health (DCH).

Administrative Service(s): The contractual obligations of the Supplier that include but not are limited to Utilization Management, network management, Quality improvement, marketing, Enrollment, Member Services, Claims payment, Information Systems, financial management, and reporting.

Adoption Assistance (AA): A program established by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) that provides financial and medical Benefits to adoptive families who adopt children with special needs up to eighteen (18) years of age. There are three (3) categories of Adoption Assistance: (1) monthly Adoption Assistance payments; (2) Medicaid benefits; and (3) non-recurring Adoption Assistance (such as adoption fees, court costs, attorney fees and other expenses). Georgia's Adoption Assistance Policies can be found online at: http://www.odis.dhr.state.ga.us/3000_fam/3480_medicaid/medicaid.htm.

Adoption Assistance Member (AA Member): A Member receiving Adoption Assistance (AA) and enrolled in the Georgia Families 360° program.

Adoption Assistance (AA) Member Consecutive Enrollment Period: The consecutive twelve (12) month period beginning on the AA Member's first day of Enrollment in the Georgia Families 360° CMO or the date the DCH sends the AA Member the notice of Enrollment, whichever is later. For AA Members that use their option to return to the Medicaid Fee-for-Service delivery system without cause during the AA Member Fee-for-Service Selection Period, the twelve-month Consecutive Enrollment Period will commence when the AA Member is enrolled in the Medicaid Fee-for-Service delivery system. This is not to be construed as a guarantee of eligibility during the AA Member Consecutive Enrollment Period.

Adoption Assistance (AA) Member Fee-for-Service Selection Period: The ninety (90) Calendar Day period beginning on the AA Member's initial Enrollment in the Georgia Families 360° CMO or the date DCH sends the AA Member notice of the Enrollment, whichever is later. During this period an AA Member may elect to opt out of the Georgia Families 360° CMO without cause and return to the Medicaid Fee-for-Service delivery system. AA Members who do not make a choice to return to the Medicaid Fee-for-Service delivery system during this ninety (90) Calendar Day period will be deemed to have chosen to remain enrolled in the Georgia Families 360° CMO until the Member's next AA Member Consecutive Enrollment Period.

Adoptive Parent: An adult who provides a child a permanent home through a court process that, once final, names the Adoptive Parent as the child's legal parent.

Advance Directives: A written instruction, such as a living will or durable power of attorney for Health Care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of Health Care when the individual is incapacitated.

After-Hours: Provider office/visitation hours extending beyond the normal business hours of a Provider. This may include Saturday hours.

Aged, Blind or Disabled (ABD): Medical Assistance for persons who are aged (sixty-five (65) years of age or older), legally blind, and/or disabled. These individuals receive Fee-for-Service Medicaid and are not eligible for the Georgia Families Program.

Agent: An entity that contracts with the State of Georgia to perform administrative functions, including but not limited to: Fiscal Agent Contractor activities; outreach, eligibility, and Enrollment activities; Information Systems and technical support, etc.

Aim Statement: A written and Measurable description of desired improvement that defines a clear and firm intention for improvement and is time-specific, Measurable and focused on the population that will be affected by the improvement activity. The Aim Statement should be easy to remember and answer the following questions: What will we improve? For whom? How much? By when?

Appeal: A request for review of an Action, as "Action" is defined in 42 C.F.R. §438.400.

Appeals Process: The overall process that includes Appeals at the Supplier level and access to the State Fair Hearing process (the State's Administrative Law Hearing).

Assess: The process used to examine and determine the level of Quality or the progress toward improvement of Quality and/or performance related to Supplier service delivery systems.

Attestation: The Supplier attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.

Authoritative Host: A system that contains the master or “authoritative” data for a particular data type, e.g. Member, Provider, CMO, etc. The Authoritative Host may feed data from its master data files to other systems in real time or in batch mode. Data in an Authoritative Host is expected to be up-to-date and reliable.

Authorized Representative: A person authorized by the Member in writing to make health-related decisions on behalf of a Member, including, but not limited to Enrollment and Disenrollment decisions, filing Appeals and Grievances with the Supplier, and choice of a Primary Care Physician (PCP). The Authorized Representative is the Parent, Adoptive Parent or legal guardian for a child. For an adult, this person is the legal guardian (guardianship action), Health Care power of attorney, other person that has power of attorney, or another signed Health Insurance Portability and Accountability Act (HIPAA) compliant document indicating who can make decisions on behalf of the Member. For Foster Care Members and Juvenile Justice Members, the Authorized Representative is Division of Family and Children Services (DFCS) or Department of Juvenile Justice (DJJ) respectively.

Automatic Assignment (or Auto-Assignment): The Enrollment of an eligible person, for whom Enrollment is mandatory, in a CMO chosen by DCH or its Agent. Also the assignment of a new Member to a PCP chosen by the CMO, pursuant to the provisions of this Contract.

Babies Can’t Wait: Georgia's statewide interagency service delivery system for infants and toddlers, from birth to age three, with developmental delays or disabilities and their families. Established by Part C of the Individuals with Disabilities Education Act (IDEA).

Bed Days: A day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

Behavioral Health: The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or Substance Abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five [DSM 5] published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in Behavioral Health usually have symptoms, behaviors and/or skill deficits which impede their functional abilities and affect their quality of life.

Behavioral Health Crisis: An intensive behavioral, emotional or psychiatric situation that exceeds an individual’s current resources and coping mechanisms which, if left untreated, could result in an emergency situation.

Behavioral Health Home (BHH): A Behavioral health home is responsible for the integration and coordination of the individual’s health care (physical as well as behavioral health care services). Behavioral Health Home providers do not need to provide all the services themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated.

Behavioral Health Services: Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Benefits: The Health Care services set forth in this Contract, for which the Supplier has agreed to provide, arrange, and be held fiscally responsible.

Blocked Call: A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Border Provider: Providers located within fifty (50) miles of the Georgia border. Border Providers are located in Alabama, Florida, North Carolina, South Carolina and Tennessee.

Business Days: Monday through Friday from 9:00 A.M. to 5:00 P.M. EST, excluding State holidays.

Calendar Days: All seven days of the Week.

Calendar Years: January through December.

Capitated Service: Any Covered Service for which the Supplier receives an actuarially sound Capitation Payment.

Capitation: A Contractual arrangement through which a Supplier agrees to provide specified Health Care services to Members for a fixed amount per member per month.

Capitation Payment: A payment, fixed in advance, that DCH makes to a Supplier for each Member covered under this Contract for the provision of Covered Services and who are assigned to the Supplier. Capitation Payments are unique for each program. For instance, Capitation Payments may be referred to as Planning for Healthy Babies (P4HB) Capitation Payments, Foster Care/Juvenile Justice Capitation Payments, or Adoption Assistance Capitation Payments. This payment is made regardless of whether the Member receives Covered Services during the period covered by the payment. Payments are contingent upon the availability of appropriated funds.

Capitation Rate: The fixed monthly amount, including the Value Based Purchasing (VBP) Withhold, that the Supplier is paid by DCH for each Member assigned to the Supplier to ensure that Covered Services under this Contract are provided. Capitation Rates are unique for each program. For instance, Capitation Rates may be referred to as Georgia Families Capitation Rates, P4HB Capitation Rates, Foster Care/Juvenile Justice Capitation Rates or Adoption Assistance Capitation Rates. Payments are contingent upon the availability of appropriated funds.

Care Coordination: The process of actively linking a Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified.

Care Coordination Team (CCT): The team assigned to each Georgia Families 360° Member to assist in navigating the Health Care system and coordinating with the DFCS or the DJJ to develop work flows and processes, including those related to the transmission of clinical and non-clinical Georgia Families 360° Member information. The CCT will not substitute any of the interdisciplinary teams or case management functions supporting Home and Community Based Services (HCBS).

Care Coordinator: The lead member of the Care Coordination Team and who serves as the key point of contact between the CMO and State agencies, the Georgia Families 360° Member in Foster Care or receiving Adoption Assistance, the Foster Parent(s), Adoptive Parent(s), Caregivers and Providers. The qualifications of the Care Coordinator will be based on the individual needs of the Georgia Families 360° Member in Foster Care or receiving Adoption Assistance.

Caregiver: The DFCS-authorized caretaker for a FC Member may be the FC Member's Foster Parent(s), relative(s), or twenty-four (24)-hour childcare facility staff.

Care Management: Traditional Case Management provided to Georgia Families 360° Members.

Care Management Organization (CMO): An entity organized for the purpose of providing Health Care, with a Health Maintenance Organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers, and furnishes Health Care services on a capitated basis to Members.

Case Management: A Person-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote Quality cost-effective outcomes. Case Management serves as a means for achieving Member wellness and autonomy through advocacy, communication, education, and identification of services and resources. Interventions are undertaken with the purpose of helping Members receive appropriate care. Case Management is distinguished from Utilization Management in that it is voluntary and it is distinguished from Disease Management by its intensity and focus on any disease(s) or Condition(s) the Member has.

Category of Eligibility: Defined set of requirements used to identify individuals who are eligible for Medicaid, Peach Care for Kids® and P4HB and the services the individuals are eligible for. Non-qualified aliens or undocumented immigrants may be eligible for emergency assistance only.

Category of Service (COS): Classifications of the service types and the providers authorized to deliver the services as defined by DCH.

Centers for Medicare & Medicaid Services (CMS): The Agency within the U.S. Department of Health and Human Services responsible for the Medicare, Medicaid and the Children's Health Insurance Programs.

Certified Nurse Midwife (CNM): A registered professional nurse who is legally authorized under State law to practice as a nurse-midwife, and has completed a program of study and clinical experience for nurse-midwives or equivalent.

Child and Family Teams (CFT): A group of people responsible for development, coordination, and Monitoring of individualized plans developed in a family-driven model. The group includes, at a minimum, the child and family, any Foster Parents, a behavioral health representative, and any individuals important in the child's life including both professionals and non-professionals who are invited to participate by the child and family whose combined expertise and involvement ensures plans are individualized, culturally competent and person-centered, build upon strengths and capabilities and address youth health and safety issues.

Child Protective Services (CPS): An office within DFCS that investigates reports of child abuse or neglect and provides services to protect the child and strengthen the family.

Children 1st: A State program administered by the Department of Public Health (DPH) which identifies and screens children (birth to age 5) at risk for poor health and developmental outcomes, refers children to appropriate services, and monitors health status. The program is designed to serve as a single point of entry to a statewide collaborative system of public health and other prevention based programs and services.

Children's Health Insurance Program (CHIP) formerly State Children's Health Insurance Program (SCHIP): A joint federal-state Health Care program for targeted, low-income children, established pursuant to Title XXI of the Social Security Act. Georgia's CHIP is called PeachCare for Kids®.

Children's Intervention School Services (CISS): The Georgia Medicaid program that provides reimbursement for specified medically-necessary services that are received in schools and provided by or arranged by a Local Education Agency (LEA) for Medicaid eligible students under the age of twenty-one (21) with an Individualized Education Program (IEP).

Children's Medical Services: Administered by the Department of Public Health Children's Medical Services provides Care Coordination and other needed medical/health services for eligible children and their families who are not enrolled in managed care. Children's Medical Services may provide, arrange for and/or pay for comprehensive physical evaluations, diagnostic tests, inpatient/outpatient hospitalization, medications, and other medical treatments, therapy, Durable Medical Equipment, hearing aids related to the child's -eligible Condition, and genetic counseling.

Chronic Condition: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is considered Routine Care.

Claim: A bill for services, a line item of services, or all services for one recipient within a bill.

Claim Adjustment: A claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, payment amount can be changed.

Claims Administrator: The entity engaged by DCH to provide Administrative Service(s) to the CMOs in connection with processing and adjudicating risk-based payment, and recording Encounter Claims data for Members.

Clean Claim: A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: (i) A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; (ii.) A Claim for which Fraud is suspected; and (iii.) A Claim for which a Third Party Resource should be responsible.

Cold-Call Marketing: Any unsolicited contact by the CMO, with a Potential Member, for the purposes of Marketing a Member's selection or Enrollment in a particular CMO.

Community Mental Health Rehabilitation Services (CMHRS): Services that are intended for the maximum reduction of mental disability and restoration of an individual to his or her best possible functional level.

Complex Care Coordination: Rigorously coordinated care management provided to Georgia Families 360° Members, which includes Care Coordination of medical and social supports for Georgia Families 360° Members with multiple Chronic Conditions.

Completion/Implementation Timeframe: The date or time period projected for a project goal or Objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the Supplier.

Comprehensive Child and Family Assessment (CCFA): An intake assessment provided to children in Foster Care through the DFCS, which includes the following components: family assessment, Trauma Assessment, Medical Assessment, relative and non-relative home evaluation and reassessments. The Supplier will be responsible for ensuring that the Medical

Assessment and Trauma Assessments are completed within the timeframes set forth in this Request for Proposals (RFP).

Comprehensive Child and Family Assessment (CCFA) Provider: A Provider that renders clinical services to Foster Care Members and their families. CCFA Providers are responsible for the submission of the Comprehensive Child and Family Assessment final report which includes the Medical Assessment and Trauma Assessment.

Condition: A disease, illness, injury, disorder, of biological, cognitive, or psychological basis for which evaluation, Monitoring and/or treatment are indicated.

Consecutive Enrollment Period: The consecutive twelve (12) month period beginning on the first day of Enrollment or the date the notice is sent, whichever is later. For Members that use their option to change CMOs without cause during the first ninety (90) Calendar Days of Enrollment, the twelve-month Consecutive Enrollment Period will commence when the Member enrolls in the new CMO. This is not to be construed as a guarantee of eligibility during the Consecutive Enrollment Period. FC Members and Juvenile Justice (JJ) do not have the option to change CMOs without cause.

Consulting Provider: The Provider who Evaluates a Member at the request of the Member's Primary Care or Referring Provider. The consultation may occur via a Telemedicine mode of delivery.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): CAHPS surveys ask Medicaid and PeachCare for Kids[®] Members or their parents/guardians to report on and Evaluate their experiences with their Health Care. The surveys cover topics that are important to Members and focus on aspects of quality that Members and parents/guardians are best qualified to assess, such as the communication skills of providers and ease of access to Health Care services. The acronym CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). DCH uses the Adult and Child CAHPS surveys.

Contested Claim: A Claim that is denied because the Claim is an ineligible Claim, the Claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the Claim requires special treatment.

Continuing Care Provider: A Provider who formally agrees: to provide to enrolled individuals, screening, diagnosis, and treatment for Conditions identified during Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening visits (within the Provider's capacity) or Referral to a Provider capable of providing the appropriate services; maintains a complete health history, including information received from other Providers; is responsible for providing needed physician services for acute, episodic and/or chronic illnesses and Conditions; and ensures accountability by submitting reports reasonably required by the Supplier and/or DCH.

Contract: The written agreement between the State and the Supplier; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Award: The date upon which the Apparent Successful Vendor Letter(s) is issued by Department of Administrative Services (DOAS).

Contract Effective Date: The date when the rights and obligations under the Contract become operational. For purposes of this Contract, the Effective Date is the date upon which the CMS approves Contract.

Contract Execution Date: The date upon which all parties have signed the Contract.

Supplier: The CMO with a valid Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner that Contracts hereunder with the State for the provision of comprehensive Health Care services to Members on a capitated basis.

Supplier's Representative: The individual legally empowered to bind the Supplier, using his/her signature block, including his/her title.

Coordination of Care: The deliberate organization of Member care activities by a CMO between two or more Providers involved in a Member's care, in order to facilitate the appropriate delivery of Health Care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required Member care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. .

Co-payment: The part of the cost-sharing requirement for Members in which a fixed monetary amount is paid for certain services/items received from the Supplier's Providers.

Core Provider: Those service providers that are deemed to satisfy the staffing and service scope requirements for the Department of Behavioral Health and Developmental Disabilities' (DBHDD's) core customers as defined in DBHDD's Provider manual. Recent changes in terminology used in the Behavioral Health Medicaid Services system now refers to Core Providers as Comprehensive Community Providers.

Core Services: Those supports/services provided by outpatient Behavioral Health agencies offering a comprehensive range of Mental Health, addictive disease, and/or specialty services that meet conditions of the Medicaid program specifically under the Medicaid Rehabilitation Option. Also known as Community Behavioral Health Rehabilitation Services.

Corrective Action: A reaction to a problem, complaint or issue that has already occurred. The actions initiated are intended to fix the problem/issue and modify the quality system so that the process that caused it is monitored to prevent a recurrence. Documentation for a Corrective Action provides evidence that the problem was recognized, corrected and proper controls were implemented to make sure that it does not happen again. The process for reacting to problems, complaints or other issues includes:

- i. Reviewing and defining the problem/issue
- ii. Finding the cause of the problem/issue
- iii. Developing an action plan to correct the problem/issue and prevent a recurrence
- iv. Implementation of the action plan
- v. Evaluating the effectiveness of the correction

Corrective Action Plan: The detailed written plan required by DCH to correct or resolve a deficiency or event that may result in the assessment of a liquidated damage or sanction against the CMO.

Corrective Action Preventive Action (CAPA) Process: A step-by-step process for completing and documenting preventive and corrective actions. The steps assist investigators in detecting potential problems or reacting to existing problems and eliminating or correcting them. The CAPA process may be linked to liquidated damages.

Corrective Action Preventive Action (CAPA) Program: A fundamental management tool that provides a simple step by step process for completing and documenting corrective or preventive actions. The end result of implementation of this program is a complete, well documented investigation and solution that will satisfy DCH's requirements and form the basis for an effective continuous improvement plan. Liquidated damages may be linked to this program.

Cost Avoidance: A method of paying Claims in which the Provider is not reimbursed until the Provider has demonstrated that all available health insurance has been exhausted.

Court Appointed Special Advocate (CASA): National Association that supports and promotes court-appointed advocates for abused or neglected children in order to provide children with a safe and healthy environment in permanent homes.

Covered Services: Those Medically Necessary Health Care services provided to Members, the payment or indemnification of which is covered under this Contract

Credentialing Verification Organization (CVO): An entity contracted by the State to determine the qualifications and ascribed privileges of providers to render specific Health Care services. The entity will make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families.

Crisis: A condition of instability/danger or dramatic emotional or circumstantial upheaval in a person's life requiring action or change.

Critical Access Hospital (CAH): A hospital that meets the requirements of CMS to be designated as a Critical Access Hospital and that is recognized by DCH as a Critical Access Hospital for purposes of Medicaid.

Cultural Competency: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Deliverable: A document, manual or report submitted to DCH by the Supplier to fulfill requirements of this Contract.

Demonstration (also Family Planning Waiver, Planning for Health Babies, or the P4HB Program): The 1115 Demonstration waiver program in Georgia supported by CMS that expands the delivery of Family Planning Services to uninsured women, ages eighteen (18) through forty-four (44), who have family income at or below 200 percent of the Federal poverty level (FPL) and who are not otherwise eligible for Medicaid or CHIP. Georgia's only 1115 Demonstration waiver is referred to as the Family Planning Waiver, Planning for Healthy Babies, or the P4HB Program. This Demonstration includes three distinct groups: women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal poverty level and are eligible for Family Planning Only Services; women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal Poverty Level (FPL) who have delivered a very low birth weight (VLBW) VLBW infant and are eligible for Family Planning Services and Interpregnancy Care Services; and women ages eighteen (18) through forty-four (44) who are current Medicaid recipients, have delivered a VLBW infant and are eligible for Resource Mother services only.

Demonstration Disenrollment: The removal of a P4HB participant from participation in the Demonstration.

Demonstration Enrollee: An individual meeting P4HB Program eligibility requirements who selects or is otherwise assigned to a Georgia Families Supplier in order to receive Demonstration services.

Demonstration Enrollment: The process by which an individual eligible for the P4HB program applies to utilize a Georgia Families Supplier to receive Demonstration services and such application is approved by DCH or its Agent.

Demonstration Period: The period from January 1, 2011 through January 31, 2015 in which the Demonstration will be effective. This period may be extended upon CMS' approval of DCH's requested extension.

Demonstration Provider: A physician, advanced practice nurse or other Health Care provider who meets the State's Medicaid provider enrollment requirements for the Demonstration, hospital, facility, or pharmacy licensed or otherwise authorized to provide Demonstration related Services to P4HB participants within the State or jurisdiction in which they are furnished. Also known as a P4HB Provider.

Demonstration Related Emergency Medical Condition: A medical condition resulting from a Demonstration related Service and manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the woman in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. A Demonstration related Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

Demonstration Related Post Stabilization Services: Covered Services related to a Demonstration related Emergency Medical Condition that are provided after a P4HB Participant is stabilized in order to maintain the stabilized Condition or to improve or resolve the P4HB participant's Condition.

Demonstration Related Services: Those Demonstration services identified in the CMS Special Terms and Conditions and approved by CMS that are available to P4HB participants.

Demonstration Related Urgent Care Services: Medically Necessary treatment of a Demonstration related injury, illness or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Dental Home: A Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the State Plan. P4HB members are not eligible for a Dental Home.

Dental Subspecialty Providers: Specialized dental providers including endodontists, oral pathologists, orthodontists, oral surgeons, periodontists, pedodontists, and prosthodontists.

Department of Behavioral Health and Developmental Disabilities (DBHDD): The Georgia State agency that provides treatment and support services to people with Mental Illnesses I and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD serves people of all ages with the most severe and likely to be Long-Term Conditions, including consumers with forensic issues.

Department of Community Health (DCH): The single State Agency in the State of Georgia responsible for oversight and administration of the Medicaid program, the PeachCare for Kids® program, the Planning for Healthy Babies Program and the State Health Benefits Plan (SHBP).

Department of Community Health Performance, Quality and Outcomes Unit (DCH PQO Unit): A unit within the DCH Medicaid Division charged with ensuring that all aspects of the department's Quality Strategic Plan are implemented, and defining enhancements to the plan that would drive health improvements for Georgia's Medicaid population served by the CMOs.

Department of Early Care and Learning (DECAL): The Georgia State agency that is responsible for meeting the child care and early education needs of Georgia's children and their families. Also known as "Bright from the Start."

Department of Juvenile Justice (DJJ): The Georgia State agency that serves the State's youthful offenders up to the age of twenty-one (21). While holding youthful offenders accountable for their actions through probation supervision and secure detention, DJJ provides youth with medical and psychological treatment, as well as specialized programs designed to equip youth with the social, intellectual and emotional tools they will need as adults.

Department of Public Health: The Georgia State agency with the ultimate responsibility for the health of communities and the entire population.

Detention Hearing (also known as 72-Hour Hearing or Probable Cause Hearing): An informal hearing within seventy-two (72) hours of a child's removal from the home is required when the juvenile court or the court intake officer has not released the child to the custody of his or her parents after removal from the home. If the seventy-two (72)-hour period expires on a Saturday, Sunday, or legal holiday, the hearing must be held on the next day of business which is not a Saturday, Sunday, or legal holiday. O.C.G.A. § 15-11-506. At the seventy-two (72)-hour hearing, the judge will determine whether it is safe to return the child to the home or if the child should be detained until a full hearing can be held to determine whether the child is deprived.

Diagnostic Related Group (DRG): Any of the payment categories that are used to classify patients and especially Medicare patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred. The payment category is determined primarily by the principal diagnosis, surgical procedure used, age of patient, and expected length of stay in the hospital.

Diagnostic Services: Any medical procedures or supplies recommended by a physician or other licensed medical practitioner, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature or extent of illness, injury, or other health deviation in a Member.

Discharge: Point at which Member is formally released from a hospital, by the treating physician, an authorized member of the physician's staff or by the Member after they have indicated, in writing, their decision to leave the hospital against medical advice.

Discharge Planning Pilot Program: A pilot program the Supplier will implement with hospital(s) that agree to participate to improve coordination for Members being discharged from the hospital. The intent of this program is to improve Quality of care and outcomes, as well as to reduce readmissions.

Disenrollment: The removal of a Member from Enrollment but not necessarily from the Medicaid or PeachCare for Kids® programs.

Division of Family and Children Services (DFCS): DFCS has statutory responsibility for the care of children and young adults who have been removed from the home and placed in the conservatorship of DFCS.

Division of Family and Children Services (DFCS) Case Manager: A staff professional who provides assistance to children and families by helping them address psychological and social problems related to child abuse and neglect. DFCS Case Managers provide interventions and perform duties related to various social services program areas such as Child Protective Services (CPS), Foster Care, resource development, and Adoption Assistance.

Division of Family and Children Services (DFCS) Clinical Program Specialist: DFCS region-specific staff whose responsibilities include, but are not limited to, the following:

- i. Oversight of DFCS children receiving Behavioral Health Services and collaborating with the DBHDD program specialist serving specific regions.
 - a. Reviews the status of any child receiving inpatient treatment at a psychiatric residential treatment family or psychiatric hospital at least monthly.
 - b. Participates in discharge goals and planning.
- ii. Monitors all children in Foster Care receiving psychotropic medication.
- iii. Maintains a regional listing of available Behavioral Health providers.
- iv. Guides or assists DFCS Case Managers as FC Members receiving Behavioral Health Services, developmental disability services, or special medical services transition from non-Foster Care Medicaid to Foster Care Medicaid and vice versa to ensure continuity of services.

Division of Family and Children Services (DFCS) Revenue Maximization Specialist (RMS): A regional eligibility specialist trained in Title IV-E Foster Care and Adoption Assistance programs and Medicaid eligibility with data entry in SHINES and the System for the Uniform Calculation and Consolidation of Economic Support (SUCCESS) for child welfare funding determinations and Medicaid eligibility.

Documented Attempt: A bona fide, or good faith, attempt on the part of the Supplier to Contract with a Provider. Such attempts may include written correspondence that outlines contracted negotiations between the parties, including rate and Contract terms disclosure, as well as documented verbal conversations, to include date and time and parties involved.

Driver Diagrams: A road map for changes and interventions that provides a way to organize thoughts around what needs to be done in order to achieve the aim. There are two types of drivers: primary drivers – system components that will contribute to improving outcomes and; secondary drivers – elements of the associated primary drivers that help create the changes. The secondary drivers are interventions expected to affect primary drivers and thus outcomes, and are evidence-based, necessary and sufficient for improvement.

Durable Medical Equipment (DME): Equipment, including assistive technology, which: (i.) can withstand repeated use; (ii.) is used to service a health or functional purpose; (iii.) is ordered by a qualified practitioner to address an illness, injury or disability; and (iv.) is appropriate for use in the home, work place, or school.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit: A comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age twenty-one (21), as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The EPSDT benefit also covers Medically Necessary diagnostic services. The Supplier is required to arrange for and cover, under the EPSDT benefit, any Medicaid covered service listed in Section 1905(a) of the Act if that treatment or service is determined to be Medically Necessary to correct or ameliorate defects and physical and Mental Illnesses or Conditions. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for Mental Health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age twenty-one (21) enrolled in the Medicaid and PeachCare for Kids® program. P4HB participants are not eligible for the EPSDT Benefit.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program: The program that defines the policy, reimbursement, and oversight for the EPSDT services described under the EPSDT Benefit. The goal of the EPSDT program is to ensure that individual children get the health care they need when they need it.

Emergency Medical Condition: A medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

Emergency Medical Screening: An examination: (i.) provided on hospital property, and provided for that patient for whom it is requested or required, (ii.) performed within the capabilities of the hospital's emergency room (ER) (including ancillary services routinely available to its ER), (iii.) the purpose of which is to determine if the patient has an Emergency Medical Condition, and (iv.) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or Physician Assistant as permitted by State statutes and regulations and hospital bylaws.

Emergency Services: Covered inpatient and outpatient services furnished by a qualified Provider needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the Prudent Layperson standard.

Encounter: A distinct set of Health Care services provided to a Member enrolled with the Supplier on the dates that the services were delivered.

Encounter Claims: Records of Claims paid by the Supplier, or by its Subcontractors, to Providers that have provided Health Care services to Members. The Supplier is required to submit Encounter Claims to the State's Fiscal Agent Contractor that include required, optional, and situational data fields as specified in the Encounter Data Companion Guides, relevant 837 and National Council for Prescription Drug Programs standards, and other Encounter Claims data reporting documentation, where applicable.

Claims submissions should include the following, non-exhaustive list of essential data elements:

- i. All data captured during the course of a single Health Care Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, and medical devices and equipment associated with the Member receiving services during the Encounter;
- ii. The identification of the Member receiving services; the Provider(s) delivering the Health Care services during the single Encounter; and the Ordering Prescribing Referring (OPR) Providers for the Health Care services, where applicable. Reporting must include all Health Care, health homes and Mental Health services delivered to eligible Members;
- iii. The identification of the Supplier, or the Supplier's Subcontractor, responsible for the adjudication and payment of the Encounter Claim;
- iv. A unique, unduplicated identifier for the single Encounter; and
- v. Adjudication information for the Encounter Claim such as the date the Encounter Claim was received; whether the Encounter Claim was paid or denied; the date the Encounter Claim was paid, denied or voided; the amount paid including separately identified interest payments; payments to Hospital Medicaid Financing Program Providers; etc.

Enrollment: The process by which an individual eligible for Medicaid or PeachCare for Kids® applies (whether voluntary or mandatory) to utilize the Supplier's plan in lieu of the Fee-for-Service program and such application is approved by DCH or its Agent.

Enrollment Period: The twelve (12) month period commencing on the effective date of Enrollment.

Evaluate: The process used to examine and determine the level of Quality or the progress toward improvement of Quality and/or performance related to Supplier service delivery systems.

Expedited Review: For cases in which a Provider indicates, or the Supplier determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Supplier must make an expedited authorization decision with twenty-four (24) hours and provide notice as expeditiously as the Member's health Condition requires and no later than three (3) Business Days after receipt of the request for service. The Supplier may extend the twenty-four (24) hour period for up to five (5) Business Days if the Supplier justifies to DCH a need for additional information and how the extension is in the Member's interest.

External Quality Review (EQR): The analysis and evaluation by an external quality review organization of aggregated information on Quality, timeliness, and access to the Health Care services that the Supplier or its Subcontractors furnish to Members.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs External Quality Review, and other related activities.

Family Planning Provider: A physician advanced practice nurse, or other Health Care provider who meets the State's Medicaid provider Enrollment requirements for providing family planning services to eligible members.

Family Planning Services: Family Planning Services and supplies include at a minimum:

- i. Education and counseling necessary to make informed choices and understand contraceptive methods;
- ii. Initial and annual complete physical examinations;
- iii. Follow-up, brief and comprehensive visits;
- iv. Pregnancy testing;
- v. Contraceptive supplies and follow-up care;
- vi. Diagnosis and treatment of sexually transmitted diseases; and
- vii. Infertility assessment.

Family Planning Waiver: See Demonstration.

Federally Qualified Health Center (FQHC): An entity that provides outpatient health programs pursuant to Section 1905(l) (2) (B) of the Social Security Act.

Federal Financial Participation (FFP): The funding contribution that the Federal government makes to the Georgia Medicaid and PeachCare for Kids® programs.

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services. Federal Poverty Levels are used to determine eligibility for certain programs and benefits.

Fee-for-Service (FFS): A method of reimbursement based on payment for specific services rendered to eligible Medicaid and PeachCare for Kids® individuals that are not participants in the Georgia Families or Georgia Families 360° programs.

Financial Relationship: A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity that equates to at least five percent (5%) or more of the disclosing entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation arrangement with an entity. This includes a mortgage, deed of trust, note or other obligation.

Fiscal Agent Contractor (FAC) or Fiscal Agent: The entity contracted with DCH to process Medicaid and PeachCare for Kids® Claims and other non-Claim specific payments.

Foster Care: Twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the Title IV-E agency (DFCS) has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Foster Care Member (FC Member): A Member in Foster Care and enrolled in the Georgia Families 360° program.

Foster Parent: A substitute Caregiver who assumes the daily caretaking responsibilities for children in DFCS custody who have been placed in their home.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law.

Full Month: All Calendar Days included in a month (i.e., all 28, 30 or 31 days of the month in consideration).

Full Quarter: Three consecutive Full Months.

Full Time Provider: defined as a location operating for more than sixteen (16) hours in an office location each Week.

Geographic Access: A Provider Network fulfilling access criteria within set geographic restrictions

Georgia Crisis and Access Line (GCAL): A twenty-four (24)-hour phone line sponsored by DBHDD to assist with coordinating access to care or provide support in an emergency or crisis.

Georgia Families: The risk-based managed care delivery program for Medicaid and PeachCare for Kids® in which DCH Contracts with CMOs to manage the care of eligible Members.

Georgia Families 360: The risk-based managed care delivery program for FC Members, AA Members and juvenile justice Members.

Georgia Families 360 Members (GF 360 Members): Includes Foster Care Members, Adoption Assistance Members and Juvenile Justice Members.

Georgia Health Information Network (GaHIN): The technical infrastructure used to facilitate secure electronic exchange of electronic health records among authorized Health Care Providers throughout the entire State of Georgia.

GaHIN Authorized User/Member Affiliate: Qualified Entities and GaHIN Member Users having authorized access to the GaHIN.

GaHIN Member Agreements: Written agreements that GaHIN and/or its Agents determine are required as a condition for a Qualified Member's participation in the network.

GaHIN Member Users/Member Affiliates: Any entity, organization or individual person who has been identified and authorized by a Qualified Member to access the GaHIN, in a manner defined by the respective Qualified Member, in compliance with an agreement between the Member User and the Qualified Member and applicable law. Member Users may include, but are not limited to, hospitals or Health Care systems, and employees, Suppliers, or Agents of a Qualified Member.

Georgia Pediatric Program (GAPP): The program serving medically fragile children operating in part under a Home- and Community-Based Waiver.

Georgia Technology Authority (GTA): The State agency that manages the State's information technology (IT) infrastructure, i.e. data center, network and telecommunications services and security, establishes policies, standards and guidelines for State IT, promotes an enterprise approach to State IT, and develops and manages the State portal.

Grievance: An expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided or

aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights.

Grievance System: The overall system that addresses the manner in which the CMO handles Grievances at the Supplier level.

Health Care: Health Care means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental Condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Healthcare Effectiveness Data and Information Set (HEDIS®): A widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA).

Health Care Professional: A physician or other Health Care Professional, including but not limited to podiatrists, optometrists, chiropractors, psychologists, dentists, physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians licensed in the State of Georgia.

Health Care Service Plan: An individualized plan developed with and for a Georgia Families 360° FC Member and AA Member which includes, but is not limited to, the following:

- i. Summary of current medical and social needs and concerns;
- ii. Short and Long Term needs and goals;
- iii. A treatment plan to address the FC Member or AA Member; and
- iv. A description of who will provide such services. The Health Care Service Plan will be coordinated by the CCT.

Health Check (EPSDT) Program: The Early and Periodic Screening components of the EPSDT benefit are covered under the Health Check (EPSDT) Program.

Health Information Technology: Hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for and support the use of Health Care entities or patients for the electronic creation, maintenance, access, or exchange of health information. Source is ARRA - H.R.1 -115 Sec. 3000 (5).

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV: Enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, the legislation was signed into law on February 17, 2009, to promote the adoption and meaningful use of Health Information Technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that includes requirements to protect the privacy of individually identified health information in any format, including written or printed, oral and electronic, to protect the security of individually identified health information in electronic format, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers. When referenced in this Contract it includes all related rules, regulations and procedures.

Health Maintenance Organization: An entity organized for the purpose of providing Health Care and has a Health Maintenance Organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which Contracts with Providers and furnishes Health Care services on a capitated basis to Members.

Health Professional Shortage Area (HPSA): An area designated by the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental or Mental Health Providers. These areas can be geographic, demographic or institutional in nature. A care area can be found using the following website: <http://hpsafind.hrsa.gov/>.

Health Risk Screening: The Health Risk Screening is used to collect comprehensive information on FC Members or AA Members.

High Fidelity Wraparound: According to the U. S. National Wraparound Initiative (<http://www.nwi.pdx.edu/>), an approach to Behavioral Health Services designed to meet needs that are prioritized by the youth and family, improve their ability and confidence to manage their own services and supports, develop or strengthen their natural supports, and integrate the work of all child servicing systems and natural supports into one streamlined plan

Historical Provider Relationship: A Provider who has been the main source of Demonstration, Medicaid or PeachCare for Kids® services for the Member or P4HB participant during the previous year (decided on by the most recent Provider on the Member's or P4HB participant's Claim history).

Home- and Community-Based Services (HCBS): Includes all services included in a Home- and Community-Based waiver program. Georgia's HCBS programs include the Independent Care Waiver Program, the Community Based Alternatives for Youth (CBAY) Program, the New Options Waiver (NOW) Program, the Elderly and Disabled Waiver Program, and the Comprehensive Supports Waiver Program (COMP). Supplier is not required to provide HCBS, but must provide all other Medicaid State Plan services required under the Contract for any FC Member or AA Member enrolled in an HCBS waiver program.

Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)): A law enacted by the Georgia State legislature and codified as O.C.G.A. § 31-8-179 et seq. The Hospital Medicaid Financing Program Act establishes (i) a hospital provider fee that is assessed by the State on Hospital Medicaid Financing Program Act Providers and (ii) an additional add-on payment with each CMO Claim payment that is equal to 11.88% of the Hospital Medicaid Financing Program Act Provider's contracted reimbursement rate with the CMO.

Hospital Medicaid Financing Program Act Provider: An institution licensed pursuant to Chapter 7 of Title 31 of the O.C.G.A. which is primarily engaged in providing to inpatients, by or under the supervision of physicians, Diagnostic Services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, and other specialty hospitals but shall not include psychiatric

hospitals as defined in paragraph (7) of Code Section 37-3-1, Critical Access Hospitals as defined in paragraph (3) of Code Section 33-21A-2, or any state owned or state operated hospitals.

Immediately: Within twenty-four (24) clock hours.

Implementation Phase: The period of time between Contract Effective Date through the Operational Start Date.

Incentive Arrangement: Any mechanism under which a Supplier may receive additional funds over and above the Capitation Payments, excluding Provide incentive payments made under Value Based Purchasing, for exceeding targets specified in the Contract.

Incurred-But-Not-Reported (IBNR): Estimate of unpaid Claims liability, includes received but unpaid Claims.

Individual Recovery/Resiliency Plan (IRP): The treatment plan or plan of care for individuals engaged in the Behavioral Health system that comprehensively addresses the Mental Health and/or addictive disease needs of the individual. This written plan establishes and documents treatment goals and Objectives based on the most recent diagnostic assessment; specific strategies and methods for treating needs identified by the diagnostic assessment; schedule for accomplishing the goals and Objectives; responsibility for providing each treatment component and responsibility of the individual to engage in recovery; and reflects the health status and progress, including changes in functioning over time. The Resiliency Plan typically is a term used to reflect a plan specifically designed for youth and adolescents.

Individualized Education Program (IEP): A mandate of the Individuals with Disabilities Education Act (IDEA) that defines the individualized objectives of a child who has been found with a disability, as defined by federal regulations. The IEP is intended to help children reach educational goals more easily than they otherwise would and refers both to the educational program to be provided to a child with a disability and to the written document that describes that educational program.

Individualized Family Service Plan (IFSP): A document developed when a child under the age of three (3) is found eligible for early-intervention services. The IFSP focuses on the child, family, and the services that a family needs to help them enhance the development of their child.

Individually Identifiable Health Information: See Protected Health Information.

Individuals with Disabilities Education Act (IDEA): A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Individuals with Disabilities Education Act (IDEA) Part B: A law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to infants, toddlers, children and youth with disabilities. Part B focuses on children and youth ages three (3) to – twenty-one (21) and their receipt of special education and related services. For Medicaid Members aged three (3)- to twenty-one (21), the CMOs are not responsible for reimbursing Local Education Agencies (LEAs) for the provision of Medically Necessary IDEA Part B services, provided pursuant to an IEP in the school setting.

Individuals with Disabilities Education Act (IDEA) Part C: Part C of IDEA serves infants and toddlers through age 2 with developmental delays or who have diagnoses of physical or mental Conditions with high probabilities that these Conditions will result in developmental delays.

Information: (i) Structured Data: Data that adhere to specific properties and Validation criteria that is stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; and (ii.) Document: Information that does not meet the definition of Structured Data that includes, at minimum, text, files, spreadsheets, electronic messages and images of forms and pictures.

Information System/Systems: A combination of computing hardware and software that is used in: (i.) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. Structured Data (which may include digitized audio and video) and documents; and/or (ii.) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

In-Network Provider: A Provider that has entered into a Provider Contract with the Supplier to provide Health Care services.

Inpatient Facility: Hospital or clinic for treatment that requires at least one overnight stay.

Insolvent: Unable to meet or discharge financial liabilities.

Intensive Care Coordination: Care coordination provided to Georgia Families 360° Members, at a greater frequency, duration, and scope than traditional case management to support Members with managing chronic or acute conditions.

Intensive Customized Care Coordination: A provider-based High Fidelity Wraparound intervention, as defined by the U. S. National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is gained. Intensive Customized Care Coordination encourages the use of community resources through Referral to appropriate traditional and non-traditional providers, paid, unpaid and natural supports. Intensive Customized Care Coordination is a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, and reviewing the delivery and outcome of appropriate services for individuals through a wraparound approach. Care Coordinators (CC), who deliver this intervention, work in partnership with the individual and their family/caregivers/legal guardian are responsible for assembling the Child and Family Team (CFT), including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities and address individual health and safety issues.

Intensive Family Intervention (IFI): A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the Utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic Foster Care, Psychiatric Residential Treatment Facilities, or therapeutic residential intervention services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- i. Defuse the current Behavioral Health Crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- ii. Ensure linkage to needed community services and resources; and
- iii. Improve the individual child's/adolescent's ability to self-recognize and self-manage Behavioral Health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

IFI services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her Behavioral Health needs/strengths and goals as identified in the individualized resiliency plan.

Intensive Family Intervention Provider (IFI Provider): Those service Providers that are deemed to satisfy the staffing and service scope requirements for DBHDD's core customers as defined in DBHDD's provider manual.

Interpregnancy Care (IPC): A benefit available to those P4HB participants who meet the Demonstration's eligibility requirements and who delivered a Very Low Birth Weight baby on or after initiation of the Demonstration.

Interpregnancy Care Service Providers: Those Demonstration Providers serving the IPC P4HB participants including Nurse Case Managers and Resource Mothers.

Interpregnancy Care Services: Services available under the Demonstration for P4HB participants who meet the eligibility criteria for the IPC program. These services are in addition to Family Planning Services and include: limited Primary Care services; management and treatment of chronic diseases; Substance Abuse treatment (detoxification and intensive outpatient rehabilitation); case management, including Resource Mothers Outreach; limited dental; prescription drugs (non-family planning) for the treatment of Chronic Conditions that may increase the risk of a subsequent VLBW delivery; and Non-Emergency Transportation.

Interpretation Services: The act or result of explaining, discovering, or ascertaining the meaning of all non-English language between speakers who speak different languages. Interpretation Services allow the transference of meaning between spoken languages. The interpreter must be fluent in both the original language and the target language and must translate the language to make it understandable. Interpretation Services are available free of charge to Potential Members and enrolled Members.

Interstate Compact on Adoption and Medical Assistance (ICAMA): Established in 1986, an agreement among member states to safeguard and protect the interstate interests of children covered by an Adoption Assistance agreement when they move or are adopted across state lines. ICAMA, which has the force of law within and among party states, enables the provision of medical Benefits and services when a child with special needs is adopted by a family from another state, or the adoptive family moves to another state.

Interstate Compact on the Placement of Children (ICPC): Enacted by Georgia in 1977, a uniform law that has been enacted by all fifty (50) states, the District of Columbia, and U. S. Virgin

Islands. It establishes orderly procedures for the interstate placement of Foster Care children and assigns responsibility for those involved in placing the child.

Juvenile Justice Member (JJ Member): A Member in the custody of DJJ while residing in community residential facilities and enrolled in the Georgia Families 360° program.

Juvenile Probation and Parole Specialist (JPPS): A DJJ staff professional who provides intake, informal adjustment, and probation services to youth for the Juvenile Court and aftercare and commitment services to youth under DJJ supervision. At a minimum, the JPPS will be solely responsible for coordinating youth placements in residential treatment settings, supervision in their communities, and development of service plans that may consist of Health Care, Mental Health, and educational needs identified during the youth's initial assessment that may not be limited to Referrals to collaborative agencies or resource providers.

Kenny A. Consent Decree: In June 2002, Children's Rights, Incorporated out of New York, filed a class action lawsuit against the State of Georgia on behalf of children in the state's legal custody. The lawsuit alleged violations of constitutional and statutory rights arising out of the operation of the State's Foster Care systems in Fulton and DeKalb counties. In October 2005, the plaintiffs and defendants settled the lawsuit under the Kenny A. vs. Sonny Perdue Consent Decree, which established independent accountability agents with the responsibility of monitoring the State's progress and producing public reports every six (6) months. These reports are available at: <http://aysps.gsu.edu/faculty-research/publications/kenny-a-v-perdue-monitoring-reports/>. Under the terms and conditions of the Kenny A. Consent Decree, the State is to achieve and sustain thirty-one (31) outcomes, as well as maintain certain practice standards related to service planning, placement experience, Health Care, investigation of maltreatment allegations concerning children in Foster Care, court reviews and reporting. Some of these standards are new requirements for administrators and case managers, and others are existing agency policy and practice requirements receiving heightened attention. In addition, the consent decree stipulates various State and county infrastructure requirements. These stipulations pertain to automation, caseload sizes, training, supervision of private providers, Foster Parent licensing, and financing. A copy of the decree is attached hereto as Exhibit 1 of Attachment H of this RFP.

Key Staff: Supplier's staff which includes the Chief Executive Officer, Member Services Director, Provider Services Director, Utilization Management Director, Chief Medical Officer, Quality Management Director, Health Services Director and the Program Implementation Manager. Key Staff must be full-time employees located in Georgia with no other client responsibilities other than the Georgia Families, Georgia Families 360° or P4HB programs.

Limited-English-Proficient Population: Individuals with a primary language other than English who must communicate in that language if the individual is to have an equal opportunity to participate effectively in, and benefit from, any aid, service or benefit provided by the Health Care Provider.

Local Education Agency (LEA): The official designation for a school district in the State of Georgia.

Local Interagency Planning Teams (LIPT): A requirement of Georgia law, these teams are responsible for improving and facilitating the coordination of services for children with severe emotional disorders (SED) and/or addictive disease (AD). Team membership may include representatives from DFCS, DBHDD, DJJ, DPH, service Providers, educators, and Foster Parents or parent advocates, when their child is discussed. Teams meet as needed, usually no less than once a month, depending on the needs of the children.

Long Term: A period greater than thirty (30) Calendar Days.

Low Birth Weight (LBW): Birth weight below 2,500 grams (5.5 pounds).

Mandated Reporters: People in professions who have regular contact with vulnerable people such as children, disabled persons and senior citizens and are therefore legally required to report (or cause a report to be made) when abuse, neglect or exploitation is observed or are suspected. The specific professionals are typically named in state law. Georgia identified Mandated Reporters in the Official Code of Georgia Annotated. for adults and children §§ 30-5-1, et seq. and 19-7-5(c)(1) which include, but are not limited to: Physicians licensed to practice medicines, interns or residents; dentists; psychologists; chiropractors; podiatrists; pharmacists; physical therapists; occupational therapists; licensed professionals and counselors; nursing personnel; social work personnel; day care personnel; employees of a public or private agency engaged in professional health-related services; and law enforcement personnel.

Mandatory Enrollment: The process whereby an individual eligible for the Demonstration, Medicaid or PeachCare for Kids® is required to enroll in a CMO, unless otherwise exempted or excluded, to receive covered Demonstration, Medicaid or PeachCare for Kids® services.

Mandatory Provider (MP): A Provider identified by DCH as having provided the top eighty percent (80%) of Medicaid Encounter Claims within that Provider's Category of Service and Service Region for the Georgia Families eligible population in State Fiscal Year 2014. In addition to the percentage of services, Public Health Departments are considered Mandatory Providers.

Marketing: Any communication from the Supplier to any Demonstration, Medicaid or PeachCare for Kids® eligible individual that can reasonably be interpreted as intended to influence the individual to enroll in that particular CMO, or not enroll in or disenroll from another CMO.

Marketing Materials: Materials that are produced in any medium, by or on behalf of the Supplier, and can reasonably be interpreted as intended to market to any Member.

Material Subcontractor: A Subcontractor, excluding Providers, receiving Subcontractor Payments from the Supplier in amounts equal to or greater than ten (10) million dollars annually during the State fiscal year.

Measurable: Applies to a Supplier Objective and means the ability to determine definitively whether or not the Objective has been met, or whether progress has been made toward a positive outcome.

Medicaid: The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act, which in Georgia is administered by DCH.

Medicaid Care Management Organizations Act: O.C.G.A. §33-21A-1, et seq. MEDICAID CARE MANAGEMENT ORGANIZATIONS ACT. A bill passed by the Georgia General Assembly, signed into law by the Governor, and effective July 1, 2008 which outlines several administrative requirements with which the administrators of the Medicaid managed care plan, must comply. Some of the requirements include dental Provider networks, emergency room Claims payment requirements, eligibility verification, and others.

Medicaid Eligible: An individual eligible to receive services under the Medicaid Program but not necessarily enrolled in the Medicaid Program.

Medicaid Management Information System (MMIS): Computerized system used for the processing, collecting, analysis, and reporting of Information needed to support Medicaid and CHIP functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manual.

Medical Assessment: An initial medical evaluation completed for FC Members and JJ Members as follows:

- i. For each child newly entering or re-entering Foster Care, the Medical Assessment is part of the CCFA. These assessments must follow the requirements set forth in Georgia's Medicaid EPSDT program, and include dental, hearing and developmental screenings.
- ii. For JJ Members, a Medical Assessment must follow the requirements set forth in Georgia's Medicaid EPSDT program, including dental, hearing and developmental screenings

Medical Director: The Georgia-licensed physician designated by the Supplier to exercise general supervision over the provision of health service Benefits by the Supplier.

Medical Home: A person-centered approach to providing comprehensive Primary Care that facilitates partnerships between individuals and their providers, and where appropriate, the individual's family and other supports. A focal point for information sharing and Referral to specialists and sub-specialists as well as community evaluations and interpretation of specialists.

Medical Records: The complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's Participating Primary Care or Demonstration Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

Medical Screening: An examination used to identify an unrecognized or recognized disease in individuals without signs or symptoms.

Medically Necessary Services: Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary Services are those that are:

- i. Required to correct or ameliorate a defect, physical or Mental Illness, or a Condition
- ii. Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's medical Condition
- iii. Compatible with the standards of acceptable medical practice
- iv. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
- v. Not provided solely for the convenience of the Member or the convenience of the Health Provider
- vi. Not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage

- vii. Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available

Member: A Medicaid, P4HB, or PeachCare for Kids® recipient who is currently enrolled in a CMO unless otherwise noted.

Member Education and Outreach Plan (a/k/a the “Georgia Families 360° Education and Outreach Plan”): The plan detailing all education and outreach activities that the Supplier will use to reach Georgia Families 360° Members. The Georgia Families 360° Member Education and Outreach plan must be approved by DCH.

Members with Special Health Care Needs (MSHCN): Any Member who:

- i. Ranges in age from birth up to but not including age twenty-one years (one [1] through <twenty-one [21]);
- ii. Requires regular, ongoing therapeutic intervention and evaluation by Medicaid enrolled Health Care Professionals; and either (a) has a serious ongoing illness, a complex chronic condition, or a disability that has lasted or is anticipated to last at least twelve (12) continuous months or more; or (b) has an illness, Condition or disability that significantly limits Activities of Daily Living or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development.

Mental Health: A state of emotional and psychological well-being in which the individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.

Mental Illness: A behavioral or psychological syndrome or disorder that presents as a mental or behavioral anomaly and reflects an underlying psychobiological dysfunction the consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning).

Methodology: The planned process, steps, activities or actions taken by the Supplier to achieve a goal or Objective, or to progress toward a positive outcome.

Monitoring: The process of observing, evaluating, analyzing and conducting follow-up activities.

Multidisciplinary Team (MDT): A team consisting of persons representing various disciplines associated with key components of the Foster Care assessment process. The purpose of the MDT meetings is to review the outcome and recommendations of the CCFA Provider related to the assessment of the FC Member and the Member’s family.

The disciplines which may participate as part of the MDT should include, but are not limited to the following:

- i. Legal custodian (DFCS Case Manager, CPS investigator, CPS ongoing case manager, DFCS supervisor, and/or independent living coordinator for any youth fourteen (14) years or older);
- ii. CCFA Provider conducting the Trauma Assessment;
- iii. School system representative with direct knowledge of the educational status of the child;

- iv. Medical health provider with direct knowledge of the medical and dental status of the Foster Care child including the Babies Can't Wait service coordinator if applicable;
- v. Representative from the appropriate court system if the child had any court or law enforcement involvement including local law enforcement officials or a Court Appointed Special Advocate (CASA);
- vi. A Mental Health representative with direct knowledge of the Mental Health or Substance Abuse issues affecting the child or family;
- vii. Foster Parent(s) or Out of Home Placement provider where the child resided during the assessment process with direct knowledge of the child's behavior and activity during the assessment; and
- viii. Any other individual having appropriate information directly related to the FC Member's case.

The MDT meeting is coordinated and facilitated by the individual who completed the family assessment.

National Child Traumatic Stress Network: Established by the U.S. Congress in 2000 as part of the Children's Health Act, the National Child Traumatic Stress Network (NCTSN) is a collaborative of over one hundred fifty (150) centers in university, hospital, and diverse community-based organizations committed to raising the standard of care and improving access to services for traumatized children, their families and communities.

National Committee for Quality Assurance (NCQA): An organization that sets standards, and evaluates and accredits health plans and other managed care organizations.

National Provider Identifier (NPI): A unique ten-digit identification number issued to Health Care providers in the United States by the CMS. Providers must use their NPI to identify themselves in all HIPAA transactions.

Neonatal Intensive Care Unit (NICU): Hospital unit which provides intensive care services for sick and premature newborns.

Neonatal Intensive Care Unit (NICU) Supplemental Payments: Payments made to the Care Management Organizations for Georgia Families Members when those Members receive certain services in a NICU.

Net Capitation Payment: The Capitation Payment, adjusted for the applicable VBP Withhold, made by DCH to the Supplier excluding NICU Supplemental Payments, Obstetrical Delivery Payments, or other medical services that are on a per occurrence basis rather than a per Member basis.

Non-Capitated Services: Services not included in the Supplier's Capitation Rate.

Non-Emergency Transportation (NET): A ride, or reimbursement for a ride, provided so that a Member or P4HB Participant with no other transportation resources can receive services from a medical provider. NET does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.

Non-Institutional Claims: Claims submitted by a medical Provider other than a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF/ID).

Normal Birth Weight: Birth weight greater than or equal to 2,500 grams (5.5 pounds).

Nurse Case Manager (NCM): Supplier staff responsible for assisting Members identified through the health assessment as Members with Special Health Care Needs with obtaining Medically Necessary Services, health-related services and coordinating their clinical care needs with holistic consideration.

Nurse Practitioner Certified (NP-C): A registered professional nurse who is licensed by the State of Georgia and meets the advanced educational and clinical practice requirements beyond the two or four years of basic nursing education required of all registered nurses.

Objective: A Measurable step, generally in a series of progressive steps, to achieve a goal.

Obstetrical Delivery Payment: A one-time payment made to the CMO for the delivery of a Georgia Families newborn. This payment is in addition to the Georgia Families Capitation Payment for the newborn. The CMO is eligible for the Obstetrical Delivery Payment based on submission of the paid Claim associated with the related obstetrical and/or hospital services as defined by DCH. Also known as the OB Kick Payment.

Office of Insurance and Safety Fire Commissioner: The Agency in the State of Georgia responsible for licensing, overseeing, regulating, and certifying insuring entities.

Ombudsman Coordinator: An employee of the Supplier who is responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that Members have access to Covered Services and non-Covered Services. The Ombudsman Coordinator is also responsible for interacting with DCH's equivalent ombudsman staff and submitting reports to DCH.

Ombudsman Liaison: An employee of the Supplier who is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to Health Care services, and identifying the communication and education needs of Members, Providers and caregivers. The Ombudsman Liaison must assist Members and Providers in coordinating services with local community organizations and working with advocacy organizations. The Ombudsman Liaison is also responsible for interacting with DCH's equivalent ombudsman staff and submitting reports to DCH.

Operational Start Date: The date upon which the Supplier begins providing services under the Contract.

Ordering, Prescribing, Referring (OPR) Provider: Pursuant to the Patient Protection and Affordable Care Act and resulting regulations at 42 CFR 455.410(b), a physician or non-physician practitioner that orders, prescribes or refers services for a Member. OPR providers must be enrolled in Medicaid as either a Participating Medicaid Provider or as an OPR Provider and his or her National Provider Identifier (NPI) number must be included on submitted Claims.

Out of Home Placement: The separation of a child from his/her parent or legal guardian because of abuse and/or neglect or special medical circumstances. The child may be placed in a variety of placement settings including, but not limited to, the home of a relative, a DFCS or Child Placing Agency (CPA) family foster home, or a twenty-four (24) hour child care institution.

Out-of-Network Provider: A Provider of services that does not have a Provider Contract with the Supplier.

Parent Company: A Parent Company is one which owns and controls other companies, usually known as subsidiaries.

Patient Centered Medical Home (PCMH): Georgia recognizes Providers as PCMHs if they have received NCQA PCMH recognition. A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care. A medical home achieves these goals through a high level of accessibility, providing excellent communication among patients, physicians and staff and taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.

Part Time Provider: A location operating for fewer than sixteen (16) hours in an office location each Week.

Participating Provider: A Provider that has signed a Contract with the Supplier to provide services to Members.

Patient Protection and Affordable Care Act (PPACA): The Patient Protection and Affordable Care Act is a federal statute, signed into law on March 23, 2010. The law includes numerous health-related provisions that will take effect over a four year period, including expanding Medicaid eligibility, subsidizing insurance premiums, establishing health insurance exchanges and support of medical research. Also known as Affordable Care Act (ACA).

PeachCare for Kids®: The State of Georgia's Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act.

Peer Support Services: An evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. Designed and delivered by peers who have been successful in the recovery process, peer supports extend the reach of treatment beyond the clinical setting and help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services are provided by a Certified Peer Specialists (CPS), peer support providers who have graduated with a certificate from a state approved CPS training. CPS can be provided by an adult peer specialist certified to those with mental illness and/or addictive disease, a youth peer specialist certified to support peers with mental illness and/or addictive disease, or a family peer specialist to support parents with children with serious emotional disturbance.

Performance Improvement Project (PIP): A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy benefit management services including but not limited to Claims processing and maintenance of associated systems and related processes.

Physical Health: The treatment focused on the care and oversight of the general medical Condition of a person and related Physical Health Care services.

Physician Assistant (PA): A trained, licensed individual who performs tasks that might otherwise be performed by physicians or under the direction of a supervising physician.

Physician Incentive Plan: Any compensation arrangement between a Supplier and a Provider that is designed to identify and reward desired behavior or outcomes.

Physician Practice Connections-Patient Centered Medical Home (PPC®-PCMH): The PPC-PCMH is a Recognition Program that emphasizes systematic use of patient-centered, coordinated care management processes. In order to obtain the PPC-PCMH Recognition, the entity must meet specific elements in the following categories: (1) Access and Communication, (2) Patient Tracking and Registry Functions, (3) Care Management, (4) patient Self-Management and Support, (5) Electronic Prescribing, (6) Test Tracking, (7) Referral Tracking, (8) Performance Reporting and Improvement, and (9) Advanced Electronic Communication.

Planning for Healthy Babies Program (P4HB): The name of the 1115 Family Planning Demonstration Waiver Program in Georgia. See definition of Demonstration.

Population Health Management (PHM): The management, integration and outcome measurement of any program affecting the health and productivity of the Georgia Families population, i.e. corporate wellness, disease management, catastrophic case management, Utilization Management, Employee Assistance Program (EAP), disability, and/or worker's compensation programs.

Post-Stabilization Services: Covered Services, related to an Emergency Medical Condition that are provided after a Member is Stabilized in order to maintain the stabilized Condition or to improve or resolve the Member's Condition.

Potential P4HB Participant: An individual meeting the eligibility requirements for the Demonstration who is subject to Mandatory Enrollment in a CMO but is not yet enrolled in a specific CMO.

Pre-Certification: Review conducted prior to a Member's admission, stay or other service or course of treatment in a hospital or other facility.

Preconception Health Care: The primary prevention of maternal and perinatal morbidity and mortality comprised of interventions that identify and modify biomedical, behavioral and social risks to pregnancy outcomes for women and their offspring. To have maximal impact on pregnancy outcomes, strategies to address risks must occur before conception or before prenatal care is typically initiated.

Preferred Health Organization (PHO): A coordinated care plan that: (i.) has a network of providers that have agreed to a contractually specified reimbursement for covered Benefits with the organization offering the plan; (ii.) provides for reimbursement for all covered Benefits regardless of whether the Benefits are provided with the network of providers; and (iii.) is offered by an organization that is not licensed or organized under State law as an Health Maintenance Organization.

Pregnancy Rate: The number of pregnancies occurring to females in a specified age group per 1,000 females in the specified age group. The rate is calculated by using the following formula: $\text{Pregnancy rate} = [\text{Number of pregnancies in age group} / \text{female population in age group}] * 1000.$

Rates that use Census Population Estimates in the denominator are unable to be calculated when the selected population is unknown.

Prevalent Non-English Language: A language other than English, spoken by a significant number or percentage of Potential Members or P4HB Participants.

Preventive Action: An intervention initiated to stop a potential problem from occurring. A Preventive Action assumes that adequate Monitoring and controls are in place in the Quality system to assure that potential problems are identified and eliminated before they happen. If something in the Quality system indicates that a possible problem is or may develop, a Preventive Action must be implemented to avert and then eliminate the potential situation. Documentation for a Preventive Action provides evidence that an effective Quality system has been implemented that is able to anticipate, identify and eliminate potential problems. The process for detecting potential problems/issues and eliminating them includes:

- i. Identifying the potential problem/issue
- ii. Finding the cause of the potential problem/issue
- iii. Developing a plan to prevent the occurrence of the problem/issue
- iv. Implementing the plan
- v. Reviewing the actions taken and the effectiveness in preventing the problem

Preventive Services: Services provided by a physician or other licensed health practitioner within the scope of his or her practice under State law to: prevent disease, disability, and other health Conditions or their progression; treat potential secondary Conditions before they happen or at an early remediable stage; prolong life; and promote Physical and Mental Health and efficiency.

Primary Care: All Health Care services and laboratory services, including periodic examinations, preventive Health Care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of Referrals to specialty Providers described in this Contract, and for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner or alternative Provider types such as specialists to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP): A licensed health care practitioner, usually a doctor, nurse practitioner, or physician assistant who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required Primary Care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, OB/GYNs, Physicians' Assistants, or nurse practitioners. The PCP's role is to:

- Provide preventive care and teach healthy lifestyle choices
- Identify and treat common conditions
- Assess the urgency of your medical problems and direct you to the best place for that care
- Make referrals to medical specialists when necessary.

Primary Dental Provider (Dentist): A licensed dentist who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is

responsible for providing all required general dental services to Georgia Families (excluding Family Planning Only P4HB participants) and Georgia Families 360° Members. A Dentist shall include general dental practitioners provided that the Dentist is able and willing to carry out all Dentist responsibilities in accordance with these Contract provisions and licensure requirements. The Dentist is responsible for coordinating Referrals, as needed, with Dental Subspecialty Providers and all subsequent dental care.

Prime Contractor: Primary Supplier of the Contract who holds full responsibility of the completion of the job. The Supplier, regardless of use of Subcontractors, is the Prime Contractor of this Contract.

Prior Authorization: Authorization granted in advance of the rendering of a service after appropriate medical review. Also known as Pre-Authorization or Prior Approval.

Prior Authorization Portal: The electronic web-based system through which Providers and the Suppliers communicate about Prior Authorization requests submitted by Providers.

Proposed Action: The proposal of an Action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the Supplier to act within the time frames provided in 42 CFR 438.408(b).

Prospective Payment System (PPS): A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, Long-Term care hospitals, and skilled nursing facilities.

Protected Health Information (PHI): A subset of health information, including demographic information collected from an individual and (1) created or received by a Health Care provider, health plan, employer, or Health Care clearinghouse, and (2) relates to the past, present, or future Physical or Mental Health or Condition of an individual; the provision of Health Care to an individual; or the past, present, or future payment for the provision of Health Care to an individual; and (i) that identifies the individual; or (ii) is a reasonable basis to believe the information can be used to identify the individual. This information is (i) transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information (i) in education records covered by the Family Educational Rights and Privacy Act, (ii) in employment records held by a covered entity in its role as employer; (iii) regarding persons who have been deceased for more than fifty (50) years; and (iv) in records described at 20 U.S.C. § 1232g (a) (4) (B) (iv).

Provider: Any person (including physicians or other Health Care Professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide Health Care Services that has contracted with a Care Management Organization to provide Health Care services to Members.

Provider Complaint: A written expression by a Provider, which indicates dissatisfaction or dispute with the Supplier's policies, procedures, or any aspect of a Supplier's administrative functions.

Provider Contract: Any written Contract between the Supplier and a Provider that requires the Provider to perform specific parts of the Supplier's obligations for the provision of Health Care services under this Contract.

Provider Directory: A listing of Health Care service Providers under Contract with the Supplier that is prepared by the Supplier as a reference tool to assist Members in locating Providers available to provide services.

Provider Number (or Provider Billing Number): An alphanumeric code utilized by Health Care payers to identify providers for billing, payment, and reporting purposes.

Provider Withhold: A percentage of payments or set dollar amounts that a Supplier deducts from a Provider's payment or fee, or salary payment, and that may or may not be returned to the Provider, depending on specific predetermined factors.

Prudent Layperson: A person with average knowledge of health and medicine who could reasonably expect the absence of immediate medical attention to result in an emergency medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that could cause:

- i. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

Psychiatric Residential Treatment Facility (PRTF): A separate, standalone entity providing a range of comprehensive psychiatric services to treat the psychiatric Condition of residents under age twenty-one (21) years on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's Condition or prevent further regression so that the services will no longer be needed. (42 CFR §483.352, subpart D of part 441)

Qualified Electronic Health Record: "An Electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists; and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relevant to Health Care quality; and to exchange electronic health information with and integrate such information from other sources." Source is ARRA - H.R.1 -115 Sec. 3000 (13)

Qualified Entities (QEs): Entities that have permission from DCH and/or its designee to access services available on the GaHIN Network and meet a set of DCH-established criteria, have completed an approval process, and have signed participation documentation with Supplier. QEs ensure that Participant Users and/or vendors with which they have agreements comply with the applicable terms of participation and related policy documentation.

Qualified Member: Individuals who meet a set of established criteria, successfully complete the approval process, and sign agreements to abide by GaHIN policies. GaHIN Member User have permission to access, consume, and make available data transport services on the statewide health information network.

Quality: The degree to which the Supplier increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

Query-Based Exchange: Technology and functionality that GaHIN Authorized Users/Member Affiliates will use to search for and locate individual Member records.

Rapid Cycle Process Improvement: A Quality improvement method that identifies, implements and measures changes made to improve a process or a system. Rapid-Cycle improvement implies that changes are made and tested over short time frames (Weeks to months) rather than years.

Re-admission: Subsequent admissions of a patient to a hospital or other Health Care institution for treatment within thirty (30) Calendar Days of the date of Discharge.

Recoupment: The recovery by the Supplier of any Medicaid debt by reducing present or future Medicaid payments and applying the amount withheld to the indebtedness.

Referral: A request by a PCP for a Member to be evaluated and/or treated by a different physician, usually a specialist.

Referral Services: Those Health Care services provided by a Health Care Professional other than the Primary Care Provider and which are ordered and approved by the Primary Care Provider or the Supplier.

Referring Provider: The Provider who has evaluated the Member, determined the need for a consultation (or other service), and has arranged the services of the Consulting Provider for the purpose of diagnosis and/or treatment.

Regional Interagency Action Team (RIAT): These teams provide feedback from each of DBHDD's five (5) regions for collaborative learning regarding the operation of the LIPT. The RIAT addresses service gaps, barriers, fragmentation and duplication across partners at the regional level, as well as other issues relating to children's Behavioral Health. Membership includes the chairpersons of the LIPTs located within the region, regional representation by mandated agencies, LIPT trainers, and a Member's family representative. These teams are not required by law.

Reinsurance: An agreement whereby the Supplier transfers risk or liability for losses, in whole or in part, sustained under this Contract. A Reinsurance agreement may also exist at the Provider level.

Remedial Action: Action required immediately to remedy a situation until a thorough investigation and a permanent solution is implemented. When remedial actions are necessary, the actions and the resources required must be listed and the steps that must be taken immediately to avoid any further adverse effects are explained. All actions taken are documented and become part of the 'Action Plan' section of the Corrective Action/Preventive Action actions. If a remedial action is all that is needed, a rationale for that decision and appropriate follow up must be documented.

Remedy: The State's means to enforce the terms of the Contract through performance guarantees and other actions.

Reprocessing (Claims): Upon determination of the need to correct the outcome of one or more Claims processing transactions, the subsequent attempt to process a single Claim or batch of Claims.

Requirements Analysis Documents (RADs): A set of documents that describe the technical and business process requirements of each Deliverable identified in the Contract. Each requirement is defined in such way that its achievement is capable of being objectively verified by a prescribed method (for example inspection, demonstration, analysis, or test) and serves as a contractual basis between DCH and Supplier. DCH shall post such RADs on the DCH website and the Supplier shall access this information as determined by DCH. DCH reserves the right to modify the RADs as needed. The initial RADs will be developed by DCH during the Implementation Phase.

Residential Placement: An Out of Home Placement setting designed to meet the needs of children and youth with behavioral, emotional and Mental Health needs that prevent them from being able to reside in a less structured family home setting. A residential treatment facility offers a structured physical environment and a treatment program designed to help children improve their ability to function in multiple areas of life. For JJ Members, Residential Placement may also be referred to as Room Board and Watchful Oversight (RBWO).

Residential Placement Provider: A Provider contracted with DFCS or DJJ providing Residential Placements.

Resource Mother: A paraprofessional that provides a broad range of services to P4HB IPC participants and their families.

Resource Mother Outreach: Service under the P4HB program made available to women who receive Medicaid Benefits and give birth to a VLWB baby. The Resource Mother Outreach section offers support to mothers and provides them with information on parenting, nutrition, and healthy lifestyles.

Responsible Health Organization: Includes CMOs and FFS and is the party stated on the DCH MMIS portal as evidenced by the Provider's screen print out when the service is rendered within seventy-two (72) hours of that screen shot.

Revenue Codes: A listing of three digit numeric codes utilized by institutional Health Care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).

Routine Care: Treatment of a Condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physicians' office) or by the patient.

Rural Health Clinic (RHC): A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to Primary Care in underserved rural areas. RHCs are required to use a team approach of physicians and mid-level practitioners (nurse practitioners, Physician Assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least fifty percent (50%) of the time with a midlevel practitioner. RHCs may also provide other Health Care services, such as Mental Health or vision services, but reimbursement for those services may not be based on their allowable costs.

Rural Health Services: Medical services provided to rural sparsely populated areas isolated from large metropolitan counties.

Security Rule: Establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic Protected Health Information. PHI Ref. 45 CFR Part 160 and Subparts A and C of Part 164.

Service Authorization: A Provider's request for the provision of a service.

Service Region: A geographic area defined by the State that is used for reporting and analytical purposes.

SHINES: A web-based, statewide automated child welfare information system (SACWIS) that offers DFCS child welfare professionals a comprehensive Case Management tool.

Short Term: A period of thirty (30) Calendar Days or less.

Span of Control: Information systems and telecommunications capabilities that the Supplier itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The Supplier Span of Control also includes Information Systems and telecommunications capabilities outsourced by the CMO.

Special Health Needs Care Managers: Provides clinical service to facilitate development of a FC Member or AA Member Health Care Service Plan and coordination of clinical services among PCPs and specialty providers to ensure Georgia Families 360° Members with special Health Care needs have access to, and appropriately utilize, Medically Necessary Covered Services.

Stabilized: With respect to an Emergency Medical Condition; that no material deterioration of the Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, the woman has delivered (including the placenta).

State: The State of Georgia.

State Fair Hearing: See Administrative Law Hearing.

State Health Benefit Plan (SHBP): The health benefit plan administered by the Georgia Department of Community Health covering State employees, public school teachers, public school employees, retirees and their eligible dependents, and other entities under Official Code of Georgia for health insurance.

State Plan: A comprehensive written statement submitted by DCH describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal Financial Participation (FFP) in the State program.

State-Vaccine-Eligible Child: With respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B) of the Social Security Act.

Subcontract: Any written Contract between the Supplier and a third party, including a Provider, to perform a specified part of the Supplier's obligations under this Contract.

Subcontractor: Any third party who has a written Contract with the Supplier that have been assigned delegated functions and who have interactions with Members' Coordination of Care or the delivery of care.

Subcontractor Payments: The all-inclusive amount the Supplier pays a Subcontractor for services rendered.

Substance Abuse: Substance Abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. The term may also reference the field of clinical study and treatment of individuals who have experienced chronic disease related to Substance Abuse.

Substantiated Maltreatment: A disposition of a Child Protective Services (CPS) investigation which concludes that child maltreatment, as defined by federal and state law, and CPS policy, has occurred as supported by a preponderance of the evidence.

System Access Device: A device used to access Information System functions; can be any one of the following devices if it and the System are so configured: (i.) Workstation (stationary or mobile computing device), (ii.) Network computer/"winterm" device, (iii.) "Point of Sale" device, (iv.) Phone, or (v.) Multi-function communication and computing device, e.g. Personal Digital Assistant (PDA).

System for the Uniform Calculation and Consolidation of Economic Support Services (SUCCESS): An integrated computer system utilized by DFCS and DCH to record information and generate Benefits to assistance units (group or individual(s) applying for or receiving Benefits).

System Function Response Time: Based on the specific sub-function being performed:

- i. Record Search Time-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
- ii. Record Retrieval Time-the time elapsed after the retrieve command is entered until the record data begins to appear on the monitor.
- iii. Print Initiation Time- the elapsed time from the command to print a screen or report until it appears in the appropriate queue.
- iv. On-line Claims Adjudication Response Time- the elapsed time from the receipt of the transaction by the Supplier from the Provider and/or switch vendor until the Supplier hands-off a response to the Provider and/or switch vendor.

System of Care: A spectrum of effective, highly-coordinated community-based services and supports for children and youth with or at risk for Mental Health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families' and youths' needs to help them to function better at home, in school, in the community, and throughout life.

System of Care core values and philosophy include an expectation that services and supports: are culturally and linguistically competent; ensure availability and access to effective traditional and nontraditional services as well as natural and informal supports that address physical, emotional, social, and educational needs; are planned in true partnership with the child and family and a family peer professional representative; and include intensive care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated

and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

This definition is culled from an Issue Brief by the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, <http://gucchdtacenter.georgetown.edu/resources/>. The Supplier will reference and incorporate revised definitions, protocol, and operations as indicated according to published updates issued by the National Technical Assistance Center for Children's Mental Health.

System Unavailability: Failure of the system to provide a designated user access based on service level agreements or software/hardware problems within the Supplier's Span of Control.

Telecommunication Device for the Deaf (TDD): Special telephony devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones.

Telemedicine: Delivery of medical or other health services provided to a patient utilizing real-time interactive communication equipment to exchange the patient's information from one site to another via an electronic communication system.

Third Party Resource: Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or Member.

Transition of Care: The movement of patients between Health Care practitioners and/or settings as their Condition and care needs change during the course of a chronic or acute illness. For FC Members, JJ Members and AA Members, Transition of Care planning may involve activities or needs related to a Member's placement in DFCS custody or under DJJ supervision, transition from FFS Medicaid or commercial health plans to the Georgia Families 360° program; transition from a CMO to the Georgia Families 360° CMO, changes in Residential Placement, aging out of Foster Care or exiting DJJ supervision.

Translation Services: The act or process of changing or converting one language to another language. The translator must be fluent in both the original source language and the target language and must translate the language to make it understandable. Translation Services may also include the use of computer tools or technology. Translation Services are available free of charge to Potential Members and enrolled Members.

Trauma Assessment: A component of the CCFA provided to FC Members placed in DFCS custody. The comprehensive Trauma Assessment involves an in-depth exploration of the nature and severity of the traumatic events experienced directly or witnessed by the child, the sequence of those events, and the current trauma-related symptoms to determine the best type of treatment for that specific child. A CCFA Provider must use an assessment tool approved by DCH to identify the types and severity of symptoms the child is experiencing. The comprehensive Trauma Assessment must provide recommendations to coordinate services and meet the child's needs.

Trauma Screening: A brief, focused inquiry to determine the specific traumatic events experienced by the child. A Trauma Screening is conducted to direct the Trauma Assessment.

Unique Provider: A provider who furnishes, bills, or is paid for health care services provided to Members and who has been assigned a designated National Provider Identifier (NPI). The provider is identified utilizing the designated NPI number. Multiple practice locations are not taken into consideration when identifying the provider.

Unique Provider Identifier: The National Provider Identifier (NPI) number assigned to an individual provider notwithstanding the provider's multiple office or practice locations.

Urgent Care: Medically Necessary treatment for an injury, illness, or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Utilization: The rate patterns of service usage or types of service occurring within a specified time.

Utilization Management (UM): A service performed by the Supplier which seeks to assure that Covered Services provided to Members are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established or administered by DCH.

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

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Value Based Purchasing: An enhanced approach to purchasing and program management that focuses on value over volume. It is part of a comprehensive strategy that aligns incentives for Members, Providers, Supplier and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, Quality of care and savings.

Value Based Purchasing (VBP) Performance Management Team (PMT): Monitors CMO performance on VBP initiatives. Members of the VBP Performance Management Team include:

- i. Medicaid Director
- ii. DCH senior level employee(s)
- iii. Leadership from Georgia Health Care departments that support Medicaid: Quality management, provider networks, medical management, member services, community outreach and finance;
- iv. Contract Liaisons;
- v. DCH and Supplier representative from legal; as appropriate
- vi. As appropriate, management from enterprise functions (e.g., communications, information technology);
- vii. Key leadership from the Supplier (e.g., Medical Director Chief Operating Officer or other designee approved by DCH); and
- viii. As appropriate, operational-level Supplier staff.

Value Based Purchasing (VBP) Withhold: DCH will withhold five percent (5%) of the Supplier's Capitation Payments for Members for the VBP program. DCH may return all, part or none of the withheld funds to the Supplier as incentive payments based on the Supplier achieving identified VBP performance targets. The maximum incentive payment to the Supplier will be the full five percent (5%) VBP Withhold.

Very Low Birth Weight (VLBW): Birth weight below 1,500 grams (3.3 pounds).

Virtual Health Record (VHR): A virtual view of many data sources that contain patient health records. The VHR enables authorized users to query Member health information.

Week: The traditional seven-day week, Sunday through Saturday.

Work Week: The traditional work week, Monday through Friday.

Working Days: Monday through Friday but shall not include Saturdays, Sundays, or State and Federal holidays.

Acronyms:

AA Member – Adoption Assistance Member

AAAHC – Accreditation Association for Ambulatory Health Care

AAPD – American Academy of Pediatric Dentistry

ABD – Aged Blind Disabled

ACE – Administrative Claiming for Education

ACIP – Advisory Committee on Immunization Practices

AD – Addictive Disease

ADL – Activities of Daily Living

AFDC – Aid to Families with Dependent Children

AHRQ – Agency for Healthcare Research and Quality

AICPA – American Institute of Certified Public Accountants

BIN – Bank Identification Number

CAH – Critical Access Hospital

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CAPA – Corrective Action Preventive Action

CAPTA – Child Abuse Prevention and Treatment Act

CASA – Court Appointed Special Advocate

CBAY – Community-Based Alternatives for Youth

CCFA – Comprehensive Child and Family Assessment

CCT – Care Coordination Team

CCP – Comprehensive Community Providers

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CFT – Child and Family Team

CHIP – Children's Health Insurance Program – formerly known as the State Children's Health Insurance Program (SCHIP)

CISS – Children's Intervention School Services

CLIA – Clinical Laboratory

CMHRS – Community Mental Health Rehabilitation Services

CMO – Care Management Organization

CMS – Centers for Medicare & Medicaid Services

CNM – Certified Nurse Midwives

COMP – Comprehensive Supports Waiver Program

COS – Category of Service

CPS – Child Protective Services

CSB – Community Service Boards

CVO – Credentialing Verification Organization

DBHDD – Department of Behavioral Health and Developmental Disabilities

DCH – Department of Community Health

DECAL – Department of Early Care and Learning

DFCS – Division of Family and Children Services

DJJ – Department of Juvenile Justice

DMAP – Division of Medical Assistance Plans

DME – Durable Medical Equipment

DO – Doctor of Osteopathy

DOAS – Department of Administrative Services

DOE – Department of Education

DPH – Department of Public Health

DRG – Diagnostic Related Group

ED – Emergency Department or Emergency Room (ER)

EDI – Electronic Data Interchange

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ER – Emergency Room or Emergency Department (ED)

eRFP –electronic Request for Proposal

eRFQC – electronic Request for Qualified Contractors

EVS – Eligibility Verification System

FAC – Fiscal Agent Contractor

FC Member – Foster Care Member

FFP – Federal Financial Participation

FFS – Fee-for-Service

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

GaHIN – Georgia Health Information Network

GAPP – Georgia Pediatric Program

GCAL – Georgia Crisis and Access Line

GEPS – Georgia Enterprises for Products and Services

GFMOC – Georgia Families Monitoring and Oversight Committee

GTA – Georgia Technology Authority

HCBS – Home and Community-Based Services

HEDIS – Healthcare Effectiveness Data and Information Set

HHS – US Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Maintenance Organization

HPSA – Health Professional Shortage Area

IBNR – Incurred-But-Not-Reported

ICAMA – Interstate Compact on Adoption and Medical Assistance

ICF/ID – Intermediate care facility for the intellectually disabled

ICPC – Interstate Compact on the Placement of Children

ICWP – Independent Care Waiver Program

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IFI – Intensive Family Intervention

IFSP – Individualized Family Service Plan

INS – U.S. Immigration and Naturalization Services

IPC – Interpregnancy Care component of the 1115 Demonstration Waiver

JJ Member – Juvenile Justice Member

JPPS – Juvenile Parole/Probation Specialist

LBW – Low Birth Weight

LEAs – Local Education Agencies

LIM – Low-Income Medicaid

LIPT – Local Interagency Planning Team

MDT – Multidisciplinary Team

MMIS – Medicaid Management Information System

MP – Mandatory Providers

MSHCN – Members with Special Health Care Needs

NAIC – National Association of Insurance Commissioners

NCM – Nurse Care Manager

NCQA – National Committee for Quality Assurance

NCTSN – National Child Traumatic Stress Network

NET – Non-Emergency Transportation

NICU – Neonatal Intensive Care Unit

NOIA – Notice of Intent to Award

NOW – New Options Waiver Program

NP-C – Certified Nurse Practitioners

NPI – National Provider Identifier

O.C.G.A. – Georgia Code Research Tool

OSAH – Office of State Administrative Hearings

P4HB – Planning for Healthy Babies 1115 Demonstration Waiver

PA – Physician Assistant

PBM – Pharmacy Benefit Manager

PCMH – Patient Centered Medical Home

PCP – Primary Care Provider

PDF – Portable Document Format file

PDSA – Plan Do Study Act

PHI – Protected Health Information

PHM – Population Health Management

PHO – Preferred Health Organization

PIP – Performance Improvement Project

MPPM – Per Member Per Month

PPACA – Patient Protection and Affordable Care Act

PPC@-PCMH - Physician Practice Connections-Patient Centered Medical Home

PPS – Prospective Payment System

PQO - Performance, Quality and Outcomes

PRTF – Psychiatric Residential Treatment Facility

QAPI – Quality Assessment Performance Improvement

QEs – Qualified Entities

RBWO – Room Board and Watchful Oversight

RFP – Request for Proposal

RHC – Rural Health Clinic

RIAT – Regional Interagency Team

RSM – Right from the Start Medicaid

SED – Severe Emotional Disorder

SHBP – State Health Benefit Plan

SHD – Systems Help Desk

SSA – Social Security Act

SSI – Supplemental Security Income

SUD – Substance use Disorder

SUCCESS – System for the Uniform Calculation and Consolidation of Economic Support

TANF – Temporary Assistance for Needy Families

TCN – Transaction Control Number

TDD – Telecommunication Device for the Deaf

TGM – Team Georgia Marketplace

UM – Utilization Management

UPIN – Unique Provider Identifier Number

UR – Utilization Review

URAC – Utilization Review Accreditation Commission

VBP – Value Based Purchasing

VFC – Vaccines for Children

VHR – Virtual Health Record

VLBW – Very Low Birth Weight

W3C – World Wide Web Consortium

Georgia Families Background

In 2003, the Georgia Department of Community Health (DCH) identified unsustainable Medicaid growth and projected that without a change to the system, Medicaid would require fifty percent (50%) of all new State revenue by 2008. In addition, Medicaid Utilization was driving more than thirty-five percent (35%) of total growth each year. For these reasons, DCH decided to employ a care management approach to organize its fragmented System of Care, enhance access, achieve budget predictability, explore possible cost containment opportunities and focus on system-wide performance improvements. Georgia Families includes the following Members:

- a. *Recipients of Medicaid and PeachCare for Kids®*: Effective June 1, 2006, the State of Georgia implemented Georgia Families through which Health Care services are delivered to eligible recipients of Medicaid and PeachCare for Kids®.
- b. *Planning for Healthy Babies (P4HB)*: In 2011, DCH implemented the P4HB program to reduce the number of Low Birth Weight (LBW) and Very Low Birth Weight (VLBW) births in Georgia. Through the Georgia Families program, P4HB participants receive Family Planning Services and Interpregnancy Care (IPC) services. Additionally, women participating in the IPC component of P4HB receive Primary Care visits; management and treatment of chronic diseases; substance use disorder (SUD) treatment (detoxification and intensive outpatient rehabilitation); Case Management; Resource Mother Outreach (support services such as supportive counseling, Non-Emergency Transportation, and linkage to community resources); limited dental services; and prescription drugs (non-family planning).

DCH's intent in employing a care management approach to serve Members is to:

- a. Continually and significantly improve the Quality of Health Care and services provided to Members
- b. Offer Care Coordination to Members
- c. Enhance access to Health Care services
- d. Achieve budget predictability as well as cost containment
- e. Create system-wide performance improvements
- f. Improve efficiency at all levels
- g. Improve the Health Care status of the Member
- h. Establish a Member-Provider relationship through its use of Medical Homes
- i. Establish a climate of contractual accountability for improving health outcomes
- j. Slow the rate of expenditure growth in the Medicaid program
- k. Expand and strengthen a sense of the Member's responsibility and engagement in their Health Care

Since 2006, Georgia Families has evolved from a startup program focused on operations to a more mature program focusing on Quality of care, Care Management Organization (CMO) accountability and Member outcomes. DCH has regularly gathered meaningful stakeholder feedback about the program and has used this feedback to enhance the program. For example, in 2011, DCH conducted over thirty (30) focus groups with Members and advocates, Providers, vendors and legislators; solicited feedback through online surveys; and convened three (3) task forces and one (1) workgroup. Through this collaborative process, DCH worked with the CMOs to implement a variety of Quality improvement initiatives to improve Quality and health outcomes of Members, broadened its Georgia Families Monitoring and oversight activities, and has implemented or is in process of implementing administrative simplifications to improve the Member and Provider experience. Below are examples of initiatives DCH has implemented specific to Georgia Families and overarching Medicaid initiatives that also impact Georgia Families.

Quality Improvement Initiatives

- a. DCH is collaborating with the National Initiative for Children's Healthcare Quality (NICHQ) and the Georgia OB/Gyn Society to increase postpartum care rates, incorporate the reproductive life plan discussion into the postpartum care visit, and encourage reproductive life plan and long-acting reversible contraceptive discussions in the antepartum visits.
- b. In 2014, DCH collaborated with the current CMOs to consolidate Performance Improvement Projects (PIPs) into one common, "Bright Futures" PIP to drive improvements in all of the activities performed during each preventive health visit as described in the Bright Futures Periodicity Schedule.
- c. In partnership with the current CMOs, DCH implemented a statewide PIP to reduce avoidable emergency room visits.
- d. DCH engaged its External Quality Review Organization to provide tutorials to the current CMOs on conducting PIPs.
- e. DCH encourages Provider use of electronic health record Systems through CMS' Health Information Technology (Health IT) incentive program. Increased use of electronic health records was an intervention employed by the current CMOs to decrease avoidable emergency room visits. Through May 2014, Georgia issued more than \$217 million in payments of federal funds to eligible providers through CMS' Medicaid Electronic Health Records Incentive Program.
- f. DCH is leading the nation in reporting of the initial core set of Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality measures. For federal fiscal year 2011, Georgia received recognition in the 2012 Annual Report on the Quality of Care for Children in Medicaid and CHIP for reporting nineteen (19) of the twenty-four (24) CHIPRA measures – more than any other state.
- g. DCH developed a program that awards the CMOs with Auto-Assignment of Members based on a calculation of the CMOs' Quality of the services provided. DCH reviews nineteen (19) performance measures as part of the Auto-Assignment algorithm per each six (6)-month cycle. The award of auto-assignees for high-quality services encourages the CMOs to achieve better Quality outcomes for their Members.

Monitoring and Oversight Activities

DCH has enhanced its oversight and Monitoring of CMO performance through the expansion and accreditation of HEDIS®-based performance measurement, demonstrated improvement through PIPs and cross-State agency collaboration initiatives. DCH currently measures fifty-four (54) Healthcare Effectiveness Data and Information Set (HEDIS)/National Committee on Quality Assurance (NCQA) Quality Metrics.

Administrative Simplifications

DCH continually seeks opportunities to implement administrative simplifications to streamline Medicaid processes and encourage Provider participation. These opportunities are pursued in an effort to reduce the administrative burden Providers may experience and permit Providers to focus more on providing patient care. Likewise, DCH expects the CMO partners to pursue similar administrative simplification opportunities within their own operation. DCH-led administrative simplification activities include but are not limited to:

- a. DCH implemented standardized Prior Authorization request forms and an electronic web portal through which Providers submit all Prior Authorization requests. This information, in turn, is provided to the appropriate CMO for review, as CMOs retain authority for Prior Authorization of services for their Members. Using such a portal allows for standardization and creates efficiencies for Providers. For example, if a Provider submits a Prior Authorization request for a surgery and the Member is in process of transitioning to a new CMO, the Provider is not required to resubmit the Prior Authorization request to the new CMO. The new CMO will access the initial Prior Authorization and complete its own review and approval process.
- b. DCH implemented a centralized Provider enrollment portal in 2013. This centralized portal requests one set of information from Providers wishing to apply for Medicaid and/or the CMOs. This streamlined and consistent application has been well received by the Provider community. This all-inclusive application reduces the administrative burden of providers completing four (4) different Provider applications with four (4) different entities.
- c. The centralized Provider enrollment portal has led to another effort. DCH plans to implement a Credentialing Verification Program to simplify the Medicaid and Georgia Families Enrollment process for Providers and improve efficiencies by reducing administrative burden. Providers will submit electronic applications and other required materials to a Credentialing Verification Organization (CVO) contracted by DCH. The CVO will process the Provider credentialing or re-credentialing information to apply to the Fee-for-Service and managed care delivery programs. The CMOs will not conduct separate Provider credentialing and re-credentialing processes. The CVO process is anticipated to be implemented July of 2015.
- d. DCH plans to implement a modernized eligibility system in calendar year 2016. This modernized eligibility system will streamline the eligibility determination and CMO enrollment process. Specifically, the new system is envisioned to allow Members to select a plan at the time of application. This will allow membership in the CMO sooner; earlier connection with care coordination and case management; and presumably better Member outcomes. Also, the system will improve the accuracy issues some providers currently experience in determining which Medicaid program or CMO the Member is enrolled.

Georgia Families 360° Background

Children in Foster Care typically have more intensive Health Care needs than other children who are not in Foster Care and are typically served by multiple agencies. They often suffer from trauma, abuse and neglect and may require care for chronic physical problems. Additionally, they tend to have more Behavioral Health problems and require more psychosocial services than other children receiving Medicaid services. These youth face severe environmental instability and shifting guardianship between birth parents, Foster Parents, guardians or an adoptive family. This environmental instability causes frequent changes in Health Care Providers, fragmented Medical Records and inconsistent access to appropriate care. Likewise, youth in Department of Juvenile Justice (DJJ) custody while residing in community residential facilities have a greater need for coordination of Health Care services due to the number and complexity of issues impacting their physical and mental well-being.

DCH convened stakeholder task forces that provided input about program design as well as input on an ongoing basis. Additionally, DCH formed a Foster Care, Adoption Assistance and juvenile justice joint task force which included representatives from DCH and the following State agencies:

- a. Department of Behavioral Health and Developmental Disabilities (DBHDD);
- b. Department of Juvenile Justice (DJJ);
- c. Department of Human Services (DHS), the Division of Family and Children Services (DFCS);
- d. Department of Public Health (DPH);
- e. Department of Early Care and Learning (DECAL); and
- f. Department of Education (DOE).

The joint task force provided advisory support during program development and implementation for the transition of children and youth into Georgia Families 360°. Input from joint task force members helped to ensure a program that is child-centric and focused on Coordination of Care.

Georgia Families and Georgia Families 360° Enrollment and Eligibility

The following table provides the Member Enrollment for Georgia Families, P4HB, and Georgia Families 360° programs. DCH will implement potential open Enrollment and Auto-Assignment processes in order to enroll all Georgia Families Members with the selected CMOs. All Georgia Families 360° will be enrolled into one (1) CMO.

Table 1: Medicaid Managed Care Enrollment (November 2014)

Medicaid Managed Care Enrollment (November 2014)	
Georgia Families	1,304,079
Planning for Healthy Babies	12,414
Georgia Families 360°	23,386
Total	1,339,879

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The below subsections provide detailed information about the selected Supplier's responsibilities. The Supplier shall be responsible for the provision of Covered Services and Benefits, Coordination of Care and other services for the following Medicaid populations:

1. Georgia Families Members
 - a. Eligible recipients of Medicaid and PeachCare for Kids®
 - b. Participants of the Planning for Healthy Babies (P4HB) Demonstration
2. Georgia Families 360° Members

The Requirements and Scope of Work outline the responsibilities that apply to each of these populations. However, the Supplier should note that Covered Services and Benefits may vary for each population. The Requirements and Scope of Work is structured as follows:

1. All Georgia Families program requirements included in section I also apply to Members served through Georgia Families 360° unless otherwise specified in section II.
2. Section II provides additional requirements that apply only to Georgia Families 360° Members. Any reference in this section to Members shall be construed to include only Members enrolled for the Georgia Families 360° program.
3. Georgia Families program requirements that vary for or do not apply to Members enrolled in the P4HB Demonstration are indicated by reference to P4HB participants. Additionally, P4HB participants include the following:
 - a. Family Planning
 - b. Interpregnancy Care (IPC)
 - c. Resource Mother (care management)

Additional information is available at: <https://dch.georgia.gov/planning-healthy-babies>

Suppliers should note the following:

1. The Department of Community Health (DCH) will designate only one (1) successful Supplier to contract for the Georgia Families 360° Requirements defined in section II.
2. Centers for Medicare and Medicaid Services (CMS) recently announced the review of current Medicaid managed care regulations and anticipates proposed changes will be available for comment in early 2015. DCH will review the draft and final regulations upon issuance to incorporate into Attachment I, Draft Contract, to comply with required Federal regulations.
3. The U.S. Health and Human Services Office of the Inspector General's (OIG) forthcoming State Standards for Access to Care in Medicaid Managed Care will provide guidance to states for ensuring access to Providers. DCH will review the report upon issuance and may revise Attachment I, Draft Contract, to comply with OIG recommendations.

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4. DCH submitted a Section 1115 waiver extension request for the Family Planning program and must receive Centers for Medicare and Medicaid Services (CMS) approval of the waiver extension.

The scope of this Request for Proposal (RFP) includes the development, and implementation of the Georgia Families and Georgia Families 360° managed care programs. The Supplier will implement a Program for which the Supplier is responsible for providing Georgia Medicaid and Children’s Health Insurance Program (CHIP) State Plan services, Care Coordination and other services.

A holistic, person-centered approach to care will be a hallmark of the Supplier’s delivery system. Person-centered care focuses on the person and not only on the person’s disease, illness or Condition. In a person-centered system, behaviors and symptoms are understood after first learning about how the person experiences his or her situation. This requires an understanding of the person’s life circumstances and preferences, combined with up-to-date evidence-based knowledge about individualized medical treatment.

I. GEORGIA FAMILIES

A. Project Management

The Supplier must provide ongoing project management from program implementation through the Operational Start Date. Project management activities apply across all Georgia Families, Georgia Families 360° and P4HB populations unless otherwise specified.

1. Implementation Planning

The Supplier will begin operations of the Georgia Families, Georgia Families 360° and P4HB programs upon the anticipated Operational Start Date of July 1, 2016.

- a. Within ten (10) Calendar Days of the Contract Execution Date, the Supplier must designate a dedicated project manager (“Care Management Organization (CMO) Project Manager”) and CMO project management team (“CMO Project Management Team”).
- b. The Supplier shall develop an implementation project plan (“CMO Project Plan”) and timeline for performing the requirements set forth in this RFP for the Implementation Phase and Contract Year 1 and for Monitoring progress toward completion of key tasks necessary for a smooth transition from the current incumbent Georgia Families and Georgia Families 360° contractors. The CMO Project Plan must detail due dates for completion of tasks and interdependencies between activities and must identify responsible parties.
- c. The Supplier shall submit the proposed CMO Project Plan with its proposal and update the CMO Project Plan to incorporate DCH input within fourteen (14) Calendar Days of Contract Execution Date. The format for the CMO Project Plan shall be in a version of Microsoft Excel or Microsoft Project as agreed upon by DCH. The Supplier shall provide weekly status reports in a DCH-approved format, including updates to the workplan and timeline. The Supplier must continue to submit revised workplans throughout the

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planning, implementation and deployment phases based upon requested updates or revisions from DCH.

- d. The Supplier will participate in weekly status meetings covering a variety of topics, which shall include but will not be limited to: project health, progress against project schedule, status of Deliverables and action items, upcoming Deliverables, risks, issues, mitigation plans, and contingency plans.

2. CMO Project Plan

The proposed CMO Project Plan must comply with all due dates established by DCH and at a minimum outline how the Supplier proposes to:

- a. Undertake the tasks necessary to obtain National Committee for Quality Assurance (NCQA) accredited status, as outlined in section M.
- b. Transition Members from their prior CMO, as further described below in section A.2 Transition Plan.
- c. Submit a staffing plan within thirty (30) Calendar Days of Contract Notice of Award.
- d. Develop training materials for Supplier staff that address the Georgia Families, Georgia Families 360° and P4HB programs and Medicaid.
- e. Execute contract(s) with Subcontractor(s) (if any) the Supplier proposes to involve in the administration of the services under the Contract.
- f. The Supplier must operate from a Georgia-based location within thirty (30) miles of DCH's Atlanta offices and is excluded from providing services from any offshore locations.
- g. Establish all workplace requirements (e.g., telephones and equipment, Information Systems, etc.) are in place and operative as of the Operational Start Date.
- h. Ensure Member and Provider call centers and toll-free telephone numbers to operate during all required hours.
- i. Obtain signed Provider Contracts with Medicaid Providers to demonstrate statewide access as defined in section I.
- j. Develop any required materials, such as policies, procedures, Member and Provider communications.
- k. Establish a comprehensive testing environment to ensure all requirements for the Implementation Phase are thoroughly tested and ongoing policy changes or enhancements can be verified.
- l. Establish web sites to support Member and Provider program participation and program goals.

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- m. Provide a detailed communication plan that documents the Supplier's communication with Members, Providers, DCH, sister agencies, the Credentialing Verification Organization (CVO), the State's Fiscal Agent Supplier and other program stakeholders.
- n. Provide a detailed Member Education and Outreach Plan within one hundred fifty (150) Calendar Days prior to the Contract Operational Start Date for DCH review and approval.
- o. Initiate training related to the System of Care approach in the delivery of physical and Behavioral Health Care services to Members.

3. Readiness Review

- 4. The Supplier shall participate in a two (2) phase readiness review conducted by DCH and DCH-engaged stakeholders prior to the Operational Start Date according to a schedule to be stipulated by DCH. DCH will appoint specific Multidisciplinary Teams to conduct readiness review activities based on the level and type of CMO activities or functions under review.

The readiness review will focus on the Contract Deliverables and the Supplier's ability to comply with the terms of the Contract. See the Suppliers' Library for a draft readiness review tool. Please note that DCH is providing this draft tool for information only, and will continue to update the tool with additional Deliverables based on scope requirements, the Supplier's proposal and contract negotiations. The scope of the reviews will include, but will not be limited to, review and/or verification of the Supplier's progress on the following:

- a. Statewide network access
 - 1. Provider Letters of Intent were submitted with the Supplier's proposal and Provider Agreements have been signed resulting in Provider Contracts sufficient to demonstrate network access.
 - 2. Ongoing benchmarks toward Provider network access.
 - 3. Supplier demonstrates network access through Geo Access reporting and gap analysis. DCH will provide the Supplier with a Member file thirty (30) Calendar Days prior to the Operational Start Date.
- b. Subcontractors (if any) are in place and operationally ready
- c. Systems readiness
 - 1. Supplier demonstrates ability to exchange Information with DCH and DCH Agents, Assign Members to a Primary Care Provider (PCP) and Dental Home, process eligibility files, pay Claims, submit Encounter Claim data and process Prior Authorizations and Pre-Certifications, etc.
 - 2. Supplier has developed content and required interfaces for Member and Provider web sites.
- d. Member and Provider call centers' readiness

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- e. Staffing plan and staffing levels dedicated to the Requirements set forth in this Attachment
- f. Progress and status in hiring and training staff, and cross-training staff
- g. Transition of Care plan
- h. Training plan and training of Providers and CMO staff
- i. Development of policies and procedures required under the terms of this Attachment, such as those addressing privacy and PCP and Dental Home assignment
- j. Provider education and outreach, including outreach plan for encouraging Providers to serve as PCPs or Dental Homes
- k. Care Management / Care Coordination
- l. Quality Management / Quality Improvement
- m. System of Care
- n. Utilization Management
- o. Physical Health and Behavioral Health Coordination
- p. Participation in the Monitoring and Oversight Committees
- q. Policies and procedures for the Grievance System and Complaint System
- r. Financial solvency

DCH will provide a summary of the findings as well as areas requiring Remedial Action after each readiness review phase. The Supplier may not begin operations until DCH has determined that the Supplier is capable of meeting readiness review standards. The Supplier's failure to pass the readiness review thirty (30) Calendar Days prior to the beginning of service delivery may result in Liquidated Damages, delayed operations and /or immediate Contract termination.

5. Transition Planning

The Supplier must include a transition plan as part of its implementation CMO Project Plan. The transition plan must outline specific goals and Objectives that articulate how the Supplier will coordinate with DCH to assume responsibility for Members transitioning from another CMO. An impact statement should be produced outlining the potential impact of the transition of Members, the existing infrastructure and operations and support staff.

Specifically, the Supplier must:

- a. Work to ensure Members will be served in a timely and appropriate manner to maintain continuity of care for the Members.

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- b. Detail how activities will differ for existing Medicaid Members upon the Operational Start Date versus new Members coming into the program after the Operational Start Date.
- c. Accept and recognize existing Pre-Certifications and Prior Authorizations.

The transition plan must also identify the tools, techniques, and methodologies that are needed to perform an efficient and effective transition.

B. Supplier Staffing

The Supplier shall demonstrate to DCH's satisfaction that it has the necessary staffing, by function and qualifications, to fulfill its obligations as described in this Scope of Work. In addition, the Supplier shall have adequate infrastructure, organization, management, and systems in place to carry out the requirements of the Georgia Families Program.

The Supplier shall provide a detailed listing of contact information for all of its Material Subcontractors, including a description of the Subcontractor's organization and the responsibilities that are delegated to the Subcontractor. The Supplier will not contract with or permit the performance of any work or services by Material Subcontractors without prior written consent of DCH.

1. Assignment and Credentials

The Supplier warrants and represents that all persons, including independent Contractors and consultants assigned by it to perform work under the Contract, shall be employees or formal Agents of the Supplier and shall have the credentials necessary (i.e., licensed, and bonded, as required) to perform the work required herein. The Supplier shall include a similar provision in any contract with any Subcontractor selected to perform work hereunder. The Supplier also agrees that DCH may approve or disapprove the Supplier's Subcontractors or its staff assigned to the Contract prior to the proposed Subcontractor engagement or staff assignment. DCH's decision on this matter shall not be subject to Appeal.

The Supplier shall ensure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice in the State of Georgia. On at least an annual basis, the CMO and its Subcontractors will verify that applicable staff have all necessary current licenses that are in good standing and will provide a list to DCH of licensed staff and current licensure status.

In addition, the Supplier warrants that all persons assigned by it to perform work under the Contract shall be employees or authorized Subcontractors of the Supplier and shall be fully qualified, as required in the RFP and specified in the Supplier's proposal and in the Contract, to perform the services required herein. Personnel commitments made in the Supplier's proposal shall not be changed unless approved by DCH in writing. Staffing will include the named individuals at the levels of effort proposed.

The Supplier shall provide and maintain sufficient qualified personnel and staffing to enable the Deliverables to be provided in accordance with the RFP, the Supplier's proposal and the Contract. The Supplier shall submit to DCH a detailed staffing plan, within thirty (30) Calendar Days of Contract Notice of Award, which includes plans to fill any staffing needs to

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have a sufficient level of support during the Implementation Phase and after the Operational Start Date. Such staffing plan must include a timetable for filling all staffing position(s) after the Notice of Award. The Supplier must provide DCH with resumes of Key Staff, reporting responsibilities, Supplier staff to Member ratios and an organizational chart during the Implementation Phase with updates provided to DCH within two (2) Business Days of any changes or vacancies. The staffing plan must include the employees and management for all CMO functions.

2. Key Staff

At a minimum, the Supplier shall provide the following Key Staff:

- a. A dedicated project manager to lead program implementation and facilitate ongoing operations. The CMO Project Manager must be stationed at the CMO's metropolitan Atlanta headquarters. The Project Manager must also be onsite at the DCH offices in Atlanta, Georgia at times specified by DCH during the planning, implementation and deployment phases of the Contract.
- b. An Executive Administrator who is a full-time administrator with clear authority over the general administration and implementation of the requirements detailed in the Contract.
- c. A Chief Medical Officer who is a licensed physician in the State of Georgia. The Chief Medical Officer shall be actively involved in all major clinical program components of the CMO, shall be responsible for the sufficiency and supervision of the Provider network, and shall ensure compliance with federal, State and local reporting laws on communicable diseases, child abuse, neglect, etc.
- d. A Quality Improvement Director with appropriate education, training and licensure, if applicable. The QI director shall possess or obtain within six (6) months of hire, training in one or more of the following areas:
 1. Strategic planning
 2. Six Sigma Certification
 3. Lean Six Sigma Certification
 4. Plan-Do-Study-Act Cycle
 5. Rapid Cycle Improvement
- e. A Chief Financial Officer who oversees all budget and accounting systems.
- f. A Strategic Planner to support clinical Quality improvement.
- g. Utilization Management Director
- h. An Information Management and Systems Director and a complement of technical analysts and business analysts as needed to maintain the operations of Supplier Systems and to address System issues in accordance with the terms of the Contract.

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- i. A Pharmacist who is licensed in the State of Georgia.
- j. A Dental Consultant who is a licensed dentist in the State of Georgia.
- k. A Mental Health Coordinator who is a licensed Mental Health professional in the State of Georgia.
- l. A Member Services Director.
- m. A Provider Services Director.
- n. A Provider Relations Liaison.
- o. A Grievance/Complaint Coordinator.
- p. Compliance Officer.
- q. A Prior Authorization/Pre-Certification Coordinator who is a physician, registered nurse, or physician's assistant licensed in the State of Georgia.
- r. Sufficient staff in all departments, including but not limited to, Member services, Provider services, and Prior Authorization and concurrent review services to ensure appropriate functioning in all areas.
- s. Hospital-based care managers whose responsibilities include visiting with patients and interacting with hospital staff to ensure proper Utilization and Discharge planning.
- t. Staff trained in the System of Care approach to service delivery.
- u. Ombudsman Staff including Ombudsman Liaison and Ombudsman Coordinator during the entire Contract term. The Supplier must consider and monitor current Enrollment levels when evaluating the number of Ombudsman staff necessary to meet Member needs. The Ombudsmen staff is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to health care services, and communication and education of Members and Providers. The Supplier shall comply with all staffing/personnel obligations set out in the RFP and the Contract, including but not limited to those pertaining to security, health, and safety issues.

The Supplier shall provide the DCH Project Leader with a staff roster every ninety (90) days during the Term of the Contract. This roster shall set forth the names, titles, and physical location of all Members of the Supplier's staff (including Subcontractor and Supplier affiliates), their areas of assignment and the number of hours they are required to work.

3. Staffing Changes

DCH may reject any proposed changes in Key Staff and may require the removal or reassignment of any Supplier's employee or Subcontractor's employee that the Department deems to be unacceptable in the exercise of its reasonable judgment. DCH's decision on this matter shall not be subject to Appeal.

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Notwithstanding the above provisions, the parties acknowledge and agree that the Supplier may terminate any of its employees designated to perform work or services under the Contract, as permitted by applicable law. In the event of Supplier termination of any Key Staff, Supplier will provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee with a person of equivalent training, experience, and talent within ten (10) Calendar Days of the termination.

The Supplier shall notify DCH within five (5) Business Days via written communication in the event of any changes to Key Staff listed above, including the Executive Administrator, Chief Medical Officer, Quality Improvement Director, Utilization Management Director, Management Information Systems Director, and Chief Financial Officer. The Supplier shall replace any of the Key Staff with a person of equivalent experience, knowledge and talent. Within ten (10) Calendar Days of the termination, Supplier shall provide the DCH Project Leader with the resume of the proposed replacement and offer the DCH Project Leader, and/or his authorized representatives, the opportunity to interview that person. If the DCH Project Leader is not reasonably satisfied with the apparent skill and qualifications of the proposed replacement, he or she shall notify Supplier within ten (10) Calendar Days after receiving the resume or conducting the interview (whichever occurs last). Once that has occurred, the Supplier shall propose another replacement and the DCH Project Leader shall have the same right of approval. Such process shall be repeated until a proposed replacement is approved by the DCH Project Leader. If, after sixty (60) Calendar Days from the notice of termination, a qualified replacement is not approved, liquidated damages may be assessed against and imposed on Supplier.

DCH also may require the removal or reassignment of any Supplier employee or Subcontractor employee that DCH deems to be unacceptable. DCH's decision on this matter shall not be subject to Appeal. Notwithstanding the above provisions, the parties acknowledge and agree that the Supplier may terminate any of its employees designated to perform work or services under the Contract, as permitted by applicable law. In the event of Supplier termination of any Key Staff identified in section the Supplier shall provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee.

The Supplier must submit to DCH quarterly the Supplier Information Report that includes but is not limited to the changes to Supplier's local staff information as well as local and corporate organizational charts.

4. Failure to Comply

If DCH, in its sole discretion, determines that the Supplier's services and/or performance under the terms, conditions, and requirements of the Contract are insufficient, unacceptable, or unsatisfactory, the Supplier, after notice from DCH, agrees that it will make every attempt to Remedy the deficiency within two (2) Business Days.

Should the Supplier at any time: 1) refuse or neglect to supply adequate and competent supervision; 2) refuse or fail to provide sufficient and properly skilled personnel, equipment, or materials of the proper Quality or quantity; 3) fail to provide the services in accordance with the timeframes, schedule or dates set forth in the Contract; or 4) fail in the performance of

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any term or condition contained in the Contract; 5) knowingly or unknowingly accept payment from DCH of an amount in excess of what it is owed at the time of the payment under the terms of the Contract, DCH may (in addition to any other contractual, legal or equitable remedies) proceed to take any one or more of the following actions after five (5) Calendar Days written notice to the Supplier:

- a. Withhold any monies then or next due to the Supplier.
- b. Obtain the services or their equivalent from a third party, pay the third party for same, and Withhold the amount so paid to third party from any money then or thereafter due to the Supplier.
- c. Withhold monies in the amount of any damage caused by any deficiency or delay in the services.
- d. Any combination of the above.

In addition to the consequences indicated above, if it is determined that Supplier knowingly submitted any false statement, invoice or other document to DCH, Supplier shall also be subject to the sanctions imposed by Georgia Code Research Tool (O.C.G.A.) §16-10-20.

5. Criminal Background Checks

The Supplier further agrees that it will not permit any of its employees or its Subcontractor's employees, including temporary or replacement employees, to perform the services under the Contract unless and until they pass any background test or check requested by the Department.

The Supplier also agrees to abide by 42 USCS § 1320a-7 and all other related provisions or laws. To that end, the Supplier shall not employ or use any company, entity, or individual that is on the Federal Exclusions List or any company, entity, or individual subject to 42 USCS § 1320a-7.

By signing or executing the Contract, the Supplier states and certifies that it is in compliance with and that it will continue to comply with the Anti-Kickback Act of 1986, 41 USCS § 51-58, and Federal Acquisition Regulation 52.203-7.

Additionally, by signing or executing the Contract, the Supplier states and certifies that neither it nor any of its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any State or Federal department or agency.

C. Covered Services and Benefits

1. Included Services

The Supplier shall at a minimum provide Medically Necessary Services and Benefits pursuant to the Georgia Medicaid State Plan, the Georgia CHIP State Plan and the Georgia Medicaid Policies and Procedures Manuals. Such Medically Necessary Services shall be

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furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Supplier may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

The Supplier shall at a minimum provide to P4HB participants Demonstration Related Services and Benefits pursuant to the CMS SPECIAL TERMS AND CONDITIONS (STCs), pertaining to the Planning for Healthy Babies 1115 Demonstration Waiver Program. .

Dental Preventive Services that carry a limitation per year shall be limited to a twelve (12) - rolling month period.

2. Medical Necessity

Supplier shall ensure Medically Necessary Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services available through the Georgia Medicaid State Plan. Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary Services are those that are:

- a. Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;
- b. Compatible with the standards of acceptable medical practice in the community;
- c. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- d. Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and
- e. Not primarily custodial care unless custodial care is a Covered Service or benefit under the Members evidence of coverage.

There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

For Medicaid children under twenty-one (21) years of age, the Supplier is required to provide Medically Necessary Services to correct or ameliorate Physical and Behavioral Health disorders, a defect, or a Condition identified during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening or preventive visit regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905(a) of the Social Security Act.

3. Individuals with Disabilities Education Act (IDEA) Services

For Members up to and including age two (2), the Supplier shall be responsible for Medically Necessary IDEA Part C services provided pursuant to an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).

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For Members ages three (3) to twenty-one (21), the Supplier shall not be responsible for Medically Necessary IDEA Part B services provided pursuant to an IEP or IFSP. Such services shall remain in Fee-for-Service (FFS) Medicaid. The Supplier shall be responsible for all other Medically Necessary Covered Services and Benefits.

4. EPSDT Benefit

a. General Provisions

The Supplier must ensure that Medicaid and PeachCare for Kids® children younger than twenty-one (21) years of age receive the services available under the federal EPSDT Benefit.

The Supplier shall comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and federal regulations at 42 Code of Federal Regulations (CFR) 441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The Supplier shall comply with all EPSDT Program requirements pursuant to the Georgia Medicaid Policies and Procedures Manuals.

The Supplier shall develop an EPSDT plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the EPSDT Program. The EPSDT plan shall emphasize outreach and compliance Monitoring for children and adolescents (young adults), taking into account the multi-lingual, multi-cultural nature of the Georgia Families population, as well as other unique characteristics of this population. The EPSDT plan shall include procedures for ensuring compliance with DCH's adopted EPSDT periodicity schedule, follow-up of missed appointments, including missed Referral appointments for problems identified through preventive screens and exams. The EPSDT plan shall also include procedures for Referral, tracking and follow up for annual dental examinations and visits. The Supplier shall submit its initial EPSDT plan to DCH no later than one hundred twenty (120) days prior to the Operational Start Date and as updated for review and approval. The Supplier shall submit to DCH annually a report and evaluation of its EPSDT plan according to DCH specifications.

The Supplier shall ensure Providers perform all components of the EPSDT preventive health visit according to the requirements documented in the DCH-approved periodicity schedule. The visit must include a comprehensive health and developmental history (including assessment of both Physical and Mental Health development), comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam), appropriate immunizations (according to the schedules established by the Advisory Committee on Immunization Practices (ACIP) for individuals 0 – 18 years of age and nineteen (19) and older), laboratory tests (including blood lead level assessment appropriate to age and risk), and health education (including anticipatory guidance). All five (5) components must be performed for the visit to be considered an EPSDT preventive health visit.

b. Outreach and Informing

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The Supplier's EPSDT outreach and informing shall include:

1. The importance of preventive care;
2. The periodicity schedule and the depth and breadth of services;
3. How and where to access services, including necessary transportation and scheduling services; and
4. A statement that services are provided without cost.

The Supplier shall inform its newly enrolled families with EPSDT eligible children about the EPSDT benefit within thirty (30) Calendar Days of Enrollment with the Supplier. This requirement includes informing pregnant women and new mothers, either before or within seven (7) days after the birth of their children, that EPSDT services are available.

The Supplier shall provide to each PCP, on a monthly basis, a list of the PCP's EPSDT eligible Members who appear not to have had an Encounter during the initial ninety (90) Calendar Days of CMO Enrollment, and/or who are not in compliance with the EPSDT periodicity schedule. The Supplier shall require its Providers contact the Members' parents or guardians to schedule an appointment for those screens and services that appear not to be in compliance with the EPSDT periodicity schedule. If the PCP has Medical Record evidence that appropriate screens have occurred for the Member, the Supplier must incorporate these visits into its tracking system and remove the Member from the PCP's list of Members who are non-compliant with the EPSDT periodicity schedule.

Informing of the Health Check Program may be oral (on the telephone, face-to-face, or films/tapes) or written and may be conducted by Supplier personnel or Health Care Providers. At a minimum, the Supplier shall provide written notification to its families with EPSDT eligible children when appropriate periodic assessments or needed services are due. The Supplier shall conduct all outreach and informing in non-technical language at or below a fifth (5th) grade reading level. The Supplier shall use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with requirements for written material as described in this scope of work section G.2. The Supplier shall document all outreach efforts it makes to inform Members (or their parents/guardians) regarding EPSDT services.

The Supplier may provide incentives to Members and/or Providers to encourage compliance with periodicity schedules as described in section C.4.

c. Early and Periodic Screenings – the Preventive Health Visit

PCPs within the Supplier's network are responsible for providing, at the time of the Member's preventive visit, all of the EPSDT required components along with those identified in the State's adopted periodicity schedule. The required EPSDT components include:

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1. A comprehensive health and developmental history (including assessment of both physical and Mental Health development);
2. Appropriate immunizations (according to the schedule established by the ACIP for individuals eighteen (18) and younger and individuals nineteen (19) and older; Certain laboratory tests (including the federally required blood lead level assessment appropriate to age and risk screening);
3. Health Education (including anticipatory guidance);
4. Measurements (including head circumference for infants and body mass index);
5. Sensory screening (vision and hearing);
6. Tuberculosis and lead risk screening;
7. Oral health assessment; and
8. Sexually Transmitted Infection/ Human Immunodeficiency Virus STI/HIV screening.

The Supplier's contracts with network hospitals/birthing centers shall include requirements to ensure the EPSDT initial newborn preventive visit occurs in the hospital/birthing center. The newborn preventive visit should be completed within twenty-four (24) hours after birth and prior to Discharge of the infant.

The Supplier shall provide for a blood lead screening test for all EPSDT eligible children at twelve (12) and twenty-four (24) months of age. Children between thirty-six (36) months of age and seventy-two (72) months of age should receive a blood lead screening test if there is no record of a previous test.

The Supplier shall have a lead Case Management program for EPSDT eligible children and their households when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter. The lead Case Management program shall include education, a written Case Management plan that includes all necessary Referrals, coordination with other specific agencies, environmental lead assessments, and aggressive pursuit of non-compliance with follow-up tests and appointments. The Supplier must ensure reporting of all blood lead levels to the Department of Public Health.

The Supplier shall have procedures for Referral of those Members eligible for the EPSDT Program and follow up with oral health professionals, including annual dental examinations and services by an oral health professional. Dental visits must be performed by a dentist, or other licensed dental professionals working under the supervision of a dentist according to the provisions of Georgia's scope of practice laws, and can occur in settings other than dentist's office, such as a clinic or a school. The Supplier's oral health Providers must follow the American Academy of Pediatric Dentistry (AAPD's) Periodicity Schedule.

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The Supplier shall provide inter-periodic screening visits that occur between the complete periodic visits and are Medically Necessary to determine the existence of suspected physical or Mental Illnesses or Conditions. This includes at a minimum vision and hearing services. An interperiodic visit may be performed only for vision or hearing services.

The Supplier shall allow Referrals for further diagnostic and/or treatment services to correct or ameliorate defects, and physical and Mental Illnesses and Conditions discovered during the EPSDT preventive health visits. The PCP may make such Referrals and follow up pursuant to the PCP's contract with the Supplier, as appropriate.

The Supplier shall ensure an initial health and screening visit is performed, as appropriate, for all newly enrolled EPSDT eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth for all newborns. If the Member's PCP provides Medical Record evidence to the Supplier that the initial health and screening visit have already taken place, this evidence will meet the Contract requirement. The Supplier should incorporate this evidence for this Member in its tracking system. The Supplier shall share EPSDT screening results with their PCPs.

Minimum Supplier compliance with the Health Check screening requirements is an eighty percent (80%) screening ratio for the periodic preventive health visit using the methodology prescribed by CMS to determine the screening ratio. This requirement and screening percentage is related to the CMS-416 Report requirements.

d. Diagnostic and Treatment Services

If a suspected problem is detected by a preventive health screening examination as described above, the Member shall be evaluated as necessary for further diagnosis. This diagnosis will be used to determine treatment needs.

EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a physical or Mental Illness or condition discovered or shown to have increased in severity during an EPSDT preventive health visit. Such Medically Necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-Covered Services as defined in Title XIX of the Social Security Act. The Supplier shall provide Medically Necessary, Medicaid-covered diagnostic and treatment services.

When a preventive health screening examination indicates the need for further evaluation of a Member's health, the Referral for diagnosis must be made without delay. Follow-up is required to ensure that the Member receives a complete diagnostic evaluation. If the Member is receiving care from a Continuing Care Provider, diagnosis may be part of the screening and examination process.

Continuing Care Providers may have to arrange for certain specialty services that are beyond the scope of their practice (e.g. cardiology or ophthalmology); and may agree, at their option, to make direct dental Referrals.

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The Supplier must provide for EPSDT diagnostic and treatment services, which must include:

1. Vision Services: At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.
2. Dental Services: At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health, at as early an age as necessary. Also included are emergency dental services, such as those services necessary to control bleeding, relieve pain, eliminate acute infection, etc. Dental services may not be limited to Emergency Services.
3. Hearing Services: At a minimum, include diagnosis and treatment for defects in hearing, and include hearing aids.
4. Developmental Assessment: Include structured tests and instruments administered by the professional to whom the Member has been referred after potential problems have been identified by the screening process.
5. Diagnosis, Treatment, and Follow-Up for Lead Toxicity: If a child is found to have blood lead levels equal to or greater than 10 ug/dL, Providers are to use their professional judgment regarding patient management and treatment.
6. Other Necessary Health Care: provide other necessary Health Care, Diagnostic Services, treatment, and other measures to correct or ameliorate defects, and physical and Mental Illnesses and Conditions discovered by the screening services.

e. Tracking

The Supplier shall establish a tracking system that provides information on compliance with EPSDT requirements. This system shall track, at a minimum, the following areas:

1. Initial newborn EPSDT visit occurring in the hospital;
2. Periodic and preventive/well child screens and visits as prescribed by the periodicity schedule;
3. Diagnostic and treatment services, including Referrals;
4. Immunizations, lead, tuberculosis and dental services;
5. Missed periodic and preventive/visits and notification to Members of missed visits;
6. Activities listed in the CMS-416 Report, The Supplier must submit to DCH a report, using the CMS-416 Report's template that is specific to their Member population on a quarterly basis.

The Supplier shall establish a reminder/notification system that must be integrated with its tracking system allowing timely notifications of preventive visits coming due and

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missed appointments. The system must also interface with the Providers' notifications to the CMO of the Members' missed appointments.

All Information generated and maintained in the tracking system shall be consistent with Encounter Claims requirements as specified elsewhere herein.

5. Enhanced Services

In addition to the Covered Services provided above, the Supplier shall provide enhanced services to outreach to and educate Members. The Supplier shall provide such services in a manner that will increase a Members' understanding of the availability of Covered Services, the importance of seeking and receiving such services and how doing so may help to improve outcomes. For example, the Supplier shall do the following:

- a. Place strong emphasis on programs to enhance the general health and well-being of Members;
- b. Make health promotion materials available to Members;
- c. Participate in Medicaid fairs and community-sponsored health fairs;
- d. Coordinate with community resources to facilitate a holistic approach to Member care; and
- e. Provide education to Members' families and other Health Care Providers about early intervention and management strategies for various illnesses.

The Supplier shall not charge a Member for participating in health education services that are defined as either enhanced or Covered Services.

6. Experimental, Investigational or Cosmetic Procedures, Drugs, Services, or Devices

Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manuals, in no instance shall the Supplier cover experimental, investigational or cosmetic procedures, drugs, services or devices or those not recognized by the Federal Food and Drug Administration, the United States Public Health Service, Medicaid and/or the Department's contracted peer review organization as universally accepted treatment.

7. Moral or Religious Objections

The Supplier must provide and reimburse for all Covered Services and Benefits. If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Supplier elects not to provide, reimburse for, or provide coverage of a counseling or Referral Service because of an objection on moral or religious grounds, the Supplier shall notify:

- a. DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;
- b. Members within sixty (60) Calendar Days before adopting the policy with respect to any service; and

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- c. Members before and during Enrollment.

The Supplier shall provide to the DCH Enrollment Broker for use in Member CMO selection counseling information with respect to any service the Supplier elects not to provide, reimburse for or provide coverage of counseling or Referral Service because of an objection on moral or religious ground

The Supplier acknowledges that such objection will be grounds for recalculation of rates paid to the Supplier by DCH.

D. Special Coverage Provisions

1. Emergency Services

Emergency Services shall be available without Prior Authorization or approval twenty-four (24) hours a day, seven (7) Days a Week to treat an Emergency Medical Condition.

An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or Mental Health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- a. Placing the Physical or Mental Health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b. Serious impairment to bodily functions;
- c. Serious dysfunction of any bodily organ or part;
- d. Serious harm to self or others due to an alcohol or drug abuse emergency;
- e. Injury to self or bodily harm to others; or
- f. With respect to a pregnant woman having contractions: (i) That there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

The Supplier shall provide payment for Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Supplier's Provider Network. These services shall not be subject to Prior Authorization requirements. The Supplier shall be required to pay for all Emergency Services that are Medically Necessary until the Member is Stabilized. The Supplier shall also pay for any screening examination services conducted to determine whether an Emergency Medical Condition exists.

The Supplier shall provide payment for Demonstration related Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Supplier's network. These services shall not be subject to prior authorization requirements. The Supplier shall be required to pay all Demonstration related Emergency Services that are Medically Necessary until the P4HB participant is stabilized. The Supplier shall also pay for

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any screening examination services conducted to determine whether a Demonstration related Emergency Medical Condition exists.

The Supplier may not deny or inappropriately reduce payment to a Provider of Emergency Services for any evaluation, diagnostic testing, or treatment provided to a Member for an emergency Condition or make payment for Emergency Services contingent on the Member or Provider of Emergency Services providing any notification, either before or after receiving emergency Health Care services.

In processing Claims for Emergency Services, the Supplier shall consider, at the time that a Claim is submitted, at least the following criteria:

- a. The age of the patient;
- b. The time and day of the Week the patient presented for services;
- c. The severity and nature of the presenting symptoms;
- d. The patient's initial and final diagnosis; and
- e. Any other criteria prescribed by the Department, including criteria specific to patients under eighteen (18) years of age.

The Supplier shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a Prudent Layperson.

The attending Emergency Room physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently Stabilized for transfer or Discharge, and that determination is binding on the Supplier, who shall be responsible for coverage and payment.

The Supplier shall not retroactively deny a Claim for an emergency screening examination or a Demonstration related emergency screening examination because the Condition, which appeared to be an Emergency Medical Condition or Demonstration related Emergency under the Prudent Layperson standard, turned out to be non-emergency in nature. Likewise, the Supplier shall not routinely or arbitrarily employ the practice of paying a triage rate that reduces reimbursement and places an administrative burden on the Provider to appeal such a payment. If an emergency screening examination or a Demonstration related emergency screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition or Demonstration related Emergency does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, the Supplier shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee-for-Service Medicaid program.

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The Supplier may establish guidelines and timelines for submittal of notification regarding provision of Emergency Services and Demonstration related Emergency Services, but, the Supplier shall not refuse to cover an Emergency Service or Demonstration related Emergency Service based on the emergency Room Provider, hospital, or Fiscal Agent's failure to notify the Member's Medical Home, Supplier's representative, or DCH of the Member's screening and treatment within said timeframes.

When a representative of the Supplier instructs the Member to seek Emergency Services the Supplier shall be responsible for payment for the Medical Screening examination and for other Medically Necessary Emergency Services, without regard to whether the Condition meets the Prudent Layperson standard.

When a representative of the Supplier instructs the P4HB participant to seek Demonstration related Emergency Services, the Supplier shall be responsible for payment for the Demonstration related Medical Screening examination without regard to whether the Condition meets the prudent layperson standard.

The Member who has an Emergency Medical Condition or Demonstration related Emergency Service shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific Condition or stabilize the patient.

Once the Member's Condition is Stabilized, the Supplier may require Pre-Certification for hospital admission or Prior Authorization for follow-up care.

2. Post-Stabilization Services

The Supplier shall be responsible for providing access to and payment for Post-Stabilization care services and Demonstration related Post Stabilization care services twenty-four (24) hours a day, seven (7) days a Week, both inpatient and outpatient, related to an Emergency Medical Condition or Demonstration related Emergency medical conditions, that are provided after a Member is Stabilized in order to maintain the Stabilized Condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the Member's Condition.

The Supplier shall be responsible for payment for Post-Stabilization Services and Demonstration related Post Stabilization Services that are Prior Authorized or Pre-Certified by a Provider or organization representative, regardless of whether they are provided within or outside the Supplier's Network of Providers.

The Supplier is financially responsible for Post-Stabilization Services and Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Supplier's Provider Network that are administered to maintain the Member's Stabilized Condition for one (1) hour while awaiting response on a Pre-Certification or Prior Authorization request.

The Supplier is financially responsible for Post-Stabilization Services and Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Supplier's Provider network, that are not prior authorized by a CMO

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Provider or organization representative but are administered to maintain, improve or resolve the Member's Stabilized Condition if:

- i. The Supplier does not respond to the Provider's request for Pre-Certification or Prior Authorization within one (1) hour;
 - ii. The Supplier cannot be contacted; or
 - iii. The Supplier's Representative and the attending physician cannot reach an agreement concerning the Member's care and a CMO physician (i.e., the Chief Medical Officer or a Medical Director) is not available for consultation. In this situation, the Supplier shall give the treating physician the opportunity to consult with the Supplier's physician and the treating physician may continue with care of the Member until the Supplier's physician is reached or one of the criteria below in section I.D.2.a.
- a. The Supplier's financial responsibility for Post-Stabilization Services and Demonstration related Post Stabilization Services it has not approved will end when:
- i. An In-Network Provider with privileges at the treating hospital assumes responsibility for the Member's care;
 - ii. An In-Network Provider assumes responsibility for the Member's care through transfer;
 - iii. The Supplier's Representative and the treating physician reach an agreement concerning the Member's care; or
 - iv. The Member is Discharged.

In the event the Member receives Post-Stabilization Services or Demonstration related Post Stabilization Services from a Provider outside the Supplier's network, the Supplier shall reimburse the non-contracted Provider for the Post-Stabilization Services at a rate equal to the rate paid by the Department for Claims that it reimburses directly. The Supplier is prohibited from billing the Member for Post-Stabilization Services.

3. Urgent Care Services

The Supplier shall provide Urgent Care services and Demonstration related Urgent Care Services to Members as necessary. Such services shall not be subject to Prior Authorization or Pre-Certification.

4. Family Planning Services

The Supplier shall provide access to Family Planning Services within the Provider network to Members and P4HB participants. In meeting this obligation, the Supplier shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act, for the provision of Family Planning Services. The Supplier shall verify its efforts and Documented Attempts to contract with Title X Clinics by maintaining records of communication. The Supplier shall not limit Members' or P4HB participants'

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freedom of choice for Family Planning Services to In-Network Providers and the Supplier shall cover services provided by any qualified Provider regardless of whether the Provider is In-Network. The Supplier shall not require a Referral if a Member or P4HB participant chooses to receive Family Planning Services and supplies from outside of the network.

The Supplier shall inform Members and P4HB participants of the availability of Family Planning Services and must provide services to Members and P4HB participants wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy.

Family Planning Services and supplies for Members and P4HB participants include at a minimum:

- a. Education and counseling necessary to make informed choices and understand contraceptive methods;
- b. Initial and annual complete physical examinations including a pelvic examination and pap test;
- c. Follow-up, brief and comprehensive visits;
- d. Pregnancy testing;
- e. Contraceptive supplies and follow-up care;
- f. Diagnosis of sexually transmitted infections with the following exception: P4HB participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration;
- g. For P4HB participants: Drugs, supplies, or devices related to the women's health services described above that are prescribed by a Health Care Provider who meets the State's Provider Enrollment requirement; (subject to the national drug rebate program requirements); and
- h. Infertility assessments with the following exception: P4HB participants are excluded from receiving this benefit.

The Supplier shall furnish all services on a voluntary and confidential basis, even if the Member is less than eighteen (18) years of age.

P4HB participants who deliver a Very Low Birth Weight Baby is only eligible to receive P4HB Resource Mother services.

5. Sterilizations, Hysterectomies and Abortions

In compliance with 42 C.F.R. § § 441.251 through 441.258, the Supplier shall cover sterilizations and hysterectomies, only if all of the following requirements are met:

- a. The Member is at least twenty-one (21) years of age at the time consent is obtained;

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- b. The Member is mentally competent;
- c. The Member voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services. This includes the completion of all applicable documentation;
- d. At least thirty (30) Calendar Days, but not more than one hundred and eighty (180) Calendar Days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. A Member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least seventy-two (72) hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty (30) Calendar Days before the expected date of delivery (the expected date of delivery must be provided on the consent form);
- e. An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a Member who is visually impaired, hearing impaired or otherwise disabled; and
- f. The Member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

A hysterectomy shall be considered a Covered Service only if the following additional requirements are met:

- a. The Member must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and
- b. The Member must sign and date the Georgia Families Sterilization Request Consent form prior to the Hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

A hysterectomy shall not be considered a Covered Service for P4HB participants.

Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

- a. If it is performed solely for the purpose of rendering a Member permanently incapable of reproducing;
- b. If there is more than one (1) purpose for performing the hysterectomy, but the primary purpose was to render the Member permanently incapable of reproducing; or
- c. If it is performed for the purpose of cancer prophylaxis.

Abortions or abortion-related services performed for family planning purposes are not Covered Services. Abortions are Covered Services if a Provider certifies that the abortion is Medically Necessary to save the life of the mother or if pregnancy is the result of rape or

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incest. The Supplier shall cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies.

The Supplier shall maintain documentation of all sterilizations, hysterectomies and abortions consistent with requirements in 42 CFR 441.206 and 42 CFR 441.256. The Supplier shall not accept documentation for informed consent completed or altered after the service was rendered. All documentation pertaining to sterilizations, hysterectomies, and abortions must be provided to DCH upon request.

6. Pharmacy

The Supplier is permitted to establish a Maximum Allowable Cost (MAC) pricing schedule. However, the Supplier must ensure the MAC pricing schedule is evaluated for pricing appropriateness and updated as appropriate but no less frequent than every two (2) Weeks.

The MAC pricing schedule must be reviewed no less frequent than every two (2) Weeks to ensure:

- a. Appropriateness of pricing;
- b. MAC pricing schedule does not create a barrier to access to the medication;
- c. Each medication represented on the MAC schedule has at least two (2) A-rated generic equivalents available in the Georgia marketplace;
- d. MAC pricing schedule must be posted on the Supplier's web site; and
- e. The Supplier must make available an inquiry and Appeal Process for Provider disputes over the MAC pricing schedule or individual drugs subject to the MAC pricing schedule with all inquiries and Appeals being addressed within five (5) calendar days of the receipt of the Provider inquiry or Appeal.

The Supplier shall provide pharmacy services either directly or through a Pharmacy Benefits Manager (PBM). The Supplier or its PBM may establish a preferred drug list if the following minimum requirements are met:

- a. Appropriate selection of drugs from therapeutic drug classes are accessible and are sufficient in amount, duration, and scope to meet Members' medical needs;
- b. The only excluded drug categories are those permitted under Section 1927(d) of the Social Security Act;
- c. A Pharmacy & Therapeutics Committee that advises and/or recommends preferred drug list decisions is established and maintained; and
- d. Over-the-counter medications specified in the Georgia Medicaid State Plan are included in the formulary.

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The Supplier shall make available to P4HBparticipants folic acid and/or a multivitamin with folic acid.

The Supplier shall make the preferred drug list, Utilization limits and conditions for coverage for prior authorized drugs available through its web site and provide such documentation to DCH upon request.

The Supplier shall have an automated electronic Prior Authorization Portal for the submission of Prior Authorization requests and encourage adoption by Providers. Regardless of whether Providers submit Prior Authorization requests manually or through the portal, the Supplier shall:

- a. Provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization.
- b. Provide for the dispensing of at least a seventy-two (72)-hour supply of a covered outpatient prescription drug in an emergency situation.
- c. Resolve all pharmacy Prior Authorization requests within twenty-four (24) hours unless additional information is required from the prescriber. If additional information is needed from the prescriber, documented telephonic or other telecommunication contact with the prescriber must be made every twenty-four (24) hours up to a final disposition within seventy-two (72) hours of receipt of the request.

If the Supplier chooses to implement a mail-order pharmacy program, any such program must be in accordance with State and federal law. The Supplier shall not require Members to use a mail-order pharmacy to receive covered pharmacy Benefits, but may allow Members to use a mail-order pharmacy if:

- a. Mail-order delivery is clinically appropriate;
- b. The pharmacy is willing to accept payments and terms as described in this Scope of Work;
- c. Cost sharing is no more than it is for Members utilizing services provided by retail pharmacies;
- d. The Member expressed desire to receive pharmacy services by mail-order; and
- e. The Member is allowed to cease mail-order pharmacy services and utilize retail pharmacies at any time.

7. Immunizations

The Supplier shall provide all Members less than twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. See: <http://www.cdc.gov/vaccines/schedules/hcp/index.html>.

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The Supplier shall provide P4HB participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the ACIP guidelines as needed.

The Supplier shall enter into an agreement with the Georgia Department of Public Health recognizing a Member of PeachCare for Kids® as a “State Vaccine Eligible Child” as permitted under Section 1928(b)(3) of the Social Security Act. At a minimum, this agreement shall permit the State to enjoy the discounted purchasing of vaccines for children covered under PeachCare for Kids® permitted under the section and provide appropriate reimbursement to Department of Public Health (DPH) for such vaccines utilized by the CMO’s PeachCare for Kids® membership.

The Supplier shall collaborate with the Department of Public Health to ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccines for Children (VFC) program for Medicaid and PeachCare for Kids® Members age eighteen (18) years of age and younger. The Supplier shall develop a policy for collaborating with DPH. The Supplier shall work with DCH to address challenges in providing vaccines under the VFC program.

The Supplier shall ensure that all Providers administer appropriate vaccines to the PeachCare for Kids® children eighteen (18) years old and younger. Immunizations shall be given in conjunction with EPSDT preventive health visit.

The Supplier shall ensure that all Providers use vaccines which have been made available, free of cost, under the VFC program for P4HB participants eighteen (18) years of age.

The Supplier shall provide all adult immunizations specified in the Georgia Medicaid Policies and Procedures Manuals.

The Supplier shall report all immunizations to the Georgia Registry of Immunization Transactions and Services (GRITS) in a format to be determined by DCH.

8. Transportation

The Supplier shall provide emergency transportation and shall not retroactively deny a Claim for emergency transportation to an emergency Provider because the Condition, which appeared to be an Emergency Medical Condition under the Prudent Layperson standard, turned out to be non-emergency in nature.

The Supplier is not responsible for providing Non-Emergency Transportation (NET) to Medicaid Members. Eligible Members are to contact the assigned Non-Emergency Transportation (NET) Broker for the county in which they live to arrange transportation. The Supplier is encouraged to collaborate with the NET Brokers and assist both the NET brokers and assigned Members with the coordination of NET services.

The Supplier may, however, coordinate other transportation for those Members not eligible for transportation under the NET Broker contract; provided that, Supplier understands and agrees that DCH shall not be responsible for paying for such other transportation services. The following Categories of Aid are not eligible for Non-Emergency Transportation:

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- a. 177 – Family Planning Waiver
- b. 181 - P4HB Family Planning (only)
- c. 460 - Qualified Medicare Beneficiary
- d. 466 - Specified Low Income Medicare Beneficiary
- e. 660 – Qualified Medicare Beneficiary
- f. 661 – Specified Low Income Medicare Beneficiary
- g. 662 – Q11 Beneficiary
- h. 664 – Qualified Working Disabled individuals
- i. 790 – Peachcare 101-150% Federal Poverty Level (FPL)
- j. 791 – Peachcare 151-200% FPL
- k. 792 – 201-235% FPL
- l. 793 – Peachcare > 235% FPL
- m. 815 – Aged Inmate
- n. 817- Disabled Inmate
- o. 870 – Emergency Alien – Adult
- p. 873 – Emergency Alien - Child

9. Perinatal Services

The Supplier shall provide perinatal care to women and newborn Members. The Supplier shall have adequate capacity such that any new Member who is pregnant is able to have an initial visit with her Provider within fourteen (14) Calendar Days of Enrollment. The Supplier shall have in place a system that provides, at a minimum, the following services:

- a. Pregnancy planning and perinatal health promotion and education for reproductive-age women.
- b. Perinatal risk assessment of non-pregnant women, pregnant and post-partum women, and newborns and children up to five (5) months of age. The Supplier must have the capacity to electronically accept, in a timely manner, Perinatal Case Management Initial Assessments from local public health departments completing these assessments following the presumptive eligibility determination.
- c. Childbirth education classes to all pregnant Members and their chosen partner. Through these classes, expectant parents shall be encouraged to prepare themselves physically, emotionally, and intellectually for the childbirth experience. The classes shall be offered

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at times convenient to the population served, in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation services if necessary.

- d. Access to appropriate levels of care based on risk assessment, including emergency care.
- e. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary.
- f. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems.
- g. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

The Supplier shall provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery. The Supplier shall support DCH policy not to reimburse Providers for non-Medically Necessary elective deliveries prior to thirty-nine (39) weeks gestation in support of DCH's efforts to improve birth outcomes.

10. Parenting Education

In addition to individual parent education and anticipatory guidance to parents and guardians at EPSDT preventive visits, the Supplier shall offer or arrange for parenting skills education to expectant and new parents, at no cost to the Member.

The Supplier shall create effective ways to deliver this education, whether through classes or other such means. The educational efforts shall include topics such as bathing, feeding (including breast feeding), injury prevention, sleeping, illness, when to call the doctor, when to use the Emergency Room, etc. DCH shall approve education content, class schedule and locations. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation services if necessary.

11. Mental Health and Substance Abuse

The Supplier shall provide integrated behavioral and Physical Health Care for Members with Mental Illness including for those with dual-diagnoses. Integrated Health Care for Members with Mental Illness shall be focused equally on prevention and intervention utilizing predictive modeling to identify Members at risk as well as innovative and best-practice methods to encourage Member engagement in self-care behaviors. The Supplier shall provide a full range of recovery-based services and engage non-medical services and supports as indicated to provide holistic care focused on whole-health wellness, Long Term independence, and skills building. This includes access to Certified Peer Supports for youth, adults and parents of youth with Mental Illness.

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The Supplier shall have written Mental Health and Substance Abuse Policies and Procedures that explain how they will arrange or provide for covered Mental Health and substance abuse services. Such policies and procedures shall include Advance Directives. The Supplier shall assure timely delivery of mental health and substance abuse services and coordination with other acute care services. The Supplier shall assure timely delivery of Mental Health and substance abuse services and coordination with other acute care services.

Mental Health and Substance Abuse Policies and Procedures shall be submitted to DCH for initial review within sixty (60) Calendar Days of Contract Execution Date and approval, and as updated thereafter.

The Supplier shall permit Members to self-refer to an In-Network Provider for an initial Mental Health or substance abuse assessment.

The Supplier shall permit P4HB IPC participants to receive Detoxification and Intensive Outpatient Rehabilitation Services as specified in the Special Terms and Conditions. See Attachment I.

The Supplier shall permit all initial outpatient Behavioral Health (Mental Health and Substance Abuse) evaluation, diagnostic testing, and assessment services to be provided without Prior Authorization. The Supplier shall permit up to three (3) initial evaluations per year for Members younger than twenty-two (22) years of age without requiring additional Prior Authorization.

The Supplier shall permit following any initial evaluation up to twelve (12) outpatient counseling/therapy visits to be provided without Prior Authorization.

The Supplier shall promote the delivery of Behavioral Health Services in the most integrated and person-centered setting including in the home, school or community, for examples, when identified through care planning as the preferred setting by the Member. The delivery of home- and community-based Behavioral Health Services may be incentivized by the Supplier for Providers who engage in this person-centered service delivery.

The Supplier shall provide emergency services diversion techniques and interventions (including but not limited to SBIRT-Screening, Brief Intervention and Referral to Treatment,) for Members with Mental Illness and/or substance use.

The Supplier shall provide scalable intensity of care management, disease management, Care Coordination, and complex Care Coordination based on the intensity of the Members need. Refer to section L for more details.

12. Advance Directives

In compliance with 42 CFR 438.6 (i) (1)-(2) and 42 CFR 422.128, the Supplier shall maintain written policies and procedures for Advance Directives, including Mental Health Advance Directives. Such Advance Directives shall be included in each Member's Medical Record. The Supplier shall provide these policies to all Members eighteen (18) years of age and older and shall advise Members of:

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- a. The rights under the law of the State of Georgia, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; and
- b. The Supplier's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

The information must include a description of State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) Calendar Days after the effective change.

The Supplier's information must inform Members that complaints may be filed with the State's Survey and Certification Agency.

The Supplier shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Members and their responsibility to educate Members about this tool and assist them to make use of it.

The Supplier shall educate Members about their ability to direct their care using this mechanism and shall specifically designate which staff Members and/or network Providers are responsible for providing this education.

13. Member Cost-Sharing

The Supplier shall include in Provider agreements a provision that Providers assess Member Co-payments consistent with those specified by DCH in Attachment I and as updated by DCH.

The Supplier shall ensure that Providers do not refuse to render services based on a Member's inability to pay the Member cost-share.

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The Supplier shall ensure that Providers do not utilize other methods post-delivery of services (such as but not limited to collection agencies) to fulfill Member cost-sharing responsibility.

14. Value Added Services

The Supplier is permitted to provide value added services to Members that address the needs of Members and improve health outcomes. Value added services exceed Georgia Medicaid State Plan benefits and are designed to improve Members' wellbeing, encourage prudent use of Health Care Benefits, and enhance the cost effectiveness of the Georgia Families and Georgia Families 360° program. DCH encourages the Supplier to consider the challenges in improving Member health outcomes while developing Value Added services.

The Supplier must submit any proposed value added services to DCH for review and approval prior to implementation. Additional value added services can be added at any time with DCH approval. The Supplier must provide a detailed list of value added services to the DCH Enrollment Broker.

Value added services cannot be discontinued once implemented without prior approval from DCH. Should DCH approve the Supplier's request for discontinuation of value added services, DCH reserves the right to initiate an open Enrollment Period for the Members assigned to the Supplier if value added benefits are discontinued.

Value added services are not considered during the Capitation Rate development process.

E. Member Enrollment

1. Enrollment Procedures

DCH or its Agent is responsible for Enrollment, including Auto-Assignment to a CMO, Disenrollment, education on Enrollment options, and outreach activities to those eligible to enroll in a CMO. The Supplier shall coordinate with DCH and its Agent as necessary for all Enrollment and Disenrollment functions.

DCH or its Agent will make every effort to ensure that individuals who are ineligible for Enrollment are not enrolled in Georgia Families. However, to ensure that such individuals are not enrolled in Georgia Families, the Supplier shall assist DCH or its Agent in the identification of individuals who are ineligible for Enrollment, as set forth in section E, should such individuals inadvertently become enrolled in Georgia Families.

DCH or its Agent will make every effort to ensure that individuals ineligible for Enrollment in the Demonstration are not enrolled in Georgia Families as P4HB participants. However, to ensure that such individuals are not enrolled in the Demonstration, the Supplier shall assist DCH or its Agent in the identification of P4HB participants that are ineligible for enrollment in the Demonstration but have been inadvertently enrolled in Georgia Families as P4HB participants.

The Supplier shall assist DCH or its Agent in the identification of individuals who become ineligible for Medicaid, PeachCare for Kids® and P4HB (for example, those who have died,

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been incarcerated, moved out-of-State, or no longer meet P4HB eligibility criteria due to sterilization).

The Supplier shall accept all eligible individuals for Enrollment as identified by DCH or its Agent without restrictions. The Supplier shall not discriminate against individuals on any basis, including but not limited to the basis of religion, gender, race, color, or national origin, and will not use any policy practice that has the effect of discriminating on the basis of religion, gender, race, color, or national origin or on the basis of health, health status, pre-existing Condition, or need for Health Care services.

2. Selection of a Primary Care Provider (PCP)/Medical Home

The Supplier shall ensure an adequate number of PCPs are available within its network. Assignment of a PCP should be based on a Member's identified needs and preference as well as Provider agreement and accessibility. The PCP's role is to:

- a. Provide preventive care and teach healthy lifestyle choices
- b. Identify and treat common medical Conditions
- c. Assess the urgency of the Member's medical problems and direct them to the most appropriate place for that care
- d. Make referrals to specialists when necessary.

The Supplier shall collaborate with the Supplier and Providers to decrease potentially preventable admissions and Re-admissions and avoidable use of the emergency department.

The Supplier shall send a monthly list of Members with potentially preventable admissions or Re-admission and/or avoidable use of the emergency department to the Member's PCP. The PCP shall work with Providers and the Supplier to identify and address gaps and implement innovative solutions to decreasing potentially preventable admissions or Re-admissions as well as avoidable use of the emergency department.

The Supplier shall offer its Members freedom of selecting a PCP and a PCP if different from the PCP. DCH or its Agent will encourage self-selection and continuation of any existing satisfactory Provider relationships with current provider participating in the Supplier's Network. If a Member fails to select a PCP, or if the Member has been Auto-Assigned to the CMO, the Supplier shall Auto-Assign Members to a PCP based on the following algorithm:

- a. Auto-assign Member to a Provider with whom, based on FFS Claims history, the Member has a Historical Provider Relationship, provided that the Geographic Access requirements are met.
- b. If no Historical Provider Relationship exists, Auto-Assign Member to the assigned PCP of an immediate family member enrolled in the CMO, if the Provider is an appropriate Provider based on the age and gender of the Member.

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- c. If other family members do not have an assigned PCP, Auto-Assign Member to a Provider with whom a family member has a Historical Provider Relationship if the Provider is an appropriate Provider based on the age and gender of the Member.
- d. If no Member or immediate family member has a relationship with a Provider, Auto-Assign Member to a PCP using an algorithm developed by the Supplier, and approved by DCH, based on the age and sex of the Member, and geographic proximity.

Pregnant Members may also select an obstetrician (OB) as their assigned PCP. If a pregnant Member fails to select an OB, the Supplier may Auto-Assign the Member to an OB using an algorithm developed by the Supplier and approved by DCH, based on geographic proximity.

PCP assignment shall be effective Immediately. The Supplier shall notify the Member via surface mail of their Auto-Assigned PCP within ten (10) Calendar Days of Auto-Assignment.

The Supplier shall submit its PCP Auto-Assignment Policies and Procedures during the Readiness Review at a date designated by DCH to DCH for initial review within sixty (60) Calendar Days of Contract Execution Date and approval, and as updated thereafter.

The Supplier shall require that Members are assigned to the same PCP for a period of up to six (6) months, except for the following exceptions:

- a. Members shall be allowed to change their PCP without cause during the first ninety (90) Calendar Days following PCP selection;
- b. Members shall be allowed to change their PCP with cause at any time. The following constitute cause for change:
 - 1. The PCP no longer meets the Geographic Access standards as defined in this Scope of Work;
 - 2. The PCP does not, because of moral or religious objections, provide the Covered Service(s) and Benefits the Member seeks; and
 - 3. The Member requests to be assigned to the same PCP as other family members.

Members shall be allowed to change their PCP every six (6) months.

Members with a Behavioral Health diagnosis may select a Behavioral Health Home in addition to their PCP.

Primary Care services are not Covered Services and Benefits under the Demonstration for Family Planning Services Only P4HB participants. However, the Supplier shall encourage Family Planning Only P4HB participants to choose a PCP. The Supplier shall maintain an up-to-date list of available Providers affiliated with the Georgia Association for Primary Health Care and other Providers serving the uninsured and underinsured populations who are available to provide Primary Care services. The Supplier must not use Demonstration

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funds to reimburse for Primary Care services delivered to Family Planning Services Only P4HB participants.

3. Selection of a Dental Home

All Members under age twenty-one (21) shall have access to Dentist within thirty (30) minutes/miles of the Member's home address for urban areas and within forty-five (45) minutes/miles for rural areas who will serve as the Members' Dental Home. The Dental Home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professional. The Dental Home is the Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the Medicaid State Plan.

DCH or its Agent will encourage self-selection of a Dentist and continuation of any existing satisfactory relationship with their current Dentist if the Dentist participates in the Supplier's network. If the Member does not make a selection with DCH or its Agent at time of CMO selection, fails to select a Dentist, or has been Auto-Assigned to the CMO, the Supplier shall Auto-Assign Members to a Dental Home using an algorithm developed by the Supplier and approved by DCH, based on geographic proximity.

Dental Home assignment shall be effective Immediately. The Supplier shall notify the Member via surface mail of their Dental Home Assignment within ten (10) Calendar Days of Auto-Assignment.

P4HB participants shall not receive Dental Home services.

The Supplier shall submit its Dental Home Auto-Assignment Policies and Procedures to DCH for initial review and approval within sixty (60) Calendar Days of Contract Effective Date, and as updated thereafter. The Dental Home Auto-Assignment process must address those instances when a Dental Home is not selected upon Member Enrollment.

IPC P4HB participants are not eligible for a Dental Home. IPC P4HB participants are eligible for limited dental services, which include emergency dental services.

4. Newborn Enrollment

All newborns shall be Auto-Assigned by DCH or its Agent to the mother's CMO. Mothers of newborns may change newborn CMO assignment within the first ninety (90) days following birth. The Supplier shall notify DCH or its Agent of newborns born to Members who do not appear on the monthly roster.

The Supplier shall provide assistance to any Member who is an expectant mother who contacts them wishing to make a PCP selection for her newborn and record that selection.

Within twenty-four (24) hours of the birth, the Supplier shall ensure the submission of a newborn notification form to DCH or its Agent. If the mother has not made a PCP selection, the Supplier shall Auto-Assign the newborn to a PCP within thirty (30) Calendar Days of the birth. Auto-Assignment shall be made using the algorithm set forth in section E.2. Notice

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of the PCP Auto-Assignment shall be mailed to the mother within twenty-four (24) hours of assignment.

5. Assignment after Re-Enrollment

When a Member who selects a new CMO during annual Enrollment subsequently loses Medicaid or CHIP eligibility and is Disenrolled for more than sixty (60) Calendar Days, the Member is not automatically assigned to the same CMO if re-determined as Eligible and reenrolled. Instead, the Member is permitted a new open Enrollment CMO selection. When a Member loses Medicaid or CHIP eligibility and is re-determined to be Medicaid or CHIP eligible and reenrolled in Georgia Families within sixty (60) days, the Member shall be automatically assigned to the same CMO.

F. Disenrollment

1. Disenrollment Initiated by the Member

A Member may request Disenrollment or a change in CMO Enrollment without cause during the ninety (90) Calendar Days following the date of the Member's initial Enrollment with the CMO or the date DCH or its Agent sends the Member notice of the Enrollment, whichever is later. A Member may request Disenrollment without cause every twelve (12) months thereafter.

A Member may request Disenrollment or a change in CMO Enrollment for cause at any time. The following constitutes cause for requesting Disenrollment:

- a. The Member moves out of the CMO's Service Region;
- b. The CMO does not, because of moral or religious objections, provide the Covered Services and Benefits the Member seeks;
- c. The Member needs multiple related services to be performed and not all related services are available within the Network. The Member's or participant's Provider or another Provider have determined that receiving related services from In-Network and Out-of-Network Providers would subject the Member to unnecessary risk;
- d. The Member requests to be assigned to the same CMO as family member(s); and
- e. The Member's Medicaid Category of Eligibility changes to a category ineligible for Georgia Families, and/or the Member otherwise becomes ineligible to participate in Georgia Families.

Other reasons for Disenrollment initiated by the Member, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor care, lack of access to services covered under the Contract, or lack of Providers experienced in addressing the Member's Health Care needs (DCH or Agent shall make determination of these reasons).

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The Supplier shall provide assistance to Members seeking to Disenroll. This assistance shall consist of providing Disenrollment forms to the Member and referring the Member to DCH or its Agent who will make Disenrollment determinations.

2. Disenrollment Initiated by the Supplier

The Supplier shall complete all Disenrollment paperwork for Members it is seeking to Disenroll.

The Supplier shall notify DCH or its Agent upon identification of a Member who it knows or believes meets the criteria for Disenrollment.

The Supplier may request Disenrollment if:

- a. The Member's Utilization of services is Fraudulent or abusive.
- b. The Member is placed in a Long Term care nursing facility, State institution, or intermediate care facility for individuals with intellectually disabilities.
- c. The Member's Medicaid Category of Eligibility changes to a category ineligible for Georgia Families, and/or the Member otherwise becomes ineligible to participate in Georgia Families. Disenrollments due to Member ineligibility will follow the normal monthly process as described in section F.1. Disenrollments will be processed as of the date that the Member eligibility category actually changes and will not be made retroactive, regardless of the effective date of the new eligibility category. Note exception when Members become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization.
- d. The Member has died, been incarcerated, or moved out of State, thereby making them ineligible for Medicaid.
- e. The P4HB participant no longer meets the eligibility criteria for the Demonstration.
- f. The IPC P4HB participant has reached the end of the twenty-four (24) months of eligibility for the IPC component of the Demonstration.
- g. The P4HB participant becomes pregnant while enrolled in the Demonstration.
- h. The P4HB participant becomes infertile through a sterilization procedure.

Prior to requesting Disenrollment of a Member, the Supplier shall document at least three (3) interventions over a period of ninety (90) Calendar Days that occurred through treatment, Case Management, and Care Coordination to resolve any difficulty leading to the request. The Supplier shall provide at least one (1) written warning to the Member, certified return receipt requested, regarding implications of his or her actions. This notice must be delivered within ten (10) Business Days of the Member's Action.

The Supplier shall cite to DCH or its Agent at least one (1) acceptable reason for Disenrollment before requesting Disenrollment of the Member.

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The Supplier shall submit Disenrollment requests to DCH or its Agent and the Supplier shall honor all Disenrollment determinations made by DCH or its Agent. DCH's decision on the matter shall be final, conclusive and not subject to Appeal.

3. Unacceptable Reasons for Disenrollment Requests by Supplier

The Supplier shall not request Disenrollment of a Member for discriminating reasons, including but not limited to:

- a. Adverse changes in a Member's health status.
- b. Missed appointments.
- c. Utilization of medical services.
- d. Diminished mental capacity.
- e. Pre-existing medical Condition.
- f. Uncooperative or disruptive behavior resulting from his or her special needs.
- g. Lack of compliance with the treating physician's plan of care.

The Supplier shall not request Disenrollment because of the Member's attempt to exercise his or her rights under the Grievance System.

The request of one PCP to have a Member assigned to a different PCP shall not be sufficient cause for the Supplier to request that the Member be Disenrolled from the plan. Rather, the Supplier shall utilize its PCP assignment process to assign the Member to a different and available Medical Home.

G. Georgia Families Member Services

1. General Provisions

The Supplier shall ensure that Members are aware of the following:

- a. Member rights and responsibilities;
- b. The role of the PCP and Dental Home;
- c. The role of the Family Planning Provider and PCP (for IPC P4HB participants only)
- d. How to obtain care;
- e. What to do in an emergency or urgent medical situation (for P4HB participants information must address what to do in an emergency or urgent medical situation arising from the receipt of Demonstration Related Services);
- f. How to request a Grievance, Appeal, or Administrative Law Hearings; and
- g. How to report suspected Fraud and Abuse.

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The Supplier must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting and email that allow Members to submit questions and receive responses from the Supplier while protecting the confidentiality and Protected Health Information (PHI) of the Members in all instances. The Supplier shall attempt to obtain/collect Member email addresses from Members. Upon request, the Supplier must provide materials in the format preferred by the Member.

2. Requirements for Written Materials

The Supplier shall make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. The Supplier shall notify all Members that information is available in alternative formats and how to access those formats.

The Supplier shall make all written information available in English, Spanish and all other Prevalent Non-English Languages, as defined by DCH. For the purpose of this RFP, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH.

All written materials distributed to Members shall include a language block, printed in Spanish and all other Prevalent Non-English Languages, that informs the Member that the document contains important information and directs the Member to call the Supplier to request the document in an alternative language or to have it orally translated.

All written materials shall be worded such that they are understandable to a person who reads at the fifth (5th) grade level. Suggested reference materials to determine whether this requirement is being met are:

- a. Fry Readability Index;
- b. PROSE The Readability Analyst (software developed by Education Activities, Inc.);
- c. Gunning FOG Index;
- d. McLaughlin SMOG Index;
- e. The Flesch-Kincaid Index; or
- f. Other word processing software approved by DCH.

The Supplier shall provide written notice to DCH of any changes to any written materials provided to the Members. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.

The Supplier must submit all written materials, including information for the web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the

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Member materials within thirty (30) Calendar Days of submission. DCH reserves the right to require the discontinuation of any Member materials that violate the terms of the Contract.

3. Member Handbook and Member Material Requirements

The Supplier shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Supplier shall make the Member and P4HB participant Handbooks available through the Supplier's web site. Upon request, the Supplier shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant Handbook to P4HB participant households.

- a. The Member Handbook shall include all requirements set forth in 42 CFR 438.10, and the Member Handbook shall include, but not be limited to:
 1. A table of contents;
 2. Information about the roles and responsibilities of the Member (this information to be supplied by DCH);
 3. Information about the role of the PCP including services provided and the role of the PCP
 4. Information about choosing a Medical Home;
 5. Information about the Dental Home including services provided and how a Member can select a Dental Home;
 6. Information about what to do when family size changes;
 7. Appointment procedures;
 8. Information on Benefits and services, including a description of all available Georgia Families Benefits and Services;
 9. Information on how to access services, including EPSDT services, Non-Emergency Transportation (NET) services, and maternity and Family Planning Services;
 10. Information about the Georgia Health Information Network (GaHIN) including how information will be used by the CMOs and DCH and procedures to opt out of the GaHIN; and an explanation of any service limitations or exclusions from coverage;
 11. An explanation of any service limitations or exclusions from coverage;
 12. Information about services that can be obtained through Telemedicine;
 13. A notice stating that the Supplier shall be liable only for those services authorized by the Supplier;
 14. Information on where and how Members may access Benefits not available from or not covered by the Supplier;

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15. The Medical Necessity definition used in determining whether services will be covered;
16. A description of Utilization Review policies and procedures used by the Supplier;
17. A description of all Pre-Certification, Prior Authorization or other requirements for treatments and services;
18. The policy on Referrals for specialty care and for other Covered Services not furnished by the Member's Medical Home;
19. Information on how to obtain services when the Member is out of the Service Region and for After-Hours coverage;
20. Cost-Sharing;
21. Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the Supplier's toll-free telephone line and web site;
22. A description of Member rights and responsibilities;
23. The policies and procedures for Disenrollment;
24. Information on Advance Directives;
25. A statement that additional information, including information on the structure and operation of the CMO and Physician Incentive Plans shall be made available upon request;
26. Information on the extent to which, and how, After-Hours and emergency coverage are provided, including the following:
 - a. What constitutes an Urgent and Emergency Medical Condition, Emergency Services, and Post-Stabilization Services;
 - b. The fact that Prior Authorization is not required for Emergency Services;
 - c. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent;
 - d. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered herein; and
 - e. The fact that a Member has a right to use any hospital or other setting for Emergency Services.
27. Information about the Grievance Systems policies and procedures, as set forth in section N.3, which must include the following:

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- a. The right to file a Grievance and Appeal with the Supplier;
 - b. The requirements and timeframes for filing a Grievance or Appeal with the Supplier;
 - c. The availability of assistance in filing a Grievance or Appeal with the Supplier;
 - d. The toll-free numbers Members can use to file a Grievance or an Appeal with the Supplier by phone;
 - e. The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
 - f. Notice that if a Member files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the Member may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Member; and
- b. The following information must be available to P4HB participants on the Supplier's web site and mailed to P4HB participants upon request including but not limited to the following:
1. General information pertaining to the Demonstration (eligibility, Enrollment and Disenrollment criteria, and information pertaining to the Demonstration's program components—family planning only, Interpregnancy Care (IPC), Resource Mother's Outreach);
 2. A list of Benefits and services available under each Demonstration component;
 3. A list of service exclusions or limitations under each Demonstration component;
 4. Information about the role of the Family Planning Provider;
 5. Information about the role of the PCP for the IPC P4HB participant only;
 6. Information about Providers affiliated with the Georgia Association for Primary Health Care who are available to provide Primary Care services and whose services are not covered under the Demonstration for Family Planning Only P4HB participants;
 7. Information on where and how P4HB participants may access other Benefits and services not available from or not covered by the Supplier under the Demonstration;
 8. Information about the appointment procedures;
 9. Information on how to access Demonstration services, including Non-Emergency Transportation (NET) available to the IPC P4HB participants only;
 10. A notice stating that the Supplier shall be liable only for those Demonstration services authorized by CMS under the Demonstration;

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11. A description of all Pre-Certification, Prior Authorization or other requirements for Demonstration Related Services and treatments;
12. The geographic boundaries of the Service Regions;
13. Information about the availability of Telemedicine services;
14. Notice of all appropriate mailing addresses and telephone numbers to be utilized by P4HB participants seeking information or authorization, including the Supplier's toll-free telephone line and web site;
15. A description of the P4HB participant's rights and responsibilities;
16. The policies and procedures for Disenrollment from the Demonstration;
17. Information on Advance Directives;
18. A statement that additional information, including information on structure and operation of the CMO and Physician Incentive Plans, shall be made available upon request;
19. Information on the extent to which, and how, After-Hours and emergency coverage are provided, including the following:
 - a. What constitutes an Urgent and Emergency Demonstration Related Medical Condition, Demonstration Related Emergency Services, and Demonstration Related Post Stabilization Services;
 - b. The fact that Prior Authorization is not required for Demonstration Related Emergency Services;
 - c. The process and procedures for obtaining Demonstration Related Emergency Services, including the use of the 911 telephone systems or its local equivalent;
 - d. The location of any emergency settings and other locations at which Demonstration Providers and hospitals furnish Demonstration Related Emergency and Post Stabilization Services; and
 - e. The fact that a P4HB participant has a right to use any hospital or other setting for Demonstration Related Emergency Services.
20. Information on the Grievance Systems policies and procedures, which must include the following:
 - a. The right to file a Grievance and Appeal with the Supplier;
 - b. The requirements and timeframes for filing a Grievance or Appeal with the Supplier;
 - c. The availability of assistance in filing a Grievance or Appeal with the Supplier;

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- d. The toll-free numbers P4HB participants can use to file a Grievance or an Appeal with the Supplier by phone;
- e. The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
- f. Notice that if the P4HB participant files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the P4HB participant may be required to pay the cost of services furnished while the Appeal is pending if the final decision is adverse to the P4HB participant; and
- g. Any Appeal rights that the State chooses to make available to Providers to challenge the failure of the Supplier to cover the Demonstration Related Service; and

The Supplier shall submit to DCH for review and approval initial versions, any changes and edits to the Member or P4HB participant Handbook (including P4HB), and all other Member materials the Supplier plans to distribute at least thirty (30) Calendar Days before the effective date of change.

4. Member Rights

The Supplier shall have written policies and procedures regarding the rights of Members and shall comply with any applicable federal and State laws and regulations that pertain to Member rights. These rights shall be included in the Member Handbook and P4HB Handbook. At a minimum, said policies and procedures shall specify the Member's right to:

- a. Receive information pursuant to 42 CFR 438.10;
- b. Be treated with respect and with due consideration for the Member's dignity and privacy;
- c. Have all records and medical and personal information remain confidential;
- d. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's Condition and ability to understand;
- e. Participate in decisions regarding his or her Health Care, including the right to refuse treatment;
- f. Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- g. Request and receive a copy of his or her Medical Records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;
- h. Be furnished Health Care services in accordance with 42 CFR 438.206 through 438.210;

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- i. Freely exercise his or her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the Member is treated;
- j. Not be held liable for the Supplier's debts in the event of insolvency; not be held liable for the Covered Services provided to the Member for which DCH does not pay the Supplier; not be held liable for Covered Services provided to the Member for which DCH or the CMO does not pay the Health Care Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, Referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Supplier provided the services directly; and
- k. Be responsible for cost sharing in accordance with and only to the extent set forth in 42 CFR 447.50 through 42 CFR 447.60.

5. Provider Directory

The Supplier shall provide a Provider Directory to Members. The Supplier shall make the Provider Directory available to Members through the Supplier's web site. Upon request, the Supplier shall mail via surface mail a hard copy of the Provider Directory to enrolled Member households within three (3) Business Days of receipt of the request whether verbally or in writing. Hard copy Provider Directories shall include a statement indicating that changes to the Provider Network will occur and that Members are encouraged to review the online Provider Directory or contact the Supplier for current information as needed.

The electronic Provider Directory, at a minimum, shall be searchable by Provider name, Provider type/specialty and location (to include city, zip code, physical address, and county).

6. Member Identification (ID) Card

The Supplier shall mail via surface mail a Member ID Card to all new Members according to the following timeframes:

- a. Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP/Medical Home.

The Member ID Card must, at a minimum, include the following information:

- a. The Member's name;
- b. The Member's Medicaid or PeachCare for Kids® identification number;
- c. The PCP's name, address, and telephone numbers (including After-Hours number if different from Business Hours number);
- d. Dental Home name, address and telephone number (if the Member is eligible to receive a Dental Home) including After-Hours number if different from Business Hours number;
- e. The name and telephone number(s) of the Supplier;

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- f. The Supplier's twenty-four (24) hour, seven (7) day a Week toll-free Member services telephone number;
- g. Instructions for emergencies;
- h. Minimum instructions to facilitate the submission of a Claim by a Provider;
- i. Processor Control Number and Bank Identification Number (BIN) for pharmacy Claims submission; and
- j. Toll free phone numbers for Provider call centers to assist Providers with Claims adjudication questions or issues.

The Supplier shall reissue the Member ID Card within seven (7) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.

The Supplier shall submit a front and back sample Member ID Card to DCH for initial review within sixty (60) Calendar Days of Contract Execution Date and approval, and as updated thereafter.

The Supplier shall mail via surface mail a P4HB participant ID Card to all new P4HB participants in the Demonstration within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or its Agent. The P4HB participant's ID Card will meet the requirements set forth for Member ID Cards and will identify the Demonstration component in which the P4HB participant is enrolled:

- a. A Pink color will signify the P4HB participants as eligible for Family Planning Services Only.
- b. A Purple color will signify the P4HB participants as eligible for Interpregnancy Care Services and Family Planning Services.
- c. A Yellow color will signify the P4HB participant as eligible for Case Management - Resource Mothers Outreach Only.

At the time the P4HB participant's ID card is issued or re-issued to a P4HB participant, the Supplier shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.

7. Member and Call Center

The Supplier shall operate a toll-free call center to respond to Member questions and comments. The Supplier shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, Monitoring of calls via recording or other means, and compliance with standards as described in this Scope of Work. The Supplier shall submit these call center policies and procedures to DCH for initial review within sixty (60) Calendar Days of Contract Execution Date and approval and as updated thereafter.

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The call center must comply with Title IV of the Civil Rights Act. Call center staff shall handle calls from non-English speaking callers as well as call from Members who are hearing impaired.

The Supplier shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, the Supplier shall have an automated system available between the hours of 7:00 p.m. and 7:00 a.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Supplier's Representative shall return messages on the next Business Day.

The Supplier shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities. The Supplier shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Supplier shall submit the Call Center Quality Criteria and Protocols to DCH for review and approval annually. At a minimum, the criteria and protocols shall require that, on a Calendar month basis:

- a. Average Speed of Answer: Eighty percent (80%) of calls are answered by a person within thirty (30) seconds. "Answer" shall mean for each caller who elects to speak to a live representative. The remaining twenty percent (20%) of calls will be answered by a person within an additional thirty (30) seconds, within one (1) minute of the call.
- b. Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.
- c. Blocked Call Rate, or a call that was not allowed into the system, that does not exceed one percent (1%).
- d. Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a Call Center Representative.
- e. Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.
- f. Accurate Response to Call Center Phone Inquiries: Call center representatives accuracy rate must be ninety percent (90%) or higher.

The Supplier shall establish remote phone Monitoring capabilities for at least five (5) DCH staff. DCH or its agent shall be able, using a personal computer and/or phone to monitor call

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center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information.

8. Georgia Families Member Web Site

The Supplier shall develop and maintain a Program web site on which the Supplier will provide Member and P4HB participant webpages that provide general and up-to-date information about the CMO's program, including but not limited to the following:

- a. A searchable Member Handbook as set forth in section G.3;
- b. All Member Information materials as set forth in section G.3;
- c. Portal that allows Members to access a searchable Provider Directory ;
- d. Information about how limited English speaking persons as well as those who are hearing impaired can access interpreter services;
- e. Pharmacy Preferred Drug List;
- f. Pharmacy Conditions for Coverage and Utilization Limits;
- g. What's New items;
- h. Frequently asked questions and answers;
- i. Reminder information about Medicaid eligibility redeterminations;
- j. Links to the DCH Medicaid web site and to the DCH P4HB web site;
- k. General and up to date information about the Demonstration that incorporates DCH's messaging regarding the Demonstration; and
- l. Link to the DCH Enrollment Broker web site.

The web site must have the capability for Members to submit questions and comments to the Supplier and for Members to receive responses. The Supplier shall respond to Member inquiries within one (1) Business Day of receipt and resolve the issue within seventy-two (72) Clock Hours of receipt. The Supplier shall refer any inquiries to DCH that are not within the Supplier's scope of services (e.g., inquiries about the Fee-for-Service delivery system).

The web site must comply with the Marketing policies and procedures and with requirements for written materials described in the Contract and must be consistent with applicable State and federal laws. Information provided on the Member webpages must be written at no higher than a fifth (5th) grade reading level.

The Supplier must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Supplier must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades, enhancements and/or modifications, which further the

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ordinary operation, administration, and maintenance of the web site, the Supplier shall not modify the web site prior to receipt of DCH approval.

The web site must comply with DCH's requirements for Information Systems and webpage development, including but not limited to security controls that meet the requirements of the Contract. The Supplier's web site shall also be functionally equivalent, with respect to functions described in the Contract, to the web site maintained by the State's Medicaid Fiscal Agent. See <https://www.mmis.georgia.gov/portal/>.

9. Cultural Competency

In accordance with 42 CFR 438.206, the Supplier shall have a comprehensive written Cultural Competency Plan describing how the Supplier will ensure that services are provided in a culturally competent manner to all Members and, including those with limited English proficiency, hearing impairment, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The Cultural Competency Plan must describe how the Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each. The Cultural Competency Plan must include:

- a. Member services staff and Providers, including PCPs, and Supplier staff at all levels shall receive ongoing education and training in culturally and linguistically appropriate service delivery;
- b. Plan for interpretive services and written materials, consistent with section G.10 to meet the needs of Members whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member oriented materials, and post signage in the languages of the commonly encountered group and/or groups represented in the service area;
- c. Identify community advocates and agencies that could assist Limited-English Proficiency and/or that provide other Culturally Competent services, which include methods of Outreach and Referral;
- d. Incorporate Cultural Competence into Utilization Management, Quality improvement and planning for the course of treatment;
- e. Identify and employ resources and interventions for high-risk health Conditions found in certain cultural groups;
- f. Recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State and the Supplier's membership;

The Supplier shall submit the Cultural Competency Plan to DCH for initial review within sixty (60) Calendar Days of Contract Execution Date and approval, and as updated thereafter.

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The Supplier may distribute a summary of the Cultural Competency Plan to the In-Network Providers if the summary includes information on how the Provider may access the full Cultural Competency Plan on the web site. This summary shall also detail how the Provider can request a hard copy from the CMO at no charge to the Provider.

10. Interpretation Services

The Supplier shall provide oral Translation Services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Supplier shall notify its Members of the availability of oral Translation Services and to inform them of how to access oral Translation Services. There shall be no charge to the Member for Interpretation Services.

11. Translation Services

The Supplier shall provide translation services to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Supplier shall notify its Members of the availability of translation services and to inform them of how to access translation services. There shall be no charge to the Member for translation services.

H. Marketing

1. Prohibited Activities

The Supplier is prohibited from engaging in the following activities:

- a. Directly or indirectly engaging in door-to-door, telephone, or other Cold-Call Marketing activities to Potential Members;
- b. Offering any favors, inducements or gifts, promotions, and/or other insurance products worth more than \$15.00 at one time and not more than \$50 annually per Member;
- c. Providing meals for Potential Members, regardless of value;
- d. Distributing plans and materials that contain statements that DCH determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in the Supplier's plan in order to obtain Benefits or in order to not lose Benefits or that the Supplier's plan is endorsed by the federal or State government, or similar entity; and
- e. Distributing information or materials that, according to DCH, mislead or falsely describe the Supplier's or other CMO's Provider Network, the participation or availability of Network Providers, the qualifications and skills of Network Providers (including their bilingual skills); or the hours and location of Network services.

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2. Allowable Activities

The Supplier shall be permitted to perform the following Marketing activities:

- a. Distribute general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, public transportation advertising, and other media outlets);
- b. Distribute general information through use of social media platforms to contact a greater proportion of the Members or potential Members served by the Supplier. Content intended for use on social media platforms must be approved by DCH prior to publication;
- c. Make telephone calls, mailings and home visits only to Members currently enrolled in the Supplier's plan, for the sole purpose of educating them about services offered by or available through the Supplier;
- d. Reach out to former Members via telephone calls, mailings, and home visits for a period of up to forty-five (45) Calendar Days from the date the Member is Disenrolled from the Supplier's plan for the sole purpose of surveying the former Member about services received while the Member was enrolled with the Supplier;
- e. Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the Supplier's Provider Network, provided that all CMOs in which the Provider participates have an equal opportunity to be represented; and
- f. Attend activities that benefit the entire community such as health fairs or other health education and promotion activities.

If the Supplier performs an allowable activity, the Supplier shall conduct these activities statewide.

All materials shall comply with the information requirements in 42 CFR 438.10 and detailed in this RFP.

3. State Approval of Materials

The Supplier shall submit to DCH for review within sixty (60) Calendar Days of the Contract Award and approval and approval and as updated thereafter a detailed description of its Marketing Plan and copies of all Marketing Materials (written and oral) it or its Subcontractors plan to distribute.

This requirement includes, but is not limited to posters, brochures, web sites, and any materials that contain statements regarding the benefit package and Provider network-related materials. Neither the Supplier nor its Subcontractors shall distribute any Marketing Materials without prior, written approval from DCH.

The Supplier shall submit any changes to previously approved Marketing Materials and receive approval from DCH of the changes sixty (60) Calendar Days before distribution.

I. Georgia Families Provider Network

1. General Provisions

The Supplier shall develop and maintain a network of Providers and facilities adequate to deliver Covered Services as described in this RFP while ensuring adequate and appropriate provision of services to Members in rural areas, which may include the use of Telemedicine when appropriate to the Condition and needs of the Member. The Supplier is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other Health Care Providers through whom it provides the items and services included in Covered Services.

The Supplier shall maintain a network of Providers that is adequate to assure timely access to all Covered Services and Quality care. The Supplier shall assure that all network Providers have been appropriately credentialed by DCH or its Agent, maintain current licenses, and have appropriate locations to provide the Covered Services.

The Supplier's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.

The Supplier shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network Enrollment for new Provider Contracts and also notify DCH when network Enrollment is reopened. The Supplier must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.

2. Provider Selection and Retention Policies and Procedures

The Supplier shall submit its written Provider Selection and Retention Policies and Procedures to DCH for initial review within sixty (60) Calendar Days of Contract Execution Date and approval, and as updated thereafter. In selecting and retaining Providers in its network the Supplier shall consider the following:

- a. The anticipated Georgia Families Enrollment;
- b. The expected Utilization of services, taking into consideration the characteristics and Health Care needs of its Members;
- c. The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the Covered Services;
- d. The numbers of network Providers who are not accepting new Georgia Families patients; and
- e. The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

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If the Supplier declines to include individual Providers or groups of Providers in its network, the Supplier shall give the affected Providers written notice of the reason(s) for the decision. These provisions shall not be construed to:

- a. Require the Supplier to contract with Providers beyond the number necessary to meet the needs of its Members;
- b. Preclude the Supplier from establishing measures that are designed to maintain Quality of services and control costs and that are consistent with its responsibilities to Members.

The Supplier shall ensure that all network Providers have knowingly and willfully agreed to participate in the Supplier's network. The Supplier shall not acquire established networks without contacting each individual Provider to ensure knowledge of the requirements of the Contract and the Provider's complete understanding and agreement to fulfill all terms of the Provider Contract, as outlined in section K, Provider Contracts. DCH reserves the right to confirm and validate, through both the collection of information and documentation from the Supplier and on-site visits to network Providers, the existence of a direct relationship between the Supplier and the network Providers.

The Supplier shall send all newly contracted Providers a written network participation welcome letter that includes a contract effective date for which Providers are approved to begin providing medical services to Georgia Families Members

The Supplier shall survey all Providers who chose to exit the network and use the results of Provider exit surveys to improve Provider retention and recruitment. The Supplier shall provide DCH with the Provider exit survey template initially and when updated thereafter. The Supplier shall provide DCH with results of the Provider exit survey upon request.

3. Provider Network Composition

The Supplier shall maintain an online Provider Directory and Network Listing as set forth in section G.5.

The Supplier shall, at least quarterly, validate Provider demographic data to ensure that current, accurate, and clean data is on file for all contracted Providers, which shall include the use of access and availability audits described in section I.19. Failure to conduct quarterly Validation and provide a clean file after determining errors through Validation may result in liquidation damages up to \$5,000 per day against the Supplier.

The Supplier shall ensure that all Provider network data files are tested and validated for accuracy prior to Supplier Deliverable submissions which shall include the use of access and availability audits described in section I.19. The Supplier shall scrub data to identify inconsistencies such as addresses duplicates; mismatched cities, counties, and regions; and incorrect assigned specialties. The Supplier shall be responsible for submission of Attestations for each network report. All reports are to be submitted in the established DCH format with all required data elements. Failure to submit all Attestations and complete reports in the established DCH format with all required data elements may result in Liquidated Damages up to \$5,000 per day against the Supplier.

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The Supplier shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented appropriately on all claims and associated documents. The Supplier will emphasize to Providers the need for a unique GA Medicaid ID number for each practice location unless DCH changes this requirement at a future date.

4. Primary Care Providers

The Supplier shall allow for PCPs to include not only traditional Provider types that have historically served as PCPs but also alternative Provider types such as specialists with documented physician oversight and meaningful physician engagement.

The Supplier shall include in its network as PCPs the following:

a. Physicians who routinely provide Primary Care Services in the areas of :

1. Family Practice;
2. General Practice;
3. Pediatrics; or
4. Internal Medicine.
5. Obstetrics and Gynecology

b. Nurse Practitioners Certified (NP-C) specializing in:

1. Family Practice; or
2. Pediatrics.

NP-Cs in independent practice must also have a current collaborative agreement with a Provider who has hospital admitting privileges and oversees the provision of services furnished by NP-Cs.

c. PCPs that practice in Federal Qualified Health Center (FQHCs) and Rural Health Clinic (RHCs). The Supplier shall maintain an accurate list of all Providers rendering care at these facilities.

d. Public Health Department Clinics and Hospital Outpatient Clinics if they agree to the requirements of the PCP role, including the following conditions:

1. The practice must routinely deliver Primary Care as defined by the majority of the practice devoted to providing continuing comprehensive and coordinated medical care to a population undifferentiated by disease or organ system. If deemed necessary, a Medical Record audit of the practice will be performed by the Supplier. Any exceptions to this requirement will be considered by DCH on a case-by-case basis.

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2. Any Referrals for specialty care to other Providers of the same practice may be reviewed for appropriateness.
 3. Members who have a primary diagnosis of a Severe Persistent Mental Illness may be permitted to have any physician including a psychiatrist as their PCP assuming the physician or psychiatrist agrees to serve in this role.
- e. Physician’s assistants (PAs); however, the physician should be listed as the Member’s PCP.

The Supplier is encouraged to promote and facilitate the capacity of all PCP practices to establish and meet standards for PCP operations that are consistent with the recognition requirements for a NCQA recognized Patient Centered Medical Home (PCMH™) as defined by NCQA. The Supplier shall report to DCH those PCP practices that achieve recognition or meet the NCQA requirements for recognition as a NCQA for PCMH™. The Supplier shall collaborate with other CMOs to coordinate efforts when PCPs who are contracted with one or more CMOs so that efforts are not duplicated.

The Supplier will include Behavioral Health Homes in its Medical Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated. The number of Behavioral Health Homes proposed in the network should be responsive to the prevalence of members with severe and persistent mental illness or chronic behavioral health conditions. The proposed algorithm along with assignment of Behavioral Health Homes shall be included in a Medical Home implementation plan.

The Supplier shall provide a Patient Centered Medical Home implementation plan within ninety (90) days of the Operational Start Date for DCH review and approval that identifies the methodology for promoting and facilitating NCQA PCMH recognition. The implementation plan shall include, but shall not be limited to:

- a. Payment methodology for payment to Primary Care practices as described in section K.
- b. Provision of technical support, to assist in their transformation to Physician Practice Connections-Patient Centered Medical Home (PPC®-PCMH) recognition (e.g., education, training, tools, and provision of data relevant to patient clinical care management);
- c. Facilitation of specialty Provider Network access and coordination to support the PCMH; and
- d. Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other Providers

5. Direct Access

The Supplier shall provide female Members with direct In-Network access to a women’s health specialist for covered care necessary to provide routine and preventive Health Care

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services. This access is in addition to the Member's designated source of Primary Care if that Provider is not a women's health specialist.

The Supplier shall have a process in place that ensures that Members determined to need a course of treatment or regular care Monitoring have direct access to a specialist as appropriate for the Member's Condition and identified needs. The Supplier's Chief Medical Officer shall be responsible for over-seeing this process.

6. Pharmacies

The Supplier shall maintain a comprehensive Provider network of pharmacies that ensures pharmacies are available and geographically accessible to all Members.

7. Hospitals

The Supplier shall have a comprehensive Provider network of hospitals such that they are available and geographically accessible to all Members. This includes, but is not limited to tertiary care facilities and facilities with neonatal, intensive care, burn, and trauma units.

The Supplier shall include in its network all Critical Access Hospitals (CAHs).

The Supplier shall maintain copies of all letters and other correspondence related to its efforts to include CAHs in its network. This documentation shall be provided to DCH upon request.

8. Laboratories

The Supplier shall maintain a comprehensive Provider network of laboratories that ensures laboratories are accessible to all Members. The Supplier shall ensure that all laboratory testing sites providing services under the Contract have either a clinical laboratory (CLIA) certificate or a waiver of a certificate of registration, along with a CLIA number, pursuant to 42 CFR 493.3.

9. Mental Health/Substance Abuse

The Supplier shall include in its network the three tiers of community Behavioral Health Providers listed below that meet the requirements of the Department of Behavioral Health and Developmental Disabilities, provided they have been credentialed to participate in Medicaid for that Provider type and agree to the Supplier's terms and conditions as well as rates. Additional information about these Provider types and related policies and standards is available at <https://gadbhdd.policystat.com/policy/1038203/latest/>.

- a. **Tier 1: Comprehensive Community Providers (CCP)** function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The standards and requirements for CCP Providers are found in CCP Standards for Georgia's Tier 1 Behavioral Health Safety Net, 01-200.
- b. **Tier 2: Community Medicaid Providers (CMP)** provide Behavioral Health Services and supports identified in the Medicaid State Plan for Serious Emotional Disturbance (SED) youth, young adults, Serious and Persistent Mental Illness (SPMI) Adults, and individuals

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with Substance Use Disorders (SUDs). CMP Providers must competently serve children, adolescents, emerging adults, and/or adults and have the capacity and infrastructure to provide all of the services in the core benefit package:

- c. **Tier 3: Specialty Providers (SP)** that offer an array of specialty services including but not limited to:
 - i. Intensive Family Intervention Providers for children who have Mental Illness/serious emotional disturbance (or similar diagnosis) and their families.
 - ii. Certified Peer Specialists (CPS) with personal experience for both young adults and adults to include CPS-Parents who are associated with a Family Support Organization (i.e. Federation of Families), CPS-Addiction and CPS Whole Health and Wellness.
 - iii. Care Management Entities to provide intensive, customized, Complex Care Coordination for children, youth, and young adults who have Mental Illness/serious emotional disturbance (or similar diagnosis) and their families.
 - iv. Assertive Community Treatment for adults with SPMI

Additionally, the Supplier shall include in its Provider network Providers who under the State Plan and enrolled as psychologists.

The Supplier shall maintain copies of all letters and other correspondence related to the inclusion of Community Behavioral Health Providers in its network. This documentation shall be provided to DCH upon request.

10. Federally Qualified Health Centers (FQHCs)

The Supplier shall include in its Provider network all FQHCs and utilize the Prospective Payment System (PPS) rates.

The Supplier shall maintain copies of all letters and other correspondence related to its efforts to include FQHCs in its network. This documentation shall be provided to DCH upon request.

The FQHC must agree to provide those Primary Care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for FQHC (the Manual). Services and supplies deemed necessary for the provision of Core Services as described in §901.2 of the Manual are considered part of the FQHC service. In addition, an FQHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:

- a. EPSDT/Health Check (Category of Service (COS) 600);
- b. Mental Health (COS 440);
- c. Dental Services (COS 450 and 460);
- d. Refractive Vision Care services (COS 470); and

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- e. Podiatry (COS 550).

11. Rural Health Centers

The Supplier shall include in its Provider network all RHCs based on PPS rates.

The Supplier shall maintain copies of all letters and other correspondence related to its efforts to include RHCs in its network. This documentation shall be provided to DCH upon request.

The RHC must agree to provide those Primary Care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for RHC (the Manual). Services and supplies deemed necessary for the provision of a Core Services as described in §901.2 of the Manual are considered part of the RHC service. In addition, an RHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:

- a. EPSDT/Health Check (COS 600)
- b. Mental Health (COS 440)
- c. Dental Services (COS 450 and 460)
- d. Refractive Vision Care services (COS 470)
- e. Podiatry (COS 550)

12. Telemedicine

Telemedicine allows Provider-to-Provider and Provider-to-member live interactions, and is especially useful in situations where Members do not have easy access to a Provider, such as for Members in rural areas. Providers also use Telemedicine to consult with each other and share their expertise for the benefit of treating Members.

DCH does not currently recognize provider-to-provider live interactions without a Member present. Further, DCH does not currently recognize Store-and-Forward interactions of any kind. DCH reserves the right to modify this policy decision in the future, acknowledging that such a change would require a review of the appropriateness of the Capitation Rates. However, nothing in this Scope of Work would prevent a CMO from offering Store-and-Forward use of telemedicine or Provider-to-Provider interactions without a Member present as an additional service not subject to consideration in the Capitation Rate setting process.

The Supplier shall provide for Telemedicine services to increase access to primary and specialty care as appropriate. Telemedicine presentation sites shall receive a Telemedicine presentation site facility fee consistent with the Georgia Medicaid FFS program unless otherwise negotiated. The Supplier must include in its Provider Directory information on Providers with Telemedicine capabilities and Telemedicine presentation sites. The Supplier must:

- a. Promote and employ broad-based Utilization for access to Health Insurance Portability and Accountability Act (HIPAA)-compliant Telemedicine service systems;

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- b. Follow accepted HIPAA and 42 C.F.R. Part 2 regulations that affect Telemedicine transmission, including but not limited to staff and Provider training, room setup, security of transmission lines, etc. The Supplier shall have and implement policies and procedures that follow all federal and State security and procedure guidelines;
- c. Identify, develop, and implement training for accepted Telemedicine practices;
- d. Participate in the needs assessment of the organizational, developmental, and programmatic requirements of Telemedicine programs; and
- e. A Health Care facility that receives reimbursement under this section for consultations provided by a Medicaid-Participating Provider who practices in that facility and a health professional who obtains a consultation under this section shall establish Quality-of-care protocols and patient confidentiality guidelines to ensure that telehealth consultations meet all requirements and patient care standards as required by law.

The Supplier shall determine the exact number and locations of all Telemedicine presentation sites and the number of Providers who will commit to providing Telemedicine consultations.

13. Family Planning Clinics

The Supplier shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act.

The Supplier shall maintain copies of all letters and other correspondence related to its efforts to include Title X Clinics in its network. This documentation shall be provided to DCH upon request.

14. Nurse Practitioners Certified (NP-Cs) and Certified Nurse Midwives (CNMs)

The Supplier shall ensure that Members have appropriate access to NP-Cs and CNMs, through either Provider Contracts or Referrals. This provision shall in no way be interpreted as requiring the Supplier to provide any services that are not Covered Services.

15. Dental Practitioners

The Supplier shall not deny any dentist from participating in the Georgia Families dental program if the dentist meets the below criteria:

- a. Such dentist has obtained a license to practice in this State and is an enrolled Provider who has met all requirements of DCH for participation in the Medicaid and PeachCare for Kids® programs;
- b. Licensed dentist will provide dental services to Members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, the Supplier must offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the Service Region who participate in the Supplier's Medicaid and PeachCare for Kids® dental programs;

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- c. The geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by DCH, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services;

The Supplier must establish a sufficient number of general dentists and specialists as specified by Geographic Access Requirements, specified in section I.17, to provide covered dental services to Members. The Supplier may cover certain dental services provided by a dental hygienist in a Public Health setting in accordance with all applicable laws and rules. The Supplier may also provide for services in a school environment by mobile dentistry Providers.

Should the Supplier find that the Provider does not meet these provisions and elects to deny participation, the Supplier's denial letter of a credentialed Provider's request to contract must include specific information regarding the basis for denial and how to file an Appeal.

The Supplier must report to DCH the number of dental contract denial Appeals, and Appeal outcomes on a calendar month basis.

16. Dental Home

The Supplier shall provide all Members under age twenty-one (21) a Dentist who will serve as the Members' Dental Home. The Supplier shall have written Selection Policies and Procedures describing how Members select or are assigned to a Dental Home.

P4HB participants are not eligible for a Dental Home.

17. Geographic Access Requirements

In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Supplier shall meet the Geographic Access standards for all Members outlined in Figure 1. The Supplier shall utilize the most recent Geo Access program versions available and update periodically as appropriate. The Supplier shall use GeoCoder software along with the Geo Access application package.

Beginning on the Operational Start Date, the Supplier's Geographic Access analysis, using the Geo Access tool, must include the below data standards and reporting specifications. However, DCH reserves the right to modify the data standards and report specifications at any time in its discretion. The Supplier can submit recommendations for differing data standards and report specifications for DCH consideration and approval. With this submission, the Supplier must include its rationale for requesting the change. DCH's prior written approval of the change is required.

- a. Data Standards:

- 1. The Supplier shall use the most recent eligibility files provided by DCH.

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2. The Supplier shall use the most recent Member data to geocode each Member by street address. Identifying Members at zip code centroids or randomly within zip codes is not acceptable.
3. All Supplier's Provider Network street addresses should be exactly geocoded. For any address that cannot be exactly geocoded, the address should be geocoded using a technique that takes into account population density. Placing Providers at zip code centroids or randomly within zip codes is not acceptable.
4. If more than one Provider is located at the same address, all Providers at that address should have the same geographic coordinates.
5. Physicians should be classified based on their primary specialty only. For example, a pediatric cardiologist should be classified as cardiologist, not a pediatrician. The Provider file must include the capacity for each PCP and general dentist.
6. The Supplier shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider location. For purposes of this requirement, a Full-Time Provider location is defined as a location operating for sixteen (16) or more hours in an office location each Week. For Providers who have more than one (1) office location, the Supplier must indicate each location by a separate record in the Provider file and divide the capacity of the Provider by the number of locations. For example, if the Provider capacity is one hundred fifty (150), and the Provider has two (2) offices, each office would have a capacity of seventy-five (75). The "individual capacity" option should be used when reporting PCPs. For calculating distance (miles) the Supplier must use the "maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider. DCH recognizes that transportation with NET vendors may not always follow direct routes due to multiple passengers.

b. Report Specifications:

The Supplier must prepare a separate Geographical Access reports for each county, addressing all Provider types included in Figure 1. Additionally, the Supplier shall prepare separate analyses for the following:

1. Adult PCPs for ages twenty-one (21) and over
2. Pediatric PCPs for children under the age of twenty-one (21)
3. General dentist
4. Telemedicine presentation sites
5. Provider specialists shortage as identified by DCH or the Supplier including but not limited to OB Providers

The Supplier must prepare separate Geographical Access reports showing Providers with open panels only and showing all open and closed panels.

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Figure 1. Geographic Access Standards by Provider Type

Provider Type	Urban	Rural
PCPs*	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Obstetric Providers	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a Week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an After-Hours emergency phone number and pharmacist on call), seven (7) days a Week within thirty (30) minutes or thirty (30) miles
Therapy (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

*Excluding practitioners listed below in Table.

18. Other Reports

In addition to the Geographic Access data reports, the Supplier shall submit the following separate reports:

- a. Providers and associated locations with closed panels (any Provider which the Supplier recognizes as no longer accepting new Members) and those Providers and associated locations with less than Full-Time Provider hours. The separate reports must include a listing of the Providers by name and location, Provider type and an analysis of the total number of Providers with closed panels or less than Full-Time Provider hours expressed as a percentage of the Supplier's total contracted Providers for the state and then for each Service Region.
- b. The percent of Members who do not have Provider access as defined in Figure 1.
- c. Plans or Corrective Actions to enhance access of the Providers included in these separate reports. If enhanced access is not possible (i.e., no Providers available for contracting or available Providers only practice part-time), the Supplier must describe the limitations to enhancing access. The Supplier may indicate whether a Provider's office is a primary, secondary, tertiary, etc. location.
- d. Report monthly the total number of Provider requests to contract received, the total number of Providers referred to DCH or its Agent for credentialing, the total number of contracts pending a determination, and the total of each of the approved and denied contract requests by Provider type and in aggregate.

The Supplier shall ensure that all executed Provider Contracts are processed and loaded into all systems including but not limited to the Supplier's Claims processing system, within thirty (30) Calendar Days of receipt by the Supplier or its designated Subcontracted vendor.

19. Waiting Maximums and Appointment Requirements

The Supplier shall require that all network Providers offer hours of operation that are no less than the hours of operation offered to commercial and Fee-for-Service patients. The Supplier shall encourage its PCPs to offer After-Hours office care in the evenings and on weekends.

The Supplier shall have in its network the capacity to ensure that waiting times for appointments do not exceed those outlined in Figure 2.

Figure 2. Waiting Times by Provider Type

Provider Type	Waiting Time
PCPs (routine visits)	Not to exceed fourteen (14) calendar days
PCP (adult sick visit)	Not to exceed twenty-four (24) clock hours

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Provider Type	Waiting Time
PCP (pediatric sick visit)	Not to exceed twenty-four (24) clock hours
Maternity Care	First Trimester – Not to exceed fourteen (14) Calendar Days Second Trimester – Not to exceed seven (7) Calendar Days Third Trimester – Not to exceed three (3) Business Days
Specialists	Not to exceed thirty (30) Calendar Days
Therapy: Physical Therapists, Occupational Therapists and Speech Therapists,	Not to exceed thirty (30) Calendar Days
Vision Providers	Not to exceed thirty (30) Calendar Days
Dental Providers (routine visits)	Not to exceed twenty-one (21) Calendar Days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) Calendar Days
Mental Health Providers	Fourteen (14) Calendar Days
Urgent Care Providers	Not to exceed twenty-four (24) clock hours
Emergency Providers	Immediately (twenty-four (24) clock hours a day, seven (7) days a Week) and without Prior Authorization

The Supplier shall have in its network the capacity to ensure that waiting times in the Provider’s office do not exceed those outlined in Figure 3 for pediatrics and adults.

Figure 3. Waiting Times by Appointment Type

Appointment Type	Waiting Time
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Appointment Type	Waiting Time
Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed ninety (90) minutes. After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Providers shall track waiting times by appointment, to be reviewed by DCH upon request.

The Supplier shall ensure that Provider response times for returning calls After-Hours do not exceed those outlined in Figure 4.

Figure 4. Returned Call Response Times

Call Type	Response Time
Urgent Calls	Shall not exceed twenty (20) minutes
Other Calls	Shall not exceed one (1) hour

20. Access and Availability Audits

The Supplier shall conduct access and availability quarterly audits to validate Provider network access (outreach phone calls, emails) of individual Providers within the Supplier’s Primary Care, specialty, dental, pediatric and obstetrical Provider Network. The Supplier may coordinate with other CMOs to conduct these audits to avoid duplicate contacts to Providers. The Supplier shall conduct a review of twenty-five percent (25%) of the combined network. Reviews shall include the use of “secret shopper” calls during which the caller pretends to be a Member to confirm specific information including but not limited to the following:

- a. Contact Information, such as address, phone, email, web site and fax numbers.
- b. Provider is participating in the Network
- c. Open/closed panel status.

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- d. Appointment availability and how far in advance the Member can schedule an appointment

The Supplier shall provide DCH with results of all access and availability audits upon requests. The Supplier shall take Corrective Action to remediate instances of identified non-compliance with the standards above and report all non-compliance to DCH within thirty (30) Calendar Days of the audit. Should DCH identify and notify the Supplier of non-compliance with the standards listed above, the Supplier shall provide to DCH a Corrective Action Plan within thirty (30) Calendar Days of receipt of such notice.

21. Mainstreaming

The Supplier shall encourage that all In-Network Providers accept Members for treatment, unless they have a full panel and are accepting no new Georgia Families or commercial patients. Supplier shall ensure that In-Network Providers do not intentionally segregate Members in any way from other persons receiving services.

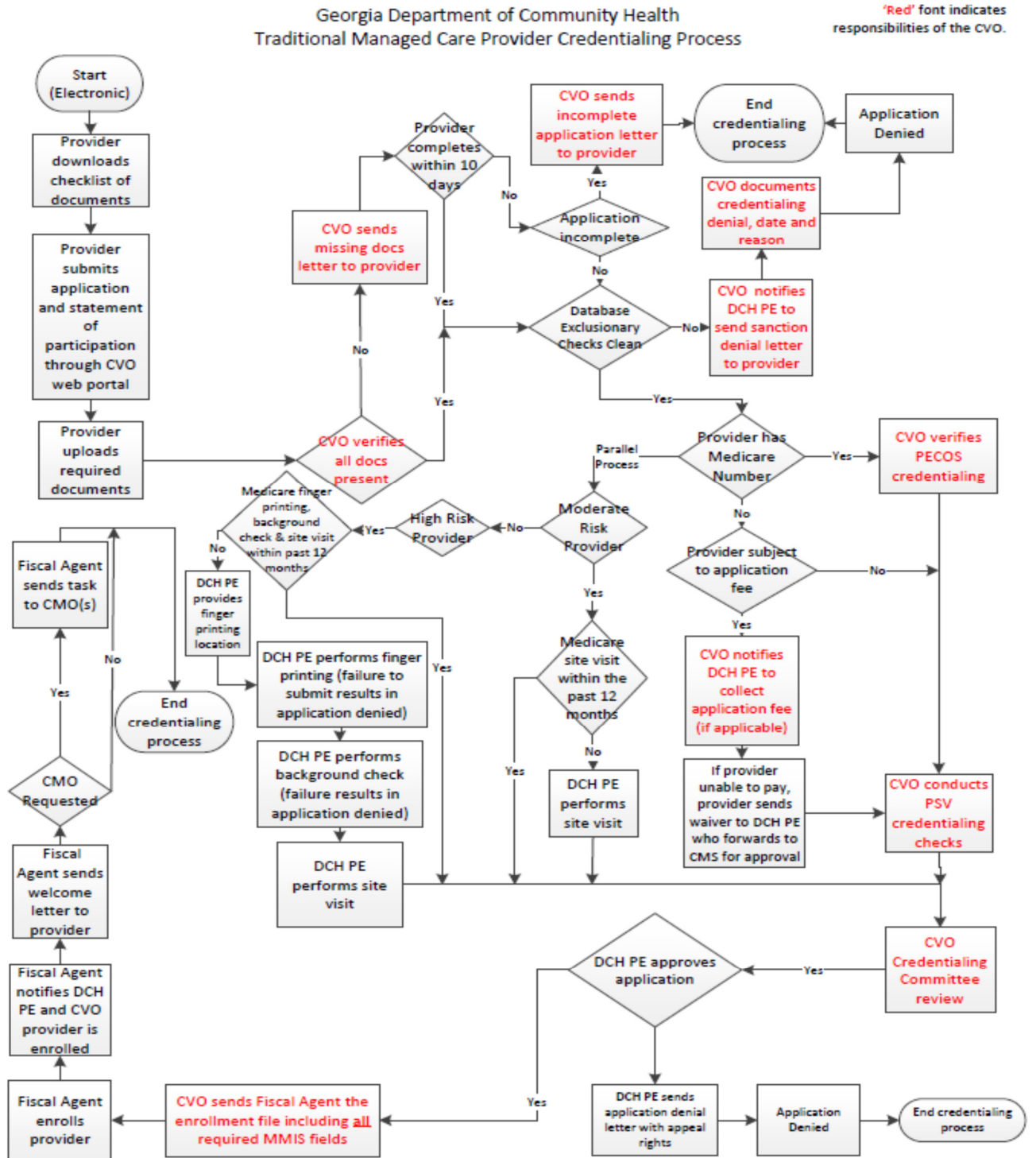
The Supplier shall ensure that Members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.

22. Provider Credentialing

DCH is contracting with a single Credentialing Verification Organization (CVO) to conduct credentialing and re-credentialing of Providers for Medicaid and the contracted CMOs. Providers must enroll with Medicaid and/or Georgia Families or Georgia Families 360° by submitting an electronic application and supporting documentation through the CVO's web-based Provider credentialing portal. The Supplier will not conduct its own Credentialing processes and shall accept the CVO's credentialing and recredentialing determinations. The Supplier cannot appeal the CVO credentialing decision. The Supplier cannot require Providers to submit supplemental or additional information for purposes of conducting a second credentialing process by the Supplier. The figure below details the Provider credentialing process. Please note that this process may be updated as DCH finalizes the requirements with the CVO.

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Figure 5: CVO Credentialing Process



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a. Credentialing Timeline

The Supplier shall coordinate with DCH's contracted CVO to confirm the status of Providers who are requesting to enroll with the Supplier and to confirm recredentialing status. The Supplier shall report to DCH any instances in which it is informed that a determination has not been made by the CVO within thirty (30) Calendar Days of application. The figure below details the timeline for the CVO's processing of clean credentialing applications. Please note this timeline may be modified as DCH finalizes requirements with the CVO.

Figure 6: CVO Credentialing Timeline

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 Provider Credentialing Timeline - Traditional Managed Care Providers
 'Clean' Applications

Step No.	Credentialing Steps	Number of Calendar Days																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
1	CVO verifies provider submitted all required docs, including statement of participation	1																														
2	CVO conducts database exclusionary checks (fraud and abuse verification)		3	4																												
3	CVO conducts PECOS Credentialing verification				5	6	7	8	9																							
4	CVO conducts PSV Credentialing verification				5	6	7	8	9																							
5	DCH PE conducts finger printing if needed (High-Risk Providers only)				10	11	12	13	14	15																						
6	DCH PE conducts background check if needed (High-Risk Providers only)				10	11	12	13	14	15																						
7	DCH PE conducts site visit, if needed (High and Moderate Risk Providers)				10	11	12	13	14	15																						
8	CVO Credentialing Committee Review															15	16	17	18	19												
9	DCH PE approves application																				20	21	22	23	24							
10	CVO sends enrollment file to Fiscal Agent																											25	26	27	28	
11	Fiscal Agent enrolls providers and notifies DCH PE and CVO provider is enrolled																											25	26	27	28	
12	Fiscal Agent sends welcome letter to Provider and notifies CMO if requested by provider (Managed Care Only)																															30

Note: This timeline represents a 30 Calendar Day window for the Credentialing process for Traditional providers submitting clean applications and enrolling with one or more CMO(s). This timeline does not include steps needed for Providers to contract with CMO(s).

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b. **Credentialing Process**

The Supplier shall refer Providers to the CVO's web site to complete the credentialing process prior to enrolling with a CMO. The Supplier shall also provide information about the re-credentialing process to all network Providers. The Supplier will refer all Providers who are not Medicaid Providers and requesting to enroll to the CVO.

The CVO updates the Provider credentialing portal and notifies DCH of the Credentialing status. If Credentialing is successful, the application is sent to DCH for final disposition. For approved applications, the CVO sends a file with all of the Provider's Enrollment data to the Fiscal Agent to update the Medicaid Management Information System (MMIS) to include the necessary Provider information. The Fiscal Agent will send the Provider a welcome letter, and notify any CMO in which the Provider has requested to also enroll.

In the event the State decides not to contract with a single CVO, the Supplier shall be responsible for all credentialing and re-credentialing of its network Providers. The Supplier would be required to submit a credentialing and re-credentialing plan to DCH for review and approval prior to beginning these processes and updates thereto.

23. Network Changes

The Supplier shall notify DCH within seven (7) Business Days of any significant changes to the Provider network or, if applicable, to any Subcontractors' Provider network. A significant change is defined as:

- a. A decrease in the total number of PCPs by more than five percent (5%);
- b. A loss of all Providers in a specific specialty where another Provider in that specialty is not available within the geographic access standards;
- c. A loss of specialty Providers in a Health Professional Shortage Areas including but not limited to Obstetric Providers;
- d. A loss of a hospital in an area where another contracted hospital of equal service ability is not available within the geographic access standards; or
- e. Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to In-Network Providers, including closed Provider panels.

The Supplier shall have procedures to address changes in the CMO's Provider network that negatively affect the ability of Members to access services, including access to a culturally diverse Provider network. Failure to adequately address significant changes in network composition that negatively impact Member access to services may be grounds for Contract termination or State determined remedies

If a PCP ceases participation in the Supplier's Provider network, the Supplier shall send written notice to the Members who have chosen the Provider as their PCP. The notice shall encourage the Member to select a new PCP as soon as possible to limit disruption in care, and explain that the DCH Enrollment Broker will assign a new PCP if the Member does not

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choose a new PCP within thirty (30) Calendar Days. The notice must contain contact information to assist the Member in selecting a new PCP. If a Member is in a prior authorized ongoing course of treatment with any other Participating Provider who becomes unavailable to continue to provide services, the Supplier shall notify the Member in writing within ten (10) Calendar Days from the date the Supplier becomes aware of such unavailability.

These requirements to provide notice to the Member prior to the effective dates of Provider termination shall be waived in instances where a Provider becomes physically unable to care for Members due to illness, a Provider dies, the Provider moves from the Service Region and fails to notify the Supplier, or when a Provider fails Credentialing. Under these circumstances, notice shall be issued Immediately upon the Supplier becoming aware of the circumstances, along with contact information to assist the Member in selecting a new PCP.

The Supplier shall submit a Continuity of Care plan to DCH sixty (60) Calendar Days prior to the anticipated mass Network changes, as defined in this section that will impact membership. DCH may require the Continuity of Care Plan drill down to the individually affected member level depending upon the situation.

24. Out-of-Network Providers

If the Supplier's network is unable to provide Medically Necessary Covered Services to a particular Member, the Supplier shall adequately and timely cover these services Out-of-Network for the Member. The Supplier must inform the Out-of-Network Provider that the Member cannot be balance billed.

The Supplier shall coordinate with Out-of-Network Providers regarding payment. For payment to Out-of-Network, or non-participating Providers, the following guidelines apply:

- a. If the Supplier offers the service through an In-Network Provider(s), and the Member chooses to access the service (i.e., it is not an emergency) from an Out-of-Network Provider, the Supplier is not responsible for payment.
- b. If the service is not available from an In-Network Provider and the Member requires the service and is referred for treatment to an Out-of-Network Provider, the payment amount is a matter between the CMO and the Out-of-Network Provider.
- c. If the service is not available from an In-Network Provider, but the Supplier has three (3) Documented Attempts to contract with the Provider, the Supplier is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
- d. If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition standard, and the Supplier has three (3) Documented Attempts to contract with the Provider, the Supplier is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
- e. When paying out of state Providers in an emergency situation, the Supplier shall not allow a Member to be held accountable for payment.

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In the event that needed services are not available from an In-Network Provider and the Member must receive services from an Out-of-Network Provider, the Supplier must reimburse the Provider. In this instance, Supplier is prohibited from billing the Member.

25. Shriners Hospitals for Children

The Supplier shall comply with the responsibilities outlined in the “Memorandum of Understanding for the PeachCare Partnership Program” executed on February 18, 2008 as amended from time to time, and attached to this RFP as Attachment I and expressly incorporated into the Contract as if completely restated herein.

The Supplier shall cooperate with DCH in making any updates or revisions to the Memorandum, as necessary.

J. Provider Services

The Supplier shall establish and maintain a Provider services function to act as the point of contact for its Providers. As such, the Supplier will provide educational material, operate a Provider services line, facilitate Provider Complaints and timely address Provider Contract and payment issues. The Supplier must staff its Provider services department with personnel qualified to fulfill the requirements as described in this section of the scope of work.

1. General Provisions

The Supplier shall provide information to all Providers about Georgia Families in order to operate in full compliance with the Georgia Families Contract resulting from this RFP and all applicable federal and State regulations.

The Supplier shall monitor Provider knowledge and understanding of Provider requirements, and take Corrective Actions to ensure compliance with such requirements.

The Supplier shall submit to DCH for initial review and approval within sixty (60) Calendar Days of Notice of Award, and as updated thereafter, all materials and information to be distributed and/or made available to Providers about Georgia Families.

All Provider Handbooks and bulletins must be in compliance with State and federal laws.

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The Supplier must seek DCH's written approval of the Supplier's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider Contracts or communications. DCH's review and response will be completed within sixty (60) Calendar Days of the Supplier's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Supplier misinterprets a Medicaid policy which is communicated to Providers, the Supplier must submit a written Corrective Action Plan to DCH within three (3) Business Days of notice from DCH. The Supplier will be required to retroactively correct and adjust any previously adjudicated Claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) Calendar Days of approval of the Corrective Action Plan.

2. Provider Handbooks

The Supplier shall provide a Provider Handbook to all Providers. The Supplier shall make the Member Handbook available through the Supplier's web site. Upon request, the Supplier shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding Georgia Families Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information:

- a. Georgia Families Covered Services;
- b. Member Eligibility categories;
- c. Medical Necessity standards and practice guidelines;
- d. Role of the Medical Home
- e. Link to the NCQA and Joint Commission web sites
- f. Role of the Dental Home
- g. Emergency Service responsibilities;
- h. EPSDT Benefit;
- i. Prior Authorization, Pre-Certification, and Referral procedures;
- j. Practice protocols, including guidelines pertaining to the treatment of chronic and complex Conditions;
- k. Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers
- l. Provider Complaint System Policies and Procedures, including but not limited to specific instructions for contacting the Supplier's Provider services staff to file a complaint and which individual(s) have the authority to review a complaint;
- m. Policies and procedures for the Provider Grievance and Appeals process

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- n. Information on the Member Grievance System, including the Member's right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the Member's right to request continuation of Benefits while utilizing the Grievance System;
- o. The Role of the CVO and link to the CVO web site;
- p. Information about the GaHIN including how information will be used by the CMOs and DCH and an explanation of any service limitations or exclusions from coverage
- q. Link to the DCH web site;
- r. Role of the DCH Fiscal Agent and link to the Fiscal Agent's web site;
- s. Information about the Georgia Families Value Based Purchasing program
- t. Transition of Care planning
- u. Care Coordination Policies
- v. Protocol for Encounter Claims element reporting/records;
- w. Medical Records standards;
- x. Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;
- y. Payment policies;
- z. The Supplier's Cultural Competency Plan;
- aa. Member rights and responsibilities;
- bb. Other Provider or Subcontractor responsibilities;
- cc. Information about the 1115 Demonstration, Planning for Healthy Babies, including:
 - 1. Demonstration description;
 - 2. Covered Demonstration Services
 - 3. Practice protocols;
 - 4. Other Provider responsibilities;
 - 5. Coding requirements;
 - 6. Prior Authorization, Pre-Certification, and Referral procedures; and
 - 7. P4HB participants' rights and responsibilities.

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The Supplier shall disseminate bulletins as needed to incorporate any needed changes to the Provider Handbook. These bulletins can be mailed hard copy or can be disseminated via email, provided hard copies are available and Providers are informed of how to request a hard copy.

The Supplier shall submit the Provider Handbook to DCH for initial review and approval within sixty (60) Calendar Days of Contract Execution Date and as updated thereafter. Any updates or revisions shall be submitted to DCH for review and approval at least thirty (30) Calendar Days prior to distribution.

3. Education and Training

The Supplier shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Supplier shall conduct initial training within thirty (30) Calendar Days of executing a contract with a newly contracted Provider. The Supplier shall also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Supplier or DCH to ensure compliance with program standards and the Georgia Families Contract and meet the needs of Providers.

The Supplier shall also provide Provider workshops, data, trainings and technical assistance, webinars and web-based tutorials about the emergence and ongoing operations of PCPs and other service delivery innovations, evidence-based and emergency best practices, delivering a person-centered approach to care and the System of Care approach to care delivery.

The Supplier shall provide training to all Demonstration Family Planning and IPC service Providers and their staff regarding the requirements of the Demonstration and the Contract provisions related to the Demonstration and special needs of the P4HB participants. The Supplier shall conduct initial training within thirty (30) Calendar Days of placing a newly contracted Provider on active status. The Supplier shall also conduct ongoing training as deemed necessary by the Supplier or DCH to ensure compliance with the Demonstration's standards and the Contract.

The Supplier's Demonstration Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling available at:
<http://fpm.emory.edu/preventive/research/projects/index.html>.

The Supplier shall develop and submit a Provider Training Manual and Training Plan, including topics, schedule and language, to DCH for initial review and approval at least thirty (30) Calendar Days prior to any scheduled trainings and as updated thereafter.

DCH may attend any training sessions specific to the Contract at its discretion.

4. Provider Relations

The Supplier shall establish and maintain a formal Provider relations function to timely and adequately respond to questions and concerns from network Providers. The Supplier shall implement policies addressing the compliance of Providers with the requirements included in this RFP and institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.

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The Supplier shall provide for at least one (1) Provider Relations Liaison per Service Region to conduct the Provider Relations functions.

5. Provider Services Call Center

The Supplier shall operate a toll-free Provider Services call center to respond to Provider questions, comments and concerns.

The Supplier shall develop call center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, Monitoring of calls via recording or other means, and compliance with standards.

The Supplier shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval, and as updated thereafter.

The Supplier's call center systems shall have the capability to track call management metrics identified in Attachment I.

Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a Week to respond to Prior Authorization and Pre-Certification requests. The call center shall have staff to respond to Provider questions in all other areas, including the Provider Complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays. The Supplier shall ensure that after regular business hours the non-Prior Authorization/ Pre-Certification line is answered by an automated system with the capability to provide callers with operating hour's information and instructions on how to verify Enrollment for a Member with an Emergency or Urgent Medical Condition. The Call Center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Supplier shall provide information to Providers on how to verify Enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.

The Supplier shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Supplier shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for initial review and approval and as updated thereafter. At a minimum, the standards shall require that, on a Calendar month basis:

- a. Average Speed of Answer: Eighty percent (80%) of calls are answered by a person within thirty (30) seconds. The remaining twenty percent (20%) of calls are answered by a person within and additional thirty (30) seconds. "Answer" shall mean for each caller who elects to speak to a live representative.
- b. Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either not permitted access to that option or disconnects from the system.

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- c. Blocked Call Rate, or a call that was not allowed into the system, that does not exceed one percent (1%).
- d. Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a call center representative.
- e. Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.
- f. Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.

The Supplier shall set up remote phone Monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Supplier will facilitate bi-annual calibration sessions with the DCH. The purpose of the calibration sessions is to ensure call center Monitoring findings conducted by the DCH and the Supplier are consistent.

6. Provider Directory

The Provider Directory shall include current names, locations, office hours and the telephone number of and non-English language(s) spoken by, current contracted Providers. The Provider Directory includes, at a minimum, information about PCPs, specialists, Family Planning Providers, dentists, pharmacies, vision providers, FQHCs and RHCs, Mental Health and substance abuse Providers, speech therapists, occupational therapists, physical therapists and hospitals. The Provider Directory shall identify Providers that are not accepting new patients for any provided services, office hours, specialty providers not accepting referrals and/or Providers that are only accepting specialty populations. The Provider Directory shall also identify if the location is a Telemedicine presentation site. The online Provider Directory shall be updated within five (5) Business Days upon any change in the Provider Network, open and closed panels and Provider service offerings.

The Supplier shall submit an updated version to DCH of the Provider Network Listing spreadsheet as defined in Attachment I, for all requested Provider types upon request. DCH may require the Supplier to include in the submission executed Signature Pages of Provider Contracts and written acknowledgements from all Providers who are part of a Preferred Health Organization (PHO), IPA, or other Network stating that they know they are in the CMO's Provider network, know they are accepting Medicaid Members, any restrictions on which Members the Provider is seeing, and that they are accepting the terms and conditions of the Provider Contract.

The Supplier must submit the Provider Directory template and specifications for the Directory that will be provided on the web site to DCH for initial review and approval within sixty (60) Calendar Day of Notice of Award, and as updated thereafter. The Supplier shall not use the new template until notification of approval from DCH.

7. Georgia Families Provider Web Site

The Supplier shall dedicate a section of its web site to Provider Services and provide general and up-to-date information about the CMO's program. At a minimum, the web site must have the capability for Providers to make inquiries and receive responses through the Medicaid Fiscal Agent's web site, <https://www.mmis.georgia.gov/portal/> and include the following:

- a. A searchable Provider Handbook as set forth in section G.2.
- b. A searchable Provider Directory that the Supplier updates within five (5) Business Days of a change, as set forth in section G.5.
- c. Customer services, including the capability for Providers to submit questions and comments to the Supplier and receive responses. The Supplier shall respond to Provider inquiries within one (1) Business Day of receipt. The Supplier shall refer any inquiries to DCH that are not within the Supplier's scope of services (e.g., inquiries about the Fee-for-Service delivery system).
- d. The capability for Providers to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate Claims electronically and consistent with the

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Supplier's policies and procedures for Provider Claims activities. To the extent a Provider has the capability; the Supplier shall submit payments to Providers electronically and submit remittance advices to Providers electronically within one (1) Business Day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.

- e. Provides information about the following:
 - 1. Grievance and Appeals Systems
 - 2. Pharmacy Preferred Drug List
 - 3. Pharmacy Conditions for Coverage and Utilization Limits
 - 4. Member rights and responsibilities
 - 5. DCH's Value-Based Purchasing program
 - 6. Information about the GaHIN including how Information will be used by the CMOs and DCH and procedures to opt out of the GaHIN
 - 7. PCP responsibilities
 - 8. Dental Home responsibilities
 - 9. Planning for Healthy Babies 1115 Demonstration
- f. Link to DCH's CVO web site.
- g. Link to the DCH Fiscal Agent web site.
- h. Link to the NCQA recognition web site.
- i. What's new items.
- j. Frequently asked questions and answers.
- k. Links to the DCH Medicaid web site, DCH P4HB web site and the Enrollment Broker web site.

The Supplier must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Supplier must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades, enhancements and/or modifications which further the ordinary operation, administration, and maintenance of the web site, the Supplier shall not modify the web site prior to receipt of DCH approval.

The Supplier's web site shall be functionally equivalent, with respect to functions described in this RFP, to the web site maintained by the State's Medicaid Fiscal Agent (<https://www.mmis.georgia.gov/portal/default.aspx/>) and consistent with the standards

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established by the Georgia Technology Authority (GTA) as published at <http://gta.georgia.gov/psg/> and amended periodically.

8. Provider Complaint System

The Supplier shall establish a Provider Complaint system that permits Providers to dispute the policies, procedures, or any aspect of a Supplier's administrative functions.

The Supplier shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and as updated thereafter. The Supplier shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Supplier's Provider services to file a Provider Complaint and which individual(s) have the authority to review a Provider Complaint.

The Supplier shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers with the remittance advice of the processed Claim. The Supplier may distribute a summary of these Policies and Procedures if the summary includes information on how the Provider may access the full Policies and Procedures on the web site. This summary shall also detail how the Provider can request a hard copy from the Supplier at no charge to the Provider.

As a part of the Provider Complaint System, the Supplier shall:

- a. Allow Providers thirty (30) Calendar Days from the date of the action to file a written complaint.
- b. Allow Providers to consolidate complaints or Appeals of multiple Claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment Claims included in the bundled complaint or Appeal.
- c. Require that the Provider's complaints are clearly documented
- d. Allow a Provider that has exhausted the Supplier's internal Appeals Process related to a denied or underpaid Claim or group of Claims bundled for Appeal the option either to pursue the appeals process described in O.C.G.A. § 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A. § 33-21A-7. If the Supplier and the Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the Health Care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Supplier and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.
- e. For all Claims that are initially denied or underpaid by the Supplier but eventually determined or agreed to have been owed by the Supplier to a Provider of Health Care

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services, the Supplier shall pay, in addition to the amount determined to be owed to the Provider, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from fifteen (15) Calendar Days after the date the Claim was submitted. The Supplier shall pay all interest required to be paid under this provision or Code Section O.C.G.A. 33-21A-7 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment.

- f. Accurately identify all interest payments on the associated remittance advice submitted by the Supplier to the Provider.
- g. Require that Providers exhaust the Supplier's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing).
- h. Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems.
- i. Identify a staff person specifically designated to receive and process Provider Complaints.
- j. Thoroughly investigate each Georgia Families Provider Complaint using applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying the Supplier's written policies and procedures.
- k. Ensure that CMO executives with the authority to require Corrective Action are involved in the Provider Complaint process.

In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Supplier shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers may request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.

The Supplier shall notify the Providers that a request for an Administrative Law Hearing must include the following information:

- a. A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;
- b. Identification of the Action being Appealed and the issues that will be addressed at the hearing;
- c. A specific statement of why the Provider believes the Supplier's Action is wrong; and
- d. A statement of the relief sought.

DCH has delegated its statutory authority to receive hearing requests to the Supplier. The Supplier shall include with the Notice of Adverse Action the Supplier's address where a Provider's request for an Administrative Law Hearing should be sent in accordance with O.C.G.A. § 49-4-153(e).

9. Claims Adjustment Requests

If the amount reimbursed by the Supplier to an enrolled Provider is not correct, a positive or negative adjustment may be necessary. Such request for Claims adjustment shall be included in the Supplier's internal Appeals Process and shall not negate a Provider's right to Appeal pursuant to O.C.G.A. §49-4-153(e). The Supplier shall develop a procedure to address Claims adjustment requests that meet the following minimum requirements:

a. Supplier Positive Adjustments

When a Provider can substantiate that additional reimbursement is appropriate, the Provider may adjust and resubmit a Claim. Provider shall submit the request, Explanation of Payment and all Claims related documentation electronically or if permitted by the CMO by U.S. mail. All documentation must be received within three (3) months from the end of the month of payment. The adjustment request must include sufficient documentation to identify each Claim identified in the request. The Supplier may return incomplete requests without further action provided it notifies the Provider of the basis for the incomplete status and allows the Provider ten (10) Calendar Days to resubmit the adjustment request. The Provider shall be required to submit documentation that supports the requested Claim adjustment. If a positive adjustment is warranted, the Supplier shall make additional reimbursement upon processing of the request. If an adjustment is not warranted, the Provider will be notified via written correspondence from the Supplier.

b. Supplier Negative Adjustments

When a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a Claim. The Provider shall be given the option to submit the written request, Explanation of Payment and all Claims related documentation either electronically or by U.S. mail. If a negative adjustment is warranted, the Supplier may either deduct the payment from future reimbursement or request reimbursement from the Provider as required by the Provider's contract with the Supplier.

The Supplier shall respond to all adjustment requests within fifteen (15) Calendar Days of receipt.

The Supplier's web site shall have functionality that allows Providers to submit, process, edit, rebill, and adjudicate Claims electronically.

The Supplier shall include Recoupment information combined within the remittance where the Recoupment occurs.

K. Provider Contracts and Payments

1. Contracts

The Supplier shall submit to DCH for initial review and approval and as updated thereafter a model for each type of Provider Contract initially and as updated thereafter and shall comply

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with all DCH procedures for contract review and approval submission. Memoranda of Agreement (MOA) shall not be permitted.

Any significant changes to the model Provider Contract shall be submitted to DCH for review and approval no later than thirty (30) Calendar Days prior to use of the revised Provider Contract.

Upon request, the Supplier shall provide DCH with copies of all executed Provider Contracts at no cost.

In addition to addressing the CMO licensure requirements, the Supplier's Provider Contracts shall:

- a. Not require Providers to participate or accept other plans or products offered by the Supplier unrelated to providing Covered Services to Members. The Supplier shall be subject to a penalty of \$1,000.00 per violation if this prohibition is violated.
- b. Prohibit the Supplier from entering into any exclusive contract agreements with Providers that exclude other Health Care Providers from contract agreements for network participation.
- c. Prohibit the Supplier from entering into a contract with or without the Provider's consent that prohibits the Provider from Contracting with another Georgia Families CMO as a condition of the Contract.
- d. Prohibit the Health Care Provider from, as a condition of contracting with the Supplier, requiring the Supplier to contract with or not contract with another Health Care Provider.
- e. Prohibit the Provider from seeking payment from the Member for any Covered Services provided to the Member within the terms of the Contract and require the Provider to look solely to the Supplier for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Georgia Medicaid or CHIP State Plans, the Georgia State Medicaid Policies and Procedures Manuals, and the Georgia Families Contract;
- f. Require the Provider to cooperate with the Supplier's Quality improvement and Utilization Review and management activities.
- g. Include provisions for the immediate transfer to another PCP or Supplier if the Member's or P4HB participant's health or safety is in jeopardy.
- h. Not prohibit a Provider from discussing treatment or non-treatment options with Members that may not reflect the Supplier's position or may not be covered by the Supplier.
- i. Not prohibit a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered.

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- j. Not prohibit a Provider from advocating on behalf of the Member in any Grievance System or Utilization Review process, or individual authorization process to obtain necessary Health Care services.
- k. Require Providers to meet appointment waiting time standards pursuant to this section I.19.
- l. Provide for continuity of treatment in the event a Provider's participation terminates during the course of a Member's treatment by that Provider.
- m. Prohibit discrimination with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely based on such license or certification. This provision should not be construed as any willing Provider law, as it does not prohibit Suppliers from limiting Provider participation to the extent necessary to meet the needs of the Members. Additionally, this provision shall not preclude the Supplier from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. This provision also does not interfere with measures established by the Supplier that are designed to maintain Quality and control costs.
- n. Prohibit discrimination against Providers serving high-risk populations or those that specialize in Conditions requiring costly treatments.
- o. Specify that CMS and DCH or its Agent will have the right to inspect, evaluate, and audit any pertinent books, financial records, documents, papers, and records of any Provider involving financial transactions related to the Georgia Families Contract.
- p. Specify Covered Services and populations.
- q. Require Provider submission of timely, complete and accurate Encounter Claims pursuant to section N.1.
- r. Include the definition and standards for Medical Necessity pursuant to the definition in Attachment B of this RFP.
- s. Specify rates of payment. The Supplier ensures that Providers will accept such payment as payment in full for Covered Services provided to Members less any applicable Member cost sharing.
- t. Provide for timely payment to all Providers for Covered Services to Members. Pursuant to O.C.G.A. 33-24-59.5(b) (1) once a Clean Claim has been received, the Supplier will have fifteen (15) Business Days within which to process and either transmit funds for payment electronically for the Claim or mail a letter or notice denying it, in whole or in part giving the reasons for such denial.
- u. Specify acceptable billing and coding requirements.
- v. Require that Providers comply with the Supplier's Cultural Competency plan.

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- w. Require that any Marketing Materials about Georgia Families developed and distributed by Providers to Members be submitted to the Supplier to submit to DCH for prior approval.
- x. Specify that in the case of newborns the Supplier shall be responsible for any payment owed to Providers for services rendered prior to the newborn's Enrollment with the Supplier.
- y. Specify that the Supplier shall not be responsible for any payments owed to Providers for services rendered prior to a Member's Enrollment with the Supplier, even if the services fell within the established period of retroactive eligibility.
- z. Comply with 42 CFR 434 and 42 CFR 438.6.
- aa. Require Providers to attempt to collect Member Co-payments.
- bb. Prohibit Providers from refusing to treat a Member on the basis of inability to pay Co-payments.
- cc. Not employ or Subcontract with individuals on the State or Federal Exclusions list.
- dd. Prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a Member of the Provider's family has a Financial Relationship.
- ee. Require Providers of transitioning Members to cooperate in all respects with Providers of other CMOs to assure maximum health outcomes for Members.
- ff. Contain a provision stating that in the event DCH is due funds from a Provider who has exhausted or waived the Administrative Review process, if applicable, the Supplier shall reduce payment by one hundred percent (100%) to that Provider until such time as the amount owed to DCH is recovered.
- gg. Contain a provision giving notice that the Supplier's negotiated rates with Providers shall be adjusted in the event the Commissioner of DCH directs the Supplier to make such adjustments to reflect budgetary changes to the Medical Assistance program.
- hh. Require the Supplier to notify the Provider in writing no less than thirty (30) Calendar Days prior to any adjustments to the Provider's contracted reimbursement rates and receive written notification from the Provider of acceptance of the new reimbursement rates.
- ii. Allow for the Supplier to recoup or withhold reimbursement made or due to a Provider, as required by and upon receipt of notice by DCH that the Provider has an outstanding balance that is owed to DCH as the result of an identified overpayment for Fee-for-Service Claims. Supplier must transfer all funds withheld or recouped to DCH.
- jj. Prohibit Providers from requiring a pre-service consultation prior to providing care.

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- kk. Require that Providers participate in all DCH and CMO driven Quality improvement, performance measurement activities and Program Integrity operations.

2. Provider Termination

The Supplier shall comply with all State and federal laws regarding Provider termination. In its Provider Contracts, the Supplier shall:

- a. Specify that in addition to any other right to terminate the Provider Contract, DCH may require Provider termination Immediately, or the Supplier may Immediately terminate on its own, a Provider's participation under the Provider Contract if a Provider fails to abide by the terms and conditions of the Provider Contract, as determined by DCH, or, in the sole discretion of DCH, fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from the Supplier specifying such failure and requesting such Provider to abide by the terms and conditions hereof.
- b. Specify that any Provider whose participation is terminated under the Provider Contract for any reason who wishes to contest the termination shall utilize the applicable Appeals procedures outlined in the Provider Contract. No additional or separate right of Appeal to DCH or the Supplier is created as a result of the Supplier's act of terminating, or decision to terminate any Provider. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, the Contract shall remain in full force and effect with respect to all other Providers.

The Supplier shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Supplier's network. If the termination was "for cause", the Supplier may terminate, suspend, or withdraw the Provider immediately and shall notify DCH in writing within one (1) Business Day of the termination. If a Member is receiving ongoing care, the Supplier shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal.

3. Provider Insurance

The Supplier shall require each Provider (with the exception of allied Mental Health professionals included in section K.3.b , and FQHCs that are section 330 grantees) to maintain, throughout the terms of the Contract, at its own expense, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Supplier pursuant to its written Contract with the Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars (\$1,000,000) per occurrence, and three million dollars (\$3,000,000) annual aggregate. Providers may be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve. DCH reserves the right to waive the insurance requirement if necessary for business need. DCH requires:

- a. The Supplier shall require allied Mental Health professionals to maintain, throughout the terms of the Contract, professional and comprehensive general liability, and medical

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malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Supplier pursuant to its written Contract with Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars (\$1,000,000) per occurrence, and one million dollars (\$1,000,000) annual aggregate. These Providers may also be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve.

- b. In the event any such insurance is proposed to be reduced, terminated or canceled for any reason, the Supplier shall provide to DCH and the Office of Insurance and Safety Fire Commissioner at least thirty (30) Calendar Days prior written notice of such reduction, termination or cancellation. Prior to the reduction, expiration and/or cancellation of any insurance policy required hereunder, the Supplier shall require the Provider to secure replacement coverage upon the same terms and provisions so as to ensure no lapse in coverage, and shall furnish DCH and Office of Insurance and Safety Fire Commissioner a Certificate of Insurance indicating the receipt of the required coverage at the request of DCH or Office of Insurance and Safety Fire Commissioner.
- c. The Supplier shall require Providers to maintain insurance coverage (including, if necessary, extended coverage or tail insurance) sufficient to ensure against Claims arising at any time during the term of the Georgia Families Contract, even though asserted after the termination of the Georgia Families Contract. DCH or the Office of Insurance and Safety Fire Commissioner its discretion, may request that the Supplier Immediately terminate the Provider from participation in the program upon the Provider's failure to abide by these provisions. The provisions of this section shall survive the expiration or termination of the Georgia Families Contract for any reason.

4. Provider Payment

With the exceptions noted below, the Supplier shall negotiate rates with Providers and such rates shall be specified in the Provider Contract. The Supplier shall also develop a plan for distributing to Providers fifty (50) percent of the Value Based Purchasing incentive payments it receives from DCH for achieving targets as described in section M.13. The Supplier is required to submit to DCH timely, complete and accurate Encounter Claims for all services, including Claims from those Providers that may be paid a Capitation Payment by the Supplier. The Supplier must require all Providers to submit detailed Encounter data.

If a Provider submits a claim to the Supplier for services rendered within seventy-two (72) clock hours after the Provider verifies the eligibility of the patient with Supplier, the Supplier shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Supplier made payment for a patient for whom it was not responsible, then the Supplier may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.

The Supplier shall be responsible for issuing an IRS Form (1099) in accordance with all federal laws, regulations and guidelines.

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a. Payments to Critical Access Hospitals

When the Supplier negotiates a contract with a Critical Access Hospital (CAH), the Supplier shall pay the CAH a payment rate based on one hundred and one percent (101%) allowable costs incurred by the CAH. DCH may require the Supplier to adjust the rate paid to CAHs if so directed by the State of Georgia's Appropriations Act.

- i. A CAH must provide notice to the Supplier and DCH of any alleged breaches in its contract by the Supplier.
- ii. If a CAH satisfies the requirement of Title 33 of the Official Code of Georgia Annotated (Medicaid Care Management Organizations Act), and if DCH concludes, after notice and hearing, that a Supplier has substantively and repeatedly breached a term of its contract with a CAH, DCH is authorized to require the Supplier to pay damages to the CAH in an amount not to exceed three (3) times the amount owed. Notwithstanding the foregoing, nothing in said Act shall be interpreted to limit the authority of DCH to establish additional penalties or fines against a CMO for failure to comply with the contract between the Supplier and DCH.

b. Payment to FQHC and RHCs

When the Supplier negotiates a contract with a FQHC and/or a RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act, the Supplier shall pay the PPS rates for Core Services and other ambulatory services per Encounter. The rates are established as described in §1001.1 of the Manual. At the Supplier's discretion, it may pay more than the PPS rates for these services. Payment Reports must consist of all Covered Service Claim types each month, inclusive of all services provided by the Supplier.

c. Payment following the Administrative Review process

Upon receipt of notice from DCH that it is due funds from a Provider, who has exhausted or waived the Administrative Review process, if applicable, the Supplier shall reduce payment to the Provider for all Claims submitted by that Provider by one hundred percent (100%), or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered. The Supplier shall promptly remit any such funds recovered to DCH in the manner specified by DCH. To that end, the Supplier's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Supplier's obligation to DCH.

d. Payment following budgetary changes to the Medical Assistance program

The Supplier shall adjust its negotiated rates with Providers to reflect budgetary changes to the Medical Assistance program, as directed by the Commissioner of DCH; to the extent, such adjustments can be made within funds appropriated to DCH and available for payment to the Supplier. The Supplier's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the

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Contract shall constitute agreement with the Supplier's obligation to DCH. Change in the terms of the Provider's reimbursement rate Methodology must be agreed to by the Provider. Suppliers are not permitted to simply send a notice advising as to a reimbursement rate Methodology change. This does not prevent routine and necessary adjustments to Maximum Allowable Charge rates.

The Supplier shall recognize and honor for payment consideration any Provider's claims with dates of service on or after the Provider credentialing date or the Provider contract effective date, whichever is later, irrespective of the date the Supplier loads the Provider into its claims processing system.

5. Administrative Review Process/Law Hearing

The Supplier shall offer the opportunity for Administrative Review to any Provider against whom it proposes to take an adverse action or denial of payment unless otherwise authorized by law to take such action without Administrative Review. The Supplier shall develop policies and procedures, which outline the Administrative Review process.

For a Provider to obtain an Administrative Review, a written request must be received at the address identified by the Supplier within thirty (30) Calendar Days of the date of the notification of the denial or reduction in payment, initial determination, or other adverse action. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation.

The Supplier shall issue an Administrative Review Response within thirty (30) Calendar Days of receipt of the request for Administrative Review. If the Supplier upholds the Proposed Action, the Supplier shall issue a Notice of Adverse Action, which informs the Provider of their right to a hearing before an Administrative Law Judge at the Office of State Administrative Hearings (OSAH).

The Supplier shall offer the Provider the opportunity for an Administrative Hearing after the Administrative Review has been completed and upon receipt of a written request from the Provider. The Request for an Administrative Hearing must be submitted within thirty (30) Calendar Days of the date of the Administrative Review response. The Request for Hearing must be accompanied by a copy of the Administrative Review Response.

All Provider Administrative Appeals shall be transmitted to the Office of State Administrative Hearings.

6. Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)).

The Supplier shall increase benefit payments to Providers in an amount consistent with the Provider rate increases included in the State of Georgia's fiscal year budget. This enhanced rate shall be effective for all dates of service for which the Hospital Medicaid Financing Program Act is in place or until modified by legislative action or DCH policy changes.

The Supplier will provide reports as requested by DCH to enable DCH to determine the amount of the increase in benefit payments to Providers as referenced in section 4.10.7.1.

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The report will include, but not be limited to monthly reports, by hospital, that provide the following data for each claim paid:

- a. Claim Number;
- b. Date of Service;
- c. Date of Payment;
- d. Base Paid Amount;
- e. Add-on Paid Amount;
- f. Interest Paid Amount; and
- g. Total Paid Amount.

Supplier must recoup or withhold reimbursement made or due to a provider, upon receipt of notice by DCH, that the provider has an outstanding balance that is owed to DCH as the result of an identified overpayment for Fee-For-Service claims. Supplier must transfer all funds withheld or recouped to DCH.

L. Utilization Management and Coordination and Continuity of Care Responsibilities

1. Utilization Management

The Supplier shall implement innovative and effective Utilization Management processes to ensure a high Quality, clinically appropriate yet highly efficient and cost-effective delivery system. The Supplier shall continually Evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Supplier must apply Objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account when determining the medical appropriateness of Health Care services.

The Supplier shall enable Pre-Certification of service requests when required and direct Providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Supplier must evaluate all review requests for medical necessity and make recommendations that are more appropriate and more cost-effective. The Supplier should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.

The Supplier shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Supplier shall have written Utilization Management Policies and Procedures that:

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- a. Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.
- b. Address which services require PCP Referral; which services require Prior Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.
- c. Describe mechanisms in place that ensure consistent application of evidence-based review criteria for authorization decisions.
- d. Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Attachment B.
- e. Provide for the Appeal by Members, or their representative of authorization decisions, and guarantee no retaliation will be taken by the Supplier against the Member for exercising that right.

The Supplier shall submit the Utilization Management Policies and Procedures to DCH for review and approval annually and as changed. Nothing in this section shall prohibit or impede the Supplier from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures in so far as that decision is accompanied by the clinical rationale for such a decision.

Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the Remedy.

The Supplier shall establish a Utilization Management Committee. The Utilization Management Committee is accountable to the Chief Medical Officer and governing body of the Supplier. The Utilization Management Committee shall meet no less frequently than on quarterly basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.

The Supplier shall develop and implement an Emergency Room (ER) diversion pilot program with hospital(s) that agree to participate to reduce inappropriate Utilization of ERs for non-emergent Conditions. The Supplier shall submit to DCH ninety (90) Calendar Days prior to beginning the ER diversion pilot program a detailed plan describing how the Supplier will work with Providers to reduce inappropriate Utilization of ERs for non-emergent Conditions. The diversion pilot shall not prohibit or delay a Member's access to ER services.

The Supplier, and any delegated Utilization Review Agent, shall not permit or provide compensation or anything of value to its employees, Agents, or contractors based on:

- a. Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or
- b. Any other method that encourages the rendering of a Proposed Action.

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2. Prior Authorization and Pre-Certification

The Supplier shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services, as described in section D, Special Coverage Provisions.

The Supplier shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.

The Supplier may require Prior Authorization and/or Pre-Certification for all non-emergent, Out-of-Network services.

Prior Authorization and Pre-Certification shall be conducted by a currently Georgia-licensed, registered or certified Health Care Professional who is appropriately trained in the principles, procedures and standards of Utilization Review.

The Supplier and its network Providers (except: Pharmacy Providers) shall use DCH's central Prior Authorization Portal for communicating Prior Authorization and Pre-Certification requests and their disposition. The Supplier shall establish an interface with the Prior Authorization Portal that allows the Supplier to receive and submit required data. Forms and Processes Related to the Medical Review Process are provided in the Suppliers Library. The Prior Authorization and Pre-Certification process shall be one hundred percent (100%) paperless. The Supplier shall outreach to and educate network Providers about use of the Portal and submission of all required documentation through the Portal.

The Supplier will retain authority for reviewing requests and making Prior Authorization and Pre-Certification determinations. The Supplier shall implement policies and procedures that incorporate how the Supplier will conduct the following activities:

- a. Accept Prior Authorization and Pre-Certification requests that Providers submit on a standardized form developed by DCH through the Prior Authorization Portal.
- b. Communicate requests for additional information from the Provider through the Prior Authorization Portal. The Supplier may directly contact the Provider with questions, but the Supplier shall communicate the same information through the Prior Authorization Portal.
- c. Review requests when a Member has an outstanding Prior Authorization and transitions Enrollment to the Supplier. The Supplier may not require the requesting Provider to re-submit the Prior Authorization request. The Supplier may make its own determination regarding approval of the request.

The Supplier shall notify the Provider of Prior Authorization determinations via the Prior Authorization Portal in accordance with the following timeframes:

- a. Standard Service Authorizations.

Prior Authorization decisions for non-urgent services shall be made within three (3) Business Days, or other established timeframe, of the request (generally submitted one

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Week prior to the service or procedure). An extension may be granted for an additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Supplier justifies to DCH a need for additional information and the extension is in the Member's best interest.

b. Expedited Service Authorizations.

For cases in which a Provider indicates, or the Supplier determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Supplier must make an expedited authorization decision within twenty-four (24) clock hours and provide notice as expeditiously as the Member's health Condition requires and no later than three (3) Business Days after receipt of the request for service. The Supplier may extend the twenty-four (24) clock hour period for up to five (5) Business Days if the Supplier justifies to DCH a need for additional information and how the extension is in the Member's interest.

c. Authorization for services that have been delivered.

Determinations for authorization involving Health Care services that have been delivered shall be made within thirty (30) Calendar Days of receipt of the necessary information.

The Supplier's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.

3. Referral Requirements

The Supplier may require that Members obtain a Referral from their PCP prior to accessing non-emergency specialized services.

In the Utilization Management Policies and Procedures discussed in section L, Prior Authorization and Pre-Certification, the Supplier shall address:

- a. When a Referral from the Member's PCP is required;
- b. How a Member obtains a Referral to an In-Network Provider or an Out-of-Network Provider when no Provider within the Supplier's network has the appropriate training or expertise to meet the particular health needs of the Member;
- c. How a Member with a Condition which requires on-going care from a specialist may request a standing Referral; and
- d. How a Member, with a life-threatening Condition or disease, which requires specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.

The Supplier shall prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a Member of the Provider's family has a Financial Relationship.

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The Supplier shall develop electronic, web-based Referral processes and systems. In the event a Referral is made via the telephone, the Supplier shall ensure that the Supplier, the Provider and DCH maintain Referral data, including the final decision, in a data file that can be accessed electronically.

In conjunction with the other Utilization Management policies, the Supplier shall submit the Referral processes to DCH for review and approval.

4. Transition of Members

The Supplier shall coordinate the transfer of information when Members transition from one CMO to another, to the Fee-for-Service system or to private insurance.

a. Inpatient Acute Coverage Responsibility

Members enrolled in a Georgia Families CMO that are hospitalized in an acute inpatient hospital facility and are placed in Foster Care during the inpatient stay will be disenrolled from the Georgia Families CMO and enrolled in the Georgia Families 360° CMO on the date the Member's 834 file is transferred to the Georgia Families 360° CMO. The Supplier is not required to cover services for an individual that has no Medicaid benefits, if the Member individual remains an acute inpatient and loses Medicaid eligibility during the stay; the Supplier is only responsible for payment until the last day of Medicaid eligibility.

Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned CMO.

The Supplier shall remain responsible for Members who become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization until they are Discharged from inpatient acute hospital care. These Members will remain the responsibility of the Supplier for all Covered Services, even if the start date for Supplemental Security Income eligibility is made retroactive to a date prior to the inpatient acute hospitalization.

Upon notification that a hospitalized Member will be transitioning to a new CMO, or to Fee-for-Service Medicaid, the current CMO will work with the new CMO, Fee-for-Service Medicaid or private insurance to ensure that Coordination of Care and appropriate discharge planning occurs.

b. Relinquishment of Members

When relinquishing Members, the Supplier shall cooperate with the receiving CMO, Fee-for-Service Medicaid or private insurance regarding the course of ongoing care with a specialist or other Provider. Suppliers must identify and facilitate Coordination of Care for all Members during changes or transitions between Suppliers, as well as transitions to Fee-for-Service Medicaid or private insurance. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations.

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Special circumstances include Members designated as having “special Health Care needs”, as well as Members who have medical Conditions or circumstances such as:

1. Pregnancy (especially women who are high risk and in their third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date)
 2. Major organ or tissue transplantation services which are in process, or have been authorized
 3. Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities
 4. Significant medical Conditions, (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments.
 5. Members who are in treatment such as:
 - i. Chemotherapy and/or radiation therapy
 - ii. Dialysis
 6. Members with ongoing needs, such as:
 - i. Durable Medical Equipment including ventilators and other respiratory assistance equipment
 - ii. Home health services
 - iii. Medically Necessary transportation on a scheduled basis
 - iv. Prescription medications
 7. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnostic and Treatment eligible Members.
 8. Members who are currently hospitalized.
- c. Long-Term Care Coverage Responsibility

Members enrolled in a CMO who are receiving services in a long-term care facility will remain the responsibility of the admitting CMO until Disenrolled from the CMO by DCH.

For the purposes of this requirement, long-term care facilities include Nursing Homes, Skilled Nursing Facilities, Psychiatric Residential Treatment Facilities and other facilities that provide long-term non-acute care.

Upon Disenrollment from the CMO, the financial responsibility for services provided to the Member transitions to the Member’s new CMO or Fee-for Service Medicaid.

Members who are in ongoing non-acute treatment in an Inpatient Facility that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by

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the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary Transition of Care. The CMO will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days.

5. Back Transfers

The Supplier shall permit transfers from a higher level of care, back to a lower level (referred to as a back transfer). The transfer is subject to medical necessity review and the payment policies outlined in the contract with the payer.

Each request will be reviewed on an individual basis to determine if the transfer is appropriate. The length of stay for the transferring hospital and for the return to the originating hospital will also be evaluated to determine if the transfer is appropriate.

If a transfer back to a hospital that provides a lower level of care does occur, the facility receiving the back-transfer will be eligible for reimbursement if Prior Authorization is obtained from the applicable payer and according to the payment agreement of that payer.

Supplier shall make available Provider education and clear policies regarding their “back transfer” pre certification requirements along with the billing procedures.

6. Court-Ordered Evaluations and Services

In the event a Member requires Medicaid-Covered Services ordered by a State or federal court, the Supplier shall fully comply with all court orders while maintaining appropriate Utilization Management practices.

7. Second Opinions

The Supplier shall provide for a second opinion in any situation when there is a question concerning a diagnosis or the options for surgery or other treatment of a health Condition when requested by any Member of the Health Care team, a Member, parent(s) and/or guardian (s), or a social worker exercising a custodial responsibility.

The second opinion must be provided by a qualified Health Care Professional within the network, or the Supplier shall arrange for the Member to obtain one outside the Provider network, if an appropriate Provider is unavailable in the Supplier’s network.

The second opinion shall be provided at no cost to the Member.

8. Coordination and Continuity of Care Responsibilities

The Supplier is responsible for employing a System of Care approach to Care Coordination and Continuity of Care. Care Coordination is a set of Member centered goal-oriented, culturally relevant and logical steps to assure that Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Coordination includes Case Management, Disease Management, Transition of Care, and Discharge Planning.

The Supplier must develop and implement Care Coordination and Continuity of Care Policies and Procedures designed to accommodate the specific cultural and linguistic needs of the Supplier's Members that include, at a minimum, the following elements:

- a. The provision of an individual needs assessment and diagnostic assessment; the development of an individualized treatment plan, as necessary, based on the needs assessment; the establishment of treatment Objectives; the Monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary.
- b. A patient-centered approach to meet the needs of Members, addressing both developmental and Chronic Conditions;
- c. The requirement for the creation of a treatment plan for Members who are determined to need a course of treatment or regular care Monitoring. . This treatment plan shall be developed by the Member's PCP with Member participation, and in consultation with any specialists caring for the Member. This treatment plan shall be approved in a timely manner by the Chief Medical Officer and in accordance with any applicable State Quality assurance and Utilization Review standards.
- d. A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning or regular care management;
- e. A strategy to ensure the timely provision of services;
- f. A strategy to ensure that the Supplier works with Members and Providers to implement an integrated approach to meeting the Physical Health and Behavioral Health needs of the Member;
- g. Use of data analytics to identify patterns of care. DCH encourages the use of predictive modeling to identify high risk Members;
- h. Procedures and criteria for making Referrals to specialists and sub-specialists;
- i. Procedures and criteria for maintaining treatment plans and Referral Services when the Member changes PCP
- j. Capacity to implement, when indicated, Case Management functions such as individual needs assessment, including establishing treatment Objectives, treatment follow-up, Monitoring of outcomes, or revision of the treatment plan.;

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- k. Requirements for patient-center care including of Members addressing both developmental and chronic conditions; and
- l. Actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care.

The Supplier shall submit the Care Coordination and Continuity of Care Policies and Procedures to DCH for review and approval within ninety (90) Calendar Days of Contract Award and as updated thereafter.

The Supplier is encouraged to use Community Health Workers in the engagement of Members in care coordination activities. This includes: Transition of Care, Discharge Planning; Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management.

a. Transition of Care

Suppliers shall identify and facilitate transitions for Members who are moving from one CMO to another or from a CMO to a Fee-for-Service Provider or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing Members, the Supplier shall cooperate with the receiving CMO or Fee-for-Service Medicaid regarding the course of ongoing care with a specialist or other Provider. Priority will be given to Members who have medical Conditions or circumstances such as:

- 1. Members who are currently hospitalized
- 2. Pregnant women who are high risk and in their third trimester, or are within thirty (30) days of their anticipated delivery date
- 3. Major organ or tissue transplantation services which are in process, or have been authorized
- 4. Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities
- 5. Members who are in treatment such as chemotherapy, radiation therapy, or dialysis
- 6. Members with ongoing needs such as Specialized Durable Medical Equipment, including ventilators and other respiratory assistance equipment
- 7. Current home health services
- 8. Medically necessary transportation on a scheduled basis
- 9. Prescription medications requiring Prior Authorizations
- 10. Members who are in ongoing outpatient treatment or who are receiving medication that has been covered by DCH or another CMO prior to their new CMO effective date

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will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary Transition of Care. The Supplier will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days.

The Supplier will monitor Providers to ensure Transition of Care from one entity to another to include Discharge planning as appropriate. Members with procedures that are scheduled to occur after their new CMO effective date, but that have been authorized by either DCH or the Member's original CMO prior to their new CMO effective date will be covered by the Member's new CMO for thirty (30) Calendar Days.

b. Discharge Planning

The Supplier shall maintain and operate a formalized Discharge Planning Program that includes a comprehensive evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following Discharge from an institutional clinical setting.

The Supplier shall implement a Discharge Planning Pilot Program with hospital(s) that agree to participate to improve coordination for Members being Discharged from the hospital. The intent of this program is to improve Quality of care and outcomes, as well as to reduce readmissions. The Supplier will place a nurse onsite in the hospital to serve as an onsite resource for Members and to provide support to Members such as patient education and care planning, reviewing medications and how to take those medications, identifying community resources that may be beneficial to the Member, assuring follow-up care is arranged for when the Members leave the hospital and regularly contacting Members after Discharge to confirm they have received follow up care.

The Supplier shall submit its plan for a Discharge Planning pilot program to DCH for review and approval prior to implementation. The plan shall include, for example, information about the hospital(s) that will participate, Member eligibility for the program, services that will be provided, and the approach to coordinating with hospital staff to supplement the care and education they are providing. The Supplier shall submit monthly reports to DCH that provide information that will track results to help identify initiatives that improve Quality of care and outcomes.

c. Care Coordination

The Supplier shall provide Care Coordination services which shall:

1. Be comprehensive: All services a Member receives are to be coordinated;
2. Be patient-centered: Should meet the needs of Members, addressing both developmental and Chronic Conditions; and
3. Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure

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that services are delivered appropriately and that information flows among care Providers and back to the PCP.

d. Coordination with Other Entities

The Supplier shall coordinate and work collaboratively with all divisions within DCH, as well as with other State agencies, and with other CMOs for administration of the Georgia Families program.

The Supplier shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children’s Intervention School Services provided by the LEAs to ensure medical necessity and prevent duplication of services.

The Supplier shall coordinate the services furnished to its Members with the services the Member receives outside the CMO, including services received through any other managed care entity.

The Supplier shall coordinate with all DCH-contracted entities involved in providing care to the Member or administering program services that also impact the CMO’s services. Coordination with other contracted-entities includes, but is not limited to, the following:

1. NET vendors to ensure Members are able to access Medically Necessary Services in a timely manner.
2. DCH’s Pharmacy Rebate Services Vendor for the purposes of processing pharmacy rebates. The Supplier shall regularly submit data, such as Omnibus Budget Reconciliation Act (OBRA ‘90) and J Code Claims feeds to the Fee-for-Service Pharmacy Rebate Services Vendor. Prior to program launch, the Supplier will accept the Fee-for-Service Pharmacy Rebate Services Vendor’s file format for data feeds and for testing interface capabilities. Rebate Vendor Data Feeds and Interfaces are provided in the Supplier’s Library. The Supplier shall respond to and resolve all inquiries and requests from the Pharmacy Rebate Vendor within thirty (30) Calendar Days of receipt of such inquiry or request. To facilitate submission and identification of Medicaid patients by network providers, Suppliers shall publish and use a unique BIN and PCN number for Georgia Medicaid pharmacy claims.
3. DCH’s CVO as set forth in section I.21, Credentialing.
4. DCH’s Fiscal Agent.
5. The State Health Benefit Plan.
6. Vendors identified by DCH to complete DCH required audits, reviews and special projects.
7. Other DCH vendors, including other Georgia Families CMOs to complete statewide initiatives.
8. Private insurance and Fee-for-Service Providers.

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The Supplier shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 45 CFR 164.

e. Integration of Physical and Behavioral Health Services

The Supplier shall develop an innovative approach to encourage PCPs, Behavioral Health Providers, and dental Providers to effectively and efficiently share behavioral and Physical Health clinical Member information, including how the Supplier will notify Behavioral Health Providers and PCPs after an inpatient Mental Health stay.

The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks as set forth in section J.2.

The Supplier shall submit an annual Health Coordination and Integration Report to the Department due June 30th of each calendar year for the prior calendar year beginning 2017. This report is subject to approval by the Department. At a minimum, this report shall include:

1. Program Goals and Objectives;
2. Summary of activities and efforts to integrate and coordinate behavioral and Physical Health;
3. Successes and opportunities for improvement;
4. Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and
5. Roadmap of activities planned for the next reporting.

f. Disease Management

The Supplier shall develop a minimum of three (3) disease management programs for individuals with Chronic Conditions. These programs must target the prevalent chronic diseases within the Supplier's population, as specified by DCH.

Disease Management functions include, but are not limited to:

1. Incorporating evidence-based guidelines or standards of care in program development.
2. Utilizing clinical data to stratify Members for Enrollment based on levels of service intensity.
3. Encouraging the Member's active participation and adherence to interventions.

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4. Educating the Member on their disease or Condition to facilitate self-management.
5. Consistently informing the Member on progress in the achievement of goals and about the areas that require further improvement.
6. Promoting Coordination of Care by collaborating and communicating with Providers and other Health Care resources to improve Member outcomes.

The Supplier must notify DCH of the disease management programs it initiates and terminates and provide evidence, on an annual basis of the effectiveness of such programs for its enrolled Members. The Supplier is encouraged to align disease management programs with Quality initiatives described in section M. The Supplier must submit Quarterly status reports to DCH which include specified Disease Management Program data in addition to the annual report.

g. Case Management

The Supplier's Case Management program shall emphasize prevention, Continuity of Care, and Coordination of Care and integration of care. The program shall link Members to, services.

1. Case Management functions include but are not limited to:
 - i. Early identification of Members who have or may potentially have special needs by receiving Referrals, reviewing Medical Records, Claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An Initial Assessment of a pregnant woman may be performed by a local public health agency at the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO;
 - ii. Assessment of a Member's risk factors such as an over- or under-utilization of services, inappropriate use of services, non-adherence to the established plan of care or lack thereof, lack of education or understanding of current condition, lack of support system, financial barriers that impede adherence to the plan of care, compromised patient safety; cultural or linguistic challenges, and physical, mental, or cognitive disabilities;
 - iii. Development of a personalized, patient-centered plan of care which is consistent with evidence-based guidelines and includes established goals that are specific and Measurable, with emphasis on Member education of disease or Condition to facilitate shared decision making and self-management;
 - iv. Coordination of Care, as previously described;
 - v. Monitoring to ensure the plan of care and interventions continue to be appropriate or revised as needed based on changes in the Member's Condition or lack of positive response to the plan of care;

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- vi. Continuity of care which includes collaboration and communication with other Providers involved in the Member's transition to another level of care to optimize outcomes and resources while eliminating fragmentation of care;
- vii. Follow up which includes assessing the achievement of established goals and identifying the overall impact of the plan of care;
- viii. Documentation which includes adherence to Member privacy and confidentiality standards, evidence of Member's progress and effectiveness of the plan of care, evaluation of Member satisfaction when appropriate;
- ix. Disenrollment from Case Management when the goals have been achieved and the Member is able to self-manage, or the needs and desires of the Member change.

Case Management functions for the IPC component of the P4HB Demonstration include:

- i. Early identification of P4HB IPC participants who have or may have special needs;
- ii. Assessment of a P4HB IPC participant's risk factors;
- iii. Development of a plan of care;
- iv. Referrals and assistance to ensure timely access to Providers included and external to the Supplier's network;
- v. Coordination of Care actively linking the P4HB IPC participant to In-Network and Out-of-Network Providers, physical and Behavioral Health Services, residential, social and other support services where needed;
- vi. Resource Mothers Outreach;
- vii. Monitoring;
- viii. Continuity of care;
- ix. Follow up; and
- x. Documentation

Details pertaining to Resource Mothers Outreach are incorporated in Attachment I to this RFP. The Supplier must utilize the Resource Mothers Training Manual specified by DCH as the training manual for the Resource Mothers Outreach.

The Supplier must monitor the effectiveness of the Resource Mothers Outreach and ensure such Outreach activities comply with the Resource Mothers Training Manual.

2. Levels of Case Management for the Georgia Families Program include:

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- i. Level I - Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem and a plan of care that has been developed which provides for health and social problem follow-up as indicated.
- ii. Level II - Services that ensure necessary Member services are available. Case managers will arrange for appointments and transportation to the Member's appointments and Referrals and verify that the Referral site is available and appropriate for the Member's needs.
- iii. Level III - Services defined in Level I and Level II plus assisting the Member to complete forms, accompanying the Member to their appointments to provide introductions and support as well as contacting the Member to schedule additional appointments. Visits to the Member's residence are included in Level III Case Management. This level of Case Management services ensures the Member successfully negotiates any transitions in care. Level III Case Management may be reserved for certain high risk Members who require special assistance to negotiate complex or highly structured health or social systems.

The Supplier shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have catastrophic or other high-cost or high-risk Conditions including pregnant women under twenty-one (21) years of age, high risk pregnancies and infants and toddlers with established risk for developmental delays.

The Supplier must notify DCH of the specific Case Management programs it initiates (i.e., OB Case Management, Behavioral Health Case Management, etc.) and terminates and provide evidence, on an annual basis of the effectiveness of such programs for its enrolled Members.

The Supplier will submit quarterly reports to DCH which include specified Case Management Program data as described in section L.8, Reporting Requirements, in addition to the annual report.

M. Quality Management and Performance Improvement

The Supplier shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).

The Supplier shall seek input from, and work with, Members, Providers and community resources and agencies to actively improve the Quality of care provided to Members.

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1. National Committee for Quality Assurance (NCQA) Accreditation

The Supplier shall apply for NCQA Interim Status by the Operational Start Date. Suppliers shall apply for NCQA Accreditation, or at other times as required by DCH as follows:

- a. July 1, 2016: Apply for NCQA Interim Status
- b. July 1, 2017: Apply for provisional status (first survey)
- c. December 31, 2017: Notify NCQA of intent to submit data
- d. June 15, 2018: Submit CY 2017 data

The Supplier shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Suppliers that lose NCQA Commendable or Excellent status, must regain the status within one (1) year.

2. Quality Oversight Committee

The Supplier shall establish multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following:

- a. A designated Health Care practitioner, qualified by training and experience, to serve as the QM Director;
- b. A committee which includes representatives from the Provider groups as well as clinical and non-clinical areas of the organization;
- c. A senior executive who is responsible for program implementation;
- d. Substantial involvement in QM activities by the Supplier's Chief Medical Officer; and
- e. Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

The Quality Oversight Committee must:

- a. Maintain records that document the committee's activities, findings, recommendations, actions, and results; and
- b. DCH must approve membership of the Quality Oversight Committee.

3. DCH Quality Strategic Plan Requirements

The Supplier shall support and comply with the DCH Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to Georgia Families and Georgia Families 360^o Members (as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).

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The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit are responsible for oversight of the Supplier's Quality program including:

- a. Monitoring and evaluating the Supplier's service delivery system and Provider Network, as well as the Supplier's processes for Quality management and performance improvement;
- b. Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members;
- c. Initiating Performance Improvement Projects with the Supplier to address trends identified through Monitoring activities, reviews of complaints and allegations of abuse, Provider Profiling, Utilization Management reviews, etc.;
- d. Monitoring the Supplier's compliance with Federal, State and DCH requirements;
- e. Ensuring the Supplier's coordination with State registries;
- f. Ensuring Supplier executive and management staff participation in the Quality management and performance improvement processes;
- g. Ensuring that the development and implementation of Quality management and performance improvement activities include Provider participation and information provided by Members, their families and guardians; and
- h. Identifying the Supplier's best practices, lessons learned and other findings for performance and Quality improvement.

4. Performance Measures

The Supplier shall comply with the Georgia Families DCH Quality Strategy to improve the health outcomes for all Georgia Families Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the Quality and health improvement performance measures. DCH will monitor Performance Measure and incentive Supplier improvement through the Value- Based Purchasing program, described in section M.13.

Several of the Adult and Child Core Set measures along with certain other HEDIS® measures utilize hybrid Methodology, that is, they require a Medical Record review in addition to the administrative data requirement for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure.

DCH establishes Performance Measure Targets for each measure. It is important that the Supplier continually improve health outcomes from year to year. The performance measure targets for each performance measure are defined in Attachment I. Performance targets are

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based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH and available at: <http://dch.georgia.gov/medicaid-quality-reporting>.

DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or Preventive Action (PA) response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Category 3 Liquidated Damages on Suppliers who do not meet the performance measure targets for any one performance measure.

The performance measures apply to the Member populations as specified by the measures' technical specifications. Supplier performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.

The Supplier must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.

5. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

Supplier shall deliver to DCH the results of CAHPS Surveys conducted by an NCQA certified CAHPS survey vendor. The survey report must include but not be limited to the following items:

- a. An Executive Summary with the description of the survey process conducted according to the CAHPS Health Plan Survey guidelines of the HEDIS protocol;
- b. Protocols for the administration of the survey via mail, telephone or mixed mode;
- c. Definition of the sample size, number of completed surveys and response rates achieved. Response rates should, at a minimum, be no less than the NCQA national average Medicaid response rates for the period; and
- d. Detailed survey results and trend analysis.

The Supplier must submit, on an annual basis to DCH, Adult and Child CAHPS Survey reports as stated in section s M.5.

6. Member and Provider Incentives

The Supplier shall implement Member and Provider incentives to increase Member and Provider participation in reaching program goals. The Supplier may provide:

- a. Incentives to Members and/or Providers to encourage compliance with periodicity schedules. Such incentives shall be established in accordance with all applicable State and federal laws, rules and regulations. Member incentives must be of nominal value

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(\$10.00 or less per item and \$50.00 in the aggregate on an annual basis per Member) and may include gift cards so long as such gift cards are not redeemable for cash or Co-payments. The Supplier shall submit the proposed incentive methods to DCH for review and receive DCH approval prior to implementation. Upon request by DCH, the Supplier shall provide DCH with reports detailing incentives provided to Members and/or Providers and illustrating efficacy of incentive programs.

In accordance with 42 CFR 1003.101, the Nominal Value requirement stated herein is not applicable where the incentive is offered to promote the delivery of preventive care services, provided:

1. The delivery of the Preventive Services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or Medicaid;
 2. The incentive is not cash or an instrument convertible to cash; and
 3. The value of the incentive is not disproportionately large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future Health Care costs reasonably expected to be avoided as a result of the preventive care).
- b. Provider incentives for the specific purpose of supporting necessary costs to transform and sustain NCQA PCMH recognition through enhanced payment or performance based incentives for achieving the necessary parameters.
 - c. Provider incentive strategies to improve Provider compliance with clinical practice guidelines to ensure consistent application of the guidelines.
- 7. Quality Assessment Performance Improvement (QAPI) Program**

The Supplier shall have in place an ongoing QAPI program consistent with 42 CFR 438.240. The program must be established utilizing strategic planning principles with defined goals, Objectives, strategies and measures of effectiveness for the strategies implemented to achieve the defined goals. The Supplier's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include:

- a. A method of Monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over utilization of services), including those with special Health Care needs;
- b. Written policies and procedures for Quality assessment, Utilization management and continuous Quality improvement that are periodically assessed for efficacy;
- c. A health Information System sufficient to support the collection, integration, tracking, analysis and reporting of data;
- d. Designated staff with expertise in Quality assessment, Utilization Management and Care Coordination as described in section L;

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- e. Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to Providers and Members;
- f. A Methodology and process for conducting and maintaining Provider profiling;
- g. Ad-Hoc reports to the Supplier's multi-disciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations and implemented system changes; annual Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas;
- h. Integration of the results from annual Performance Improvement Projects (PIPs), performance measure rate Monitoring, and compliance with federal and state standards;
- i. The impact of the Supplier's Member demographics on their ability to improve health outcomes; and
- j. A process for evaluation of the impact and assessment of the Supplier's QAPI program.

The Supplier shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCPs or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.

The Supplier's QAPI Program Plan must be submitted to DCH for review and approval within one hundred twenty days (120) of the Contract Effective Date. The Supplier shall submit any changes to its QAPI Program Plan to DCH for review and prior approval sixty (60) Calendar Days prior to implementation of the change.

Upon the request of DCH, the Supplier shall provide any information and documents related to the implementation of the QAPI program.

Annually, the Supplier shall submit to DCH a comprehensive QAPI Report, utilizing the report template that integrates all aspects of the QAPI Plan and tells the story of the effectiveness of the Supplier's QAPI Plan in meeting defined goals and Objectives and achieving improved health outcomes for the Supplier's Members. DCH may require interim reports more frequently than annually to demonstrate progress.

8. Performance Improvement Projects

As part of its QAPI program, the Supplier shall conduct clinical and non-clinical Performance Improvement Projects (PIPs) in accordance with DCH and federal protocols. In designing its Performance Improvement Projects, the Supplier shall:

- a. Show that the selected area of study is based on a demonstration of need and is expected to achieve Measurable benefit to the Member (rationale);
- b. Establish clear, defined and Measurable goals and Objectives that the Supplier shall achieve in each year of the project;
- c. Utilize Rapid Cycle Process Improvement and Plan Do Study Act (PDSA) processes;

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- d. Measure performance using Quality indicators that are Objective, Measurable, clearly defined and that allow tracking of performance and improvement over time;
- e. Implement interventions designed to achieve Quality improvements;
- f. Evaluate the effectiveness of the interventions;
- g. Establish standardized performance measures (such as HEDIS® or another similarly standardized product) as the overarching goals for the PIPs;
- h. Plan and initiate activities for increasing or sustaining improvement; and
- i. Document the data collection Methodology used (including sources) and steps taken to assure data is valid and reliable.

Each Performance Improvement Project must be completed in a period determined by DCH, to allow information on the success of the project in the aggregate to produce new information on Quality of care each year.

The Supplier shall perform the required Performance Improvement Projects, as specified by DCH and agreed upon by the Parties, on an annual basis. Plan Do Study Act cycles must be incorporated into each PIP process.

Each PIP will use a study period approved by DCH.

Each PIP must include Aim Statements and Driver Diagrams and align with the External Quality Review Organization (EQRO) prepared PIP template. PIP components will be included as agreed upon by DCH and the CMOs.

The Supplier shall submit the designated PIPs to the EQRO Supplier using the DCH specified template and format as defined in the PIP protocol approved by DCH.

The EQRO will Evaluate the CMOs' PIPs performance, using CMS approved Rapid Cycle PIP and/or other EQRO protocols. DCH reserves the right to request modification of the PIPs based on this evaluation. Modifications will be discussed with each CMO prior to implementation.

9. Clinical Practice Guidelines

The Supplier shall adopt a minimum of three (3) evidence-based clinical practice guidelines. Such guidelines shall:

- a. Be based on the health needs and opportunities for improvement identified as part of the QAPI program;
- b. Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;
- c. Consider the needs of the Members;

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- d. Be adopted in consultation with network Providers; and
- e. Be reviewed and updated periodically as appropriate.

The Supplier shall submit to DCH for review and prior approval and as updated thereafter all Clinical Practice Guidelines in use, which shall include a Methodology for measuring and assessing compliance as part of the QAPI program plan.

The Supplier shall disseminate the guidelines to all affected Providers and, upon request, to Members.

The Supplier shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

To ensure consistent application of the guidelines the Supplier shall require Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Supplier may use Provider incentive strategies to improve Provider compliance with guidelines as described in section M.

To further ensure consistent application of the Clinical Practice Guidelines, the Supplier shall perform a review of a minimum random sample of fifty (50) Members' Medical Records per evidence-based Clinical Practice Guidelines, each quarter.

10. Focused Studies

Focused Studies examine a specific aspect of Health Care (such as prenatal care) for a defined point in time. These studies are usually based on Information extracted from Medical Records or Supplier administrative data such as Enrollment files and Encounter/Claims Data. Steps that may be taken by the Supplier when conducting focused studies are:

- a. Selecting the Study Topic(s)
- b. Defining the Study Question(s) or Aim Statement
- c. Selecting the Study Indicator(s)
- d. Identifying a representative and generalizable study population
- e. Documenting sound sampling techniques utilized (if applicable)
- f. Collecting reliable data
- g. Analyzing data and interpreting study results

The Supplier may perform, at DCH discretion, a Focused Study to examine a specific aspect of Health Care (such as prenatal care) for a defined point in time. The Focused Study will have a calendar year study period and the results will be reported to DCH June 30th following

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the year of the study. DCH shall retain the right to approve or disapprove all proposed Focus Studies.

11. Patient Safety Plan

The Supplier shall have a structured Patient Safety Plan, Report, and Analysis to address incidents and concerns regarding clinical care. This plan must include written policies and procedures for processing Member complaints regarding the care received and addressing incidents and concerns with clinical care. Such policies and procedures shall include:

- a. A system of classifying incidents, concerns, and complaints according to severity;
- b. A review by the Chief Medical Officer and a mechanism for determining which incidents will be forwarded to Peer Review;
- c. A summary of incident(s), including the final disposition, included in the Provider profile.

At a minimum, the Patient Safety Program process shall:

- a. Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals;
- b. Report and analyze Medication recalls;
- c. Report and analyze Medication errors;
- d. Describe the results of site Inspections; and
- e. Report and analyze Patient Quality of Care Concerns, including those arising from patient Grievances.

The Supplier shall submit the Patient Safety Plan to DCH for initial review and approval and as updated and submit to DCH on an annual basis no later than June 30 of the Contract year a Patient Safety Program Report inclusive of the program components.

12. External Quality Review

DCH will contract with an EQRO to conduct independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in the Contract. The Supplier shall collaborate with DCH and its EQRO to develop studies, surveys and other analytic activities to Assess the Quality of care and services provided to Members and to identify opportunities for CMO improvement. To facilitate this process the Supplier shall supply data, as requested by DCH or its EQRO, to the EQRO.

13. Value Based Purchasing (VBP) Program

The Supplier shall collaborate with DCH to implement a Value-Based Purchasing (VBP) model. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, Suppliers and the State to achieve the program's overarching goals.

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The impact of initiatives is measured in terms of access, outcomes, Quality of care and savings.

a. VBP Performance Management Team

Prior to the Operational Start Date, DCH will establish a VBP performance management team (“VBP Performance Management Team”). The VBP Performance Management Team will have responsibility for planning, implementing, and executing the VBP initiative. The Team will work collaboratively with the Supplier to, review the Supplier’s progress on a monthly, quarterly and/or annual basis, determine incentive payments, and determine the need to modify priority areas, measures and targets.

In addition to DCH staff, key leadership from the Supplier such as the Chief Medical Officer, Chief Operating Officer, or other designee approved by DCH will provide input and feedback on planned priorities and initiatives. As appropriate, DCH will engage operational-level Supplier staff.

Through the VBP Performance Management Team, the Supplier and DCH shall meet at least quarterly to discuss progress on initiatives. Rapid cycle feedback is key to the success of a VBP model. The Supplier shall regularly review and provide real-time information focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis to DCH. The Supplier shall provide ongoing and ad hoc reports to DCH to highlight status and progress of initiatives, as well as successes and challenges. Regularly reviewing data is necessary for DCH and the Supplier to identify where initiatives are not resulting in improvements necessitating adjustments to the implemented approach. When adjustments are necessary, the Supplier shall report to DCH changes the Supplier will make to continually work towards improvements.

b. VBP Performance Measures and Related Targets

Attachment I outlines the performance measures and related targets that the Supplier must achieve under the VBP model. The Supplier must establish, in collaboration with DCH, initiatives that it will undertake to achieve the specified targets. Such initiatives may differ from or include other required initiatives, such as Performance Improvement Projects (PIPs) and Focused Studies. Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Supplier’s Capitation Rates (“VBP Withhold”) from which incentive payments will be made to the Supplier for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and Validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.

c. VBP Incentive Payment

The Supplier will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Supplier will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Supplier’s performance relative to the targets for the

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thirteen (13) performance measures. The maximum incentive payment to the Supplier will be the full five percent (5%) withhold.

$$\text{Supplier Payout Amount} = (\text{Number of Performance Targets Achieved} / \text{Total Number of Performance Targets}) \times \text{Total VBP Withhold}$$

While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of the Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Supplier shall agree to a Methodology for quantifying the Supplier's success in achieving targets and payments for each measure.

The Supplier shall incentivize Providers to participate in VBP and may also incentivize Members. The Supplier shall develop a plan for distributing to Providers fifty percent (50%) of the Value Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Supplier (e.g., the Supplier may elect to incentivize Providers on a more frequent schedule than DCH's schedule for payment to the Supplier). Suppliers are encouraged to collaborate to develop and implement interventions and solutions. The Supplier shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date. The plan shall include details of how the Supplier will collaborate with Providers to determine the frequency of incentive payments to Providers and how the Supplier will encourage participation in the program.

DCH will publish a VBP Operations Manual and will be responsible for updates to such manual as determined by DCH. The Supplier shall comply with the requirements set forth in the Operations Manual.

14. Monitoring and Oversight Committee

The Supplier shall participate in the Georgia Families Monitoring and Oversight Committee ("GFMO") and associated subcommittees as requested by DCH. The GFMO and associated subcommittees will assist DCH in assessing the performance of the Supplier and developing improvements and new initiatives specific to the Georgia Families program. The GFMO will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration between State agencies, the Supplier and external stakeholders. Members of the GFMO will be appointed by the DCH Commissioner or his designee. The GFMO meetings must be attended by Supplier decision makers defined as one or more of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position; and Chief Medical Officer.

15. Member Advisory Committee

The Supplier shall establish and maintain a Member Advisory Committee consisting of persons served by the Supplier including current and past Members and/or Authorized Representatives, and representatives from community agencies that do not provide Supplier-Covered Services but are important to the health and well-being of Members. The

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Committee shall meet at least quarterly, and its input and recommendations shall be employed to inform and direct Supplier Quality management activities and policy and operational changes. The Supplier must provide meeting schedules and minutes to DCH upon request. DCH may conduct on-site reviews of the Committee meetings to ensure:

- a. The Committee is discussing issues pertinent to the Member population;
- b. The Committee is meeting as scheduled; and
- c. The Committee members are in attendance.

16. Provider Advisory Committee

The Supplier shall establish and maintain a Provider Advisory Committee consisting of Providers contracted with the Supplier to serve Members. At least two (2) Providers on the Committee shall maintain health care practices that predominantly serve Medicaid beneficiaries. The Committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Supplier Quality management activities and policy and operational changes. The Supplier must provide meeting schedules and minutes to DCH upon request. DCH may conduct on-site reviews of the Committee meetings to ensure:

- a. The Committee is discussing issues pertinent to the Member population;
- b. The Committee is meeting as scheduled; and
- c. The Committee members are in attendance.

17. Reporting Requirements

Report minimum requirements are provided in the Requirements Analysis Documents located on the DCH website.

If an extension of time is needed to complete a report, the Supplier may submit a request in writing to the DCH Performance, Quality and Outcomes Unit.

The Supplier's Quality Oversight Committee shall submit to DCH Quality Oversight Committee Reports - Ad Hoc as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

The Supplier shall submit to DCH Performance Improvement Project Reports no later than June 30 of the Contract year or per protocol described in section I.M.8.

The Supplier shall submit to DCH Focused Studies Reports no later than June 30 of the Contract year as described in section I.M.10.

The Supplier shall submit to DCH annual Patient Safety Plan Reports no later than June 30 of the Contract year as described in section I.M.11.

N. Administrative Services

1. Claims Management

The Supplier shall have adequate systems and staff in place to ensure the provision of Health Care services under the Contract are properly documented, accounted for and reported.

a. General Provisions

The Supplier shall:

- i. Adhere to the time frames and deadlines for submission, processing, payment, denial, adjudication, and Appeal of Medicaid Claims outlined in the DCH Policy Manuals. The Supplier shall administer an effective, accurate and efficient Claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by DCH (see Part I. Policy and Procedures for Medicaid/PeachCare for Kids® Manual) and in compliance with all applicable State and federal laws, rules and regulations. Any Claims processing issues caused by the Supplier will be resolved within a forty-five (45) Calendar Day limit. The Supplier shall contact Providers within fifteen (15) Calendar Days to resolve Claims processing issues. For all Claims that are initially denied or underpaid by the Supplier and are eventually determined or agreed to have been owed by the Supplier, the Supplier shall pay interest of the current prime rate in the amount of twenty percent (20%) annum, calculated from fifteen (15) Calendar Days after the date the Claim was submitted.
- ii. Maintain a Claims management system that can identify date of receipt (the date the Supplier receives the Claim as indicated by the date-stamp), real-time-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, Appealed, etc.), and date of payment (the date of the check or other form of payment).
- iii. At a minimum, the Supplier shall run one (1) Provider payment cycle per Week, on the same day each Week, as determined by DCH.
- iv. Support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of Claims payments.
- v. Encourage its Providers, as an alternative to filing paper-based Claims, to submit and receive Claims Information through electronic data interchange (EDI), i.e. electronic Claims. Electronic Claims must be processed in adherence to Information exchange and data management requirements specified in the Information Management and Systems section of this Scope of Work section N.4. As part of this Electronic Claims Management (ECM) function, the Supplier shall also provide on-line and phone-based capabilities to obtain Claims processing status Information.
- vi. Generate explanation of Benefits and remittance advices in accordance with State standards for formatting, content and timeliness and will verify that

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recipients have received the services indicated on the explanation of Benefits received and the remittance advices.

- vii. Issue a formal tracking number for Claims inquiries and shall tie any Recoupment to the original payment on the remittance advice. The Supplier shall provide the ability to separate the Provider's remittance advice by location identified through the location-specific Provider Number.
- viii. Not pay any Claim submitted by a Provider who is excluded or suspended from the Medicare, Medicaid or CHIP programs for Fraud, Waste, or Abuse or otherwise included on the U.S. Department of Health and Human Services Office of Inspector General exclusions list, or who employs someone on this list. The Supplier shall not pay any Claim submitted by a Provider that is on payment hold under the authority of DCH or its Agent(s).
- ix. Not later than the fifteenth (15) Business Day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Supplier shall suspend the Claim and request in writing (notification via e-mail, the CMO web site/Provider Portal or an interim explanation of Benefits satisfies this requirement) all outstanding Information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO shall complete processing of the Claim within fifteen (15) Business Days.
- x. For services rendered within seventy-two (72) hours after the Provider verifies the eligibility of the patient with the Supplier, the Supplier shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Supplier made payment for a patient for whom it was not responsible, then the Supplier may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.
- xi. Not apply any penalty for failure to file Claims in a timely manner, for failure to obtain Prior Authorization, or for the Provider not participating in the Supplier's network. The amount of reimbursement shall be the Provider's applicable rate for the service provided by an In-Network or Out-of-Network Provider.
- xii. Inform all network Providers about the information required to submit a Clean Claim as a provision within the Supplier/Provider Contract. The Supplier shall make available to network Providers Claims coding and processing guidelines for the applicable Provider type. The Supplier shall notify Providers ninety (90) Calendar Days before implementing significant changes to Claims coding and processing guidelines. DCH's definition of significant shall be binding.
- xiii. Perform and submit to DCH Quarterly scheduled Global Claims Analyses to ensure an effective, accurate, and efficient Claims processing function that adjudicates and settles Provider Claims. In addition, the Supplier shall assume

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all costs associated with Claims processing, including the cost of Reprocessing or resubmission, due to processing errors caused by the Supplier or to the design of systems within the Supplier's Span of Control. If, based on its review of such analysis, DCH finds the Supplier's Claims management system and/or processes to be insufficient, DCH may require from the Supplier a Corrective Action Plan outlining how it will address the identified issues.

- xiv. The Supplier's web site shall be functionality equivalent to the web site maintained by the DCH's Fiscal Agent.

b. Other Considerations

An adjustment to a paid Claim shall not be counted as a Claim for the purposes of reporting.

Electronic Claims shall be treated as identical to paper-based Claims for the purposes of reporting.

c. Encounter Claims Submission Requirements

The Georgia Families and Georgia Families 360° programs utilize Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Supplier to provide timely, complete and accurate information. Encounter data from the Supplier also allows DCH to budget available resources, set Supplier Capitation Rates, monitor Utilization, follow public health trends and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes.

The Supplier shall work with all contracted Providers to implement standardized billing requirements to enhance the Quality and accuracy of the billing data submitted to the health plan.

The Supplier shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, until such time otherwise determined by DCH. The Supplier will emphasize to Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.

The Supplier shall submit to DCH's Fiscal Agent Supplier weekly cycles of data files. All identified errors shall be submitted to the Supplier from the Fiscal Agent Supplier each Week. The Supplier shall address identified issues and resubmit the corrected file to the Fiscal Agent Supplier within seven (7) Business Days of receipt.

The Supplier is required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, Member Name, and DOB. These items must match the states eligibility and Provider file.

The Supplier submitted Claims must consistently include:

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1. Patient name
2. Date of birth
3. Place of service
4. Date of service
5. Type of service
6. Units of service
7. Diagnostic related groupings (DRGs)
8. Treating Provider
9. NPI number of rendering Provider
10. NPI number of OPR Provider
11. Tax Identification Number
12. Facility code
13. A unique Transaction Control Number (TCN)
14. All additionally required CMS 1500 or UB 04 codes
15. CMO Paid Amount

For each submission of Claims per as described in this section, the Supplier must provide via DCH's required electronic format the following Cash Disbursements data elements:

1. Provider/Payee Number
2. Name
3. Address
4. City
5. State
6. Zip
7. Check date
8. Check number
9. Check amount
10. Check code (i.e., EFT, paper check, etc.)

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The Supplier will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.

The Supplier shall submit ninety-nine (99%) percent of Encounter Claims within thirty (30) Calendar Days of Claims payment both for the original Claim and any adjustment. DCH will validate Encounter Claims submission according to the cash disbursement journal of the Supplier and any of its applicable Subcontractors.

The Supplier shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the Fiscal Agent Supplier and DCH. The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim counts as an error for that Encounter (this is regardless of how many other errors are detected in the TCN.)

The Supplier's failure to comply with the defined standard(s) will be subject to a Corrective Action Plan and the Supplier may be liable for Liquidated Damages.

d. Emergency Health Care Services

The Supplier shall not deny or inappropriately reduce payment to a Provider of Emergency Services for any evaluation, diagnostic testing, or treatment provided to a Member for an emergency Condition.

The Supplier shall not make payment for Emergency Services contingent on the Member or Provider of emergency Health Care services providing any notification, either before or after receiving Emergency Services.

In processing Claims for Emergency Services, the Supplier shall consider, at the time that a Claim is submitted, at least the following criteria:

1. The age of the patient;
2. The time and day of the Week the patient presented for services;
3. The severity and nature of the presenting symptoms;
4. The patient's initial and final diagnosis; and
5. Any other criteria prescribed by DCH, including criteria specific to patients less than eighteen (18) years of age.

The Supplier shall configure or program its automated Claims processing system to consider at least the conditions and criteria described in this subsection for Claims presented for Emergency Services.

If a Provider that has not entered into a contract with the Supplier provides Emergency Health Care Services or post-stabilization services to the Supplier's Member, the Supplier shall reimburse the non-contracted provider for such Emergency Services and post-stabilization services at a rate equal to the rate paid by DCH for Medicaid Claims that it reimburses directly.

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2. Fraud, Waste and Abuse

a. Program Integrity

The Supplier shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures and standards of conduct for the prevention, detection, reporting and Corrective Action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services under the Contract.

The Supplier shall submit its Program Integrity Policies and Procedures, which shall include the compliance plan and pharmacy lock-in program described below.

The Supplier shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and Provider type within seven (7) Business Days of the settlement.

b. Compliance Plan

The Supplier's compliance plan shall include, at a minimum, the following:

1. The designation of a Compliance Officer who is accountable to the Supplier's senior management and is responsible for ensuring that the policies that establish effective lines of communication between the Compliance Officer and the Supplier's staff, and between the Compliance Officer and DCH staff, are followed.
2. Provision for internal Monitoring and auditing of reported Fraud, Waste and Abuse violations, including specific methodologies for such Monitoring and auditing.
3. Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Supplier's Fraud, Waste and Abuse compliance plan.
4. Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues.
5. Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against.
6. Policies of enforcement of standards through well publicized disciplinary standards.
7. Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities.
8. Procedures for the detection of Fraud, Waste and Abuse that include, at a minimum, the following:
 - a. Prepayment review of claims
 - b. Claims edits

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- c. Post-processing review of Claims
 - d. Provider profiling
 - e. Quality Control
 - f. Utilization Management
9. Written standards for organizational conduct.
 10. Effective training and education for the Compliance Officer and the organization's employees, management, board Members and Subcontractors.
 11. Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials.
 12. Provisions for the investigation, Corrective Action and follow-up of any suspected Fraud, Waste and Abuse reports.
 13. Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified.
 14. Procedures for reporting suspected Fraud, Waste and Abuse cases to the Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.

As part of the Program Integrity Program, the Supplier may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures discussed in Attachment I. The pharmacy lock-in program shall:

1. Allow Members to change pharmacies for good cause, as determined by the Supplier after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug.
 2. Provide Case Management and education reinforcement of appropriate medication use.
 3. Annually assess the need for lock-in for each Member.
 4. Require that the Supplier's Compliance Officer report on the program on a monthly basis to DCH.
 5. Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.
- c. Coordination with DCH and Other Agencies

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The Supplier shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Supplier's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.

The Supplier's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.

The Supplier shall inform DCH Immediately about known or suspected cases and it shall not investigate or resolve the suspicion without making DCH aware of, and, if appropriate, involved in, the investigation, as determined by DCH.

3. Internal Grievance/Appeals System

a. General Requirements

The Supplier's Grievance System shall include a process to receive, track resolve and report on Grievances from its Members. The Supplier's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Supplier's Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing See O.C.G.A. §49-4-153 (e).

The Supplier shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Supplier's policies and procedures shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.

The Supplier shall process each Grievance and Administrative Review using applicable State and federal laws and regulations, the provisions of the Contract, the Supplier's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

The Supplier shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.

The Supplier shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Supplier shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.

The Supplier shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision-

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making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:

1. An Appeal of a denial that is based on lack of medical necessity.
 2. A Grievance regarding denial of expedited resolutions of an Administrative Review.
 3. Any Grievance or Administrative Review that involves clinical issues.
- b. Member Medical Review Process for PeachCare for Kids®

DCH also allows a state review on behalf of PeachCare for Kids® Members. If the Member or parent believes that a denied service should be covered, the parent must send a written request for review to the Supplier in which the affected child is enrolled. The Supplier will conduct its review process in accordance with section N.3.

If the decision of the Supplier review maintains the denial of service, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Grievance Committee. The request should be sent to:

Department of Community Health
PeachCare for Kids®
Administrative Review Request
2 Peachtree Street, NW, 37th floor
Atlanta, GA 30303-3159

The decision of the Formal Grievance Committee will be the final recourse available to the Member. In reference to the Formal Grievance level, the State assures:

1. Enrollees receive timely written notice of any documentation that includes the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which Enrollment may continue, pending review.
2. Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services, failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Grievance level.
3. Decisions are written when reviewed by DCH and the Formal Grievance Committee.

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4. Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.
5. Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, Members will be notified of the timeframes for the Appeals Process once an Appeal is filed with the Formal Grievance Committee.
6. Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.
7. Reviews that are not expedited due to an enrollee's medical Condition will be completed within ninety (90) Calendar Days of the date a request is made.
8. Reviews that are expedited due to an enrollee's medical Condition shall be completed within seventy-two (72) clock hours of the receipt of the request.

c. Grievance Process

A Member's Authorized Representative may file a Grievance to the Supplier either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.

The Supplier shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Supplier's Chief Medical Officer, who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making.

The Supplier shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar Days of receipt. The Supplier shall have procedures in place to notify all Members in their primary language of Grievance resolutions.

The Supplier shall issue the disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.

d. Proposed Action

All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member's Condition or disease.

In the event of a Proposed Action, the Supplier shall notify the Member in writing. The Supplier shall also provide written notice of a Proposed Action to the Provider. This notice must meet the language and format requirements in accordance with section N.3 of this RFP and be sent in accordance with the timeframes described in section N.3.

1. The notice of Proposed Action must contain the following:

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- a. The Action the Supplier has taken or intends to take, including the service or procedure that is subject to the Action.
 - b. Additional information, if any, that could alter the decision.
 - c. The specific reason used as the basis of the Action.
 - d. The reasons for the Action must have a factual basis and legal/policy basis.
 - e. The Member's right to file an Administrative Review through the Supplier's internal Grievance System as described in section N.3.
 - f. The Provider's right to file a Provider Complaint as described in section I.7;
 - g. The requirement that a Member exhaust the Supplier's internal Administrative Review Process;
 - h. The procedures for exercising the rights outlined in this section ;
 - i. The circumstances under which Expedited Review is available and how to request it; and
 - j. The Member's right to have Benefits continue pending resolution of the Administrative Review with the Supplier, Member instructions on how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.
2. The Supplier shall mail the Notice of Proposed Action within the following timeframes:
- For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of one of the following exceptions:
- a. The Supplier has factual information confirming the death of a Member.
 - b. The Supplier receives a clear written statement signed by the Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
 - c. The Supplier establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
 - d. The post office returns Supplier mail directed to the Member indicating no forwarding address and the Member's whereabouts are unknown (refer to 42 CFR 431.231(d) for procedures if the Member's whereabouts become known).
 - e. The Member's Provider prescribes an immediate change in the level of medical care.

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The date of Action will occur in less than ten (10) Calendar Days, in accordance with 42 C.F.R. §483.12(a) (5) (ii), which provides exceptions to the thirty (30) Calendar Days' notice requirements of 42 C.F.R. § 483.12(a) (5) (i).

For Standard Service Authorization decisions that deny or limit services, within the timeframes required in section 4.11.2.7.1 of Attachments I and J.

If the Supplier extends the timeframe for the decision and issuance of notice of Proposed Action according to section 4.11.2.7 of Attachment I and J, the Supplier shall give the Member written notice of the reasons for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. The Supplier shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.

For authorization decisions not reached within the timeframes required in section 4.11.2.7 of Attachments I and J for either standard or expedited Service Authorizations (which constitutes a denial and is thus an adverse action), notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.

e. Notice in Case of Probable Fraud

The Supplier may shorten the period of advance notice to five (5) Calendar Days before date of Action if the Supplier has facts indicating that Action should be taken because of probable Member Fraud and the facts have been verified, if possible, through secondary sources.

f. Administrative Review Process

An Administrative Review is the request for review of a "Proposed Action". The Member, the Member's Authorized Representative or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review either orally or in writing. Unless the Member or Provider requests Expedited Review, the Member, the Member's Authorized Representative or the Provider acting on behalf of the Member with the Member's written consent, must follow an oral filing with a written, signed, request for Administrative Review. An Administrative Review must be filed within thirty (30) Calendar Days of the notice of Proposed Action.

Administrative Reviews shall be filed directly with the Supplier, or its delegated representatives. The Supplier may delegate this authority to an Administrative Review committee, but the delegation must be in writing.

The Supplier shall ensure that the individuals who make decisions on Administrative Reviews are individuals who were not involved in any previous level of review or decision-making; and who are Health Care Professionals who have the appropriate clinical expertise in treating the Member's Condition or disease if deciding any of the following:

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1. An Administrative Review of a denial that is based on lack of medical necessity.
2. An Administrative Review that involves clinical issues.

The Administrative Review process shall provide the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing, and to examine the Member's case file, including Medical Records, and any other documents and records considered during the Administrative Review process. The Supplier shall inform the Member of the limited time available to provide this in case of Expedited Review.

The Administrative Review process must include as parties to the Administrative Review the Member, the Member's Authorized Representative, the Provider acting on behalf of the Member with the Member's written consent, or the legal representative of a deceased Member's estate.

The Supplier shall resolve each Administrative Review and provide written notice of the resolution, as expeditiously as the Member's health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Supplier receives the Administrative Review. For Expedited reviews and notice to affected parties, the Supplier has no longer than three (3) Working Days or as expeditiously as the Member's physical or Mental Health Condition requires, whichever is sooner. If the Supplier denies a Member's request for Expedited Review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) Calendar Days with a written notice. The Supplier shall also make reasonable efforts to provide oral notice for resolution of an Expedited Review of an Administrative Review.

The Supplier may extend the timeframe for standard or expedited resolution of the Administrative Review by up to fourteen (14) Calendar Days if the Member, Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, requests the extension or the Supplier demonstrates (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the Member's interest. If the Supplier extends the timeframe, it must, for any extension not requested by the Member, give the Member written notice of the reason for the delay.

g. Notice of Adverse Action

If the Supplier upholds the Proposed Action in response to an Administrative Review filed by the Member, the Supplier shall issue a Notice of Adverse Action within the timeframes described in section N.3.

The Notice of Adverse Action shall meet the language and format requirements as specified in section N.3 and include the following:

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1. The results and date of the Adverse Action including the service or procedure that is subject to the Action.
 2. Additional information, if any, that could alter the decision.
 3. The specific reason used as the basis of the Action.
 4. The right to request a State Administrative Law Hearing within thirty (30) Calendar Days from the date of the Notice of Adverse Action. The time for filing will begin when the filing is date stamped.
 5. The right to continue to receive Benefits pending a State Administrative Law Hearing.
 6. How to request the continuation of Benefits.
 7. Information explaining that the Member may be liable for the cost of any continued Benefits if the Supplier's Action is upheld in a State Administrative Law Hearing.
 8. Circumstances under which expedited resolution is available and how to request it.
- h. Administrative Law Hearing

The State will maintain an independent Administrative Law Hearing process as defined in O.C.G.A. §49-4-153 and as required by federal law, 42 CFR 431.200. The Administrative Law Hearing process shall provide Members an opportunity for a hearing before an impartial Administrative Law Judge. The Supplier shall comply with decisions reached as a result of the Administrative Law Hearing process.

The Supplier is responsible for providing counsel to represent its interests. DCH is not a party to the case and will only provide counsel to represent its own interests.

A Member or Member's Authorized Representative may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by the Supplier. The parties to the Administrative Law Hearing shall include the Supplier as well as the Member, Member's Authorized Representative, or representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member. DCH reserves the right to intervene on behalf of the interest of either party.

The hearing request and a copy of the adverse action letter must be received by the Supplier within thirty (30) Calendar Days or less from the date that the notice of Action was mailed.

A Member may request a continuation of Benefits while an Administrative Law Hearing is pending.

The Supplier shall make available any records and any witnesses at its own expense in conjunction with a request pursuant to an Administrative Law Hearing.

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- i. Continuation of Benefits while the Supplier Appeal and Administrative Law Hearing are Pending

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

1. Within ten (10) Calendar Days of the Supplier mailing the Notice of Adverse Action.
2. The intended effective date of the Supplier’s Proposed Action.

The Supplier shall continue the Member’s Benefits if the Member or the Member’s Authorized Representative files the Appeal timely; the Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized Provider; the original period covered by the original authorization has not expired; and the Member requests extension of the Benefits.

If, at the Member’s request, the Supplier continues or reinstates the Member’s benefit while the Appeal or Administrative Law Hearing is pending, the Benefits must be continued until one of the following occurs:

1. The Member withdraws the Appeal or request for the Administrative Law Hearing.
2. Ten (10) Calendar Day pass after the Supplier mails the Notice of Adverse Action, unless the Member, within the ten (10) Calendar Day timeframe, has requested an Administrative Law Hearing with continuation of Benefits until an Administrative Law Hearing decision is reached.
3. An Administrative Law Judge issues a hearing decision adverse to the Member.
4. The time period or service limits of a previously authorized service has been met.

If the final resolution of the Appeal is adverse to the Member, that is, upholds the Supplier’s Action, the Supplier may recover from the Member the cost of the services furnished to the Member while the Appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

If the Supplier or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Supplier shall authorize or provide these disputed services promptly, and as expeditiously as this Member’s health Condition requires.

If the Supplier or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Supplier shall pay for those services.

4. Information Management and Systems

The Supplier shall develop, maintain, and update, at no cost to DCH, Members or Providers, an Information management system for the purpose of integrating all components of the delivery of care to its Members included in Attachment I. The system shall have the capability to securely store and transmit Information, interface with other relevant systems

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and report data in a format specified by DCH. The Supplier shall ensure the system is available and accessible to users at times and in a format that encourages meaningful use by stakeholders.

a. General Provisions

The Supplier shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet Georgia Families and Georgia Families 360° requirements, State and federal reporting requirements, all other Contract requirements and any other applicable State and federal laws, rules and regulations including, as amended, HIPAA.

The Supplier shall have Information management processes and Information Systems that enable it to retain and maintain access to Provider's historical Information for the purpose of Claims processing and Provider inquiries for a period of up to five (5) years.

The Supplier is responsible for maintaining Systems that shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.

The Supplier shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management Information as well as other system functions and Information. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.

The Supplier shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its Agents and every Supplier.

The Supplier shall provide a continuously available electronic mail communication link (e-mail system) with the State. This system shall be:

1. Available from the workstations of the designated Supplier contacts; and
2. Capable of attaching and securely sending documents created using software products other than Supplier systems, including the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

By no later than April 30th of each year, the Supplier will provide DCH with an annual progress/status report of the Supplier's Systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Supplier's Span of Control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The Systems refresh plan will also indicate how the Supplier will ensure that the version and/or release level of all of its

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Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the Systems component.

The Supplier is responsible for all costs associated with the Suppliers Systems refresh plan.

b. Health Information Technology and Exchange

The Supplier shall have in place or develop initiatives towards implementing electronic health information exchange and Health Care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased Information on cost and Quality of care through health information technology.

The Supplier shall develop an incentive program for the adoption and Utilization of electronic health records that result in improvements in the Quality and cost of Health Care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Supplier shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers.

The Supplier shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).

1. If not already participating in the GaHIN, the Supplier shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Contract Execution Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process;
2. The Supplier shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;
3. DCH and/or its designee shall provide detailed on-boarding information for use by the Supplier to establish interoperability with the GaHIN; and
4. Costs incurred by the Supplier to establish interoperability with the GaHIN shall be the sole responsibility of the Supplier.

The Supplier shall make Member health Information accessible to the GaHIN.

Through their system and interoperability with the GaHIN, the Supplier shall provide the following types of patient health information on Members including, but not limited to:

1. Member-specific Information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic Information, as appropriate;

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2. Name and address of each Member's PCP;
3. Acquisition and retention of the Member's Medicaid ID;
4. Provider-specific Information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;
5. Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check Program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnosis, and treatment given, including drugs prescribed;
6. Record of future scheduled service appointments, if available, and Referrals;
7. Complete record of all immunizations;
8. Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the Claims or "visits" module of the Virtual Health Record (VHR); and
9. Any Utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description.

The Supplier shall access the GaHIN to display Member health Information within their system for the purpose of Care Coordination and management of the Members.

The Supplier shall provide DCH with a list of Authorized Users who may access patient health data from the Supplier's Systems. DCH shall review and approve the list, including revisions thereto, of the Supplier's Authorized Users who may access patient health data from the Supplier's systems. The Supplier shall be permitted to access the GaHIN for purposes associated with this RFP only.

The Supplier shall encourage contracted Providers participation in the GAHIN as well.

c. Global System Architecture and Design Requirements

The Supplier shall comply with federal and State policies, standards and regulations in the design, development and/or modification of the Systems it will employ to meet the aforementioned requirements and in the management of Information contained in those Systems. Additionally, the Supplier shall adhere to DCH and State-specific system and data architecture preferences as indicated in this Scope of Work.

The Supplier's Systems shall:

1. Employ a relational data model in the architecture of its databases and relational database management system (RDBMS) to operate and maintain them.
2. Be SQL and ODBC compliant.

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3. Adhere to Internet Engineering Task Force/Internet Engineering Standards Group standards for data communications, including TCP and IP for data transport.
4. Conform to standard code sets detailed in Attachment I.
5. Contain industry standard controls to maintain Information integrity applicable to privacy and security, especially PHI. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a Methodology to be developed jointly and mutually agreed upon by the Supplier and DCH.
6. Partner with the State in the development of future standard code sets, not specific to HIPAA or other federal effort and will conform to such standards as stipulated by DCH.

Where Web services are used in the engineering of applications, the Supplier's Systems shall conform to World Wide Web Consortium (W3C) standards such as XML, UDDI, WSDL and SOAP so as to facilitate integration of these Systems with DCH and other State systems that adhere to a service-oriented architecture.

Audit trails shall be incorporated into all Systems to allow Information on source data files and documents to be traced through the processing stages to the point where the Information is finally recorded. The audit trails shall:

1. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action.
2. Have the date and identification "stamp" displayed on any on-line inquiry.
3. Have the ability to trace data from the final place of recording back to its source data file and/or document.
4. Be supported by listings, transaction Reports, update Reports, transaction logs, or error logs.
5. Facilitate auditing of individual Claim records as well as batch audits.
6. Be maintained for seven (7) years in either live and/or archival systems, as applicable. The duration of the retention period may be extended at the discretion of and as indicated to the Supplier by the State as needed for ongoing audits or other purposes.

The Supplier shall house indexed images of documents used by Members and Providers to transact with the Supplier in the appropriate database(s) and document management systems to maintain the logical relationships between certain documents and certain data.

The Supplier shall institute processes to ensure the validity and completeness of the data it submits to DCH. At its discretion, DCH will conduct general data validity and

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completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Member ID, date of service, Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, Revenue Codes, date of Claim processing, and date of Claim payment.

Where a System is herein required to, or otherwise supports, the applicable batch or on-line transaction type, the system shall comply with HIPAA-standard transaction code sets as specified in Attachment I, and as updated thereafter.

The Supplier System(s) shall conform to HIPAA standards for information exchange, and as updated thereafter.

The layout and other applicable characteristics of the pages of Supplier web sites shall be compliant with Federal “section 508 standards” and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.

Supplier Systems shall conform to any applicable Application, Information and Data, Middleware and Integration, Computing Environment and Platform, Network and Transport, and Security and Privacy policy and standard issued by GTA as stipulated in the appropriate policy/standard and as updated thereafter. These policies and standards can be accessed at:

http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.htmlhtml

d. Data and Document Management Requirements by Major Information Type

In order to meet programmatic, reporting and management requirements, the Supplier’s Systems shall serve as either the Authoritative Host of key data and documents or the host of valid, replicated data and documents from other systems. [Attachment I] lays out the requirements for managing (capturing, storing and maintaining) data and documents for the major Information types and subtypes associated with the aforementioned programmatic, reporting and management requirements.

e. System and Data Integration Requirements

All of the Supplier’s applications, operating software, middleware, and networking hardware and software shall be able to interface with the State’s systems and DCH vendors systems and will conform to standards and specifications set by the Georgia Technology Authority and the agency that owns the systems. These standards and specifications are detailed in Attachment I.

The Supplier’s System(s) shall be able to transmit and receive transaction data to and from the MMIS as required for the appropriate processing of Claims and any other transaction that may be performed by either System.

The Supplier shall generate Encounter data files no less than weekly (or at a frequency defined by DCH) from its Claims management system(s) and/or other sources. The files will contain settled Claims and Claim Adjustments and encounters from Providers with whom the Supplier has a Capitation arrangement for the most recent month for which all such transactions were completed. The Supplier will provide these files electronically to

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DCH and/or its designated Agent in adherence to the procedure and format indicated in Attachment I and as updated thereafter.

The Supplier's System(s) shall be capable of generating all required files in the prescribed formats (as referenced in Attachment I, including any updates thereto) for upload into state Systems used specifically for program integrity and compliance purposes.

The Supplier's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

f. System Access Management and Information Accessibility Requirements

The Supplier's System shall employ an access management function that restricts access to varying hierarchical levels of system functionality and Information. The access management function shall:

1. Restrict access to Information on a "need to know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;
2. Restrict access to specific system functions and Information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by DCH and the Supplier; \
3. Restrict attempts to access system functions (both internal and external) to three (3), with a system function that automatically prevents further access attempts and records these occurrences; and
4. At a minimum, follow the GTA Security Standard and Access Management protocols, and updates thereto.

The Supplier shall make System Information available to duly Authorized Representatives of DCH and other State and federal agencies to evaluate, through inspections or other means, the Quality, appropriateness and timeliness of services performed.

The Supplier shall have procedures to provide for prompt electronic transfer of System Information upon request to In-Network or Out-of-Network Providers for the medical management of the Member in adherence to HIPAA and other applicable requirements.

g. System Availability and Performance Requirements

The Supplier will ensure that Member and Provider portal and/or phone-based functions and information, such as confirmation of CMO Enrollment (CCE) and electronic Claims management (ECM), Member services and Provider services, are available to the applicable System users twenty-four (24) hours a day, seven (7) Days a Week, except during periods of scheduled System Unavailability agreed upon by DCH and the Supplier. Unavailability caused by events outside of a Supplier's Span of Control is outside of the scope of this requirement.

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The Supplier shall ensure that at a minimum, all other System functions and Information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday with the exception of State holidays.

The Supplier shall ensure that the average response time that is controllable by the Supplier is no greater than the requirements set forth below, between 7:00 a.m. and 7:00 p.m. EST, Monday through Friday for all applicable system functions except a) during periods of scheduled downtime, b) during periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Supplier's Span of Control or c) for Member and Provider portal and phone-based functions such as CCE and ECM that are expected to be available twenty-four (24) hours a day, seven (7) days a Week:

1. Record Search Time – The response time shall be within three (3) seconds for ninety-eight percent (98%) of the record searches as measured from a representative sample of DCH System Access Devices, as monitored by the Supplier;
2. Record Retrieval Time – The response time will be within three (3) seconds for ninety-eight percent (98%) of the records retrieved as measured from a representative sample of DCH System Access Devices;
3. On-line Adjudication Response Time – The response time will be within five (5) seconds ninety-nine percent (99%) of the time as measured from a representative sample of user System Access Devices;
 - a. Screen Edit Time (Note: this is called Screen Display Time in the MMIS contract.)
 - b. The system Screen Display Time must be within 2 seconds for 95% of the time. Screen Display Time is the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor.
 - c. New Screen Page Time – must be within 2 seconds for 95% of the time. New Screen/Page Time is the time elapsed from the time a new screen is requested until the data from the screen appears or loads to completion on the monitor.
 - d. Print Initiation Time – must be within 2 seconds for 95% of the time. Print Initiation Time is the time elapsed from the command to print a screen or report until it appears in the appropriate queue.

The Supplier shall develop an automated method of Monitoring the CCE and ECM functions on at least a thirty (30) minute basis twenty-four (24) hours a day, seven (7) Days per Week. The Monitoring method shall separately monitor for availability and performance/response time each component of the CCE and ECM systems, such as the voice response system, the PC software response, direct line use, the swipe box method and ECM on-line pharmacy system.

- h. System Span of Control

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Upon discovery of any problem within its Span of Control that may jeopardize System availability and performance as defined herein, the Supplier shall notify the DCH Director, Contract Compliance and Resolution, in person, via phone, and electronic mail followed by surface mail notification.

The Supplier shall deliver notification as soon as possible but no later than 7:00 p.m. EST if the problem occurs during the Business Day and no later than 9:00 a.m. EST the following business day if the problem occurs after 7:00 p.m. EST.

Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Supplier shall notify the DCH Director, Contract Compliance and Resolution, within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on System Unavailability protocols.

The Supplier shall provide to the DCH Director, Contract Compliance and Resolution, Information on System Unavailability events, as well as status updates on problem resolution. These up-dates shall be provided on an hourly basis and made available via electronic mail, telephone and the Supplier's web site/DCH Portal.

Unscheduled System Unavailability of CCE and ECM functions, caused by the failure of systems and telecommunications technologies within the Supplier's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the Supplier's discovery of System Unavailability. Unscheduled System Unavailability to all other Supplier System functions caused by systems and telecommunications technologies within the Supplier's Span of Control shall be resolved, and the restoration of services implemented, within four (4) hours of the Supplier's discovery of System Unavailability.

Cumulative System Unavailability caused by systems and telecommunications technologies within the Supplier's Span of Control shall not exceed one (1) hour during any continuous five (5) Calendar Day period.

The Supplier shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Supplier's Span of Control. The Supplier is obligated to work with identified vendors to resolve and report system availability and performance issues.

Full written documentation that includes a Corrective Action or Remedial Action response that describes what caused the problem, how the problem will be prevented from occurring again, and within a set time frame for resolution must be submitted to DCH within the DCH required timeframe of the problem's occurrence.

i. **Business Continuity and Disaster Recovery**

Regardless of the architecture of its Systems, the Supplier shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that at a minimum addresses the following scenarios: (a) the central computer installation and

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resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e. causes unscheduled System Unavailability.

The Supplier shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore System functions per the standards outlined elsewhere in the Contract. The Supplier will prepare a report of the results of these tests and present to DCH staff within five (5) Business Days of test completion. DCH or its designee, federal auditors, or the State Auditor, reserves the right to conduct a site visit of the Supplier's disaster recovery location with one (1) Business Day prior notice.

In the event that the Supplier fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in the Contract, the Supplier shall be required to submit to the State a Corrective Action Preventive Action (CAPA) that describes how the failure will be resolved. The CAPA will be delivered within five (5) Business Days of the conclusion of the test.

The Supplier shall submit monthly System Availability and Performance Reports to DCH as described in the RADs as amended from time to time.

j. System User and Technical Support Requirements

The Supplier shall provide Systems Help Desk (SHD) services to all DCH staff and the other agencies that may have direct access to Supplier Systems.

The Systems Help Desk (SHD) shall be available via local and toll free telephone service and via e-mail from 7 a.m. to 7 p.m. EST Monday through Friday, with the exception of State holidays. Upon State request, the Supplier shall staff the SHD on a State holiday, Saturday, or Sunday at the Supplier's expense.

SHD staff shall answer user questions regarding Supplier System functions and capabilities; report recurring programmatic and operational problems to appropriate Supplier or DCH staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon Methodology; and redirect problems or queries specific to data access authorization to the appropriate State login account administrator.

The Supplier shall submit to DCH for review and approval its SHD Standards. At a minimum, these standards shall require that between the hours of 7:00 a.m. and 7:00 p.m. EST ninety percent (90%) of calls are answered by the fourth (4th) ring, the call

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abandonment rate is five percent (5%) or less, the average hold time is two (2) minutes or less, and the Blocked Call rate does not exceed one percent (1%).

Individuals who place calls to the SHD between the hours of 7:00 p.m. and 7:00 a.m. EST shall be able to leave a message. The Supplier's SHD shall respond to messages by noon the following Business Day.

Recurring problems not specific to System Unavailability identified by the SHD shall be documented and reported to Supplier management within one (1) Business Day of recognition so that deficiencies are promptly corrected in accordance with this RFP.

Additionally, the Supplier shall have an IT service management system that provides an automated method to record, track, and report on all questions and/or problems reported to the SHD. The service management system shall:

1. Assign a unique number to each recorded incident.
2. Create State defined extract files that contain summary information on all problems/issues received during a specified time frame.
3. Escalate problems based on their priority and the length of time they have been outstanding.
4. Perform key word searches that are not limited to certain fields and allow for searches on all fields in the database.
5. Notify support personnel when a problem is assigned to them and re-notify support personnel when an assigned problem has escalated to a higher priority.
6. Generate a list of all problems assigned to a support person or group.
7. Perform searches for duplicate problems when a new problem is entered.
8. Allow for entry of at least five hundred (500) characters of free form text to describe problems and resolutions.
9. Generate Reports that identify categories of problems encountered, length of time for resolution, and any other State-defined criteria.

The Supplier's call center systems shall have the capability to track call management metrics identified in Attachment I, and updates thereto.

k. System Change Management Requirements

The Supplier shall absorb the cost of routine maintenance, inclusive of defect correction, System changes required to effect changes in State and federal statute and regulations, and production control activities, of all Systems within its Span of control.

The Supplier shall provide DCH, prior written notice of non-routine System changes excluding changes prompted by events described in the System Access Management

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and Information Accessibility Requirements section above and including proposed corrections to known system defects, within ten (10) Calendar Days of the projected date of the change. As directed by the State, the Supplier shall discuss the proposed change in the Systems Work Group.

The Supplier shall respond to State reports of System problems not resulting in System Unavailability and shall perform the needed changes according to the following timeframes:

1. Within five (5) Calendar Days of receipt, the Supplier shall respond, via phone and in writing via email to notices of system problems.
2. Within fifteen (15) Calendar Days, the correction will be made and confirmed to the State or a Requirements Analysis and Specifications document will be due.
3. The Supplier will correct the deficiency by an effective date to be determined by DCH.
4. Supplier systems will have a system-inherent mechanism for recording any change to a software module or subsystem.

The Supplier shall put in place procedures and measures for safeguarding the State from unauthorized modifications to Supplier Systems.

Unless otherwise agreed to in advance by DCH as part of the activities described in the System User and Technical Support Requirements section above, scheduled System Unavailability to perform System maintenance, repair and/or upgrade activities shall take place between 11 p.m. EST on a Saturday and 6 a.m. EST on the following Sunday.

I. System Security and Information Confidentiality and Privacy Requirements

The Supplier shall provide for the physical safeguarding of its data processing facilities and the systems and Information housed therein. The Supplier shall provide DCH with access to data facilities upon DCH request. The physical security provisions shall be in effect for the life of the Contract and thereafter.

The Supplier shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

The Supplier shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

The Supplier shall ensure that the operation of all of its systems is performed in accordance with State and federal regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations. Relevant publications are included in Attachments I and J.

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The Supplier will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a Supplier's Span of Control.

The Supplier shall ensure compliance with:

1. 42 CFR Part 431 Subpart F (confidentiality of information concerning applicants and Members of public medical assistance programs)
2. 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and
3. Special confidentiality provisions related to people with HIV/AIDS and Mental Illness.

The Supplier shall provide its Members with a privacy notice as required by HIPAA. The Supplier shall provide the State with a copy of its Privacy Notice for its filing.

m. Information Management Process and Information Systems Documentation Requirements

The Supplier shall ensure that written System Process and Procedure Manuals, and updates thereto, document and describe all manual and automated system procedures for its Information management processes and Information Systems in accordance to CMS seven conditions and standards, and amendments thereto. Available at: http://www.acs-inc.com/wp_state_self_assessment.aspx.

The Supplier shall develop, prepare, print, maintain, produce, and distribute distinct System Design and Management Manuals, User Manuals and Quick/Reference Guides, and any updates thereafter, for DCH and other agency staff that use the DCH Portal.

The System User Manuals shall contain Information about, and instructions for, using applicable System functions and accessing applicable system data.

When a System change is subject to State approval, the Supplier shall draft revisions to all appropriate manuals impacted by the system change i.e. user manuals, technical specifications etc. prior to State approval of the change.

All of the aforementioned manuals and reference guides shall be available in printed form and on-line via the DCH Portal. The manuals will be published in accordance to the applicable DCH and/or Georgia Technology Authority (GTA) standard.

Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) Business Days of the update taking effect.

5. Administration and Management

The Supplier shall be responsible for the administration and management of all requirements of this RFP. All costs related to the administration and management of this RFP shall be the responsibility of the Supplier.

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a. Place of Business and Hours of Operation

The Supplier shall maintain a place of business in the metropolitan Atlanta Area within thirty-five (35) miles of 2 Peachtree Street, NW Atlanta, GA 30303. The Supplier must have at least one (1) satellite office serving no less than two (2) contiguous Service Regions. The central business office must be accessible for foot and vehicle traffic. All documentation must reflect the address of the location identified as the legal, duly licensed, central business office. This business office must be open at least between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday with the exception of State holidays. The Supplier shall ensure that the office(s) are adequately staffed to ensure that Members and Providers receive prompt and accurate responses to inquiries.

The Supplier shall provide access twenty-four (24) clock hours a day, seven (7) days per week to its web site. The Supplier shall provide seventy-two (72) clock hours advance notice of web site upgrades, servicing and updates.

b. Training

The Supplier shall conduct ongoing training for its entire staff, in all departments, to ensure appropriate functioning in all areas and that staff is aware of all programmatic changes. The Supplier must train its staff using a curriculum specific to their areas of responsibility. The training program must include, for example, training about the Georgia Medicaid and PeachCare for Kids® programs, Medicaid regulations, issues specific to the enrolled populations and managed care operations. Staff must receive training about the functionality of Information Systems so that they are fully capable of using the systems to complete their job functions. The Supplier shall also ensure that staff have the necessary qualifications and education to perform their assigned jobs. The Supplier and its staff shall attest that staff have received required trainings and have necessary qualifications and education.

The Supplier shall submit a staff training plan to DCH for initial review and approval, and as updated thereafter. Designated staff will be required to attend DCH in-service training on an ad-hoc basis. DCH will determine the type and scope of training.

DCH may attend any training sessions conducted by or on behalf of the Supplier specific to the Contract at its discretion.

c. Data and Report Certification

The Supplier shall certify all data pursuant to 42 CFR 438.606. The data that must be certified include, but are not limited to, Enrollment Information, Encounter Data, Contractual Reports, inclusive of all Quality management reports and other Information required by the State and contained in Contracts, proposals and related documents. The data must be certified by one of the following: the Supplier's Chief Executive Officer, the Supplier's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the Supplier's Chief Executive Officer or Chief Financial Officer. Specific to the Quality management reports, the Chief Medical Officer must

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review and attest to the accuracy of all Quality management reports submitted to DCH. The signature of the Chief Medical Officer is required on all Quality management reports:

1. By virtue of submission, the Supplier attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.
2. Inaccurate data, reports, and other documents provided to the State by the Supplier are subject to applicable Liquidated Damages.

The Supplier shall submit the certification concurrently with the certified data.

d. **Turnover Planning**

No later than thirty (30) Calendar Days after the Contract Execution Date, the Supplier must submit a detailed turnover plan (“Turnover Plan”) to DCH. The Turnover Plan must:

1. Specify how the Supplier will turn over any and all records, files, methodologies, data and any supplemental documentation which DCH would require for DCH or another contractor to take over operation of the Georgia Families and/or Georgia Families 360° programs in the event of Contract expiration or termination for any reason.
2. Include all elements of turnover phases, including specific schedule.
3. Include a statement of resources and training that would be necessary to facilitate and efficiently turnover the Georgia Families and/or Georgia Families 360° programs to the State or another contractor.
4. Include a statement of commitment to maintain the level of resources dedicated to full-program operations through the contract termination.

Any Turnover Plan revisions required by DCH must be finalized within five (5) Calendar Days of DCH’s feedback.

6. Monitoring and Reporting

The Supplier shall support DCH in its program Monitoring and reporting efforts for program performance and trending analysis through submission of ongoing, dashboard and ad hoc reports to DCH for all activities described in the scope of work. The Supplier shall provide ad hoc reports to DCH upon request and within timeframes agreed to by DCH and the Supplier.

The Supplier shall meet with DCH Business Owners during implementation to discuss all data requirements and the Supplier’s recommended reports. The Supplier shall accommodate DCH’s requests for data and reporting based on implementation decisions as well as for ongoing requests during operations.

a. **Ongoing Reporting**

The Supplier shall collect, validate and report required program data to DCH in an accurate and timely manner. The Supplier’s Chief Executive or Financial Officer, or a designee vested with their authority, shall attest to the accuracy and completeness of all

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submitted reports, in accordance with 42 CFR §438.604. In addition, the Supplier shall comply with all state and federal requirements set forth in this section and throughout the RFP.

The Supplier shall comply with all the reporting requirements established by this RFP. The Supplier shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. DCH may modify reports, specifications, templates, or timetables as necessary during the contract year. Supplier changes to the format must be approved by DCH prior to implementation. The Supplier shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with section N.4. The Supplier's failure to submit the Reports as specified may result in the assessment of Liquidated Damages.

The Supplier shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, unless otherwise indicated.

1. Weekly Reports shall be submitted on the same day of each Week as determined by DCH;
2. Monthly Reports shall be submitted within fifteen (15) Calendar Days after the end of each month;
3. Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter Immediately preceding the due date;
4. Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12th) month of the contract year ending June 30th;
5. Ad-hoc, as determined by DCH; and
6. Bi-annual.

For reports required by the Office of Insurance and Safety Fire Commissioner and DCH, the Supplier shall submit such reports according to the Office of Insurance and Safety Fire Commissioner schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in the Contract, should the Office of Insurance and Safety Fire Commissioner schedule of due dates be amended at a future date, the due dates in the Contract shall automatically change to the new due dates.

The Supplier shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Supplier's responsibility shall be limited to data in its possession.

b. Public Reporting

DCH will periodically publish information or receive requests from audiences such as legislators that may require data from the Supplier. DCH will provide the Supplier with Information about the data DCH would like to publish or must produce, and the Supplier shall produce all reports or summary data for DCH to incorporate into a larger report. The Supplier shall develop these reports considering the audience to be targeted.

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The Supplier shall not publish reports on its web site or any other forum without prior consent from DCH.

c. Ongoing Reporting and Monitoring Meetings

The Supplier must be prepared to participate in regularly scheduled meetings with DCH staff to review decisions, resolve issues and define operational enhancements. These meeting schedules will be determined by DCH.

The Supplier and its various levels of staff as determined by DCH must attend onsite meetings at DCH on a monthly basis to report on all activities, trends, opportunities for improvement and recommendations for programmatic and policy changes at the frequency determined by DCH. Suppliers must collaborate and provide best practices and lessons learned to reach Georgia Families and Georgia Families 360° program goals.

7. Turnover Planning

No later than thirty (30) Calendar Days after the Contract Effective Date, the Supplier must submit a detailed turnover plan to DCH. The turnover plan must:

- a. Specify how the Supplier will turn over any and all records, files, methodologies, data and any supplemental documentation which DCH would require for DCH or another contractor to take over operation of the Georgia Families and/or Georgia Families 360° programs in the event of Contract expiration or termination for any reason
- b. Include all elements of turnover phases, including specific schedule
- c. Include a statement of resources and training that would be necessary to facilitate and efficiently turnover the Georgia Families and/or Georgia Families 360° programs to the State or another contractor
- d. Include a statement of commitment to maintain the level of resources dedicated to full-program operations through the contract termination

Any turnover plan revisions required by DCH must be finalized within five (5) Calendar Days of DCH's feedback.

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II. Georgia Families 360°

The Supplier shall comply with requirements set forth in section I Georgia Families Covered Services of this RFP and all requirements included in this section.

Georgia Families 360° Members may be eligible for certain P4HB services.

A. Project Implementation

1. Implementation Planning

In addition to the elements included in section I.A, the Georgia Families 360° proposed workplan must comply with all due dates established by DCH and address the following Georgia Families 360° Supplier activities:

- a. Submission of a Network Development Plan with specific consideration to composition and access of Providers with experience in trauma-informed care, pediatricians and Comprehensive Child and Family Assessment (CCFA) Providers.
- b. Submission of a Staffing Plan that details the staffing levels dedicated to the requirements for Georgia Families 360° Members.
- c. Detailed plans on how the Supplier will undertake to build relationships with Division of Family and Children Services (DFCS) staff at the regional and county level, and the DFCS units designated for Kenny A., Interstate Compact on Adoption and Medical Assistance and (ICAMA) and Interstate Compact on the Placement of Children (ICPC) services. Such plans shall address education, training and process development.
- d. Development of transition policies and procedures, including the guidelines it will use to identify Members with Special Health Care Needs.
- e. Detailed plans on how the Supplier will undertake to build relationships with Department of Juvenile Justice (DJJ) staff at the regional level. Such plans shall address education, training and process development.
- f. Submission of policies and procedures related to the provision of all required health screenings and assessments within the prescribed timeframes.
- g. Submission of policies and procedures for conducting the Health Risk Screening.
- h. Submission of the Member Education and Outreach Plan.
- i. Training of Providers, Supplier staff, court personnel, law enforcement and others on trauma-informed care and the System of Care approach.
- j. Submission of policies and procedures related to Care Coordination Teams, Virtual Health Records, privacy requirements and other activities or requirements specific for Members.

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- k. Submission of privacy policies and procedures for Members, including staff and Provider training and re-training protocols.
- l. Submission of detailed policies and procedures for the ombudsman staff.
- m. Submission of policies and procedures related to the ability to share Care Coordination and Case Management Information electronically with DFCS and DJJ staff.
- n. Submission of Member Services policies and procedures including the 24/7 Call Center.
- o. Detailed plans for coordinating with other DCH sister agencies, such as DPH, Department of Early Care and Learning (DECAL) and Department of Education (DOE_.

The scope of the Georgia Families 360° readiness reviews will include, but not be limited to, review and/or verification of the Supplier's progress on the areas identified in section I.A. and will include but not be limited to:

- a. Network Provider composition and access with specific focus on Providers with experience in trauma-informed care, pediatricians, PCPs, specialists, Behavioral Health Providers, CCFA Providers, and dental Providers;
- b. Staffing Plan and staffing levels with special emphasis on Care Coordinators and Nurse Case Managers;
- c. Supplier's plans for building relationships with DFCS staff at the regional and county level and the DFCS units designated for Kenny A., ICAMA and ICPC services, and such plan shall address education, training and process development;
- d. Supplier's ability to provide all required health screenings and assessments set forth in this RFP within the prescribed timeframes;
- e. Training of Providers, Supplier staff, court personnel, law enforcement and Care Coordination Teams,
- f. Ability to share Information electronically with DFCS and DJJ staff;
- g. Development of policies with protocols with Georgia Crisis and Access Line (GCAL)

2. Transition Planning

In the event that DCH contracts with a new Georgia Families 360° Supplier, that Supplier must provide, within thirty (30) Calendar Days of the Contract Execution Date, an updated and detailed draft of the of the Transition of Care plan described in section I.L for Members currently enrolled in the Georgia Families 360° program. The plan must outline specific goals and objectives that articulate how the Supplier will coordinate with DCH and DCH sister agencies to assume responsibility for Members transitioning from another CMO and other scope of work activities. An impact statement should be produced outlining the potential impact of the transition of Georgia Families 360° Members, the existing infrastructure and operations and support staff. At a minimum, this plan shall address communications and outreach, specific timeframes for executing the Transition of Care plan, dedicated Supplier

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staff involvement in the Transition of Care plan, approach and involvement with sister agencies, and ensuring continuity of care and plans for conducting all applicable health and Trauma Assessments, if applicable. DCH shall have fifteen (15) Calendar Days to review the draft Transition of Care plan and the Supplier shall have fifteen (15) Calendar Days from completion of DCH's review to submit the finalized Transition of Care Plan to DCH.

3. Georgia Families 360° Staffing

The Georgia Families 360° Supplier must comply with all requirements included in section I.B. of this RFP. In addition, the following requirements apply to the Georgia Families 360° program.

The Georgia Families 360° Supplier shall submit a Staffing Plan that details the staffing levels dedicated to the requirements for Georgia Families 360° Members with special emphasis on Care Coordinators, Nurse Case Managers, staff with System of Care knowledge and experience, Quality management and Utilization Management personnel, and staffing.

a. Staff Training

Georgia Families 360° Supplier shall conduct ongoing staff training of staff to address the unique needs of Georgia Families 360° Members. Trainings shall include but are not limited to the following issues: the roles and responsibilities of the DCH, DFCS, Department of Behavioral Health and Developmental Disabilities (DBHDD), DOE, DCH, DECAL and DJJ with regard to the Georgia Families 360° program, and how DCH and partner agencies will coordinate with the Georgia Families 360° Supplier; the Kenny A. Consent Decree; and the needs of Georgia Families 360° Members.

b. Care Coordination Teams

The Georgia Families 360° Supplier shall develop a Care Coordination Team staffing plan and submit to DCH within thirty (30) days of the Contract Notice of Award. This staffing plan shall indicate how the Georgia Families 360° Supplier will maintain adequate Georgia Families 360° Supplier staff to Member ratios and number of Care Coordination personnel and management staff having expertise in Physical Health, Behavioral Health, and the Georgia Families 360° Members to build Care Coordination Teams. Care Coordinators must be located Statewide in the areas in which they serve. The Georgia Families 360° Supplier must continue to assess the staff's ability to complete these functions in a timely nature, and will take Corrective Action as necessary and provide to DCH results of these assessments upon request.

The Georgia Families 360° Supplier shall require Care Coordination Teams and any other staff positions that may have direct contact with Georgia Families 360° Members or Georgia Families 360° Member Information to pass a background check as a condition of hire, and every two (2) years thereafter. The Georgia Families 360° Supplier's staff will not be placed in contact with Georgia Families 360° Members, nor be permitted to co-locate in DFCS or DJJ offices or access Georgia Families 360° Member Information, until the Georgia Families 360° Supplier has completed the initial background check and staff has passed the background check. The Georgia Families 360° Supplier shall ensure that

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all Georgia Families 360° Supplier staff, who have not passed a background check or who are alleged to have committed a criminal offense that would prohibit him or her from having contact with Georgia Families 360° Members or accessing their Information, are not permitted to work with Georgia Families 360° Members or have access to their Information.

The Georgia Families 360° Supplier will build individual Care Coordination Teams for Georgia Families 360° Members based on their specific needs and will assign the Care Coordination Team within one (1) Business Day of Enrollment. The Care Coordination Team will be updated as necessary as determined by the Georgia Families 360° Member's Health Care Service Plan. The Georgia Families 360° Supplier staff available to participate in Care Coordination Teams shall include at a minimum:

1. Masters level licensed social worker or counselor;
2. Nurse Care Manager (NCM) to assist Georgia Families 360° Members identified through the health assessment as Members with Special Health Care Needs;
3. Behavioral Health Specialist with at least five (5) years of Behavioral Health experience;
4. Family Peer Support Specialist;
5. Youth Peer Support Specialist; and
6. Care Coordinator.

The Care Coordination Team shall involve and include the preferences of the Georgia Families 360° Member and the family (Adoptive Parent(s), Foster Care Parent(s), Caregiver and/or biological family members as indicated by DFCS or DJJ) in Care Coordination processes, care planning, and care plan implementation in adherence to System of Care youth- and family-driven principles.

The Georgia Families 360° Supplier shall develop transition policies and procedures, including the guidelines it will use to identify Georgia Families 360° Members with Special Health Care Needs requiring priority coordination and care, within ninety (90) Calendar Days of the Operational Start Date.

c. Ombudsman Staff

The Georgia Families 360° Supplier must offer Georgia Families 360° Members an Ombudsmen Liaison and Ombudsman Coordinator during the entire Contract term.

The Georgia Families 360° Supplier must have at a minimum one (1) Ombudsmen Liaison and one (1) Ombudsman Coordinator. The Georgia Families 360° Supplier must consider and monitor current Enrollment levels when evaluating the number of Ombudsman Liaisons necessary to meet Georgia Families 360° Member needs. The Georgia Families 360° Supplier must also at least annually evaluate the Ombudsman Liaison and Coordinator positions, work plan(s) and job duties, and allocate an additional

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FTE Ombudsmen position or positions to meet Ombudsmen duties based on increases in the number of Georgia Families 360° Members.

The CMO Ombudsmen staff is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to Health Care services, and communication and education for the Georgia Families 360° Member, Providers, Caregivers, Foster and Adoptive Parents, State agencies and Residential Placement Providers. The Georgia Families 360° Supplier shall provide monthly detailed reports on activities associated with the CMO's responsibilities detailed in Attachment I.

To meet the requirements for the Ombudsman Liaison and Coordinator positions statewide, DCH encourages the Georgia Families 360° Supplier to contract or have a formal memorandum of understanding for advocacy and/or Translation Services with associations or organizations that have culturally diverse populations within the Georgia Families 360° Supplier service area. However, the Georgia Families 360° Supplier has primary responsibility for the Ombudsman Liaison and Coordinator positions. The Georgia Families 360° Supplier must monitor the effectiveness of the associations and agencies under contract and may alter the contract(s) with written notification to the Department.

The Ombudsman Liaison and Ombudsman Coordinator must be knowledgeable and have experience working with the Georgia Families 360° population, and shall have adequate time to advocate for Members. Responsibilities of the CMO Ombudsman staff shall include:

1. Investigate and resolve access and cultural sensitivity issues identified by Georgia Families 360° Supplier staff, State agency staff, Providers, advocating organizations, Georgia Families 360° Members, Foster Parents, Adoptive Parents, Caregivers and Residential Placement Providers;
2. Monitor complaints to identify trends or specific problem areas of access and care delivery;
3. Recommend policy and procedural changes to Georgia Families 360° Supplier needed to improve Georgia Families 360° Member access to care; and
4. Provide ongoing input to the Georgia Families 360° Supplier on how changes in the Georgia Families 360° Supplier Provider network will affect Georgia Families 360° Members access to medical care and continuity of care.

B. Georgia Families 360° Special Coverage and Provisions

The Georgia Families 360° Supplier must comply with all requirements included in section I.D. of this RFP. In addition, the following requirements apply to the Georgia Families 360° program.

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The Georgia Families 360° Supplier shall at a minimum provide Medically Necessary Services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals.

1. Required Assessments and Screenings

A critical component of the success of the Georgia Families 360° Supplier depends upon the Georgia Families 360° Supplier's ability to conduct and report required assessments and screenings upon Georgia Families 360° Member Enrollment. These tools are used to identify immediate needs of Members transitioning into and out of Georgia Families 360°. Required assessments and screening vary by population type and include:

a. Comprehensive Child and Family Assessment (CCFAs)

The CCFA is used by DFCS to assist in developing case plans, making placement decisions, expediting permanency and planning for effective service intervention. The Supplier shall be responsible for ensuring that the Medical and Trauma Assessments required for the Foster Care (FC) Members as part of the CCFA are conducted and reported in a timely manner as set forth herein. Each instance of failure to meet a timeframe specified in this section shall constitute a Category 4 event as set forth in Attachment I.

b. Medical Assessments for FC Members shall include all EPSDT periodicity schedule requirements relevant to the Georgia Families 360° Member's age. The Georgia Families 360° Supplier shall ensure Providers conducting the Medical Assessment provide outcomes of the assessment to the Georgia Families 360° Supplier within twenty (20) Calendar Days of Georgia Families 360° Supplier's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH. The Georgia Families 360° Supplier must provide outcomes of the Medical Assessments to the CCFA Provider within twenty (20) Calendar Days of Georgia Families 360° Supplier's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH.

c. Trauma Assessment Screenings.

The Trauma Assessment Screening, at a minimum, shall include:

1. A trauma history with information about any trauma that the child may have experienced or been exposed to as well as how they have coped with that trauma in the past and present.
2. Completion of the age appropriate assessment tool.
3. A summary of assessment results and recommendations for treatment (if needed).

The Supplier shall contract with CCFA Providers for the provision of CCFA Trauma Assessment Screenings for the following Georgia Families 360° Members:

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1. Members Newly Entering or Re-entering Foster Care

The Supplier shall ensure that a CCFA Provider has initiated contact with or visit(s) with the Member newly entering or re-entering Foster Care as a FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Supplier's receipt of written notification from DFCS of the FC Member's Detention Hearing. The Supplier must coordinate all necessary visits with the CCFA Provider to ensure that the final Trauma Assessment is completed within the timeframes referenced in the Contract.

A CCFA Provider must prepare a written Trauma Assessment report and submit such report to the Georgia Families 360° Supplier. The Supplier must then submit the written Trauma Assessment report to the CCFA Provider preparing the final CCFA report within twenty (20) Calendar Days of the Supplier's receipt of written notification from DFCS of the FC Member's Detention Hearing.

If the CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment during the FC Member's Multidisciplinary Team meeting. In the case of a verbal report, the Georgia Families 360° Supplier shall be responsible for assuring the CCFA Provider submits the final written Trauma Assessment report to the CCFA Provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Georgia Families 360° Supplier's receipt of written notification from DFCS of the FC Member's Detention Hearing.

2. Trauma Assessments for Adoption Assistance (AA) Members and Enrolled FC Members

Trauma Assessments may be required for AA Members in the event of abuse or neglect as reported by a Provider, Adoptive Parent or others. Trauma Assessments may also be required for a Member who has been a FC Member for a period of twelve (12) or more months and whose completed CCFA is more than twelve (12) months old. Under these two (2) circumstances, the Georgia Families 360° Supplier shall:

- i. Ensure that the CCFA Provider has initiated contact with or visit(s) with the AA or FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Georgia Families 360° Supplier's receipt of written notification from DFCS. The Georgia Families 360° Supplier must coordinate all necessary visits with the CCFA Provider to ensure that the final Trauma Assessment is completed within the timeframes referenced in this RFP.
- ii. The CCFA Provider must prepare a written Trauma Assessment report and submit such report to the CCFA Provider preparing the final CCFA report within twenty (20) Calendar Days of the Georgia Families 360° Supplier's receipt of written notification from DFCS.

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- iii. If the CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment. In the case of a verbal report, the Georgia Families 360° Supplier shall be responsible for assuring the CCFA Provider submits the final written Trauma Assessment report to the CCFA Provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Georgia Families 360° Supplier's receipt of written notification from DFCS.

The Georgia Families 360° Supplier shall coordinate for and ensure that FC or AA Members follow up on and receive any care specified within the Trauma and Medical Assessments in accordance with the following timeliness requirements. The Georgia Families 360° Supplier shall:

1. Provide follow up for dental treatment within thirty (30) Calendar Days of the EPSDT dental visit if the dental screening yields any concerns or the need for dental treatment.
 2. Obtain an audiological assessment and treatment or prescribed corrective devices initiated within thirty (30) Calendar Days of the screening, based on the results of the hearing screening.
 3. Provide a developmental assessment if the developmental screening completed as part of the EPSDT visit yields any developmental delays or concerns. The EPSDT Provider is responsible for making a Referral for the assessment, and the Georgia Families 360° Supplier is responsible for ensuring the child has the assessment within thirty (30) Calendar Days of the screening.
 4. The Georgia Families 360° Supplier shall ensure that Providers refer FC Members ages three (3) years and under who are exposed to Substantiated Maltreatment to the Children 1st program for a developmental screening as required by the Child Abuse Prevention and Treatment Act (CAPTA).
- d. Medical Assessments for Juvenile Justice (JJ) Members

The Georgia Families 360° Supplier shall be responsible for assuring the Medical Assessments for Georgia Families 360° JJ Members are completed within ten (10) Calendar Days of the Georgia Families 360° Supplier's receipt of the eligibility file from DCH or electronic notification from DJJ or DCH whichever comes first for a Member newly entering or re-entering as a Georgia Families 360° JJ Member. Providers conducting the assessment must provide outcomes to the Georgia Families 360° Supplier and the Georgia Families 360° Supplier shall send the outcome of the Medical Assessment to the Georgia Families 360° JJ Member's Residential Placement Provider within fifteen (15) Calendar Days of the Georgia Families 360° Supplier's receipt of the eligibility file from DCH or electronic notification from DJJ, whichever comes first. The medical components of the Medical Assessment for the JJ Member shall include an initial medical evaluation that includes all components of the EPSDT periodicity schedule relevant for the age of the JJ Member.

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e. Health Risk Screening

The Georgia Families 360° Supplier shall provide a Health Risk Screening within thirty (30) days of receipt of the eligibility file from DCH. The Health Risk Screening is used to develop a comprehensive understanding of the Georgia Families 360° Members' health status and will be used by the Georgia Families 360° Supplier to develop the Health Care Service Plan and used by the Care Coordination Team to determine the Georgia Families 360° Member's Care Coordination needs. The Health Risk Screening is independent of the assessments conducted for the CCFA; however, the Georgia Families 360° Supplier may utilize the information from the CCFA it coordinates to further inform the comprehensive understanding of the Georgia Families 360° Member's health.

The Georgia Families 360° Supplier must Assess the need to complete a new Health Risk Screening each time a Georgia Families 360° Member moves to a new placement or based on a change in the Member's medical or Behavioral Health as identified by Providers.

The Georgia Families 360° Supplier shall submit policies and procedures for conducting the Health Risk Screening and the tools that will be used to conduct the screenings to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operational Start Date.

2. Kenny A. Consent Decree

The Georgia Families 360° Supplier shall review the Kenny A. Consent Decree.

Members in custody of Fulton and DeKalb counties are required to receive services within the timeframe identified in the Kenny A. Consent Decree (Attachment I). The Georgia Families 360° Supplier must provide all Medical Services and adhere to timeliness requirements defined in the Kenny A. Consent decree for FC Members in custody of Fulton and DeKalb counties.

3. State Plan Services for Georgia Families 360° Members Enrolled in an Home- and Community-Based Services (HCBS) Waiver Program

The Georgia Families 360° Supplier must provide all Medicaid State Plan services required by section I.C. for Georgia Families 360° Members enrolled in an HCBS waiver program except any services provided under the applicable 1915(c) waiver, which shall remain available to such Georgia Families 360° Members via the Fee-for-Service program. DCH shall have the final determination as to which services are covered under the waiver and which services are the responsibility of the Georgia Families 360° Supplier.

C. Georgia Families 360° Member Enrollment

The Georgia Families 360° Supplier must comply with all requirements included in section I.E. of this RFP. In addition, the Georgia Families 360° Supplier shall enroll Georgia Families 360° Members in the program and Immediately begin Care Coordination upon the receipt of an eligibility file or electronic notification from DCH, DFCS or DJJ stating that the Member is eligible for the Georgia Families 360° program.

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1. Selection of a Primary Care Provider (PCP)

All Georgia Families 360° Members shall be assigned a PCP as discussed in section I.E.2. The PCP Auto-Assignment process is as follows when a PCP is not selected upon Enrollment.

a. FC Members

- i. If the DFCS Case Manager, Caregiver, Foster Parent or FC Member does not voluntarily select a PCP upon Enrollment in the Georgia Families 360° program, the Georgia Families 360° Supplier shall Auto-Assign the FC Member a PCP within two (2) Business Days of receipt of notification of the FC Member's Enrollment in the Georgia Families 360° program.
- ii. An eligibility file or electronic notification from DCH or DFCS will serve as notification.

b. AA Members:

- i. If an AA Member or Adoptive Parent does not voluntarily select a PCP upon Enrollment in the Georgia Families 360° program, the Supplier shall Auto-Assign the AA Member a PCP within two (2) Business Days of receipt of notification of the AA Member's Enrollment in the CMO.
- ii. An eligibility file or electronic notification from DCH will serve as notification.

c. JJ Member:

- i. If the Residential Placement Provider's identified Core Provider does not voluntarily select a PCP upon Enrollment in the Georgia Families 360° program, the Supplier shall Auto-Assign the JJ Member a PCP within two (2) Business Days of receipt of notification of the Georgia Families 360° JJ Member's Enrollment in the CMO.
- ii. An eligibility file or electronic notification from DCH or DJJ will serve as notification.

2. Re-Assignment of PCP

To ensure continuity of care when an FC or JJ Member changes placement, the Supplier must assess the FC or JJ Member's PCP access and assign the FC or JJ Member to a new PCP as necessary, according to the following process:

a. FC Member is relocated

- i. The Georgia Families 360° Supplier will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DFCS.
- ii. The Georgia Families 360° Supplier must assess the FC Member's access to the currently assigned PCP within one (1) Business Day of receipt of notification.

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- iii. The Georgia Families 360° Supplier must notify within the same Business Day the DFCS Case Manager, Caregiver, Foster Parent or FC Member if the PCP no longer meets the Geographic Access standards as defined in section I.17.
- iv. The DFCS Case Manager, Caregiver, Foster Parent or FC Member must select a new PCP within two (2) Business Days of the Georgia Families 360° Supplier's notification or the Georgia Families 360° Supplier shall auto-assign a new PCP if no selection is made during this timeframe.

This full process must be complete within three (3) Business Days of the Georgia Families 360° Supplier's receipt of notification of the FC Member's relocation.

b. JJ Member is relocated:

- i. The Georgia Families 360° Supplier will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DJJ.
- ii. The Georgia Families 360° Supplier must assess the JJ Member's access to the currently assigned PCP within one (1) Business Day of receipt of notification and must notify the Residential Placement Provider's identified Core Provider if the PCP no longer meets the Geographic Access standards as defined in section I.17.
- iii. The Residential Placement Provider's identified Core Provider must select a new PCP within two (2) Business Days of the Georgia Families 360° Supplier's notification or the Georgia Families 360° Supplier shall auto-assign a new PCP if no selection is made within this timeframe.

This full process must be complete within three (3) Business Days of the Georgia Families 360° Supplier's receipt of notification of the JJ Member's relocation.

For FC Members, the Supplier shall allow the FC Member, DFCS staff, Caregiver or Foster Parent to change the designation based on the needs of a child. For AA Members, the Supplier shall allow the AA Member or Adoptive Parent to change the PCP designation based on the needs of a child. For JJ Members, the Supplier shall allow the Juvenile Parole/Probation Specialist (JPPS) or Residential Placement Provider's designated Core Provider to change a PCP designation based on the needs of the youth.

3. Selection of a Dental Home

All Georgia Families 360° Members shall be assigned a PCP as discussed in section E.3. The Dental Home Auto-Assignment process is as follows when a PCP is not selected upon Enrollment.

a. FC Members:

- i. If the DFCS Case Manager, Caregiver, Foster Parent or FC Member does not voluntarily select a Dentist upon Enrollment, the Georgia Families 360° Supplier shall

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assign the FC Member to a Dentist within five (5) Business Days of receipt of notification of the FC Member's enrollment.

- ii. The eligibility file from DCH or written notification from DCH or DFCS will serve as notification of the FC Member's Enrollment.

b. AA Members:

- i. If an AA Member or Adoptive Parent does not voluntarily select a Dentist upon Enrollment, the Georgia Families 360° Supplier shall assign the AA Member a Dentist within five (5) Business Days of receipt of notification of the AA Member's Enrollment.

- ii. The eligibility file from DCH will serve as notification of the AA Member's Enrollment.

c. JJ Members:

- i. If the Residential Placement Provider's identified Core Provider does not voluntarily select a Dentist upon Enrollment, the Georgia Families 360° Supplier shall assign the JJ Member a Dentist within five (5) Business Days of receipt of notification of the JJ Member's Enrollment.

- ii. An eligibility file or written notification from DCH or DJJ will serve as notification of the JJ Member's Enrollment.

4. Re-Assignment of Dental Home

To ensure continuity of care when a FC or JJ Member changes placement, the Georgia Families 360° Supplier must Assess the FC or JJ Member's Dental Home access and assign the FC or JJ Member to a new Dental Home as necessary, according to the following process:

a. FC Member is relocated

- i. When a FC Member is relocated, the Georgia Families 360° Supplier will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DFCS.
- ii. The Georgia Families 360° Supplier must Assess the FC Member's access to the currently assigned Dentist within two (2) Business Days of receipt of notification.
- iii. The Georgia Families 360° Supplier must notify, within two (2) Business Days, the DFCS Case Manager, Caregiver, Foster Parent or FC Member if the Dentist no longer meets the Geographic Access standards as defined in section I.17.
- iv. The DFCS Case Manager, Caregiver, Foster Parent or FC Member must select a new Dentist within five (5) Business Days of the Georgia Families 360° Supplier's notification or the FC Member's relocation.

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This full process must be complete within five (5) Business Days of the Georgia Families 360° Supplier's receipt of notification of the FC Member's relocation.

- b. JJ Member is relocated:
 - i. The Georgia Families 360° Supplier will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DFCS.
 - ii. The Georgia Families 360° Supplier must Assess the JJ Member's access to the currently assigned Dentist within two (2) Business Days of receipt of notification.
 - iii. The Georgia Families 360° Supplier must notify within two (2) Business Days that the Residential Placement Provider's identified Core Provider if the PCP no longer meets the Geographic Access standards as defined in section I.17.
 - iv. The Residential Placement Provider's identified Core Provider must select a new PCP within two (2) Business Days of the Georgia Families 360° Supplier's notification or the DJJ's relocation.

This full process must be complete within five (5) Business Days of the Georgia Families 360° Supplier's receipt of notification of the JJ Member's relocation.

For FC Members, the Supplier shall allow the FC Member, DFCS staff, Caregiver or Foster Parent to change the Dentist designation based on the needs of a child. For AA Members, the Supplier shall allow the AA Member or Adoptive Parent to change the Dentist designation based on the needs of a child. For JJ Members, the Supplier shall allow the JPPS or Residential Placement Provider's designated Core Provider to change a Dentist designation based on the needs of the youth.

D. Georgia Families 360° Member Disenrollment

1. Disenrollment Initiated by an AA Member

AA Members may elect to Disenroll from the program without cause during the Georgia Families 360° AA Member Fee-for-Service Selection Period and for cause as, stated in section I.F., at any time. AA Members Disenrolling from the Georgia Families 360° CMO shall return to the Medicaid Fee-for-Service delivery system. A Member may request Disenrollment without cause during the ninety (90) Calendar Days following the date of the Member's initial Enrollment with the Georgia Families 360° CMO or the date DCH or its Agent sends the Member notice of the Enrollment, whichever is later. AA Members may request Disenrollment without cause every twelve (12) months thereafter.

AA Members may request Disenrollment from the Georgia Families 360° CMO for cause at any time. The following constitutes cause for Disenrollment:

- i. The Georgia Families 360° CMO does not, because of moral or religious objections, provide the Covered Service the AA Member seeks;

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- ii. The Member needs related services to be performed and not all related services are available within the Provider Network. The Member's Provider or another Provider have determined that receiving related services from In-Network and Out-of-Network Providers would subject the Member to unnecessary risk;
- iii. Other reasons, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor Quality of care, lack of access to services covered under the Contract, or lack of Providers experienced in dealing with the Member's Health Care needs. (DCH or its Agent shall make determination of these reasons); and
- iv. The Georgia Families 360° Supplier shall provide assistance to AA Members seeking to Disenroll. This assistance shall consist of providing Disenrollment forms to the AA Member and referring the AA Member to DCH or its Agent who will make Disenrollment determinations.

2. Change of Enrollment status of a FC or JJ Member

In the event a FC or JJ Member's eligibility category changes to a category ineligible for the Georgia Families 360° program and remains eligible for Medicaid and Georgia Families:

- i. The Member shall remain enrolled with the Supplier's Georgia Families plan until the Member's next Enrollment Period;
- ii. The change in CMO Enrollment will be reflected in the updated Georgia Families Member eligibility roster and associated change in Capitation Rate;
- iii. The Disenrollment from the Georgia Families 360° program and Enrollment in the Georgia Families program will be processed within three (3) Business Days of the date that the FC or JJ Member eligibility category actually changes and will not be made retroactive. Note exception when Members become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization;
- iv. The Georgia Families 360° Supplier must issue Georgia Families Member Enrollment materials pursuant to section I.G.;

In the event a FC or JJ Member's eligibility category changes to a category ineligible for Georgia Families and the youth is enrolled in Supplemental Security Income (SSI), the youth will return to the Medicaid Fee-for-Service delivery system.

E. Georgia Families 360° Member Services

The Georgia Families 360° Supplier must comply with all requirements included in section I.G. of this RFP. In addition, the following requirements apply to the Georgia Families 360° program:

1. Member Information Requirements

The Georgia Families 360° Supplier must provide DCH a Georgia Families 360° Member Education and Outreach Plan (hereinafter "Outreach Plan") no later than one hundred fifty (150) Calendar Days prior to the Operational Start Date and shall adhere to all requirements

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included in section I.G. DCH shall have at least ten (10) Calendar Days to review the Outreach Plan and the Georgia Families 360° Supplier shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized Outreach Plan to DCH. In addition to the other requirements included in section I.G., the Georgia Families 360° Member Education and Outreach Plan shall address the development of the following:

- i. Georgia Families 360° Member Information Packet;
- ii. Georgia Families 360° Member Handbook;
- iii. Member Identification Card;
- iv. Twenty-four (24) hour Call Center; and
- v. Other outreach or education activities identified by the Georgia Families 360° Supplier and approved by DCH.

The Georgia Families 360° Supplier shall send electronically via secure portal on the Georgia Families 360° Supplier's web site a FC Member information packet to the DFCS Case Managers for FC Members and a JJ Member information packet to the Juvenile Probation and Parole Specialist (JPPS) for JJ Members who are newly enrolled in the CMO within five (5) Calendar Days of receipt of the eligibility file from DCH. Upon request from the DFCS Case Manager or JPPS, the Georgia Families 360° Supplier will mail the Member information packet to the Foster Parent, Caregiver, Residential Placement Provider or State agency staff. The Georgia Families 360° Supplier shall mail the Member information packet to the AA Member or Adoptive Parent for AA Members who are newly enrolled in the CMO within five (5) Calendar Days of receipt of the eligibility file from DCH. The information packet shall include but not be limited to the following:

- i. A welcome letter that includes the name and contact information for the Georgia Families 360° Member's Care Coordinator;
- ii. A Georgia Families 360° Member Handbook;
- iii. A new Member ID card;
- iv. Information about how to change the Member's PCP and Dental Home Dentist;
- v. A form requesting information about any special Health Care needs and specific services for which the Georgia Families 360° Supplier may need to coordinate services;
- vi. Information for Georgia Families 360° Members about the roles of the Care Coordination Team and how to seek help in scheduling appointments, and accessing Care Coordination services;
- vii. Information for Georgia Families 360° Members about the role of the Georgia Families 360° Call Center and how to access the Call Center;
- viii. Explanation of the Disenrollment procedures for AA Members stated in section F;

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- ix. Information about seventy-two (72) hour emergency prescription drug supply;
- x. For FC Members in DFCS custody in DeKalb and Fulton counties only, information on the Kenny A. Health Care requirements; and
- xi. Information about the Ombudsman Liaison.

2. Member Handbook

The Georgia Families 360° Supplier shall develop no later than one hundred twenty (120) Calendar Days prior to the Operational Start Date a Georgia Families 360° Member Handbook (hereinafter “Handbook”) specific to the needs of Georgia Families 360° Members and shall adhere to all requirements included in section I.G.. DCH shall have fifteen (15) Calendar Days to review the Handbook and the Georgia Families 360° Supplier shall have five (5) Calendar Days from completion of DCH’s review to submit the finalized Handbook to DCH.

At a minimum, the Georgia Families 360° Member Handbook shall address the following topics:

- i. Roles of DFCS and DJJ in consenting to the FC Members’ and JJ Members’ Health Care services;
- ii. Role of the PCP and Dental Home;
- iii. Role of Care Coordination Team related to Coordination of Care and services;
- iv. How to access the Care Coordination Team; and
- v. Continuity of care and transition issues.

3. Member Identification (ID) Card

The Georgia Families 360° Supplier shall reissue the FC Member ID card under the following circumstances:

- i. Foster Care ID card:
 - a. AFC Member, DFCS Staff, Caregiver or Foster Parent reports a lost card;
 - b. A FC Member has a name change;
 - c. A FC Member, DFCS staff, Caregiver or Foster Parent requests a new PCP;
 - d. The FC Member moves to a new placement;
 - e. Any other reason that results in a change to the information disclosed on the FC Member’s ID card.
- ii. The AA Member ID card:

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- a. AA Member or Adoptive Parent reports a lost card;
 - b. AA Member has a name change;
 - c. AA Member or Adoptive Parent requests a new PCP; or for
 - d. Any other reason that results in a change to the information disclosed on the AA Member's ID card.
- iii. The Supplier shall reissue the JJ Member ID card under the following circumstances:
- a. JJ Member, the JPPS or Residential Placement Provider reports a lost card;
 - b. JJ Member has a name change;
 - c. JJ Member, the JPPS or Residential Placement Provider requests a new PCP
 - d. JJ Member moves to a new placement
 - e. Any other reason that results in a change to the information disclosed on the JJ Member's ID card.

All ID cards shall be issued initially within five (5) Calendar Days of receipt of the eligibility file from DCH and reissued within five (5) Calendar Days of a request for reissue based on the events named above.

4. Member Call Center

The Georgia Families 360° Supplier must provide a twenty-four (24) hour call center staffed with experienced personnel familiar with Georgia Families 360°, Georgia child-serving agencies and the Georgia Provider community. The call center staff shall be trained to accurately assist Georgia Families 360° Members with general inquiries, identify the need for Crisis intervention and provide Referrals to GCAL or other appropriate resources for emergency and Crisis needs. The Supplier shall work with GCAL to develop Crisis protocols. The Supplier shall submit such protocols to DCH for review and approval no later than ninety (90) Calendar Days of the Operational Start Date. DCH shall have fifteen (15) Calendar Days to review the protocols and the Supplier shall have five (5) Calendar Days from completion of DCH's review to submit the finalized protocols to DCH.

The Supplier must develop appropriate, interactive scripts for call center staff to use during initial welcome calls when making outbound calls to new Members and to respond to Member calls. The Supplier's call center staff must also use a DCH-approved script to respond to Members who call to request assistance with PCP selection. The Supplier must develop special scripts for emergency and unusual situations, as requested by DCH. All scripts must be clear and easily understood. The Supplier must review the scripts annually to determine any necessary revisions. DCH reserves the right to request and review call center scripts at any time.

The Georgia Families 360° Supplier's call center job descriptions must detail the level and type of training related to Crisis calls, including how personnel are trained to recognize callers

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in Crisis and then manage triage. The Georgia Families 360° Supplier must have an operational process through which emergency and Crisis calls are prioritized over routine calls, protocols that support warm transfers and technology that enables direct telephonic/computer connectivity to emergent and Crisis intervention resources.

The Georgia Families 360° Supplier shall develop Georgia Families 360° call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, Monitoring of calls via recording or other means, and compliance with standards. The Georgia Families 360° Supplier shall meet the following standards for the Georgia Families 360° call center operations:

- i. Average Speed of Answer: Ninety percent (90%) of calls are answered by a person within thirty (30) seconds with the remaining ten percent (10%) answered within an additional thirty (30) seconds by a live operator measured weekly. "Answer" shall mean for each caller who elects to, is connected to speak to a live representative; and the remaining ten percent (10%) of calls shall be answered by a person within an additional thirty (30) seconds.
- ii. Other Standards shall be equivalent to or greater than the standards provided in section I.G.7.

F. Georgia Families 360° Provider Network

1. General Requirements

The Georgia Families 360° Supplier must comply with all requirements included in section I.I of this RFP. In addition, the following requirements apply to the Georgia Families 360° program.

The Georgia Families 360° Supplier must expand upon its Georgia Families Provider network to meet the unique needs of Georgia Families 360° Members. The Georgia Families 360° Supplier shall employ innovative solutions for providing access in underserved areas. For example, the Georgia Families 360° Supplier may consider the provision of Physical Health and Behavioral Health Telemedicine services in local schools. The Georgia Families 360° Provider network must, at a minimum, include the following:

- i. Primary Care and specialist Providers who are trained or experienced in trauma-informed care and in treating individuals with complex special needs, including the population which comprises the Georgia Families 360° Members;
- ii. Providers who have knowledge and experience in identifying child abuse and neglect;
- iii. Providers who render Core Services and Intensive Family Intervention (IFI) services. The Georgia Families 360° Supplier is encouraged to contract with the Community Service Boards to provide Comprehensive Community Providers;
- iv. Providers as defined by DCH to ensure network access for Georgia Families 360° Members. These Providers must meet the State's credentialing requirements; and

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- v. Providers recommended by DCH to ensure network access for Georgia Families 360° Members, including independent Behavioral Health providers and non-traditional providers. Such providers must meet the State's credentialing requirements. The Georgia Families 360° Supplier must make three (3) Documented Attempts to contract with providers recommended by DCH to ensure network access for Members and shall maintain copies of all letters and other correspondence related to its efforts to include these providers in its network. This documentation shall be provided to DCH upon request.

The Georgia Families 360° Supplier is also expected to form productive relationships with Provider associations with experience serving the population which comprises Georgia Families 360° Members.

The Supplier shall provide the option for Providers to enroll for the purposes of serving the Georgia Families 360° population only rather than the universe of all Medicaid Members associated with all Georgia Families enrollees in the Supplier's plan.

2. Credentialing

The Georgia Families 360° Supplier shall include Providers recommended by DFCS, DBHDD, DJJ, DOE, DECAL or DPH in its Provider network if the Provider or agency meets the enrollment criteria for Georgia Fee-for-Service Medicaid and are credentialed by DCH's contracted Credentialing Verification Organization (CVO) and are able to negotiate a Provider agreement.

G. Georgia Families 360° Provider Services

The Georgia Families 360° Supplier must comply with all requirements included in section I.J of this RFP. In addition, the following requirements apply to the Georgia Families 360° program:

1. Provider Handbook

The Georgia Families 360° Supplier shall develop and provide to DCH no later than one hundred twenty (120) Calendar Days before the Operational Start Date a Georgia Families 360° Provider Handbook specific to the needs of the Georgia Families 360° Members.

The Georgia Families 360° Provider Handbook must contain special requirements for Georgia Families 360° Members, including how Georgia Families 360° Members, Caregivers, Foster and Adoptive Parents, DFCS staff and DJJ staff may access Care Management, the requirements that Behavioral Health Providers and PCPs shall coordinate care for Members, the requirement that PCPs providing the CCFAs must provide timely assessment results to the Georgia Families 360° Supplier as detailed in section I.J. and requirements included in the Kenny A. Consent Decree. The Georgia Families 360° Provider Handbook must also detail Provider requirements and legal obligations for providing medical information as required by DFCS and DJJ, and/or necessary for court hearings.

H. Education and Training

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The Georgia Families 360° Supplier must comply with all requirements included in section IJ.3 of this RFP. In addition, the following requirements apply to the Georgia Families 360° program:

1. General Requirements

The Georgia Families 360° Supplier shall submit to DCH a Georgia Families 360° Provider education and training approach within one hundred fifty (150) Calendar Days of the Operational Start Date. The education and outreach approach must include, at a minimum:

- i. Obtaining recommendations from experts in the field including DFCS, DBHDD, DOE, DPH, DECAL and DJJ to identify relevant training modules;
- ii. Initial and ongoing training of Supplier staff and the Provider network, as applicable, that addresses, but is not limited to, the following issues: The roles and responsibilities of DCH, DFCS, DBHDD, DOE, DCH, DECAL and DJJ with regard to the Georgia Families 360° program, and how DCH and partner agencies will coordinate with the Georgia Families 360° Supplier;
- iii. Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules;
- iv. Coordinating care utilizing a System of Care approach between: Foster Parents and Caregivers; DFCS Case Managers, JPPS or other involved case managers; attorneys; guardians ad litem; judges; law enforcement officials; Adoptive Parents; and other involved parties from State agencies;
- v. Requirements for providing Health Care Services to the Georgia Families 360° Member, including:
 - a. Medical consent requirements;
 - b. Required timelines for services and assessments;
 - c. Specific medical information required for court requests and judicial review of medical care;
 - d. Appropriate Utilization of psychotropic medications;
 - e. Evidence-based Behavioral Health treatment interventions; and
 - f. Specific Behavioral Health and Physical Health needs of these children and young adults who comprise the Georgia Families 360° population.
- vi. Training in trauma-informed care;
- vii. The effect of abuse and neglect on the developing brain;
- viii. The effect of intrauterine assault, fetal alcohol syndrome and shaken baby syndrome;

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- ix. How to screen for and identify Behavioral Health disorders;
- x. The Georgia Families 360° Supplier's Referral process for Behavioral Health Services; and
- xi. The availability of a Care Coordination Team for Members and how to access the Care Coordinator.

2. Training for Law Enforcement Officials and Judges

The Georgia Families 360° Supplier shall provide one training(1) training per quarter of the Contract for law enforcement officials, judges, district and county attorneys representing DFCS and DJJ and attorneys about the requirements of the Contract and needs of Georgia Families 360° Members. DCH, DFCS, DJJ and other sister agencies may also participate in these trainings. The Georgia Families 360° Supplier shall provide multiple methods of training to engender the most participation. Examples of training methods include but are not limited to face-to-face; workshops; Internet-based (webinars or other tutorials); etc.

3. Trainings for DCH Sister Agencies

The Georgia Families 360° Supplier shall prepare trainings and educational materials for use by DCH and the Georgia Families 360° Supplier to educate DCH staff, sister agencies and HCBS Case Managers about the Georgia Families 360° program and the necessity of collaboration and coordination. DCH encourages the Supplier to collaborate with DCH sister agencies to improve staff training rates and shall incorporate innovative approaches to training sister agencies which may include co-locating Supplier staff with sister agency staff.

The Georgia Families 360° Supplier shall submit a training plan that includes proposed locations, dates of trainings and training materials to DCH sixty (60) Calendar Days prior to the Operational Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and the Georgia Families 360° Supplier shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH. The Georgia Families 360° Supplier shall update training materials annually, at a minimum, and more often if a change in law or policy alters the content of the training materials.

4. Children 1st and Babies Can't Wait (BCW)

The Georgia Families 360° Supplier shall educate network Providers about the federal laws on child find (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) and require network Providers to identify and refer any Georgia Families 360° Member birth through thirty-five (35) months of age suspected of having a developmental delay or disability, or who is at risk of delay, to the designated Children 1st program for assessment and evaluation.

Evidence of this education shall be documented and available to DCH or its designee.

The Georgia Families 360° Supplier shall send appropriate staff to attend Local Interagency Planning Team (LIPT) and Regional Interagency Action Team (RIAT) meetings when its enrolled FC or JJ Member is on the agenda.

I. Utilization Management and Coordination and Continuity of Care Responsibilities

The Georgia Families 360° Supplier must comply with all requirements included in section I.L. of this RFP. Additionally, the Georgia Families 360° Supplier must consider the role of non-medical factors (ex. placement changes, involvement with the juvenile justice system, etc.) that may drive inappropriate Utilization of medical resources and challenges to Coordination of Care when developing Utilization Management and Coordination and Continuity of Care policies. The following requirements apply to the Georgia Families 360° program:

1. Prior Authorization and Pre-Certification

The Georgia Families 360° Supplier may require that the prescriber's office request Prior Authorization as a condition of coverage or payment for a prescription drug provided that a decision whether to approve or deny the prescription is made within twenty-four (24) hours of the Prior Authorization request. If a Georgia Families 360° Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the Georgia Families 360° Supplier must allow the pharmacist to dispense a seventy-two (72) clock hour emergency supply of the prescribed. The Georgia Families 360° Supplier must reimburse the pharmacy for the temporary supply of medication and contracted dispensing fee.

The Georgia Families 360° Supplier's Prior Authorization processes for Behavioral Health Services shall recognize the intensive and/or ongoing need for these services often present among the Georgia Families 360° Members, and should not be unnecessarily burdensome to Providers or Georgia Families 360° Members. For example, medical necessity reviews for Member stays in a Psychiatric Residential Treatment Facility (PRTF) must account for the high level needs of the Members and must not be unnecessarily burdensome for Providers or the CMO. DCH recommends that the Georgia Families 360° Supplier does not conduct medical necessity reviews for Members in a PRTF more frequently than every seven (7) Calendar Days.

Prior Authorization will not be required for the first twelve (12) individual or group outpatient psychotherapy sessions provided by a contracted Behavioral Health Provider, per twelve (12)-month rolling period. Such sessions may include the initial evaluation. Additional visits will be reviewed and approved based on a medical necessity review conducted by the Georgia Families 360° Supplier.

2. Transition of Members – DCFS Transitional Round Tables

The Georgia Families 360° Supplier will support DFCS and participate in DFCS transitional roundtables in transition planning for FC Members turning eighteen (18) years of age and exiting Foster Care. DFCS will begin transition planning one (1) year prior to a FC Member reaching their eighteenth (18th) birthday and aging out of Foster Care (and will repeat the planning process one (1) year prior to the twenty first (21st) birthday if the youth elects to continue services to age twenty one (21). For FC Members electing to continue services to age twenty six (26), the Georgia Families 360° Supplier shall offer transition planning services to the FC Member at age twenty five (25), but shall not be required to provide such services if the FC Member declines to receive them. Transition planning for Members

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entering the CMO on or after their seventeenth (17th) birthday shall start within one (1) month of entry into the CMO. A youth exiting FC due to age should not need to transition to a nursing facility or institution because they lacked a plan for continued support. Transition planning activities may include but are not limited to:

- i. Working with DFCS to assess the FC Member's home and community support needs to remain in the community and maintain stability through the transition out of Foster Care including but not limited to the following:
 - a. Determining and identifying the array of services needed and providers of these services;
 - b. Assessing needs and providing recommendation for access for specialized supports including but not limited to positive behavioral supports, medication support, Durable Medical Equipment, communication devices or vehicle or home adaptations.
- ii. Reviewing the FC Member's health status and other appropriate factors to determine if the FC Member meets the general eligibility criteria for entering a HCBS waiver program;
- iii. Initiating of the waiver application processes and if necessary, placing youth on waiver waiting list(s); and
- iv. In collaboration with DFCS, educating FC Members about options for services and supports available after eligibility terminates. Such options may include Independence Plus, IDEA participation, and application for post-secondary options. Education shall include information on accessing disability services available from educational institutions and employers where appropriate.

3. Transition of Members – DJJ Transitional Round Tables

The Georgia Families 360° Supplier will support DJJ and participate in DJJ transitional roundtables in transition planning for JJ Members returning to their homes. The transition planning will begin upon the JJ Member's Enrollment in the CMO and the transitional roundtable will be initiated by DJJ. Transition planning activities may include but are not limited to:

- i. Assessing the JJ Member's home and community support needs to remain in the community and maintain stability through the transition out of the juvenile justice system including but not limited to the following:
 - a. Determining and identifying the array of services needed and Providers of these services.
 - b. Assessing needs and providing recommendations for access for specialized supports including but not limited to positive behavioral supports, medication support, Durable Medical Equipment, communication devices or vehicle or home adaptations.

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- c. Reviewing the JJ Member's health status and other appropriate factors to determine if the JJ Member meets the general eligibility criteria for entering a HCBS waiver program.
- ii. Initiating the waiver application processes and if necessary, place youth on waiver waiting list(s).

In collaboration with DJJ, educating JJ Members about options for services and supports available after eligibility in the CMO terminates. Such options may include Independence Plus, IDEA participation, application for post-secondary options, housing and vocational opportunities. The DJJ and CMO education shall include information on accessing disability services available from educational institutions and employers where appropriate.

4. Transition of Care

The Supplier shall employ System of Care principles in the coordination and delivery of services to ensure coordinated planning across and between multiple child-serving agencies which also serve the Members. The Supplier will coordinate with DCH, DFCS, DPH, DJJ, DOE, DBHDD and DECAL as needed when a Member transitions into or out of the CMO to maintain continuity of care and services and minimize disruptions to the Member including:

- i. When a FC Member or JJ Member is transitioning from another CMO or from private insurance, the Supplier shall contact the FC Members' or JJ Members' prior CMO or other insurer and request information about the FC or JJ Member's needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH or electronic notification from DFCS, DCH or DJJ and receipt of a signed release of information form from DFCS or DJJ.
- ii. When an AA Member is transitioning from another CMO or from private insurance, the Georgia Families 360° Supplier shall contact the AA Members' prior CMO or other insurer and request information about the AA Member's needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent.
- iii. When a Georgia Families 360° Member is transitioning from Fee-for-Service Medicaid the Georgia Families 360° Supplier shall coordinate with DCH staff designated to coordinate Administrative Services for the Georgia Families 360° Members, and contact the FC Member's or JJ Member's prior Service Providers including but not limited to PCPs, specialists and dental Providers, and request information about the FC Members' or JJ Members' needs, current medical necessity determinations, and authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH or electronic notification from DFCS, DJJ or DCH and receipt of a signed release of information form from DFCS or DJJ.
- iv. When a AA Member is transitioning from Fee-for-Service Medicaid, the Georgia Families 360° Supplier shall coordinate with DCH staff designated to coordinate Administrative

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Services for the AA Member, and contact the AA Member's prior Service Providers including but not limited to PCPs, specialists and dental Providers, and request information about the AA Members' needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent.

- v. The Georgia Families 360° Supplier must authorize all services included in treatment plans by prior CMOs, private insurers or Fee-for-Service Medicaid for Members transitioning from another CMO, private insurance or Fee-for-Service Medicaid. The Georgia Families 360° Supplier must authorize the Member to continue care with his or her Providers and current services, including the issuance of an Out-of-Network authorization to ensure the Georgia Families 360° Member's Condition remains stable and services are consistent to meet the Georgia Families 360° Member's needs. All such authorizations or allowances will continue for the later of a period of at least thirty (30) Calendar Days or until the Georgia Families 360° Supplier's authorized Health Care Service Plan is completed.
- vi. The Georgia Families 360° Supplier shall provide additional coordination to ensure continuity of care for Members with Special Health Care Needs as detailed in section I.L.4.
- vii. When Members Disenroll from the Georgia Families 360° program, the Supplier is responsible for transferring to the DCH the Member's Care Management history, six (6) months of Claims history, and pertinent information related to any special needs of transitioning Members.

5. Administrative Processes Required for FC and JJ Members

The Georgia Families 360° Supplier shall implement a systematic administrative process to coordinate with DFCS, including providing DFCS with requested information and coordinating with PCPs or specialists for medical information when required by DFCS and/or necessary for court hearings for FC Members. A coordination plan shall be due within one hundred fifty (150) Calendar Days prior to the Operational Start Date. DCH shall have at least fourteen (14) Calendar Days to review the materials and the Georgia Families 360° Supplier shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

The Georgia Families 360° Supplier shall implement a systematic administrative process to coordinate with DJJ, including providing DJJ with requested information and coordinating with PCPs or specialists for medical information when required by DJJ and/or necessary for court hearings for JJ Members. A DJJ coordination plan shall be due within one hundred fifty (150) Calendar Days prior to the Operational Start Date. DCH shall have at least fourteen (14) Calendar Days to review the materials and the Georgia Families 360° Supplier shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

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The Georgia Families 360° Supplier shall have documented Georgia Families 360° Members Care Coordination policies and procedures for coordinating care and creating linkages with external organizations, including but not limited to school districts, Child Protective Service agencies, early intervention agencies, Behavioral Health, and developmental disabilities service organizations. Such policies and procedures must include details on the Georgia Families 360° Supplier's approach for documenting Care Coordination activities and creating linkages with external organizations for each Georgia Families 360° Member. The Georgia Families 360° Supplier shall submit the policies and procedures to DCH for review within one hundred twenty (120) Calendar Days of the Operational Start Date and within ten (10) Calendar Days of any subsequent updates. In all instances, DCH shall have at least fourteen (14) Calendar Days to review the materials and the Georgia Families 360° Supplier shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

6. Care Coordination Responsibilities

The Georgia Families 360° Supplier shall implement an approach to coordination that employs person-centered strategies, collaboration with DCH and sister agencies and does not focus solely on the Member's immediate Health Care needs. The following approach to person-centered care shall be incorporated into the Georgia Families 360° Supplier's Care Coordination program:

- i. Uses the person's own situation and experiences as a starting point based upon information gathered during outreach and Health Risk Assessment activities and the individuals Claims history;
- ii. Strives to understand behaviors, clinical symptoms and clinical, as well as non-clinical, drivers of Utilization from the perspective of the person;
- iii. Tailors care and treatment to each individual;
- iv. Promotes both empowerment of the person and shared decision-making;
- v. Involves the person and/or Caregiver as an active, collaborative partner; and
- vi. Strives to involve the person's social network in his/her care.

The Georgia Families 360° Supplier's ability to provide rigorous and immediate Care Coordination to meet individual needs of Georgia Families 360° Members will be a key indicator of success. Care planning for Members must begin Immediately upon the Georgia Families 360° Supplier's receipt of the eligibility file or electronic notification from DCH, DFCS or DJJ.

7. Health Care Service Plans

The Georgia Families 360° Supplier shall use the results of all assessments and screenings included in section II.B. to develop a Health Care Service Plan, which identified the Members Care Coordination needs for all new Georgia Families 360° Members within thirty (30) Calendar Days of Member Enrollment. The Georgia Families 360° Supplier must document

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the involvement of the Georgia Families 360° Member's PCP, dentist, Behavioral Health Providers, specialists or other Providers in the development of the Health Care Service Plan and provide evidence of such documentation to DCH, DFCS and DJJ.

The Georgia Families 360° Supplier shall develop a process by which Georgia Families 360° Supplier will regularly review and update the Georgia Families 360° Members' Health Care Service Plans, which shall include:

- i. The detailed description of the involvement of the Georgia Families 360° Member's PCP, dentist, Behavioral Health Providers, specialists or other Providers in the development of the Health Care Service Plan;
- ii. The approach for updating or revising the Health Services Plan; and
- iii. Details on the Monitoring and follow-up activities conducted by the Georgia Families 360° Supplier with the Georgia Families 360° Members' Providers.

Such process shall be submitted to DCH for review and approval within ninety (90) Calendar Days of the Operational Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and the Georgia Families 360° Supplier shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

The Georgia Families 360° Supplier is responsible for ensuring that the Health Care Service Plan for Georgia Families 360° Members with Severe Emotional Disturbance (SED) shall include a safety and contingency Crisis plan. The development of such a plan will be coordinated between the Georgia Families 360° Supplier, Comprehensive Community Providers and/or Intensive Family Intervention (IFI) Providers.

8. Care Coordination Teams

All Georgia Families 360° Members will have access to Care Coordination services and an interdisciplinary Care Coordination Team. The Care Coordination Team will include a Care Coordinator and clinical representatives to meet the individual needs of Members. The Care Coordination Team will:

- i. Coordinate with DFCS and DJJ to develop work flows and processes, including those related to the transmission of clinical and non-clinical Georgia Families 360° Member information. These workflows and processes shall be subject to the approval of DCH.
- ii. Provide information to and assist Providers, Georgia Families 360° Members, Foster Parents, Adoptive Parents, Caregivers, DFCS Staff, DJJ, JPPS and Residential Placement Providers with access to care and coordination of services.
- iii. Ensure access to primary, dental and specialty care and support services, including assisting Georgia Families 360° Members, Caregivers, Foster and Adoptive Parents, DFCS staff and DJJ Staff with locating Providers, and scheduling and obtaining appointments as necessary.

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- iv. Expedite the scheduling of appointments for Medical Assessments and facilitating Providers timely submittal of Assessment results used to determine Residential Placements as requested by DFCS and DJJ as discussed in section II.B. The Georgia Families 360° Supplier must give high priority to this function in its Care Coordination operations.
- v. Compile Assessment results used to determine Residential Placements as requested by DFCS and DJJ and submitting those results to the appropriate DFCS or DJJ entity within the timeframes identified in section II.B.
- vi. Assist with coordinating non-emergent transportation for Georgia Families 360° Members as needed for Provider appointments and other Health Care Services.
- vii. Broker community supports for Members and arrange for Referrals to community-based resources as necessary.
- viii. Document efforts to obtain Provider appointments, arrange transportation, establish meaningful contact with the Georgia Families 360° Members' PCP, Dentists, specialists and other Providers, and arrange for Referrals to community-based resources. Such documentation shall include details on any barriers or obstacles to obtaining appointments, arranging transportation, establishing meaningful contact with Providers or arranging Referrals to community-based resources.
- ix. Provide Georgia Families 360° Members with access to information about the Prior Authorization processes of the Georgia Families 360° Supplier and its business partners.
- x. Define program requirements and processes, including the Georgia Families 360° Member Appeals Processes and how the Georgia Families 360° Supplier will provide assistance to Providers and Georgia Families 360° Members with navigating these processes.
- xi. Educate the Georgia Families 360° Supplier's staff about coordinating with DFCS and DJJ as identified in the Georgia Families 360° Supplier's DFCS and DJJ Communication Plan. The Plan should include, but not be limited to, when medical information is required by DFCS and DJJ and/or is necessary for court hearings.
- xii. Educate Providers about providing medical information to DFCS or DJJ as requested, including but not limited to medical information necessary for court hearings. If the Provider has not timely responded to a DFCS or DJJ request and/or a court's subpoena or request for such information, the Georgia Families 360° Supplier must timely contact the Provider in question to require him or her to provide the requested information. The Georgia Families 360° Supplier shall remind the Provider of his or her legal obligations to produce such information, including those obligations arising out of the Network Provider agreement with the Supplier; including those obligations arising out of the Network Provider agreement with the Supplier.
- xiii. Work with PCPs and specialists of prior health plans to ensure continuity of care for Members with Special Health Care Needs (MSHCN) receiving services authorized in a

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treatment plan by their prior health plan, to address issues that will help Georgia Families 360° Member's Condition remain stable and services are consistent to meet the Georgia Families 360° Member's ongoing needs.

- xiv. Provide application assistance to MSHCN who may qualify for Supplemental Security Income (SSI) benefits.

The Care Coordinator will ensure the Care Coordination Team has the information it needs to make timely and appropriate authorizations and Referrals to meet Georgia Families 360° Member needs. This includes, but is not limited to, contacting prior health plans and Providers for information the Care Coordination Team may need to work with current Providers to develop treatment plans. The Care Coordinator will ensure that approved care plans and authorizations are communicated timely to treating Providers, DFCS, DJJ and other agencies as required, whether via the Virtual Health Record or by direct communications. The Care Coordinator will ensure that Georgia Families 360° Members, Providers, Caregivers, Foster and Adoptive Parents, DFCS, DJJ, Residential Placement Providers and other agencies also have the most current information regarding community resources available to assist Georgia Families 360° Members with meeting their needs and assist Georgia Families 360° Members with connecting with these resources.

The Care Coordination Teams must include an interdisciplinary group of professionals identified specifically to meet the needs of each individual Member.

Based on information identified through required assessments, the Supplier shall stratify Members according to their risk(s), cost and impactability. The level of intensity of Care Management services provided by Care Coordination Teams must be tailored in intensity to meet the needs of each individual Member as identified in Attachment B. The Georgia Families 360° Supplier shall provide the following levels of Care Management services:

- i. Care Management;
- ii. Intensive Care Coordination. The Care Coordinator must provide the following monthly contacts to Georgia Families 360° Members receiving Complex Care Coordination:
 - a. One (1) Face-to-face visit
 - b. One (1) weekly contact
 - c. One (1) Child and Family Team Meeting
 - d. One (1) care plan update
- iii. Complex Care Coordination services including Georgia Families 360° Members with a previous Mental Health inpatient stay or an inpatient stay for a psychosocial disorder and members with Special Health Care Needs Members identified as needing Intensive Customized Care Coordination services due to Behavioral Health needs must receive Care Coordination services provided by Coordinators who have been certified and trained in the delivery of High Fidelity Wrap Around care. The Supplier must provide the

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following monthly contacts to Georgia Families 360° Members receiving Complex Care Coordination:

- a. Two (2) face-to-face visits
- b. One (1) weekly contact
- c. A minimum of two (2) hours per week Care Coordination
 1. One (1) Child and Family Team Meeting
 2. One (1) care plan update

The Georgia Families 360° Supplier shall include a Nurse Care Manager (NCM) to assist Georgia Families 360° Members identified through the health assessment as Members with Special Health Care Needs. The NCM will help Members with Special Health Care Needs obtain Medically Necessary care, health-related services and coordinate clinical care needs with holistic consideration. The Georgia Families 360° Supplier's NCM must coordinate across a Georgia Families 360° Member's Providers and health systems. The Georgia Families 360° Supplier must have a process to facilitate maintain and coordinate both care and communication with State agency staff, Providers, Caregivers, Foster or Adoptive Parents, Service Providers, and Georgia Families 360° Members.

9. Health Outcomes

The Georgia Families 360° Supplier shall submit written policies and procedures for tracking and reporting individual Georgia Families 360° Member health outcomes, including the mechanism for reporting whether a Member's health outcomes improved as a result of the CMO's Care Coordination activities. The Georgia Families 360° Supplier shall submit such policies and procedures to DCH for review within ninety (90) Calendar Days of the Operational Start Date and within ten (10) Calendar Days of any subsequent updates. In both instances, DCH shall have at least ten (10) Calendar Days to review the materials and the Georgia Families 360° Supplier shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

10. Medication Management

The Georgia Families 360° Supplier shall develop a medication management program specific to the needs of the Georgia Families 360° Members. At a minimum, the medication management program must assess prescribing patterns and treatment plans for psychotropic medications, medications at risk of abuse and other medications identified by DCH or the Georgia Families 360° Supplier. An annual report describing activities and the effectiveness of the efforts over the reporting period and the future efforts and activities planned for the next reporting period.

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11. Health Coordination and Integration for Georgia Families 360° Members

The Georgia Families 360° Supplier shall comply with all requirements included in section I.L.8. In addition, the Georgia Families 360° Supplier shall submit an annual Health Coordination and Integration Report which includes:

- i. Effectiveness measures with clear metrics; and
- ii. Successes (e.g., exceeding performance targets) and opportunities for improvement.

J. Quality Improvement

The Georgia Families 360° Supplier must comply with all requirements included in section I.M. of this RFP. In addition, the following requirements apply to the Georgia Families 360° program:

1. Value-Based Purchasing

The Georgia Families 360° Supplier shall participate in DCH's VBP program pursuant to section I.M.13. In addition to VBP performance targets identified for the Georgia Families program, the Georgia Families 360° Supplier must achieve the performance measures and related targets outlined in Attachment I.

2. Monitoring and Oversight Committee

The Georgia Families 360° Supplier shall participate in the Georgia Families 360° Monitoring and Oversight Committee ("GF360MOC") and associated subcommittees as requested by DCH. The GF360MOC will be a separate committee from the GF360MOC to address the unique needs of Georgia Families 360° Members. The GF360MOC and associated subcommittees will assist DCH in assessing the performance of the Georgia Families 360° Supplier and developing improvements and new initiatives specific to the Georgia Families 360° program. The GF360MOC will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration among State agencies, the Georgia Families 360° Supplier and external stakeholders. Members of the GF360MOC will be appointed by the DCH Commissioner or his designee. The GF360MOC meetings must be attended by the Georgia Families 360° Supplier decision makers defined as one of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position, and Chief Medical Officer.

K. Georgia Families 360° Information Management Systems

The Georgia Families 360° Supplier must comply with all requirements included in section I.N of this RFP. In addition, the following requirements apply to the Georgia Families 360° program:

1. Health Information Technology Exchange

Through their system and interoperability with the GaHIN, the Georgia Families 360° Supplier shall provide the following types of patient health information on Georgia Families 360° Members including, but not limited to:

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- i. Georgia Families 360° Member specific Information including, but not limited to name, address of record, and date of birth, race/ethnicity, gender and other demographic Information, as appropriate, for each Georgia Families 360° Member;
- ii. Name and address of each Georgia Families 360° Member's PCP and Caregiver;
- iii. Name and contact Information of each FC or JJ Member's DFCS Case Manager, JPPS or Residential Placement Provider, as well as non-medical personnel such as the CMO Care Coordinator, as appropriate;
- iv. Acquisition and retention of the Georgia Families 360° Member ID is required, but due to a lag in the assignment of the Medicaid ID number, the Georgia Families 360° Supplier shall utilize and retain the Georgia Families 360° Member's DFCS personal identification number ("Person ID") to identify and link each Member to a unique Medicaid ID after it has been assigned. Both of these values shall be available and distinguishable in the VHR. The Georgia Families 360° Supplier may choose to assign an additional unique identifier for each Georgia Families 360° Member for internal use, if appropriate;
- v. Description and quarterly update of each Georgia Families 360° Members individual Health Care Service Plan, including the plan of treatment to address the Georgia Families 360° Member's physical, psychological, and emotional Health Care problems and needs;
- vi. Provider-specific Information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;
- vii. Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check Program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnosis, and treatment given, including drugs prescribed;
- viii. Record of future scheduled service appointments, if available, and Referrals;
- ix. Record of all diagnoses applicable to the Georgia Families 360° Member, with emphasis on Behavioral Health diagnoses utilizing either the DSM IV-R or ICD-9 or ICD-10 national code sets as based on Claims submitted;
- x. Record of current and/or past medications and doses (including psychoactive medications), and where available, the prescribing physician, date of prescription(s) and target symptoms;
- xi. Monthly progress notes from Behavioral Health exams or treatments. A Provider must submit notes at more frequent intervals if necessary to document significant changes in a Georgia Families 360° Member's treatment or progress. Notes should include the following:

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- a. Primary and secondary (if present) diagnosis. Assessment Information, including results of a mental status exam, history or assessments used for Residential Placement purposes;
 - b. Brief narrative summary of a Georgia Families 360° Member’s progress or status;
 - c. Scores on each outcome rating form(s);
 - d. Referrals to other Providers or community resources; and
 - e. Any other relevant care information.
- xii. Listing of a Georgia Families 360° Member’s known clinical history, health problems and allergies;
- xiii. Complete record of all immunizations;
- xiv. Listing of the Georgia Families 360° Member’s Durable Medical Equipment (DME), which shall be reflected in the Claims or “visits” module of the VHR;
- xv. Record of notification within two (2) Business Days of the provision of Emergency Services to a Georgia Families 360° Member if the Foster Parent, Adoptive Parent, Caregiver or DFCS Staff did not provide consent; and
- xvi. Any Utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description. This is applicable to codes pertaining to a service event, Health Care Provider, and Georgia Families 360° Member records.

The Georgia Families 360° Supplier shall access the GaHIN to display Georgia Families 360° Member health Information within their System for the purpose of Care Coordination and management of the Georgia Families 360° Members.

The Georgia Families 360° Supplier shall provide DCH with a list of Authorized Users who may access patient health data from the Georgia Families 360° Supplier’s Systems. DCH shall review and approve the list of the Georgia Families 360° Supplier’s Authorized Users who may access patient health data from the Georgia Families 360° Supplier’s Systems. The Georgia Families 360° Supplier shall be permitted to access the GaHIN for purposes associated with this Addendum only.

L. Georgia Families 360° Reporting Requirements

The Georgia Families 360° Supplier must provide all reports included in section I.N. If the Supplier is a vendor on other projects, such as Georgia Families, these reports must be submitted separately for Georgia Families 360° Members.

The Supplier must submit data reports relating to the Georgia Families 360° population as indicated above based on the specifications provided by DCH. The Supplier shall provide sample reports for DCH approval within thirty (30) Calendar Days of the Operational Start Date. Supplier must also submit ad hoc reports as indicated by DCH.

Supplier General Information Worksheet

Supplier General Information

This spreadsheet requests basic information concerning the Supplier and may establish other requirements the Supplier must meet to be considered eligible for award. Read each question carefully and provide all requested answers.

Question #	Description	
1	Provide Company Information:	
	Description	Response
	Company Name (Provide full legal name)	
	Address 1	
	Address 2	
	City	
	State	
	Zip Code	
	Authorized Person's Name	
	Telephone Number	
	eMail Address	
2	Georgia Based Business/Reciprocal Preference Law O.C.G.A. §50-5-60(b) In which state is your company domiciled?	Supplier's Domicile (State)
	For the purposes of evaluation only, Suppliers resident in the State of Georgia will be granted the same preference over Suppliers resident in another state in the same manner, on the same basis, and to the same extent that preference is granted in awarding bids for the same goods or services by such other state to Suppliers resident therein over Suppliers resident in the State of Georgia. NOTE: For the purposes of this law, the definition of a resident Supplier is a Supplier who is domiciled in the State of Georgia.	
3	Small Business: Can your company be classified as a Small Business?	Response
	<p>A Small Business is defined as a Georgia resident business which is independently owned and operated. In addition, such business must have either fewer than <u>300</u> employees or less than <u>\$30 million</u> in gross receipts per year. Georgia resident business means any business that regularly maintains a place from which business is physically conducted in Georgia for at least one year prior to any bid or proposal to the state or a new business that is domiciled in Georgia and which regularly maintains a place from which business is physically conducted in Georgia; provided, however, that a place from which business is conducted shall not include a post office box, a leased private mailbox, site trailer, or temporary structure. (Official Code of Georgia Annotated §50-5-121).</p> <p>Also, the State encourages all companies to sub-contract portions of any state contract to small and minority business enterprises. Suppliers interested in taking advantage of the Georgia income tax incentives provided for by the Official Code of Georgia Annotated Section 48-7-38, relative to the use of minority subcontractors in the performance of contracts awarded by the State of Georgia, should contact the Supplier Relations Administrator:</p> <p>Supplier Relations Administrator Department of Administrative Services 200 Piedmont Avenue, S.E. Suite 1308, West Tower Atlanta, Georgia 30334 9010 Telephone: (404) 657-6000 Fax: (404) 657-8444</p>	
4	Minority Business: Can your company be classified as a Minority Owned Business? Indicate below the percentage of company ownership/control attributable to each of the minority groups listed:	

Supplier General Information Worksheet

	<p>A Minority Business enterprise means a small business concern which is at least 51% owned and controlled by one or more minorities and is authorized to do and is doing business under the laws of the State of Georgia, paying all taxes duly assessed and domiciled within this state (Official Code of Georgia Annotated §50-5-131).</p>													
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #FFD700;">Minority Group</th> <th style="background-color: #FFD700;">Percentage of Ownership</th> </tr> </thead> <tbody> <tr> <td>African American</td> <td style="text-align: center;">%</td> </tr> <tr> <td>Hispanic / Latino</td> <td style="text-align: center;">%</td> </tr> <tr> <td>Native American</td> <td style="text-align: center;">%</td> </tr> <tr> <td>Asian American</td> <td style="text-align: center;">%</td> </tr> <tr> <td>Pacific Islander</td> <td style="text-align: center;">%</td> </tr> </tbody> </table>	Minority Group	Percentage of Ownership	African American	%	Hispanic / Latino	%	Native American	%	Asian American	%	Pacific Islander	%	
Minority Group	Percentage of Ownership													
African American	%													
Hispanic / Latino	%													
Native American	%													
Asian American	%													
Pacific Islander	%													
5	Is your company a scrutinized company? Please answer either a, b, or c as described	Response												
	<p>Any Supplier that currently and/or previously, within the last three years, has had business activities or other operations outside of the United States, must certify that it is not a “scrutinized company.” A scrutinized company is a company conducting business operations in Sudan that is involved in power production activities, mineral extraction activities, oil-related activities, or the production of military equipment, but excludes a company which can demonstrate any of the following exceptions noted in O.C.G.A. Section 50-5-84. False certification hereunder may result in civil penalties, contract termination, ineligibility to bid on state contractors for three or more years, and/or any other available remedy. If the Supplier is a scrutinized company, the Supplier shall not be eligible to bid on or submit a proposal for a contract with the State Entity unless DOAS makes a determination in accordance with O.C.G.A. Section 50-5-84 that it is in the best interests of the State to permit the scrutinized company to submit a bid or proposal. Any scrutinized company desiring DOAS to make such a determination should contact both DOAS and the Issuing Officer immediately.</p> <p>Please answer either a, b or c in the response column of this worksheet to indicate your answer:</p> <p>a. I certify my company is NOT a “scrutinized company.”</p> <p>b. I certify my company is a “scrutinized company.”</p> <p>c. I certify I have requested and received written permission from DOAS to submit a response to this Event in accordance with O.C.G.A. Section 50-5-84.</p>													
6	Have you submitted a completed Tax Compliance form?	Response												
	<p>To be eligible for contract award, the supplier must not owe taxes to the State of Georgia. Also, in accordance with Official Code of Georgia Annotated §50-5-82, the State Entity is prohibited from awarding any contract valued at more than \$100,000.00 to a nongovernmental vendor if that vendor or an affiliate of the vendor is a “dealer” failing or refusing to collect sales or use taxes on its sales delivered to Georgia. Each Supplier must submit a completed Tax Compliance Form (SPD-SP045), which has been provided as a downloadable document by accessing the link below. In the event the Supplier is being considered for contract award (and the contract is valued at more than \$100,000.00), the information provided in the Tax Compliance Form will be submitted by the State Entity to the Georgia Department of Revenue (“DOR”) for a determination as to whether the Supplier is a “prohibited source” or has other tax deficiencies. The State Entity reserves the right to submit the Supplier’s completed form to DOR for review even if the contract is valued at less than \$100,000.00. Download the Tax Compliance form using the link below and upload the completed form as part of your response:</p> <p style="text-align: center;">http://doas.ga.gov/StateLocal/SPD/Seven/Pages/Home.aspx</p> <p>Any Offeror identified as a prohibited source will be ineligible for award. Accordingly, the Offeror is strongly encouraged to check its tax status now and resolve any outstanding tax liabilities prior to submitting this response. Department of Revenue has identified the following source to allow Offerors to check current tax status:</p> <p>http://www.etax.dor.ga.gov/</p>													

Mandatory Questions

These questions are Pass/Fail. To be considered responsive, responsible and eligible for award, you must answer all questions in this section with a "YES" to pass.

Any questions you answer with a "NO" will fail the technical requirements and results in disqualification of the proposal.

By answering "Yes," you indicate that you meet the individual requirements in the response block provided. ONLY upload documents if there is a Yes in the "Upload Attachs with Additional Information?" column, to provide additional information about specific questions. Documents not requested in this column will not be evaluated.

DO NOT INCLUDE ANY COST INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

Question #	Questions per Proposal Factors/Categories	Response by Offeror. Only Yes or No Answers	Upload Attchs with Additional Information?	Attachment File Name
Proposal Factors				
1	<p>The Supplier is a Qualified Contractor pursuant to ES-RFQC-40199-465 Georgia Families Care Management Organization Qualifications.</p> <p>Supplier must answer "yes" to indicate if it meets the above mandatory requirement.</p>		No	
2	<p>The Supplier agrees to submit Contract exceptions, if applicable or will submit a statement that no exception is taken. Please note - The Department of Community Health (DCH) will not accept requests to modify indemnification language set forth in Attachments I and J of this Request for Proposal (RFP).</p> <p>Supplier must answer "yes" in the adjacent column to indicate meeting the above mandatory requirement.</p>		Yes	Contract Exceptions
3	<p>The Supplier agrees to accept the Georgia Families, Planning for Healthy Babies 1115 Demonstration Waiver (P4HB), and if applicable Georgia Families 360° Capitation Rates developed by the State in accordance with the rate methodology as described in section 5 ("Capitation Rate Methodology") of Attachment A and in Attachments I and J of this RFP for the term of this Contract as a mandatory condition for selection under this Contract.</p> <p>Supplier must answer "yes" in the adjacent column to indicate if it meets the above mandatory requirement.</p>		No	
4	<p>Supplier confirms that it has submitted the required Immigration and Security Form with its proposal.</p> <p>Supplier must answer "yes" or "no" in the adjacent column to indicate if it meets the above mandatory requirement.</p> <p>Supplier confirms that it has submitted the required Immigration and Security Form with its proposal.</p> <p>Supplier must answer "yes" or "no" in the adjacent column to indicate if it meets the above mandatory requirement.</p>		Yes	eVerify Form
5	<p>Supplier confirms that it has submitted the required Non-Collusion Form with its proposal.</p> <p>Supplier must answer "yes" in the adjacent column to indicate if it meets the above mandatory requirement.</p>		Yes	Non Collusion Form
6	<p>Supplier confirms that it has submitted the required General Information Worksheet (Tax Compliance) with its proposal.</p> <p>Supplier must answer "yes" in the adjacent column to indicate if it meets the above mandatory requirement.</p>		Yes	eral Information Worksf

Mandatory Scored Questions

Offerors must answer all the questions in this spreadsheet in the cell provided.

Failure to answer these questions will result in disqualification of the proposal.

Offerors must indicate whether their proposal meets the individual requirement and provide a supporting narrative in the space provided. The narrative description, along with any required supporting materials, will be evaluated and awarded points in accordance with Section 6, Proposal Evaluation and Award. ONLY upload documents if there is a Yes in the "Upload Attchts with Additional Information?" column, to provide additional information about specific questions. Documents not requested in this column will not be evaluated.

DO NOT INCLUDE ANY COST INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

Question #	Questions per Proposal Factors/Categories	Response by Offeror	Upload Attchts with Additional Information?	Attachment File Name
Understanding Scope of Work				
7	<p>Provide an Executive Summary that summarizes the proposed technical approach, staffing structure and task schedule for Georgia Families. The Executive Summary must include a statement of understanding and fully document the Supplier’s ability, understanding and capability to provide the requested services. The summary must:</p> <p>a. Demonstrate an expert understanding of the needs of Members in the State of Georgia, including a high-level overview of the Supplier’s strategy and approach that highlights the Supplier’s key strengths that are relevant to Georgia Families. Additionally, experience and recommendations from the Supplier’s experience and results in other Medicaid markets in serving similar populations should be included.</p> <p>b. Provide an overview of the Supplier’s proposed organization for this Project. Include an overview of Key Staff, Material Subcontractors and the Supplier’s overall staffing plan.</p> <p>c. Identify distinguishing features and innovations the Supplier will implement that will result in improved health outcomes, access to care, and a positive financial impact. Include a discussion of barriers to access and coordinating care for Members and how the Supplier intends to address those barriers. Include Supplier’s experience with addressing these barriers for similar contracts.</p> <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 20 pages excluding attachments</p>		Yes	Q7 Understanding Scope of Work
Supplier Organization				

8	<p>For the Supplier and each Material Subcontractor included in the proposal, provide the organization’s role in this project, corporate background, size, resources and details addressing the following:</p> <ul style="list-style-type: none"> a. Date Supplier (company) was formed, established, or created b. Ownership structure (whether public, partnership, subsidiary, or specified other) c. Organization chart d. Total number of employees <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 3 pages and 1 page per organization chart</p>		Yes	Q8 Supplier Organization
9	<p>Provide client references as follows:</p> <ul style="list-style-type: none"> a. Provide a minimum of three (3) different client references for Supplier, using the reference form provided as Attachment M to the RFP, for which Supplier has successfully provided services under capitated risk-based contracts with Medicaid agencies to support a program or initiative that has an aggregate average membership per year of at least four hundred thousand (400,000) Members per month within the last five (5) consecutive calendar years. Supplier may only submit client references where Supplier is the Prime Contractor and continues to have current and active client contracts. References where Supplier is providing services under grants, demonstrations or pilot programs or initiatives or where Supplier’s contract to provide services is terminated or no longer active will not be considered. The Supplier may consider the experience of subsidiaries of the Supplier’s Parent Company when submitting references. References from proposed Subcontractors may not be submitted to meet this requirement. b. If applicable, a minimum of three (3) different client references for each Material Subcontractor, using the reference form provided as Attachment N to the RFP, for which the Material Subcontractor has successfully provided services under capitated risk-based contracts with Medicaid agencies within the last five (5) consecutive calendar years. References where the Material Subcontractor is providing services under grants, demonstrations or pilot programs or initiatives or where the Material Subcontractor’s contract to provide services is terminated or no longer active will not be considered. <p>The Georgia Department of Community Health cannot be submitted as a reference in any instance described above. Include in the client reference list the following information:</p> <ul style="list-style-type: none"> a. Contact name and title. b. Contact phone number. c. Contact email address. d. Contact business address. e. Contact fax number. f. Begin date of contract(s) under which services are being rendered. g. Membership for each reference <p>Refer to Attachment D: Requirements and Scope of Work</p>		Yes	Q9 Supplier Organization
10	<p>Provide a description of and an organization chart for this project displaying the overall business structure, including how and where the proposed project fits into the Supplier’s organizational structure and displaying how the Parent Company and Material Subcontractor(s) will be incorporated into the business structure. Describe the Supplier’s approach to oversight of Material Subcontractors and their performance.</p> <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 2 pages excluding organization chart</p>		Yes	Q10 Supplier Organization

11	<p>For the Supplier and each Material Subcontractor included in the proposal, demonstrate financial viability, as evidenced by sustained bottom line profitability and no current areas of significant financial risk for the past three (3) calendar years. For the Supplier and each Material Subcontractor included in the proposal, provide copies of financial statements from the most recently completed and audited year.</p> <p>Refer to Attachment D: Requirements and Scope of Work</p>		Yes	Q11 Supplier Organization
12	<p>For the Supplier and each Material Subcontractor included in the proposal, provide a comprehensive listing and description of prior work performed, including evidence of successful outcomes (e.g., improved Quality and health outcomes, reduction of inappropriate high-end service Utilization and decreased costs). Experience included should be from work completed under contracts that are current or have been successfully completed within the last five (5) consecutive calendar years and are of similar population size, type and scope of work outlined in this RFP specific to the Supplier's and, if applicable, Material Subcontractor's experience.</p> <p>Refer to Attachment D: Requirements and Scope of Work</p> <p>Page Limit: 12 pages</p>		Yes	Q12 Supplier Organization
13	<p>Provide a statement of whether there is any pending litigation related to fraud and abuse against the Supplier, Parent Company or Material Subcontractors.</p> <p>If such exists, list each separately; explain the relevant details and areas of the Contract that could be impacted and the Supplier's strategy to mitigate such risk.</p> <p>NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Supplier must be properly licensed to render such opinions. The State may require the Supplier to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions.</p> <p>Refer to Attachment D: Requirements and Scope of Work</p> <p>Page Limit: 2 pages (Excluding Attachments)</p>		Yes	Q13 Supplier Organization
14	<p>Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Supplier or Material Subcontractor(s). If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Supplier's performance in a contract pursuant to this RFP.</p> <p>NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Supplier must be properly licensed to render such opinions. The State may require the Supplier to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions.</p> <p>Refer to Attachment D: Requirements and Scope of Work</p> <p>Page Limit: 2 pages (Excluding Attachments)</p>		Yes	Q14 Supplier Organization
15	<p>Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the Supplier or Material Subcontractor(s) within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any Corrective Actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or Children's Health Insurance Program (CHIP) contracts. The Supplier shall include the Supplier's Parent Company, and subsidiaries.</p> <p>Refer to Attachment D: Requirements and Scope of Work</p> <p>Page Limit: 3 pages</p>		Yes	Q15 Supplier Organization

16	<p>For the Supplier and each Material Subcontractor included in this proposal, provide a listing of any contracts terminated with and without cause. Please describe the reason(s) for the termination, the parties involved, and provide the address and telephone number of the client. If the contract was terminated based on the Supplier's performance, please describe any Corrective Action taken to prevent any future occurrence of the problem leading to the termination. The Supplier shall include the Supplier's Parent Company and subsidiaries involved, and provide the address and telephone number of the client. If the contract was terminated based on the Supplier's performance, please describe any Corrective Action taken to prevent any future occurrence of the problem leading to the termination.</p> <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 2 pages excluding attachments</p>		Yes	Q16 Supplier Organization
17	<p>For the Supplier, Supplier's Parent Company, subsidiaries and each Material Subcontractor included in this proposal, provide a listing of any Protected Health Information (PHI) breach. Please describe each breach and the Supplier's response. Do not include items excluded per 42 CFR 164.402.</p> <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 2 pages excluding attachments</p>		Yes	Q17 Supplier Organization
18	<p>Has the Supplier ever had its accreditation status (e.g., National Committee on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), or Accreditation Association for Ambulatory Health Care (AAAHC)) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Supplier shall include the Supplier's Parent Company, and subsidiaries.</p> <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 2 pages excluding attachments</p>		Yes	Q18 Supplier Organization
Project Implementation				

19	<p>Describe the Supplier’s approach to project management, including a summary of responsibilities for project governance and how the Supplier will track action items, risks and issues, as well as contingency and mitigation plans. Provide a proposed Program implementation Project Plan in Microsoft Excel, Microsoft Project or similar software based on the Contract implementation date of July 1, 2016 and that includes all required activities, timeframes and due dates in the Implementation Phase and Year 1 of the Contract. At a minimum, the Project Plan must include elements outlined in the Requirements and Scope of Work, for example:</p> <ul style="list-style-type: none"> a. Establishing an office location(s), call centers, and infrastructure b. Provider recruitment activities c. Staff hiring and a training plan d. Establishing interfaces to other information systems operated by DCH or its Agents e. Network contracting f. Tasks the Supplier will undertake to interface with Providers and Members through a web site, and how that interaction will support program participation and program goals g. Policy and procedure development h. Outreach to DCH’s sister agencies where applicable <p>Refer to section I.A: Project Implementation – Implementation Planning of Attachment D Page Limit: 2 pages excluding Project Plan</p>		Yes	Q19 Project Implementation
20	<p>Submit a sample Transition Plan specifying how the Supplier will coordinate with DCH to assume responsibility for Members transitioning into the Care Management Organization (CMO) from another CMO, the Fee-for-Service system or private insurance. Provide an impact statement outlining the potential impact of the transition of Members, the existing infrastructure, operations and support staff and a detailed description of the Contractor’s processes and proposed approach.</p> <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 2 pages</p>		Yes	Q20 Project Implementation
Staffing				
21	<p>Describe the Supplier’s approaches to acquiring staff, including sources of recruitment. Provide a summary of alternative actions or contingency plans if the Supplier is unable to recruit sufficient numbers of adequately trained staff on a timely basis or if the Supplier’s original staffing estimates are too low and for avoiding and minimizing the impact of personnel changes. Explain how the Supplier will assure the State that sufficiently experienced and trained personnel are available to support implementation and ongoing administration of the Georgia Families program.</p> <p>Refer to Attachment D: Requirements and Scope of Work Page Limit: 3 pages</p>		Yes	Q21 Staffing

22	<p>Describe the Supplier's Key Staff including:</p> <p>a. A listing of Key Staff members identified in the RFP, including names, titles, job descriptions, degrees and qualifications and full-time equivalents (FTEs). If the Supplier's proposed approach includes other Key Staff, the Supplier must identify these positions and provide a complete description of how these positions support those required by this RFP.</p> <p>b. Resumes and three (3) references for each proposed Key Staff member.</p> <p>Refer to section I.B: Contractor Staffing of Attachment D</p> <p>Page Limit: 3 pages excluding resumes and references</p>		Yes	Q22 Staffing
23	<p>Describe the Supplier's overall staffing for Georgia Families including:</p> <p>a. Provision of organizational charts that provide a complete and detailed description of the proposed staffing organization to be used during all phases of the Contract.</p> <p>b. Identification of staff based (1) in the office(s), (2) in the field, and (3) at a corporate office.</p> <p>c. The number of full-time equivalents (FTE) Supplier/Material Subcontractor staff who will be dedicated to this Contract as well as number of FTEs per Member by position type.</p> <p>Refer to section I.B: Contractor Staffing of Attachment D</p> <p>Page Limit: 2 pages excluding organizational charts</p>		Yes	Q23 Staffing
24	<p>Provide details about the staff training plan the Supplier intends to implement to ensure all staff, in all departments, are aware of programmatic changes. Provide the frequency with which new and existing employees are trained, how new program updates are disseminated, how the Supplier's organization tracks training completion and how comprehension is measured.</p> <p>Refer to section I.B: Contractor Staffing - Training of Attachment D</p> <p>Page Limit: 5 pages</p>		Yes	Q24 Staffing
Covered Services and Benefits				
25	<p>Describe any innovative and enhanced services that the Supplier will provide to enhance the general health and well-being of Members and to improve outcomes. Provide examples of initiatives the Supplier proposes to achieve a holistic approach to Member care. Include examples of success with similar Medicaid populations that the Supplier's organization has demonstrated.</p> <p>Refer to section I.C: Georgia Families Covered Services of Attachment D</p> <p>Page Limit: 3 pages, excluding sample materials</p>		Yes	Q25 Covered Services and Benefits
26	<p>Describe the Supplier's process of determining medical necessity and how the Supplier will ensure there is no other more conservative or substantially less costly treatment, service or setting available to achieve the desired health outcome. Describe how the Supplier's organization will manage under-Utilization and over-Utilization of services and will work to ensure a high Quality, clinically appropriate yet highly efficient and cost-effective delivery system.</p> <p>Refer to section I.C: Georgia Families Covered Services – Medical Necessity of Attachment D</p>		Yes	Q26 Covered Services and Benefits

27	<p>Describe in detail the Supplier’s understanding of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit and the Supplier’s plan and operational procedures for EPSDT outreach. Include in the description how the Supplier will:</p> <ul style="list-style-type: none"> a. Educate Members about the EPSDT Benefit and the importance of following the periodicity and immunization schedule. b. Educate Providers about the EPSDT Benefit and their roles in ensuring Members follow the periodicity and immunization schedule as well as receive the appropriate care. c. Educate relevant Material Subcontractors evaluating medical necessity. d. Use data to enhance outreach efforts. e. Use data to communicate outcomes and identify trends and areas for improvement where additional outreach and education is needed. <p>Refer to section I.C: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit – General Provisions of Attachment D.</p>		Yes	Q27 Covered Services and Benefits
28	<p>Describe the Supplier’s proposed approach to ensure children receive timely EPSDT screens in accordance with the DCH’s adopted EPSDT periodicity schedule, including the following:</p> <ul style="list-style-type: none"> a. The Supplier’s process for reminder, follow-ups, and outreach to Member. Include proactive activities as well as activities to conduct follow up with Members who do not remain current with the periodicity schedule. How will the Supplier use this information to determine reasons for lack of follow up and to provide support when needed (e.g., coordination with NET broker for transportation)? b. Developing and maintaining an electronic system to track Members’ EPSDT screening and immunization status to confirm Members have received all required EPSDT screens. c. Assisting Members by coordinating Referrals and medically necessary follow-up treatment resulting from an EPSDT screen. d. Monitoring Primary Care Providers (PCP)/Providers compliance with appointment standards and EPSDT screening requirements, including a description of what the Supplier will do if it identifies PCPs/Providers who do not meet the performance standards. e. How the Supplier anticipates the approach will improve health outcomes. <p>Include in the response a detailed summary of how the Supplier will assure that Members receive the necessary Diagnostic Services and treatment services resulting from screening results.</p> <p>Refer to section I.C: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit – Outreach and Informing of Attachment D.</p>		Yes	Q28 Covered Services and Benefits
Special Coverage and Provisions				
29	<p>Provide innovative solutions for ensuring Members have adequate access to required Family Planning Services and are accessing those services.</p> <p>Refer to section I.D: Special Coverage Provisions - Family Planning Services of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q29 Special Coverage and Provisions

30	<p>Describe the Supplier’s pharmacy Prior Authorization process. As part of the response, include:</p> <ul style="list-style-type: none"> a. Transparency in communicating the Conditions for coverage to Providers. b. Service level agreement for Prior Authorization turnaround time. c. Required credentials of those staff reviewing Prior Authorization requests and any distinction between the credentials of who is permitted to approve versus deny a request. d. The use of existing electronic Claims history to adjudicate a Prior Authorization request in an automated fashion. e. How Supplier’s organization will review and use trends in Prior Authorization requests to identify possible changes to Prior Authorization guidelines (e.g., to determine if Prior Authorization should continue for a medication that results in a high percentage of approvals). <p>Refer to section I.D: Special Coverage Provisions – Pharmacy of Attachment D Page Limit: 5 pages</p>		Yes	Q30 Special Coverage and Provisions
31	<p>Describe the Supplier’s proposed approach to ensuring Members less than twenty-one (21) years of age receive all vaccines and immunization in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. Include in the response the Supplier’s experience in coordinating with other state programs designed to improve immunization levels.</p> <p>Refer to section I.D: Special Coverage Provisions – Immunizations of Attachment D Page Limit: 2 pages</p>		Yes	Q31 Special Coverage and Provisions
32	<p>Describe the Supplier’s proposed approach to coordinating with the Department of Public Health (DPH) to ensure that Providers use vaccines for PeachCare for Kids® Members age eighteen (18) years of age and younger that are available free of cost to Providers through the State Purchasing Vaccine Program? Additionally, describe innovative approaches the Supplier will implement to ensure Providers are aware of the program and use it.</p> <p>Refer to section I.D: Special Coverage Provisions – Immunizations of Attachment D Page Limit: 2 pages</p>		Yes	Q32 Special Coverage and Provisions
33	<p>Describe the Supplier’s proposed approach to assisting Members with accessing Non-Emergency Transportation (NET).</p> <p>Refer to section I.D: Special Coverage Provisions – Transportation of Attachment D Page Limit: 2 pages</p>		Yes	Q33 Special Coverage and Provisions
34	<p>Describe how the Supplier will coordinate with public health departments to utilize their perinatal risk assessments and plans of care for newly identified pregnant women.</p> <p>Refer to section I.D: Special Coverage Provisions – Perinatal Services of Attachment D Page Limit: 2 pages</p>		Yes	Q34 Special Coverage and Provisions

35	<p>Describe the Supplier’s proposed approach to providing prenatal and postpartum services, including:</p> <p>a. How the Supplier will coordinate with Providers through which women are already receiving prenatal or postpartum care at the time of Enrollment.</p> <p>b. Innovative strategies the Supplier intends to implement to encourage pregnant women to seek prenatal and postpartum care services. Describe how the Supplier will optimize the likelihood that Members will comply with scheduled prenatal visits and return for postpartum checkups. Identify potential challenges the Supplier anticipates when facilitating prenatal care for Members and explain how the Supplier will mitigate those challenges.</p> <p>c. How the Supplier will encourage follow-up and treatment of postpartum depression and related Conditions such as drug and alcohol dependence and other mental illnesses. Include in the description how the Supplier will encourage Provider identification of postpartum depression and related Conditions, and optimize follow-up surveillance, Referral and/or treatment.</p> <p>Refer to section I.D: Special Coverage Provisions – Parenting Education of Attachment D</p> <p>Page Limit: 6 pages</p>		Yes	Q35 Special Coverage and Provisions
36	<p>Describe the Supplier’s proposed approach to the timely delivery of covered Mental Health and Substance Abuse services including any distinction between adult, adolescent, and pediatric populations.</p> <p>The description shall include:</p> <p>a. Approach to the delivery of Behavioral Health Services and Physical Health in the most integrated and person-centered setting available including for those with dual diagnoses (i.e., Mental Health and Substance Abuse diagnoses).</p> <p>b. Approach to identifying Substance Abuse.</p> <p>c. Approach to the provision of recovery-based services.</p> <p>d. Use of innovative Emergency Services diversion techniques and interventions.</p> <p>e. Innovative strategies the Supplier intends to implement for increasing access to all tiers of community Behavioral Health Providers.</p> <p>f. Potential challenges the Supplier anticipates in ensuring Members receive appropriate Mental Health and Substance Abuse care and how the Supplier will mitigate those challenges.</p> <p>Provide examples of successful strategies the Supplier has used to provide these services.</p> <p>Refer to section I.D: Special Coverage Provisions – Mental Health and Substance Abuse of Attachment D</p> <p>Page Limit: 8 pages</p>		Yes	Q36 Special Coverage and Provisions
37	<p>Describe the Supplier’s approach to identifying and initiating Care Coordination for at-risk Members diagnosed with Behavioral Health Conditions.</p> <p>Provide examples of successful strategies the Supplier has used to identify and coordinate care for at-risk Members.</p> <p>Refer to section I.D: Special Coverage Provisions – Mental Health and Substance Abuse of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q37 Special Coverage and Provisions
Member Enrollment				

38	<p>Describe the Supplier’s proposed approach to helping Members to identify PCPs who may best meet their needs, ensure continuity of care and to encourage Members to make voluntary PCP selections. Additionally, include a discussion of the Supplier’s approach to inform Members about their PCP assignment and encourage scheduling and keeping appointments. Include how the Supplier will identify and resolve Member barriers to keeping appointments.</p> <p>Refer to section I.E: Member Enrollment – Selection of a Primary Care Provider (PCP) of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q38 Member Enrollment
39	<p>Describe the Supplier’s proposed approach to ensuring Member’s with a Behavioral Health diagnosis requesting a Behavioral Health Home are assigned a Behavioral Health Home that best meets their needs. Describe how the Behavioral Health Home will coordinate all physical and Behavioral Health Care for the Member to allow better access to Health Care and improve health outcomes.</p> <p>Page Limit: 3 pages</p>		Yes	Q39 Member Enrollment
40	<p>Describe the Supplier’s proposed process to connect/assign Members to a Dental Home, including the proposed Auto-Assignment algorithm. Include how Member choice, continuity of care, and any methodology for Auto-Assignment to a Dental Home will be incorporated into the Supplier’s solution. Additionally, include a discussion of the Supplier’s approach to inform Members about their Dental Home assignment and encourage scheduling an initial appointment.</p> <p>Refer to section I.E: Member Enrollment – Dental Home of Attachment D</p>		Yes	Q40 Member Enrollment
Member Services				
41	<p>Provide the Supplier’s proposed plan for distributing Member materials, including a description of topics to be addressed. Describe the Supplier’s proposed use of technology to reach the most Members and engender the most response. Please describe successful uses of the proposed technologies and other innovations in other markets, if applicable, to reach the most Members. Describe the Supplier’s commitment to reassess the effectiveness of the Supplier’s planned approach to locate Members should the initial approach produce suboptimal results.</p> <p>Refer to section I.G: Georgia Families Member Services of Attachment D</p> <p>Page Limit: 2 pages excluding sample materials</p>		Yes	Q41 Member Services

42	<p>Describe the Supplier's proposed education and outreach program for Members, including:</p> <ul style="list-style-type: none"> a. Creative solutions the Supplier will employ to achieve Member interest participation in outreach and education activities. b. An overview of the program and proposed activities. c. Rationale for the selected areas of focus. d. Methodology to provide targeted health education. e. How the Supplier will collect and use feedback from Members to enhance the program. <p>Refer to section I.G: Georgia Families Member Services of Attachment D Page Limit: 4 pages</p>		Yes	Q42 Member Services
43	<p>Describe the Supplier's proposed approaches for obtaining correct Member contact information including Member phone numbers and email addresses.</p> <p>Refer to section I.G: Georgia Families Member Services – Member Handbook and Member Material Requirements of Attachment D Page Limit: 2 pages</p>		Yes	Q43 Member Services
44	<p>Describe the Supplier's Member services call center operations, including:</p> <ul style="list-style-type: none"> a. How the Supplier's organization will provide a fully staffed line between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday, excluding State holidays, and an automated system between the hours of 7:00 p.m. and 7:00 a.m. EST Monday through Friday and on weekends and State holidays. b. Location of operations (If out of State, describe how it will accommodate services for Georgia). c. How call center standards (e.g., average answer speed, average length of call, Blocked Calls, etc.) will be monitored and met. d. Accommodations for non-English speaking and hearing impaired callers. <p>Refer to section I.G: Georgia Families Member Services – Member Call Center of Attachment D Page Limit: 3 pages</p>		Yes	Q44 Member Services
45	<p>Describe the Supplier's proposed approach to:</p> <ul style="list-style-type: none"> a. Ensure that Member calls pertaining to immediate medical needs are properly handled. b. Train call center employees on issues such as Member rights, Cultural Competency, identification of emergency needs and the different populations included in the program, how the service offerings differ for each of those. c. Provide staff timely access to current and consistent information needed when responding to Member inquiries. <p>Refer to section I.G: Georgia Families Member Services – Member Call Center of Attachment D Page Limit: 3 pages</p>		Yes	Q45 Member Services

46	<p>Provide an overview of the Supplier’s proposed Member web site and Member portal. Include examples of proposed resources, tools and materials that will be of meaningful use to Members.</p> <p>Refer to section I.G: Georgia Families Member Services – Georgia Families Member Web Site of Attachment D Page Limit: 4 pages excluding sample resources, tools and materials</p>		Yes	Q46 Member Services
47	<p>Describe how Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each.</p> <p>Refer to section I.G: Georgia Families Member Services – Cultural Competency of Attachment D Page Limit: 2 pages</p>		Yes	Q47 Member Services
Provider Network				
48	<p>Describe the Supplier’s proposed ongoing Provider Network development outreach approach and recruitment strategy. Include in the response the Supplier’s approach to the following:</p> <ul style="list-style-type: none"> a. Developing recruitment work plans and carrying out recruitment efforts. b. Obtaining Letters of Intent with existing Medicaid Providers. c. Incenting Providers to participate in the Georgia Families program. <p>If Subcontractors will be used for certain service areas (e.g., dental, transportation, Behavioral Health), describe how their network development efforts will be coordinated with the overall recruitment strategy and how the Supplier will provide oversight and monitoring of network development activities.</p> <p>Refer to section I.I: Georgia Families Provider Network – General Provisions of Attachment D Page Limit: 6 pages</p>		Yes	Q48 Provider Network
49	<p>Demonstrate progress toward developing network capabilities for statewide access by providing signed Letters of Intent with physicians, specialists, Mental Health providers, dentists, hospitals, pharmacies, therapists, etc. for Georgia Families program networks that shall include the information, at a minimum:</p> <ul style="list-style-type: none"> a. An Excel worksheet listing every provider with a signed Letter of Intent. The worksheet must include the name of the provider, the provider’s address(es), county/counties, Service Region, provider’s Medicaid Identification Number(s) and provider type. b. Using the Geo Access tool, Statewide Geographic Access report of all providers with LOIs color coded by provider type by Service Region. <p>Refer to section I.I: Georgia Families Provider Network – Provider Network Composition of Attachment D</p>		Yes	Q49 Provider Network

50	<p>Explain the Supplier’s plan to develop a comprehensive Provider network to ensure it meets DCH access and availability requirements for all covered Benefits. Specifically include:</p> <ul style="list-style-type: none"> a. How the Supplier’s organization will identify and act upon network gaps. b. Proposed method to assess and ensure the network standards are maintained for all Provider types, including using Geo Access reporting to ensure network adequacy. c. Supplier’s process for continuous network improvement over and above contract compliance, including the approach for monitoring and evaluating PCP compliance with availability and scheduling appointment requirements and ensuring Members have access to care if the Supplier lacks an agreement with a key Provider type in a given geographic area. d. Proposed Member to Provider ratios. e. How the Supplier will address rural access issues and Health Provider Shortage Areas (HPSAs). <p>Refer to section I.I: Georgia Families Provider Network – Provider Selection and Retention Policies and Procedures of Attachment D Page Limit: 8 pages</p>		Yes	Q50 Provider Network
51	<p>Provide a description of the system the Supplier intends to use in generating Geo Access reports. Describe the system’s capacity to:</p> <ul style="list-style-type: none"> a. Identify whether the system has the capability to generate Geo Access reports based on physical address, as opposed to ZIP code as well as by Provider type. b. Develop exception reports, and for identifying Members or geographic areas where access standards are not achieved. Provide examples of the Supplier’s system’s output. <p>Refer to section I.I: Georgia Families Provider Network – Provider Selection and Retention Policies and Procedures of Attachment D</p>		Yes	Q51 Provider Network
52	<p>Describe innovative strategies the Supplier intends to use to identify specialty types for which Member access is limited. Describe initiatives the Supplier will implement for increasing the number of specialists within those specialty types that participate in the Supplier’s network.</p> <p>Identify potential challenges the Supplier anticipates in ensuring Members receive appropriate care for specialties where access concerns exist and explain how the Supplier will mitigate those challenges.</p> <p>Refer to section I.I: Georgia Families Provider Network – Provider Network Composition of Attachment D Page Limit: 3 pages</p>		Yes	Q52 Provider Network

53	<p>Describe innovative approaches the Supplier will implement to encourage Providers to attain National Committee on Quality Assurance (NCQA) patient-centered medical home recognition. If the Supplier proposes to incentivize Providers to attain certification, provide the approach to developing and implementing the incentive. The Supplier must not provide any pricing or cost information in its response.</p> <p>Refer to section I.I: Georgia Families Provider Network – Primary Care Providers and section I.M: Quality Management and Performance Improvement – National Committee for Quality Assurance (NCQA) Accreditation of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q53 Provider Network
54	<p>Describe responsibilities the Supplier will require of PCPs and how the Supplier will verify that PCPs are performing the required responsibilities.</p> <p>Refer to section I.I: Georgia Families Provider Network – Primary Care Providers of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q54 Provider Network
55	<p>Provide a description of how the Supplier intends to offer improved access to through Telemedicine. Include the following in the description:</p> <ul style="list-style-type: none"> a. Criteria for recognized sites for Members to access Telemedicine. b. Willingness to pay the presenting site a facility fee (Note: Do not include any financial information in the response). c. Types of Providers the Supplier intends to contract for the provision of Telemedicine. d. Education efforts to inform Members and Providers. e. Inclusion of public health departments as Telemedicine presentation sites. <p>Provide examples of successful Telemedicine programs the Supplier has implemented.</p> <p>Refer to section I.I: Georgia Families Provider Network – Telemedicine of Attachment D</p> <p>Page Limit: 5 pages</p>		Yes	Q55 Provider Network
56	<p>Describe innovative strategies the Supplier intends to implement to ensure appropriate access to dental Providers actively participating in the Supplier’s Provider Network and any specific initiatives the Supplier would implement related to increasing pediatric Utilization of preventive dental services.</p> <p>Identify potential challenges the Supplier may anticipate in ensuring Members receive appropriate dental care and explain how the Supplier with mitigate those challenges.</p> <p>Refer to section I.I: Georgia Families Provider Network – Dental Practitioners of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q56 Provider Network
57	<p>Describe how the Supplier will ensure that access standards are met when Members cannot access care within the Supplier’s Provider network and must utilize an Out-of-Network Provider?</p> <p>Refer to section I.I: Georgia Families Provider Network – Geographic Access Requirements and Georgia Families Provider Network – Out-of-Network Providers of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q57 Provider Network

58	<p>Describe the Supplier’s approach to auditing Provider Network accessibility. Include a description of how the below will be audited, the frequency of the audits and how deficiencies will be addressed.</p> <ul style="list-style-type: none"> a. Urgent and non-urgent PCP appointment availability and wait time. b. Urgent and non-urgent OB appointment availability and wait time. c. Urgent and non-urgent Specialty Provider availability and wait time. d. Physician twenty-four (24) hour availability. <p>Please provide sample tools the Supplier will use.</p> <p>Refer to section I.I: Georgia Families Provider Network – Waiting Maximums and Appointment Requirements and Access and Availability Audits of Attachment D</p> <p>Page Limit: 4 pages, excluding sample tools</p>		Yes	Q58 Provider Network
59	<p>Describe the processes the Supplier will implement to ensure the access standards are met if actual Enrollment exceeds projected Enrollment.</p> <p>Refer to section I.I: Georgia Families Provider Network Attachment D</p> <p>Page Limit: 1 page</p>		Yes	Q59 Provider Network
60	<p>Describe the Supplier’s process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO.</p> <p>Refer to section I.I: Georgia Families Provider Network – Provider Credentialing of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q60 Provider Network
61	<p>Describe the Supplier’s approach for timely contracting of Providers upon receipt of information from the CVO that a Provider’s credentialing is complete. Separately, identify the time from contracting that the Supplier requires to upload a credentialed and contracted Provider into the Claims payment system such that the Provider Claims could be adjudicated for payment consideration. Finally, discuss the Supplier’s willingness to pay Claims with dates of service on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Supplier’s Claims processing system.</p> <p>Refer to section I.I: Georgia Families Provider Network – Provider Credentialing of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q61 Provider Network
62	<p>Describe how the Supplier would respond to the network termination or loss of a large-scale Provider group or health system. Please develop the response taking the following areas into consideration:</p> <ul style="list-style-type: none"> a. Notification to DCH. b. The automated systems and membership supports utilized in assisting affected Members with Provider transitions. c. Systems and policies utilized for continuity of care of Members experiencing Provider transition. d. Impact if the loss is in a geographic area where other Providers of the same Provider type are not available and the Contractor’s response to that impact <p>Refer to section I.I: Georgia Families Provider Network – Network Changes of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q62 Provider Network
Provider Services				

63	<p>Provide a description of the Supplier’s Provider services program/department and how the Supplier intends to partner with the Provider community in delivering Covered Services. Include the following:</p> <ul style="list-style-type: none"> a. Information available in the Provider handbook or other media. b. Description of any formal committees or panels the Supplier will form at which Providers can offer input regarding CMO/Provider relations. c. Sample Provider outreach. <p>Provide examples of best practices related to Provider services in other states that the Supplier will utilize in Georgia. Refer to section I.J: Georgia Families Provider Services of Attachment D Page Limit: 4 pages (excluding sample materials)</p>		Yes	Q63 Provider Services
64	<p>Describe the Supplier’s proposed Provider education and training program, including:</p> <ul style="list-style-type: none"> a. A description of the training program. b. A summary of the Supplier’s plans to evaluate Provider behaviors (e.g., Provider profiling or other techniques), and how the Supplier will use such information to educate Providers about how they can improve patient outcomes. c. A workplan that outlines education and training activities, including frequency of office visits to conduct activities. d. A listing of the types of materials the Supplier will distribute (the actual materials are not to be submitted). e. How the Supplier will evaluate usefulness of educational sessions and synthesize that feedback to influence future training sessions. <p>Refer to section I.J: Georgia Families Provider Services – Education and Training of Attachment D Page Limit: 5 pages</p>		Yes	Q64 Provider Services
65	<p>Describe the Supplier’s Provider Services call center operations, including:</p> <ul style="list-style-type: none"> a. How the Supplier will provide a fully-staffed line between the hours of 7:00 a.m. and 7:00 p.m. Monday through Friday, excluding State holidays, and an automated system between the hours of 7:00 p.m. and 7:00 a.m. EST Monday through Friday and on weekends and State holidays. b. Location of operations (If out of state, describe how it will accommodate services for Georgia). c. How call center standards (e.g., average answer speed, average length of call, Blocked Calls, etc.) will be monitored and met. <p>Refer to section I.J: Georgia Families Provider Services –Provider Services Call Center of Attachment D Page Limit: 3 pages</p>		Yes	Q65 Provider Services
66	<p>Provide an overview of the Supplier’s proposed Provider web site, including examples of information that will be available on the Program web site and portals for Providers.</p> <p>Include proposed resources and tools that will be of meaningful use to Providers. Please provide a description of technology that will be used to enhance the Provider web site.</p> <p>Refer to section I.J: Georgia Families Provider Services – Georgia Families Provider Web Site of Attachment D. Page Limit: 5 pages excluding sample resources, tools and materials</p>		Yes	Q66 Provider Services

67	<p>Provide a description of the Supplier’s proposed approach to handling Provider inquiries and grievances. Include intended interaction and correspondence, as well as timeframes in which the Supplier will acknowledge and resolve inquiries and grievances. Explain how the Supplier will track Provider Complaints and inquiries and how the Supplier will use this type of information to improve Provider relations. Include a description of any type of internal reporting the Supplier will perform, and how this may influence the activities of the Supplier’s Provider Relations representatives. In addition, describe how the Supplier intends to capture and utilize measurable Provider satisfaction information. Provide an overview of how the Supplier will use information collected internally to improve operations.</p> <p>Refer to section I.J: Georgia Families Provider Services – Provider Complaint System of Attachment D Page Limit: 3 pages</p>		Yes	Q67 Provider Services
Utilization Management and Care Management				
68	<p>Describe the Supplier’s proposed approach to Utilization Management (UM), including:</p> <ul style="list-style-type: none"> a. Innovations and automation the Supplier will implement for the Utilization Management program. b. Accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers. c. Data sources and processes to determine which services require Prior Authorization and how often these requirements will be re-evaluated. d. Processes and resources used to develop and regularly review Utilization Review (UR) criteria. e. Prior Authorization processes for Members requiring services from non-participating providers or expedited Prior Authorization. f. How the Supplier will use its Utilization Management Committee to support Utilization Management activities. <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Utilization Management of Attachment D</p>		Yes	Q68 Utilization Management and Care Management
69	<p>Describe the Supplier’s proposed approach for using data collected during Utilization Management to drive appropriate use of service, improved cost efficiencies, Member and Provider education and Fraud and Abuse referrals.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Utilization Management of Attachment D Page Limit: 3 pages</p>		Yes	Q69 Utilization Management and Care Management
70	<p>Describe the Supplier’s approach for interfacing with DCH’s Prior Authorization Portal. Include a description of how the Supplier will outreach to and educate all network Providers about use of the Portal and notify Providers of the outcome of a Prior Authorization within the required timeframes.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Prior Authorization and Pre-Certification of Attachment D Page Limit: 2 pages</p>		Yes	Q70 Utilization Management and Care Management

71	<p>Provide a comprehensive discussion of the Supplier’s Coordination and Continuity of Care program and how it will meet program goals for improving Member outcomes. Include a discussion of how the Supplier will determine Member eligibility for each level of care (e.g., disease management, Case Management, etc.) and manage co-morbidities. Describe how the Supplier will tailor the program to incorporate a System of Care approach for Members according to their various Health Care needs. Also address community differences across the state, including information about issues such as geographic differences in Provider supply and cultural differences.</p> <p>Provide case studies and experience from other states illustrating the Supplier’s ability to successfully address community differences in its Care Coordination approach.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Coordination and Continuity of Care Responsibilities of Attachment D</p> <p>Page Limit: 8 pages</p>		Yes	Q71 Utilization Management and Care Management
72	<p>How will the Supplier identify community resources and agencies for inclusion in the Coordination of Care and Continuity of Care program? Describe the Supplier’s proposed outreach efforts to such agencies and how the Supplier will involve them in the continuum of care for Members.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Coordination and Continuity of Care Responsibilities of Attachment D</p> <p>Page Limit: 1 page</p>		Yes	Q72 Utilization Management and Care Management
73	<p>Describe innovative strategies the Supplier will use to identify Members in need of regular care monitoring. Include a description of how the Supplier will engage Members, families, PCPs, specialist and other Providers as necessary in the treatment plan development.</p> <p>Provide experiences from other states illustrating and best practices that the Supplier would suggest DCH implement. For each example from another state, provide statistics demonstrating the impact of the initiative (such as percent change in Utilization of a particular service, etc.).</p> <p>Submit a sample needs assessment template.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Coordination and Continuity of Care Responsibilities of Attachment D</p> <p>Page Limit: 8 pages excluding sample needs assessment template</p>		Yes	Q73 Utilization Management and Care Management

74	<p>Explain the Supplier’s hospital Discharge planning policies and procedures that will ensure seamless transition for Members. Describe pre-Discharge activities including collaborating with the Member and his/her family, as well as community resources that will be involved at Discharge and thereafter. Include any follow-up activities after Discharge the Supplier intends to perform.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p> <p>Page Limit: 3 page</p>		Yes	Q74 Utilization Management and Care Management
75	<p>Describe the Supplier’s intended approach to working with other CMOs in the event a Member changes CMOs, or moves to private insurance or to the Fee-for-Service system. Describe how the Supplier will interact with other CMOs to ensure a seamless Transition Of Care and that all relevant information is transferred.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p> <p>Page Limit: 1 page</p>		Yes	Q75 Utilization Management and Care Management
76	<p>Provide an overview of the Supplier’s proposed Discharge Planning Pilot Program. What innovations will the Supplier implement to improve Quality of care and outcomes, as well as to reduce Re-admissions? Which Member populations will the Supplier target and why? Which hospital(s) will the Supplier target and why? How will the Supplier collaborate with the hospital(s) to agree upon the proposed Discharge planning activities and on the responsibilities of the onsite nurse?</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p> <p>Page Limit: 4 pages</p>		Yes	Q76 Utilization Management and Care Management
77	<p>Provide an overview of the Supplier’s proposed Emergency Department Diversion pilot program. What innovations will the Supplier implement to improve Quality of care and outcomes, as well as to reduce inappropriate Emergency Department visits? How will the Supplier organization identify Member populations and hospital(s) for participation in the pilot? How will the Supplier collaborate with the hospital(s) to agree upon the proposed pilot activities?</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p> <p>Page Limit: 4 pages</p>		Yes	Q77 Utilization Management and Care Management

78	<p>Describe how the Supplier's coordination and continuity of care efforts will maximize Physical and Behavioral Health integration to improve outcomes including:</p> <ul style="list-style-type: none"> a. The organization's approach to coordinating Behavioral Health service delivery with Primary Care services delivered by a Member's PCP, and vice versa. b. How the Supplier will encourage the delivery of outpatient Behavioral Health Services following an inpatient Discharge for Behavioral Health Services. c. Information the Supplier will collect and maintain for use in Behavioral Health coordination efforts. d. Reports the Supplier will maintain and use that illustrate patterns of Referral as well as services provided to individuals, include an explanation of how the data and its analysis improve healthcare outcomes for Members. e. How the Supplier will share information with Providers and other stakeholders to contribute to the success of Behavioral Health coordination. f. How HIPAA requirements might pose challenges and how the Supplier will overcome or address those challenges. <p>Provide case studies and experience from other states illustrating the Supplier organization's ability to successfully integrate Physical and Behavioral Health.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Integration of Physical and Behavioral Health Services of Attachment D</p> <p>Page Limit: 7 pages</p>		Yes	Q78 Utilization Management and Care Management
79	<p>Describe the Supplier's approach to identifying Members in need of Case Management services and the level of intensity of Case Management needed. Include a description of how the Supplier will distinguish eligibility for the various levels of Case Management intensity, including the following:</p> <ul style="list-style-type: none"> a. Detailed description of the methodology used to analyze Claims data. b. Approach to predictive modeling and other data analysis for identifying Members and to tier or stratify Members according to their risk, cost and impactability. The detailed narrative must communicate the uniqueness of the Supplier's capabilities in this area. c. The proposed qualifying criteria for children, adolescents and adults, as well as, the Physical Health and Behavioral Health Conditions and factors that the Supplier will consider in identifying Members eligible for Case Management. d. A description of Member assessment tools the Supplier will use and an example template. e. How Case Management services provided to Planning for Healthy Babies 1115 Demonstration Waiver (P4HB) Interpregnancy Care component of the 1115 Demonstration Waiver (IPC) Participants may differ from those provided to other Members. <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D</p> <p>Page Limit: 6 pages, excluding Member assessment template Georgia Families UM Responsibilities: Question 7</p>		Yes	Q79 Utilization Management and Care Management

80	<p>Describe the Supplier’s approach to identifying Members in need of Case Management services and the level of intensity of Case Management needed. Include a description of how the Supplier will distinguish eligibility for the various levels of Case Management intensity, including the following:</p> <ul style="list-style-type: none"> a. Detailed description of the methodology used to analyze Claims data. b. Approach to predictive modeling and other data analysis for identifying Members and to tier or stratify Members according to their risk, cost and impactability. The detailed narrative must communicate the uniqueness of the Supplier’s capabilities in this area. c. The proposed qualifying criteria for children, adolescents and adults, as well as, the Physical Health and Behavioral Health Conditions and factors that the Supplier will consider in identifying Members eligible for Case Management. d. A description of Member assessment tools the Supplier will use and an example template. e. How Case Management services provided to Planning for Healthy Babies 1115 Demonstration Waiver (P4HB) Interpregnancy Care component of the 1115 Demonstration Waiver (IPC) Participants may differ from those provided to other Members. <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D</p> <p>Page Limit: 6 pages, excluding Member assessment template</p>		Yes	Q80 Utilization Management and Care Management
81	<p>Describe the specific levels of Case Management Members will receive based on the intensity of the Member’s needs. Recommend additional innovative Case Management strategies DCH may want to consider for the Georgia Families program.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D</p> <p>Page Limit: 5 pages</p>		Yes	Q81 Utilization Management and Care Management
Quality Management and Performance Improvement				
82	<p>Describe the Supplier’s proposed Quality Management program, including:</p> <ul style="list-style-type: none"> a. The program’s infrastructure, including coordination with Subcontractors/corporate entities, if applicable. b. The program’s lines of accountability. c. Process for selecting areas of focus and using evidence-based practices. d. How the Supplier will comply with and support the Georgia Families Quality Strategy. e. Use of the Quality Management Oversight Committee. f. Use of data to design, implement and evaluate the effectiveness of the program. g. Assurance of separation of responsibilities between Utilization Management and Quality assurance staff. <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D</p> <p>Page Limit: 6 pages</p>		Yes	Q82 Quality Management and Performance Improvement

83	<p>Describe data-driven clinical initiatives that the Supplier would propose undertaking for the Georgia Families program. Include an overview of the initiative, populations to be targeted and analyses the Supplier will conduct. Provide examples of data-driven clinical initiatives the Supplier has initiated within the past twenty-four (24) months that have yielded improvement in clinical care for a Medicaid managed care population comparable to the Georgia Families population. For each initiative described, provide statistics and results demonstrating the impact of the initiative.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D Page Limit: 3 pages</p>		Yes	Q83 Quality Management and Performance Improvement
84	<p>Describe two (2) Acute Care clinical initiatives the Supplier proposes to pursue in the first year of the Contract. Document why each topic warrants a Quality improvement investment, and describe the measurable goals for the initiative. Provide the baseline assumptions that led the Supplier organization to propose these two (2) initiatives.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D Page Limit: 2 pages</p>		Yes	Q84 Quality Management and Performance Improvement
85	<p>Describe the Supplier's proposed process to monitor Providers' implementation of and compliance with new practice guidelines. Include a description of how the Supplier will increase compliance with the use of clinical practice guidelines.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D Page Limit: 2 pages</p>		Yes	Q85 Quality Management and Performance Improvement
86	<p>Describe the Supplier's proposed methodology to identify, design, implement, and evaluate Performance Improvement Projects (PIP). Describe the Supplier's proposed methodology for a Performance Improvement Project for a population with a high level of emergency department Utilization.</p> <p>Refer to section I.M: Quality Management and Performance Improvement – Performance Improvement Projects of Attachment D Page Limit: 4 pages</p>		Yes	Q86 Quality Management and Performance Improvement

87	<p>Discuss how the Supplier will assist DCH in establishing and meeting DCH’s Value Based Purchasing (VBP) goals, including the following:</p> <p>a. How the Supplier will identify and implement initiatives and interventions to achieve targets for the identified performance measures.</p> <p>b. Data analyses the Supplier will conduct, with the assumptions used to conduct the analyses; past experience; knowledge and understanding of the Georgia Families population, including a discussion of potential barriers to performance improvement and how the Supplier intend to address those barriers; and a review of industry best practices.</p> <p>c. Methods for monitoring performance against targets, including how the Supplier will modify interventions if interventions are not successful in helping to attain targets.</p> <p>d. How the Supplier proposes to conduct as close to real-time measurement as possible, and monitoring and providing feedback to hold Providers accountable for providing appropriate services. As part of this discussion, describe the Supplier’s proposed approach to incent Provider behavior, how the Supplier will design the Provider performance incentive program and how and the degree to which these incentives will be aligned with Member incentives (if any), Supplier performance goals and DCH performance goals. Discuss the Supplier’s experience with Provider incentive programs, the structure of the programs, measurable outcomes and lessons learned. Do not include financial information in the response.</p> <p>e. Supporting rationale.</p> <p>Refer to section I.M: Quality Management and Performance Improvement – Value Based Purchasing (VBP) Program of Attachment D Page Limit: 8 pages</p>		Yes	Q87 Quality Management and Performance Improvement
88	<p>Describe the Supplier’s proposed methodology to identify, assess, and correct disparities in treatment across races and ethnic groups.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D Page Limit: 2 pages</p>		Yes	Q88 Quality Management and Performance Improvement
89	<p>How will the Supplier use the Member and Provider Advisory Committees to improve the Georgia Families program and direct Quality and operational changes? What representation will the Supplier plan to have on each committee (e.g., stakeholder types, from what geographic areas, etc.) How will the Supplier identify participants of the Member and Provider Advisory Committees?</p> <p>Provide examples from other states where the Supplier has collaborated with Member and Provider Committees for program improvement.</p> <p>Refer to section I.M: Quality Management and Performance Improvement – Member Advisory Committee and Provider Advisory Committee of Attachment D Page Limit: 5 Pages</p>		Yes	Q89 Quality Management and Performance Improvement
Utilization Management and Care Management				

90	<p>How will the Supplier ensure and verify that Subcontractor(s) submit timely, accurate, complete and required Encounter Claim data elements to the Supplier for subsequent transmission to the Department? How often and how will the Supplier verify the data?</p> <p>Refer to section I.N: Administrative Services – Claims Management of Attachment D Page Limit: 3 pages</p>		Yes	Q90 Admin Services
91	<p>Demonstrate the Supplier’s ability to perform quarterly scheduled global Claims analyses to ensure an effective, accurate, and efficient Claims processing function that adjudicates and settles Provider Claims. Include how the Supplier will make the results of such analyses known to DCH.</p> <p>Refer to section I.N: Administrative Services – Claims Management of Attachment D Page Limit: 2 pages</p>		Yes	Q91 Admin Services
92	<p>Describe how the Supplier intends to work with DCH and its Fiscal Agent Contractor (FAC) to maintain timely, accurate and complete submission of Encounter data and stay within specified Encounter Error Rates.</p> <p>Refer to section I.N: Administrative Services – Claims Management of Attachment D Page Limit: 2 pages</p>		Yes	Q92 Admin Services
93	<p>Describe the specific policies and procedures that the Supplier will adopt to prevent and detect Fraud and Abuse that may be committed by Provider, Members, employees or Subcontractors. Include in the response:</p> <ul style="list-style-type: none"> a. The Supplier’s process for ensuring that suspected Fraud and Abuse is reported timely to the Department. b. A description of the position within the Supplier’s organization responsible for Fraud and Abuse reporting. c. Methods and technology the Supplier will use to detect Fraud and Abuse. d. How the Supplier will ensure that Providers are made aware of their responsibilities regarding Fraud and Abuse. e. A copy of the Supplier’s compliance plan. <p>Refer to section I.N: Administrative Services – Fraud, Waste, an Abuse of Attachment D Page Limit: 3 pages excluding the compliance plan</p>		Yes	Q93 Admin Services

94	<p>Describe the Fraud and Abuse program the Supplier will implement including:</p> <ul style="list-style-type: none"> a. Proactive and reactive Fraud and Abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable. b. Education and training for employees. c. Process for acting upon suspected cases of Fraud and Abuse. d. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers. e. Other innovative components of the Supplier’s Fraud and Abuse program. <p>Refer to section I.N: Administrative Services – Fraud, Waste, an Abuse of Attachment D Page Limit: 3 pages</p>		Yes	Q94 Admin Services
95	<p>Describe the Supplier’s proposed Member Complaint, Grievance, and Appeals Process specifically addressing:</p> <ul style="list-style-type: none"> a. Compliance with State and Federal requirements. b. Process for Expedited Review. c. Involvement of Members and their families in the Complaint, Grievance, and Appeals Process. d. How Complaints and Grievances are tracked and trended and how the Supplier uses data to make program improvements. e. Process to review decisions overturned in fair hearings and the Supplier’s approach to address any needed changes based on this review. <p>Refer to section I.N: Administrative Services – Internal Grievance/Appeals System of Attachment D Page Limit: 3 pages</p>		Yes	Q95 Admin Services
Information Management and Systems				
96	<p>Provide a description of how the Supplier will comply with HIPAA standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the Supplier’s use of the HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the Supplier’s internal membership records, including differences in Member’s addresses.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D Page Limit: 3 pages</p>		Yes	Q96 Information Management and Systems

97	<p>Provide a general system description that describes how each component of the Supplier's management information system (MIS) will support the major functional areas of Georgia Families. Include a systems diagram that includes each component of the MIS and the interfacing or supporting systems used to ensure compliance with Contract requirements.</p> <p>Describe how the Supplier's system will:</p> <ul style="list-style-type: none"> a. Utilize files sent by DCH and DCH's Fiscal Agent Supplier. b. Share information between DCH's systems and its own system to avoid duplication of effort. c. Be used by the Supplier to ensure Material Subcontractors are meeting Program requirements. <p>Explain whether the Supplier's current information system is ready to operate according to the requirements of the Scope of Work. If it requires modifications and/or updates, describe the necessary modifications and/or updates and the Supplier's plan for completion prior to program operations.</p> <p>Additionally, provide information about who will be trained on how to use the system, and how data captured in the system can be integrated into day-to-day operations of the CMO, particularly areas such as Case Management and financial and Quality functions.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D Page Limit: 12 pages</p>		Yes	Q97 Information Management and Systems
98	<p>Describe the capability the Supplier's management team will have to access a database of service information to create ad hoc reports for both the CMO management team and DCH. Include a description of the system and software, an overview of the data that will be held, and the resources and the capability the Supplier will have to use large amounts of data to create ad hoc reports. Additionally, provide information about who will be trained on how to use the system, and how the data can be integrated into day-to-day operations of the CMO, particularly areas such as Case Management and financial and Quality functions.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D Page Limit: 3 pages, excluding reports</p>		Yes	Q98 Information Management and Systems
99	<p>Demonstrate the ability of the Supplier's applications, operating software, middleware, and networking hardware and software to interface with the State's systems and conform to standards and specifications set by the Georgia Technology Authority (GTA) as amended periodically (See: http://gta.georgia.gov/psg/).</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D Page Limit: 3 pages</p>		Yes	Q99 Information Management and Systems
100	<p>DCH would like to understand how the Supplier will encourage adoption of electronic health records and information exchange and use of the Georgia Health Information Network (GaHIN). Provide a description of initiatives and incentives to foster adoption of electronic health records and information exchange that result in improvements in the Quality and cost of Health Care services.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D Page Limit: 3 pages</p>		Yes	Q100 Information Management and Systems

101	<p>Describe the Supplier’s proposed emergency response continuity of operations and disaster recovery plan. Attach a copy of the Supplier’s plan or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery, including:</p> <ul style="list-style-type: none"> a. Employee training. b. Essential business functions and responsible key employees. c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable. d. Communication with staff and suppliers when normal systems are unavailable. e. Plans to ensure continuity of services to Providers and Members. f. Testing plan. <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D Page Limit: 3 pages, excluding sample plan</p>		Yes	Q101 Information Management and Systems
102	<p>Describe the Supplier’s strategy to maintain a field presence with Members, Providers and other stakeholders, including any commitment to establishing field office(s).</p> <p>Refer to section I.N: Administrative Services – Administration and Management of Attachment D Page Limit: 1 page</p>		Yes	Q102 Information Management and Systems
103	<p>Provide a description of the Supplier’s process to ensure Deliverables and reports are reviewed for quality, accuracy, and completeness prior to submission to DCH. Also, describe the approach to integrate these quality and accuracy findings into the Supplier’s operations to address any deficiencies or to proliferate or maintain successful practices evidenced by the review.</p> <p>Refer to section I.N: Administrative Services – Monitoring and Reporting of Attachment D Page Limit: 3 pages</p>		Yes	Q103 Information Management and Systems

104	<p>Submit a sample Turnover Plan specifying how the Supplier will provide assistance in turning over all documents in its possession, as it relates to the Contract resulting from this RFP, in the event of Contract expiration or termination for any reason. Provide a detailed description of the Supplier’s processes and proposed approach to providing turnover planning, including:</p> <ul style="list-style-type: none"> a. Providing to DCH the Turnover Plan within the timeframes cited in the RFP and including a schedule for turnover by task and phases for turnover. b. An overview of the support the Supplier will provide for the turnover activities for up to ninety (90) Calendar Days. c. Identifying and submitting all records, files, methodologies, data and any supplemental documentation which DCH would require to continue the program. d. Resources and training that would be required by DCH or another contractor to take over operation of the project. e. Coordinating tasks and activities with the incoming contractor, upon DCH request. f. Providing DCH with a turnover results report documenting completion of all tasks at each step of the turnover plan. <p>Refer to section I.N: Administrative Services – Turnover Planning of Attachment D Page Limit: 3 pages</p>		Yes	Q104 Information Management and Systems
Scenerios				
105	<p>A Member previously enrolled in private insurance enrolls in the CMO. The Member’s contact information available through the member eligibility files has not been helpful in contacting the Member. Within the first three (3) months of CMO Enrollment, the CMO has identified four (4) Emergency Room Claims; three (3) Primary Care Provider Claims; and six (6) narcotic prescription Claims. Describe how the Supplier’s organization would proceed with locating the individual and initiating Coordination of Care. Page Limit: 2 pages</p>		Yes	Q105 Scenerios
106	<p>Describe the Supplier’s proposed strategy to ensure dental access and Utilization of an annual dental visit for two (2) through twenty (20) year olds who reside in both urban as well as rural service delivery areas. Page Limit: 2 pages</p>		Yes	Q106 Scenerios
107	<p>A six (6) year old male has had multiple Emergency Department visits in the last six (6) months. He is diagnosed with asthma. A review of his prescription history shows no Claims for medications to control his asthma. The PCP reports the child has missed three (3) of the five (5) appointments that have been scheduled over the last six (6) months. He lives in a rural area of the State. Describe the Supplier’s approach to Coordination of Care for this child. Page Limit: 2 pages</p>		Yes	Q107 Scenerios

108	<p>A thirty (30) year old female who is receiving Level 2 Case Management for major depressive disorder, fibromyalgia, and diabetes has missed her last three (3) Mental Health appointments. However, she is compliant with her Primary Care appointments for her other Conditions. Provide an action plan the Supplier's organization would propose to best manage this patient.</p> <p>Page Limit: 2 pages</p>		Yes	Q108 Scenarios
109	<p>Through the CMO's connection to the GaHIN, an admission notice alerts the CMO that an adult female with a diagnosis of congestive heart failure has been admitted to an inpatient hospital setting. Describe the actions the Supplier would take and the timing of those actions to conduct Discharge planning and the follow up care that would be envisioned to reduce the likelihood of Re-admission post Discharge.</p> <p>Page Limit: 2 pages</p>		Yes	Q109 Scenarios
110	<p>A morbidly obese adult male with schizophrenia, uncontrolled Type II Diabetes, and hyperlipidemia is non-compliant with lifestyle modifications, medication therapy, diabetes testing, and follow up appointments. Describe the Supplier's organization's plan to develop and monitor a treatment plan for this Member.</p> <p>Page Limit: 2 pages</p>		Yes	Q110 Scenarios
111	<p>An eighteen (18) Week pregnant woman resides in a rural service delivery area. She has had a Very Low Birth Weight (VLBW) Baby with her last pregnancy and there is Claims evidence of two (2) other pregnancies that resulted in miscarriage. The Member has no history of prenatal vitamins or any follow up care after the confirmatory pregnancy test. Describe the Supplier's plan to engage the Member with the appropriate prenatal care and services.</p> <p>Page Limit: 2 pages</p>		Yes	Q111 Scenarios
112	<p>Describe the procedures for ensuring access to the following:</p> <ul style="list-style-type: none"> a. Well-child visits in the first fifteen (15) months of life. b. Well-child visits in the third, fourth, fifth and sixth years of life. c. Primary care practitioners for well-care visits for twelve (12) to nineteen (19) year olds. <p>Page Limit: 5 page</p>		Yes	Q112 Scenarios
113	<p>A Member's current Behavioral Health Provider is not participating in the Supplier's Network. What would the Supplier do for the Member while awaiting the Provider contracting process to be complete if the Out-of-Network Provider agrees to join the Network? Alternatively, what if the Provider refuses to participate?</p> <p>Page Limit: 2 pages</p>		Yes	Q113 Scenarios

114	<p>Describe the procedures a Member Services representative should follow to respond to the following situations:</p> <ul style="list-style-type: none"> a. A Member has received a bill for payment of Covered Services from a Network Provider or Out-of-Network Provider. b. A Member is unable to reach her PCP after normal business hours. c. A Member is having difficulty scheduling an appointment for preventive care with her PCP. d. A Member becomes ill while traveling outside of Georgia. e. A Member has a request for a specific medication that the pharmacy is unable to provide. <p>Page Limit: 3 pages</p>		Yes	Q114 Scenerios

Additional Scored Responses

All items labeled "Additional Scored Responses" is information that is requested by the State. Offerors must provide a thorough narrative description in the space provided in this spreadsheet.

Answers along with any required supporting materials, will be evaluated and awarded points in accordance with Section 6, Proposal Evaluation and Award. ONLY upload documents if there is a Yes in the "Upload Attchts with Additional Information?" column, to provide additional information about specific questions. Documents not requested in this column will not be evaluated.

Question #	Questions per Proposal Factors/Categories	Response by Offeror	Upload Attchts with Additional Information ?	Attachment File Name
360 Executive Summary				
115	<p>Provide an Executive Summary that summarizes the proposed technical approach, staffing structure and task schedule for Georgia Families 360°. The Executive Summary must include a statement of understanding and fully document the Supplier’s ability, understanding and capability to provide the full scope of work. Provide an Executive Summary that summarizes the proposed technical approach. The Executive Summary must include a statement of understanding and fully document the Supplier’s ability, understanding and capability to provide the requested services. The Supplier’s summary must:</p> <ul style="list-style-type: none"> a. Demonstrate an expert understanding of the needs of Medicaid Members in the State of Georgia who are in Foster Care, receiving Adoption Assistance or involved in the juvenile justice system residing in a community residential setting. b. Include a high-level overview of the Supplier’s strategy and approach for administering the Georgia Families 360° program. Additionally, present findings and recommendations from the Supplier’s review of the Claims data provided as part of this Request for Proposal (RFP). c. Provide an overview of the Supplier’s proposed organization for Georgia Families 360°. d. Identify distinguishing features and how the approach will result in improved health outcomes and a positive financial impact. Include a discussion of barriers to coordinating care for these populations and how the Supplier intends to address those barriers and their experience with addressing these barriers for similar contracts 		Yes	Q115 360 Executive Summary
360 Supplier Organization				

116	<p>Provide client references as follows:</p> <p>a. Provide a minimum of three (3) different client references, using the reference form provided as Attachment O to the RFP, for which Supplier has successfully provided services in fully implemented and funded services contract(s) for capitated risk-based Medicaid managed care programs for children and youth in Foster Care (state custody), receiving Adoption Assistance and/or involved with a juvenile justice system within the last five (5) consecutive calendar years. Supplier may only submit client references where Supplier is the Prime Contractor and continues to have current and active client contracts. References where Supplier is providing services under grants, demonstrations or pilot programs or initiatives or where Supplier's contract to provide services is terminated or no longer active will not be considered. The Supplier may consider the experience of subsidiaries of the Supplier's Parent Company when submitting references. References from proposed Subcontractors may not be submitted to meet this requirement.</p> <p>b. If applicable, a minimum of three (3) different client references for each Material Subcontractor, using the reference form provided as Attachment P to the RFP, for which the Material Subcontractor has successfully provided services in fully implemented and funded services contract(s) for capitated risk-based Medicaid managed care programs for children and youth in Foster Care (state custody), receiving Adoption Assistance and/or involved with a juvenile justice system within the last five (5) consecutive calendar years</p>		Yes	Q116 360 Supplier Organization
360 Project Implementation				

117	<p>Describe the Supplier’s approach to project management, including a summary of responsibilities for project governance and how the Supplier will track action items, risks and issues, as well as contingency and mitigation plans. Provide a proposed Program implementation Project Plan in Microsoft Excel, Microsoft Project or similar software based on a program Operational Start Date of July 1, 2016 and that includes all required activities, timeframes and due dates in Year 1 of the contract. At a minimum, the Project Plan must include elements outlined in the RFP, for example:</p> <ul style="list-style-type: none"> a. Establishing an office location and call centers b. Provider recruitment activities c. Staff hiring and a training plan d. Establishing interfaces to other Information Systems operated by DCH or its Agents e. Tasks the Supplier will undertake to interface with Providers and Georgia Families 360° Members through a web site, and how that interaction will support program participation and program goals <p>Refer to section II: Georgia Families 360° of Attachment D Page Limit: 2 pages excluding Project Plan</p>		Yes	Q117 360 Project Implementation
360 Staffing				

118	<p>Provide a detailed summary of the Supplier's proposed staff positions and ratios. Specifically, provide the following:</p> <p>a. A listing of Key Staff members identified in the RFP, including names, titles, job descriptions, degrees and qualifications and full-time equivalents (FTEs) who are dedicated one hundred percent (100%) to the Georgia Families 360° program with no other responsibilities outside this resulting Contract, as well as their locations and whether each Key Staff position will be filled by a Supplier's employee or a Subcontractor.</p> <p>b. If the Supplier's proposed approach includes Key Staff not identified in the RFP, a listing of these positions and a complete description of how these positions and ratios support Program requirements.</p> <p>c. The number of FTE Supplier/Material Subcontractor staff who will be one hundred percent (100%) dedicated to this contract as well as number of FTEs per Member by position type.</p> <p>d. Resumes, including credentials, clinical licensure, years of experience, level and type of experience, and three (3) references for each proposed Key Staff member. Resumes for other proposed staff must be provided at the request of the State.</p> <p>e. Where the Supplier has used job titles in its staffing model that differ from those identified in the RFP, a crosswalk of those titles.</p> <p>Refer to section II: Georgia Families 360° Staffing of Attachment D Page Limit: 5 pages, excluding job descriptions</p>		Yes	Q118 360 Staffing
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119	<p>Provide a narrative description of the proposed staffing plan that details policies, plans and staffing strategies. The proposed plan must include the following:</p> <ul style="list-style-type: none"> a. Organizational charts that provide a complete and detailed description of the proposed organizational structure the Supplier will use during all phases of the contract, including reporting hierarchy b. Roles and responsibilities of personnel c. Role of the ombudsman d. Job titles and job descriptions and the requisite qualifications, skills and credentials, including clinical licensures e. Other resources the Supplier will use to meet Program requirements f. Staff communication and retention strategies <p>Refer to section II: Georgia Families 360° Staffing of Attachment D Page Limit: 5 pages</p>		Yes	Q119 360 Staffing
120	<p>Provide a narrative description of the Supplier's approaches to recruiting staff for this Program, including:</p> <ul style="list-style-type: none"> a. Sources of recruitment b. Alternative actions or contingency plans if the Supplier is unable to recruit sufficient numbers of adequately trained staff on a timely basis or if the Supplier's original staffing estimates are too low and for avoiding and minimizing the impact of personnel changes c. How the Supplier will assure DCH that sufficiently experienced, licensed and trained personnel are available to support implementation and ongoing administration of the program d. How the Supplier will seamlessly transition staff, if necessary, from implementation to ongoing operations <p>Refer to section II: Georgia Families 360° Staffing of Attachment D Page Limit: 3 pages</p>		Yes	Q120 360 Staffing

121	Describe the role and responsibilities of the Ombudsman Liaison and Ombudsman Coordinator. Describe how the Supplier will monitor current Enrollment levels to evaluating the number of Ombudsman Liaisons necessary to meet Georgia Families 360° Member needs. Requirements and Scope of Work. Refer to section II: Georgia Families 360° Ombudsman Staff of Attachment D Page Limit: 1 page GF 360° Staffing: Question 7.		Yes	Q121360 Staffing
122	What prior experience will the Supplier require staff to have had serving populations similar to Georgia Families 360° Members, including the System of Care approach? Refer to section II: Georgia Families 360° Staffing of Attachment D Page Limit: 2 pages		Yes	Q122 360 Staffing
123	Describe the roles and responsibilities of Care Coordinators and Care Coordination teams (CCT). How will the Supplier maintain adequate Georgia Families 360° Supplier staff to Member ratios and number of Care Coordination personnel and management staff having expertise in Physical Health, Behavioral Health, and the Georgia Families 360° Members to build CCTs? Provide the Supplier's approach to locating the Care Coordinators areas in which they serve. Refer to section II: Georgia Families 360° Care Coordination Teams of Attachment D Page Limit: 4 pages		Yes	Q123 360 Staffing
124	Provide the Supplier's proposed training program and curriculum for all staff specific to areas of responsibility. Include information about the topics for which staff will receive training, how trainings will differ for new staff members versus ongoing trainings and related training schedules. Refer to section II: Georgia Families 360° Staffing of Attachment D Page Limit: 3 pages		Yes	Q124 360 Staffing
360 Special Coverage and Provisions				

125	<p>Describe the Supplier's experience in providing services through a holistic, person-centered approach, utilizing a high-fidelity wrap-around model of care.</p> <p>Refer to section II: Georgia Families 360° Special Coverage and Provisions of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q125 360 Special Coverage and Provisions
126	<p>Describe in detail how the Supplier will develop and provide interventions that will help develop resiliency in Georgia Families 360° Members who have been exposed to trauma and adverse childhood experiences.</p> <p>Refer to section II: Georgia Families 360° Special Coverage and Provisions of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q126 360 Special Coverage and Provisions
127	<p>Describe the Supplier's approach for ensuring the successful completion of required assessments and screenings. Please include a description of the following:</p> <ul style="list-style-type: none"> a. How the Supplier will coordinate with Georgia Families 360° Members and families, DCH and partner agencies b. How the Supplier will ensure assessments are initiated Immediately upon Member Enrollment in the Georgia Families 360° program c. Any challenges that the Supplier anticipates in completing required assessments and how it will mitigate these challenges <p>Provide examples of how your organization has succeeded in providing assessments to individuals similar to the Members enrolled in Georgia Families 360°.</p> <p>Refer to section II: Georgia Families 360° Required Assessments and Screenings of Attachment D</p> <p>Page Limit: 5 pages</p>		Yes	Q127 360 Special Coverage and Provisions
128	<p>Include examples of trauma assessment or screening tools the Supplier would recommend DCH consider for the use in identifying trauma in Georgia Families 360° Members.</p> <p>Refer to section II: Georgia Families 360° Required Assessments and Screenings of Attachment D</p>		Yes	Q128 360 Special Coverage and Provisions

129	<p>Submit the proposed Health Risk Screening tool the Supplier will use to develop the Member's Health Care Service Plan. Include a description of how the Supplier will use the results of assessments that sister agencies have conducted in developing the Health Care Service Plan.</p> <p>Provide examples of prior tools the Supplier's organization has used for other similar programs and detail how these tools have contributed to Supplier achieving program goals.</p> <p>Refer to section II: Georgia Families 360° Health Risk Screening of Attachment D</p> <p>Page Limit: 3 pages, excluding tool and examples</p>		Yes	Q129 360 Special Coverage and Provisions
130	<p>Describe the Supplier's approach to providing all medical services and adhering to timeliness requirements defined in the Kenny A. Consent decree for Foster Care Members (FC Member) in custody of Fulton and DeKalb counties.</p> <p>Refer to section II: Georgia Families 360° Kenny A. Consent Decree of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q130 360 Special Coverage and Provisions
360 Member Enrollment				
131	<p>Describe the Supplier's proposed approach for coordinating with DCH sister agencies to ensure Georgia Families 360° Members begin receiving services Immediately upon entering Foster Care or juvenile justice. Please include the Supplier's experience expediting enrollment in other markets.</p> <p>Refer to section II: Georgia Families 360° Member Enrollment of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q131 360 Member Enrollment
132	<p>The eligibility of Members in the Georgia Families 360° Program often changes due to their status in Foster Care or the juvenile Justice system. Describe the Supplier's proposed process for resolving Enrollment and eligibility discrepancies. Include the Supplier's organization's approach for collaborating with DCH, Division of Family and Children Services (DFCS) and Department of Juvenile Justice (DJJ) for resolving eligibility issues.</p> <p>Refer to section II: Georgia Families 360° Georgia Families 360° Member Enrollment of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q132 360 Member Enrollment

133	<p>Describe the Supplier's proposed process to assign Georgia Families 360° Members to a Primary Care Provider (PCP) within two (2) Business Days of Enrollment. Include a discussion of the Supplier's approach to:</p> <ul style="list-style-type: none"> a. Assist Georgia Families 360° Members to select a PCP and auto-assign Georgia Families 360° Members who do not make a selection within the required timeframes b. Work with DCH, DFCS, DJJ, Foster Parents, and Adoptive Parents to assign PCPs c. Track data to confirm that every Georgia Families 360° Member is assigned to a PCP d. Inform PCPs of new Georgia Families 360° Members within the required timeframes e. Confirm that PCPs received the list of assigned Georgia Families 360° Members <p>Provide a sample of the report the Supplier will use to notify PCPs of their assigned Georgia Families 360° Members. Refer to section II: Georgia Families 360° Selection of a Primary Care Provider (PCP) of Attachment D Page Limit: 3 pages</p>		Yes	Q133 360 Member Enrollment
134	<p>Describe the Supplier's proposed process for communicating with Georgia Families 360° Members about their PCP assignments and encouraging Georgia Families 360° Members to schedule regular appointments with their assigned PCPs and keep scheduled appointments. Include how the Supplier will identify and work with Georgia Families 360° Members to resolve barriers to keeping appointments and how the Supplier will work with resources available at DCH, DFCS and DJJ to communicate with Georgia Families 360° Members.</p> <p>Please include a discussion of how this process would differ when communicating about their Dental Home assignment and encouraging Georgia Families 360° Members to schedule and keep regular appointments with the Dental Homes. Refer to section II: Georgia Families 360° Selection of a Primary Care Provider (PCP) of Attachment D Page Limit: 2 pages</p>		Yes	Q134 360 Member Enrollment

135	<p>Children in Foster Care and involved with the Juvenile Justice Department often experience changes in placement. These placement changes may require assignment of new PCPs and Dental Homes. Describe the Supplier's proposed process to Assess Member access to a PCP and Dental Home timely after a change in FC Member or DJJP Member placement and assigning a new PCP or Dental Home if the prior Provider no longer meets access standards. Refer to section II: Georgia Families 360° Dental Home of Attachment D Page Limit: 2 pages</p>		Yes	Q135 360 Member Enrollment
136	<p>Describe the Supplier's process for engaging Adoptive Parents who request to opt out of the Georgia Families 360° Program to stay enrolled, including:</p> <ul style="list-style-type: none"> a. Process for outreach and engagement of AA Members b. Conducting surveys with AA Members to determine the reason for opting out c. Attempts for periodic re-engagement after Disenrollment <p>Include how the Supplier will use results from the survey to improve the program. Refer to section II: Georgia Families 360° Selection of a Primary Care Provider (PCP) of Attachment D Page Limit: 2 pages</p>		Yes	Q136 360 Member Enrollment
360 Member Services				
137	<p>Provide the Supplier's proposed plan for providing Georgia Families 360° Members with ID cards in the required timeframes (be issued initially within five (5) Calendar Days of receipt of the eligibility file from DCH and reissued within five (5) Calendar Days of a request for reissue) in the following instances:</p> <ul style="list-style-type: none"> a. Report of a lost card b. A Member name change c. A new PCP assignment d. FC or DJJ Member moves to a new placement or for any other reason that results in a change to the information disclosed on the Member's ID card <p>Refer to section II: Georgia Families 360° Member Services of Attachment D Page Limit: 3 pages</p>		Yes	Q137 360 Member Services

138	<p>Describe how the Supplier will address and manage Crisis calls during business hours as well as After-Hours. Describe resources the Supplier will use for emergency and Crisis needs, such as Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Georgia Crisis and Access Line (GCAL). If using such resources, describe how the Supplier will establish relationships with DBHDD and GCAL, use the resources, the Supplier's roles and responsibilities for Crisis calls versus those of the other resources and how the Supplier will manage the overall process.</p> <p>Refer to section II: Georgia Families 360° Member Call Center of Attachment D Page Limit: 1 page</p>		Yes	Q138 360 Member Services
139	<p>Describe the processes, protocols and guidelines the Supplier will use to achieve maximum stability and the best outcomes for Georgia Families 360° Members in Crisis as well as avoid inappropriate and unnecessary Emergency Room (ER) Utilization and hospital admissions. In the description, describe how the Supplier will prioritize emergency and Crisis calls over routine calls, protocols that will be in place to support warm transfers, and what technology the Supplier will have to enable direct telephonic/computer connectivity to emergent and Crisis intervention resources.</p> <p>Refer to section II: Georgia Families 360° Member Call Center of Attachment D Page Limit: 1 page</p>		Yes	Q139 360 Member Services
140	<p>Describe trainings and resources the Supplier will provide to call center staff related to recognition and management of Crisis calls to ensure the most expedient and risk-reducing outcomes, including a description of the level and type of training.</p> <p>Refer to section II: Georgia Families 360° Toll Free Member Call Center of Attachment D Page Limit: 1 page</p>		Yes	Q140 360 Member Services
360 Provider Network				

141	<p>Explain the Supplier's plan to develop a comprehensive Provider Network that meets the unique needs of Georgia Families 360° Members. Specifically include:</p> <p>a. Approach to contract with primary care and specialist providers who are trained or experienced in trauma-informed care and in treating individuals with complex special needs, including the Georgia Families 360° Providers who have knowledge and experience in identifying child abuse and neglect, providers who render Core Services and Intensive Family Intervention (IFI) services, significant traditional Medicaid, DFCS, DJJ and Department of Public Health (DPH) and providers meeting Credentialing requirements</p> <p>b. Recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, and carrying out recruitment efforts</p> <p>c. Strategy for retaining specialists and how the Supplier will provide access to specialists if not in the network</p> <p>d. Process for continuous network improvement, including the approach for monitoring and evaluating Provider compliance with availability and scheduling appointment requirements and ensuring Georgia Families 360° Members have access to care if the Supplier lacks an agreement with a key provider type in a given geographic area</p> <p>e. How the Supplier will ensure appointment access standards are met when Georgia Families 360° Members cannot access care within the Provider Network</p> <p>Refer to section II: Georgia Families 360° Provider Network of</p>		Yes	Q141 360 Provider Network
142	<p>Provide an example of how the Supplier has contracted for similar networks for similar populations in other programs. Provide a workplan to contract with Georgia Families 360° Providers, with accountabilities and timelines.</p> <p>Refer to section II: Georgia Families 360° Provider Network of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q142 360 Provider Network
360 Education and Training				

143	<p>Describe the Supplier’s proposed approach for collaborating with experts in the field including DFCS, DBHDD, Department of Education (DOE), DPH, Department of Early Care and Learning (DECAL) and DJJ to identify Provider training needs. Please include examples from other Supplier programs exhibiting collaboration with state agencies to identify training needs.</p> <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q143 360 Education and Training
144	<p>Describe how the Supplier will educate staff, Providers, and other relevant stakeholders regarding coordinating care utilizing a System of Care approach between: Foster Parents and Caregivers; DFCS Case Managers, Juvenile Probation/Parole Specialist (JPPS) or other involved Case Managers; attorneys ad litem; judges; law enforcement officials; Adoptive Parents; and other involved parties from State agencies. Please provide examples of education materials addressing the System of Care approach.</p> <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p> <p>Page Limit: 3 pages, excluding examples of materials</p>		Yes	Q144 360 Education and Training
145	<p>Provide the Supplier’s proposed approach to Provider outreach and education. Include a description of how initial training will differ from ongoing training. Describe proposed training materials including but not limited to:</p> <ul style="list-style-type: none"> a. Coordinating services. b. Training in trauma-informed care (include sample materials) c. The effect of abuse and neglect on the developing brain d. The effect of intrauterine assault, fetal alcohol syndrome and shaken baby syndrome e. Screen for and identify Behavioral Health disorders f. The Supplier’s Referral process for Behavioral Health services g. Care Coordination Team <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p> <p>Page Limit: 3 pages, excluding samples</p>		Yes	Q145 360 Education and Training

146	<p>What trainings will the Supplier offer to its Provider network regarding the System of Care approach to care? Submit samples of the materials that the Supplier will use in training and informing Providers about this concept.</p> <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p> <p>Page Limit: 2 Pages</p>		Yes	Q146 360 Education and Training
147	<p>How will the Supplier ensure that the Supplier's staff and network Providers (including but not limited to hospitals, pharmacies, and specialty Providers) receive in-depth training on this program, including what is and is not allowable exchange of information in a HIPAA-compliant organization, to preserve and support continuity of care. How will the Supplier ensure network Providers are aware of the requirements of this program, and how the needs of this population may differ from those of the Georgia Families population?</p> <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p> <p>Page Limit: 2 Pages</p>		Yes	Q147 360 Education and Training
148	<p>Describe how the Supplier will educate Law Enforcement Officials and Judges about the Georgia Families 360° program. Provide an overview of suggested topics that will be included in trainings for Law Enforcement Officials and Judges.</p> <p>Refer to section II: Georgia Families 360° Training for Law Enforcement Officials and Judges of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q148 360 Education and Training

149	<p>Describe the role of non-medical factors (e.g., Placement changes, involvement with the juvenile justice system, etc.) that may drive inappropriate Utilization of medical resources and how the Supplier will account for those factors in the delivery approach.</p> <p>As part of the response, include how the Supplier will identify and leverage non-Medicaid resources that may be available in a community environment, including how it will assist such community-based resources that may serve an important role in the Members' overall Health Care needs and goals even if they are not traditional Medicaid services. Provide examples of any community organizations that the Supplier anticipates involving to provide services to support Members' needs and goals.</p> <p>Refer to section II: Georgia Families 360° - Utilization Management and Care Management of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q149 360 Education and Training
150	<p>Describe how the Supplier will ensure that Georgia Families 360° Members receive seventy-two (72) hour emergency supplies of prescribed medicines when a prescription for a medication is not filled due to a Prior Authorization requirement.</p> <p>Refer to Section II: Georgia Families 360° Utilization Management and Care Management of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q150 360 Education and Training
151	<p>Describe how the Supplier will participate in FC Members and JJ Members Discharge planning. Include a description of support that it will provide to DFCS and DJJ and how the Supplier will communicate with DFCS and DJJ to determine your role in the Member's roundtable meetings.</p> <p>Refer to section II: Georgia Families 360° Transition of Members of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q151 360 Education and Training

152	<p>Describe the Supplier’s proposed plan and policies for ensuring continuity of care for Georgia Families 360° Members who are transitioning from another Care Management Organization (CMO), private insurance, or from Fee-for-Service (FFS). Include a plan for coordinating with DCH, DFCS, DPH, DJJ, DOE, DBHDD and DECAL to ensure the Member maintains continuity of care and services. Refer to section II: Georgia Families 360° Transition of Care of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q152 360 Education and Training
153	<p>Describe the responsibilities of the Supplier’s Care Coordinators and how they will assist Georgia Families 360° Members to navigate the Health Care system. Describe the range of Care Coordinators expertise to adequately respond to varying degrees of need among Georgia Families 360° Members. Refer to section II: Georgia Families 360° Care Coordination Responsibilities of Attachment D</p> <p>Page Limit: 2 pages</p>		Yes	Q153360 Education and Training
154	<p>Describe the specific types of Care Coordination services Georgia Families 360° Members will receive based on intensity of needs and history. Include details about what services will be provided at each level. Refer to section II: Georgia Families 360° Care Coordination Responsibilities of Attachment D</p> <p>Page Limit: 5 pages</p>		Yes	Q154 360 Education and Training
155	<p>Describe how the Supplier will work with State agency staff, sister agency partners, community partners, associations, and other stakeholders to ensure that the Member’s Care Coordination needs are met. Include examples of how you plan to collaborate with State agency and sister agency staff. Refer to section II: Georgia Families 360° Care Coordination Responsibilities of Attachment D</p> <p>Page Limit: 4 pages</p>		Yes	Q155 360 Education and Training
156	<p>Describe how the Supplier will monitor health outcomes at the individual Member level. Refer to section II: Georgia Families 360° Health Outcomes of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q156360 Education and Training

157	<p>Describe the Supplier’s proposed medication oversight program to ensure appropriate utilization, including a description of the inclusion criteria that you propose to use to monitor the appropriate use of psychotropic medications. Provide a detailed description of the tools your organization will use to ensure the active engagement of the retail pharmacies/pharmacists in the oversight program? (Reminder: Do not disclose specific financial information in this technical proposal.)</p> <p>Refer to section II: Georgia Families 360° Medication Management of Attachment D Page Limit: 3 pages</p>		Yes	Q157360 Education and Training
158	<p>Discuss the proposed protocols for facilitating communication and sharing of information between Primary Care and Behavioral Health Providers. Include relevant examples of how these protocols and best approaches have worked for the Supplier in similar programs, as well as relevant examples of how the Supplier has coordinated communication and sharing of information between PCPs and multiple Behavioral Health provider types.</p> <p>Refer to section II: Georgia Families 360° Health Coordination and Integration for Georgia Families 360° Members of Attachment D Page Limit: 3 pages</p>		Yes	Q158360 Education and Training
360 Admin Services				
159	<p>Describe the proposed approach for assisting DCH with development of public reports about the Georgia Families 360° Program. Include recommendations for and an overview of the types of information and data that the Supplier thinks would be beneficial to report publicly.</p> <p>Refer to section II: Georgia Families 360° Reporting Requirements of Attachment D Page Limit: 3 pages</p>		Yes	Q159 360 Admin Services

160	<p>Submit a sample Turnover Plan specifying how the Supplier will provide assistance in turning over all documents in its possession, as it relates to the Contract resulting from this RFP, in the event of Contract expiration or termination for any reason. Provide a detailed description of the Supplier's processes and proposed approach to providing turnover services, including:</p> <ul style="list-style-type: none"> a. Specific goals and objectives that articulate how the Supplier will coordinate with DCH and DCH sister agencies to assume responsibility for Georgia Families 360° Members transitioning from another CMO and other scope of work activities b. An impact statement outlining the potential impact of the transition of Georgia Families 360° Members, the existing infrastructure and operations and support staff c. Communications and outreach, specific timeframes for executing the Transition of Care Plan d. Georgia Families 360° Supplier staff involvement in the Transition of Care Plan, approach and involvement with sister agencies, and ensuring continuity of care and plans for conducting all applicable health and trauma assessments <p>Response must include all components specified in Attachment D: Requirements and Scope of Work: Requirements and Scope of Work, section A.</p> <p>Refer to section II: Georgia Families 360° Project Management of Attachment D</p> <p>Page Limit: 3 pages</p>		Yes	Q160 360 Admin Services
360 Scenerios				
161	<p>An eight (8) year old female was placed in Foster Care at birth, and has had multiple placement changes. She was diagnosed with a brain anomaly, cortical dysplasia, epilepsy, and developmental delays. She has medications prescribed to control her seizures. Recently, she has been evaluated for her developmental delays, vision problems, and for speech therapy. The PCP has not received the results of these evaluations yet.</p> <p>Medications/Treatments: Midazolam for seizures lasting longer than three (3) minutes, or for more than four (4) tonic-clonic seizures in thirty (30) minutes; Zonisamide, Valproate Sodium Syrup, Lamotrigine Tabs, Omeprazole capsules, Ketogenic diet.</p> <p>Page Limit: 3 pages</p>		Yes	Q161 360 Scenerios

162	<p>A three (3) year old male entered Foster Care upon Discharge from the hospital after his birth. He was placed by DFCS with his aunt who wants to adopt him. However, she is concerned about his future health and Behavioral Health Care needs and what Long Term supports could be available to her through DFCS and the CMO. The child has been diagnosed with autism and developmental delays. He has been hospitalized three (3) times in the last six (6) months for shortness of breath, vomiting, altered mental status and dehydration. Follow up is needed to determine what is causing these issues.</p> <p>Page Limit: 3 pages</p>		Yes	Q162 360 Scenerios
163	<p>A fifteen (15) year old female in Foster Care with multiple Behavioral Health problems has run away from her Out of Home Placement for sixty (60) out of the last one hundred eight (180) days. Due to her running episodes, she is not receiving recommended counseling services and medications. Her run episodes and Foster Care placement changes have caused changes in Behavioral Health Providers and coordination with DFCS, but she has not developed a relationship with her Providers that will allow her to disclose trauma information. She not had an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) exam for the past two (2) years, although she should have had an EPSDT exam after each incident of running.</p> <p>She has been prescribed multiple psychotropic medications, with no follow-up and no coordination to ensure they do not conflict. Her diagnoses include: oppositional defiant disorder; depression; anxiety; attachment disorder; Post Traumatic Stress Disorder (PTSD); and self-harm behaviors including cutting/burning herself.</p> <p>Page Limit: 3 pages</p>		Yes	Q163 360 Scenerios
164	<p>Nine (9) year old female who entered Foster Care four (4) days ago due to substantiated allegations of abuse and neglect. While she appears healthy, the DFCS Case Manager reports there was evidence of methamphetamine use and no food in the home.</p> <p>She has no known medical issues reported by parent. However, the child's parent reports she has not been seen by a doctor in the past two (2) years.</p> <p>Page Limit: 3 pages</p>		Yes	Q164 360 Scenerios



**CONTRACT
BETWEEN
THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH
AND
[CARE MANAGEMENT ORGANIZATION]
FOR
PROVISION OF SERVICES TO GEORGIA FAMILIES 360°**

Note: DCH shall, in its own discretion, determine which exceptions to the Contract will be addressed.

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CONTRACT SHELL

THIS CONTRACT is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as “DCH” or the “Department”) and [**Care Management Organization**] (hereinafter referred to as the “Contractor”) and is made effective on the date signed by the DCH Commissioner after any approval required from the Centers for Medicare and Medicaid Services (CMS) (hereinafter referred to as the “Contract Effective Date”).

WHEREAS, DCH is responsible for health care policy, purchasing, planning and regulation pursuant to the Official Code of Georgia Annotated (O.C.G.A.) § 31-2-1 *et seq.*;

WHEREAS, DCH is the single State agency designated to administer medical assistance in Georgia under Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. §§ 49-4-140 *et seq.* (the “Medicaid Program”), and is charged with ensuring the appropriate delivery of health care services to Medicaid recipients and PeachCare for Kids® Members;

WHEREAS, DCH, through the Department of Administrative Services (“DOAS”), issued an electronic Request for Qualified Contractors (“eRFQC”), ES-RFQC-40199-465, in November 2014 to pre-determine the suppliers who met the qualifications to be eligible to respond to a Request for Proposals;

WHEREAS, DCH caused Request for Proposals Number DCH0000100 (hereinafter the “RFP”) to be issued through DOAS, which is attached to this Contract as *Exhibit 1* and is expressly incorporated as if completely restated herein, to obtain the services of a vendor to administer the State’s risk-based managed care delivery program for Foster Care Members, Adoption Assistance Members and Juvenile Justice Members known as Georgia Families 360°;

WHEREAS, Contractor, having been determined to be an eligible supplier pursuant to the eRFQC, submitted to DCH and DOAS a Technical Proposal in response to the RFP (attached to this Contract as *Exhibit 2* and hereinafter referred to as “Contractor’s Proposal”), which is expressly incorporated into this Contract as if completely restated herein;

WHEREAS, Contractor, including its Subcontractors, represents that it has the skills, qualifications, expertise, financial resources and experience necessary to perform the services described in Contractor’s Proposal and this Contract in compliance with all applicable federal and state laws and regulations, including but not limited to Chapters 21 and 21A respectively of Title 33 of the Official Georgia Code Annotated;

WHEREAS, DCH accepts Contractor’s Proposal and enters into this Contract with Contractor for the provision of various services for the Department; and

WHEREAS, DCH and Contractor agree that the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (hereinafter referred to as “CMS”) must approve this Contract as a condition precedent to its becoming effective for any purpose.

NOW, THEREFORE, for and in consideration of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Department and the Contractor (each individually a “Party” and collectively the “Parties”) hereby agree as follows:

1.0 SCOPE OF SERVICES

- 1.0.1 The Contractor will provide Care Management services to children in foster care, adoption assistance, and those youth in the Department of Juvenile Justice (DJJ) custody while residing in community, residential facilities. A summary of the required responsibilities to be carried out by the Contractor include:
- 1.0.1.1 Provision of access to health care services, including but not limited to physical health services, behavioral health services, dental services and Care Coordination;
 - 1.0.1.2 Provision of Member education and outreach including:
 - 1.0.1.2.1 Member call center
 - 1.0.1.2.2 Member handbook and member ID cards
 - 1.0.1.2.3 Ongoing education and outreach to Members
 - 1.0.1.2.4 Provider directory
 - 1.0.1.3 Development and maintenance of a network of Providers and facilities adequate to deliver all Covered Services with an emphasis in providing services that meet the unique needs of the Members;
 - 1.0.1.4 Provision of a primary care physician (PCP) to serve as the medical home for all Members. The PCP serves as the single point of accountability and coordination—primarily for primary care;
 - 1.0.1.5 Provision of a Dental Home for Members under the age of twenty-one (21). The Dental Home is responsible for coordinating all dental care for the Member;
 - 1.0.1.6 A Provider services function to act as the point of contact for its Provider network, provide educational material, maintain a Provider Call Center, facilitate provider complaints and address provider contract and payment issues;
 - 1.0.1.7 Providing training to DCH sister agencies, law enforcement officials and judges;
 - 1.0.1.8 Ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, second opinion, Discharge Planning, and case management;
 - 1.0.1.9 Provision of a System of Care approach to Care Coordination and Continuity of Care, which ensures a set of Member-centered, goal-

oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. This includes: Transition of Care, Discharge Planning; Care Coordination, Disease Management and Case Management;

- 1.0.1.10 Providing Nurse Case Managers (NCM) to individuals with special needs;
 - 1.0.1.11 Assigning all Members a Care Coordination Team tailored to each Member's individual needs to assist in navigating the health care system, coordinating all necessary health assessments within specified timeframes and attaining provider appointments to meet timeliness requirements;
 - 1.0.1.12 Provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s);
 - 1.0.1.13 Develop an adequate system and staff to ensure the provision of health care services under this Contract are properly documented, paid for and reported; and
 - 1.0.1.14 Design and implement an information management system for the purpose of integrating all components of the delivery of care to the Members. The system shall have the capability to securely store and transmit information, interface with other relevant systems and report data in a format specified by DCH.
- 1.0.2 The Parties agree that DCH retains Contractor to furnish all of the goods, services, and other deliverables contemplated by this Contract.
- 1.0.3 The Parties agree that the Department shall not pay or otherwise compensate the Contractor for any services, goods, or deliverables outside of the above Scope of Services, which includes Contractor's Proposal (to the extent agreed upon by DCH) and this Contract. The Department shall not make any exceptions or waivers on this matter. In the event of a dispute regarding whether an item is within the Scope of Services, the Parties will attempt to reach a mutually agreeable solution. If the Parties fail to reach a mutually agreeable solution, **Section 30, Conflict Resolution**, of this Contract shall govern and not be subject to appeal.

1.0.4 If written correspondence is received by the Contractor from DCH and the Contractor believes that the correspondence will cause a change to the Scope of Services contemplated by this Contract, the Contractor shall advise the Project Leader listed in **Section 32, Notice**, of this Contract (hereinafter referred to as “DCH Project Leader”) in writing within ten (10) Business Days of receiving the initial correspondence from DCH at the address indicated in **Section 32** of this Contract. The Contractor shall request the DCH Project Leader’s written confirmation that the Scope of Services has changed.

1.0.4.1 The notice shall state the following:

1.0.4.1.1 The nature and circumstances of the communication regarded as a change in the Scope of Services by the Contractor;

1.0.4.1.2 The date of the communication;

1.0.4.1.3 The identification of the documents involved;

1.0.4.1.4 The particular technical requirements or contract requirements regarded as changed;

1.0.4.1.5 The direct and foreseeable effect of the communication regarded as a change in the Scope of Services contemplated by the Contract, including the number of hours required from Contractor’s staff to accomplish the change and the manner and sequence of performance or delivery of supplies or services, identifying which supplies or services are or will be affected; and

1.0.4.1.6 A detailed cost analysis of the alleged change, including a schedule setting forth the associated staffing costs (including staff names and hourly costs), with the totals for these categories not exceeding amounts based upon specific assumptions.

1.0.5 The DCH Project Leader shall respond within ten (10) Business Days of receipt of the Contractor’s notice.

1.0.5.1 The DCH Project Leader’s response shall either:

1.0.5.1.1 Countermand the correspondence that Contractor regards as a change;

1.0.5.1.2 Deny that the correspondence constitutes a change in the Scope of Services contemplated by the Contract;

- 1.0.5.1.3 Confirm in writing that the correspondence is a change to the Scope of Services contemplated by the Contract; or
- 1.0.5.1.4 Advise the Contractor that additional information is required to evaluate the Notice and establish the deadline by which the Contractor must provide such information.
- 1.0.6 If the Contractor complies with any order, direction, interpretation, or determination, written or oral, without providing notice in accordance with this subsection, DCH shall not be liable for any increased price, delay in performance, or contract non-conformance by the Contractor.

1.1 **BACKGROUND**

- 1.1.1 Beginning in August 2011, DCH initiated an effort to analyze redesign options for managing the financing and care of populations enrolled in Medicaid and PeachCare for Kids®. As a result of the analysis, DCH identified a need for enhanced care coordination and service integration for children in Foster Care, adoption assistance, and those youth in DJJ custody while residing in community residential facilities. Based on these identified needs, DCH implemented GF 360° for these individuals.
- 1.1.2 Children in Foster Care typically have more intensive health care needs than other children who are not in Foster Care and are typically served by multiple agencies. They often suffer from trauma, abuse and neglect and may require care for chronic physical problems. Additionally, they tend to have more Behavioral Health problems and require more psychosocial services than other children receiving Medicaid services. These youth face severe environmental instability and shifting guardianship between birth parents, foster parents, guardians or an adoptive family. This environmental instability causes frequent changes in Health Care Providers, fragmented Medical Records and inconsistent access to appropriate care. Likewise, youth in DJJ custody while residing in community residential facilities have a greater need for coordination of Health Care services due to the number and complexity of issues impacting their physical and mental well-being. DCH in collaboration with partner agencies developed the GF 360° program to specifically meet the unique needs of these Members. DCH's goals for enrolling children in Foster Care, adoption assistance, and those youth in DJJ with one (1) Georgia Families Care Management Organization (CMO) are to:
 - 1.1.2.1 Enhance the coordination of care and access to services;
 - 1.1.2.2 Improve health outcomes;
 - 1.1.2.3 Develop and utilize meaningful and complete electronic medical records; and

- 1.1.2.4 Comply fully with regulatory reporting requirements.
- 1.1.3 DCH convened stakeholder task forces that provided input about program design and provide continuous input on an ongoing basis. Additionally, DCH formed a Foster Care, Adoption Assistance and Juvenile Justice Joint Task Force which included representatives from DCH and the following state agencies:
 - 1.1.3.1 Department of Behavioral Health and Developmental Disabilities (DBHDD);
 - 1.1.3.2 Department of Juvenile Justice (DJJ);
 - 1.1.3.3 Department of Human Services (DHS), the Division of Family and Children Services (DFCS);
 - 1.1.3.4 Department of Public Health (DPH);
 - 1.1.3.5 Department of Early Care and Learning (DECAL); and
 - 1.1.3.6 Department of Education (DOE).
- 1.1.4 The Joint Task Force provided advisory support during program development and implementation for the transition of children and youth in Foster Care, receiving adoption assistance or involved with DJJ into GF 360°. Input from Joint Task Force members helped to ensure a program that is child-centric and focused on coordination of care.

1.2 ELIGIBILITY FOR GEORGIA FAMILIES 360°

- 1.2.1 Medicaid
 - 1.2.1.2 The following Medicaid eligibility categories are required to enroll in GF 360°. Children and youth in adoption assistance may elect to be served through the fee-for-service delivery system. Some of these eligibility categories (specifically 1.2.1.2.1, 1.2.1.2.3, 1.2.1.2.4 or 1.2.1.2.6 may include children or youth who are in joint custody of the DFCS and DJJ).
 - 1.2.1.2.1 Children and young adults less than twenty-six (26) years of age who are receiving foster care under Title IV-B or Title IV-E of the Social Security Act;
 - 1.2.1.2.2 Children and young adults less than twenty-one (21) years of age who are receiving other adoption assistance under Title IV-B or Title IV-E of the Social Security Act;

- 1.2.1.2.3 Children and young adults less than twenty-six (26) years of age who are receiving foster care under Title IV-B or Title IV-E of the Social Security Act and are eligible for Supplemental Security Income;
- 1.2.1.2.4 Children and young adults less than twenty-six (26) years of age who are receiving foster care under Title IV-B or Title IV-E of the Social Security Act and are enrolled in the Children's Health Insurance Program (CHIP), PeachCare for Kids®;
- 1.2.1.2.5 Children and young adults less than twenty-one (21) years of age who are receiving adoption assistance under Title IV-B or Title IV-E of the Social Security Act and are enrolled in the Children's Health Insurance Program (CHIP), PeachCare for Kids®;
- 1.2.1.2.6 Children and young adults less than twenty-six (26) years of age who are in foster care or less than twenty-six (26) and receiving adoption assistance under Title IV-B or Title IV-E of the Social Security Act and are enrolled in one of the following home and community-based services (HCBS) 1915(c) waiver programs:
- 1.2.1.2.6.1 Elderly and Disabled Waiver Program: Provides services to people who are functionally impaired or disabled, helping members to remain in their own homes, the homes of caregivers or in other community-based settings as long as possible.
 - 1.2.1.2.6.2 New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP): Offers HCBS services for people with intellectual or developmental disabilities.
 - 1.2.1.2.6.3 CBAY (Community-Based Alternatives for Youth): Provides intensive behavioral health supports to children who have been diagnosed with a serious emotional disturbance.
 - 1.2.1.2.6.4 Young adults less than twenty-six (26) who are in Foster Care or receiving adoption assistance under Title IV-E of the Social Security Act and are enrolled in the Independent Care Waiver Program (ICWP). ICWP provides services for people with physical disabilities who remain in their own homes or in the community instead of in a hospital or nursing home.

1.2.1.2.7 Children eighteen (18) years of age and under who are eligible pursuant to the Interstate Compact for the Placement of Children (ICPC).

1.2.1.2.8 Children and youth (subject to age limitations, as specified) who are eligible pursuant to the Interstate Compact for Adoption and Medical Assistance (ICAMA). Age limitations for these children are based on the DFCS eligibility requirements for Adoption Assistance Members. In ICAMA cases where Georgia is the receiving state and the child is receiving Adoption Assistance from another state, Georgia can provide Medicaid coverage under ICAMA for the period of time that the sending state continues to provide Adoption Assistance under the Adoption Assistance agreement. Age limitations and eligibility criteria vary by state and will be based on the sending state's criteria instead of DFCS' eligibility requirements.

1.2.1.3 The following youth in the Juvenile Justice System are eligible for Enrollment in GF 360°:

1.2.1.3.1 Children and youth less than nineteen (19) years of age who are eligible for Right from the Start Medicaid and who are placed in community residential care as a result of their involvement with the juvenile justice system; and

1.2.1.3.2 Children and youth less than nineteen (19) years of age who are eligible for Right from the Start Medicaid and Supplemental Security Income and who are placed in community residential care as a result of their involvement in the juvenile justice system.

1.2.3 Exclusions

1.2.3.1 The following recipients are excluded from Enrollment in GF 360°, even if the recipient is otherwise eligible for GF 360° per Section 1.2.1 and Section 1.2.2:

1.2.3.1.1 Recipients eligible for Medicare.

1.2.3.1.2 Recipients that are Members of a Federally Recognized Indian Tribe.

1.2.3.1.3 Recipients that are enrolled in fee-for-service Medicaid through Supplemental Security Income prior to enrollment in GF 360°.

- 1.2.3.1.4 Medicaid children enrolled in the Children’s Medical Services program administered by the Georgia Department of Public Health.
- 1.2.3.1.5 Children enrolled in the Georgia Pediatric Program (GAPP).
- 1.2.3.1.6 Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.
- 1.2.3.1.7 Individuals enrolled in a Hospice category of aid.
- 1.2.3.1.8 Individuals enrolled in a Nursing Home category of aid.

1.3 SERVICE REGIONS

- 1.3.1 For the purposes of coordination, planning, and analysis, DCH has divided the State, by county, into six (6) Service Regions. See **Attachment I** for a listing of the counties in each Service Region.
- 1.3.2 Contractor shall provide health care services and meet all other requirements set forth in this Contract in all six (6) Service Regions within the State.

1.4 DEFINITIONS

For purposes of this Contract the following terms are defined as follows:

Abandoned Call: A call in which the caller elects a valid option and is either not permitted access to that option or disconnects from the system.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for Health Care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the Care Management Organization (CMO) to act within the timeframes provided in 42 CFR 438.408(b).

Activities of Daily Living (ADL): Daily self-care activities including bathing, dressing, feeding, toileting, grooming, and transferring (walking, transferring from bed to wheelchair or wheelchair to toilet, etc.) and continence.

Administrative Claiming for Education (ACE): The Georgia Medicaid Administrative Claiming for Education (ACE) program allows reimbursement to Local Education Agencies (LEA) for approved administrative activities that support the Medicaid program. Reimbursement is available through a quarterly claiming process.

Administrative Law Hearing: The appeal process administered by the State in accordance with O.C.G.A. § 49-4-153 and as required by federal law available to Members and Providers after they exhaust the Contractor's Appeals Process.

Administrative Review: The formal reconsideration of a proposed Action, as a result of the proper and timely submission of a Provider's request, Member's request, or a request by DCH.

Administrative Service(s): The contractual obligations of the Contractor that include but are not limited to Utilization Management, network management, Quality improvement, marketing, enrollment, Member Services, Claims payment, Information Systems, financial management, and reporting.

Adoption Assistance (AA): A program established by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) that provides financial and medical benefits to adoptive families who adopt children with special needs up to eighteen (18) years of age. There are three (3) categories of adoption assistance: (1) monthly adoption assistance payments; (2) Medicaid benefits; and (3) non-recurring adoption assistance (such as adoption fees, court costs, attorney fees and other expenses). Georgia's Adoption Assistance Policies can be found online at http://www.odis.dhr.state.ga.us/3000_fam/3120_ado/Manual/109.doc.

Adoption Assistance Member (AA Member): A Member receiving Adoption Assistance (AA) and enrolled in the Georgia Families 360° program.

Adoption Assistance (AA) Member Consecutive Enrollment Period: The consecutive twelve (12) month period beginning on the AA Member's first day of Enrollment in the Georgia Families 360° CMO or the date the Department of Community Health (DCH) sends the AA Member the notice of Enrollment, whichever is later. For AA Members that use their option to return to the Medicaid Fee-For-Service delivery system without cause during the AA Member Fee-For-Service Selection Period, the twelve-month Consecutive Enrollment Period will commence when the AA Member is enrolled in the Medicaid Fee-For-Service delivery system. This is not to be construed as a guarantee of eligibility during the AA Member Consecutive Enrollment Period.

Adoption Assistance (AA) Member Fee-For-Service Selection Period: The ninety (90) Calendar Day period beginning on the AA Member's initial Enrollment in the Georgia Families 360° CMO or the date DCH sends the AA Member notice of the Enrollment, whichever is later. During this period an AA Member may elect to opt out of

the Georgia Families 360° CMO without cause and return to the Medicaid Fee-For-Service delivery system. AA Members who do not make a choice to return to the Medicaid Fee-For-Service delivery system during this ninety (90) Calendar Day period will be deemed to have chosen to remain enrolled in the Georgia Families 360° CMO until the Member's next AA Member Consecutive Enrollment Period.

Adoptive Parent: An adult who provides a child a permanent home through a court process that, once final, names the adoptive parent as the child's legal parent.

Advance Directives: A written instruction, such as a living will or durable power of attorney for Health Care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of Health Care when the individual is incapacitated.

After-Hours: Provider office/visitation hours extending beyond the normal business hours of a Provider. This may include Saturday hours.

Aged, Blind or Disabled (ABD): Medical assistance for persons who are aged (sixty-five (65) years of age or older), legally blind and/or disabled individuals who are not eligible for SSI. These individuals receive Fee-for-Service Medicaid only and are not eligible for Georgia Families 360° Program.

Agent: An entity that contracts with the State of Georgia to perform administrative functions, including but not limited to: Fiscal Agent Contractor activities; outreach, eligibility, and Enrollment activities; Information Systems and technical support, etc.

Aim Statement: A written and measurable description of desired improvement that defines a clear and firm intention for improvement and is time-specific, measurable and focused on the population that will be affected by the improvement activity. The Aim Statement should be easy to remember and answer the following questions: What will we improve? For whom? How much? By when?

Appeal: A request for review of an action, as "action" is defined in 42 C.F.R. §438.400.

Appeals Process: The overall process that includes Appeals at the Contractor level and access to the State Fair Hearing process (the State's Administrative Law Hearing).

Assess: The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

Attestation: The Contractor attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.

Authoritative Host: A system that contains the master or "authoritative" data for a particular data type, e.g. Member, Provider, CMO, etc. The Authoritative Host may feed data from its master data files to other systems in real time or in batch mode. Data in an Authoritative Host is expected to be up-to-date and reliable.

Authorized Representative: A person authorized by the Member in writing to make health-related decisions on behalf of a Member, including, but not limited to Enrollment and Disenrollment decisions, filing Appeals and Grievances with the Contractor, and choice of a Primary Care Physician (PCP). The Authorized Representative is the Parent, Adoptive Parent or legal guardian for a child. For an adult, this person is the legal guardian (guardianship action), health care power of attorney, other person that has power of attorney, or another signed HIPAA compliant document indicating who can make decisions on behalf of the Member. For Foster Care Members and Juvenile Justice Members, the Authorized Representative is DFCS or DJJ respectively.

Automatic Assignment (or Auto-Assignment): The assignment of a new Member to a PCP chosen by the Contractor, pursuant to the provisions of this Contract.

Babies Can't Wait: Georgia's statewide interagency service delivery system for infants and toddlers, from birth to age three, with developmental delays or disabilities and their families. Established by Part C of the Individuals with Disabilities Education Act (IDEA).

Bed Days: A day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

Behavioral Health: The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five [DSM 5] published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in Behavioral Health usually have symptoms, behaviors and/or skill deficits which impede their functional abilities and affect their quality of life.

Behavioral Health Crisis: An intensive behavioral, emotional or psychiatric situation that exceeds an individual's current resources and coping mechanisms which, if left untreated, could result in an emergency situation.

Behavioral Health Home (BHH): A Behavioral Health Home is responsible for the integration and coordination of the individual's health care (physical as well as behavioral health care services). Behavioral Health Home providers do not need to provide all the services themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated.

Behavioral Health Services: Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Benefits: The Health Care services set forth in this Contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible for.

Blocked Call: A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Border Provider: Providers located within fifty (50) miles of the Georgia border. Border Providers are located in Alabama, Florida, North Carolina, South Carolina and Tennessee.

Business Days: Monday through Friday from 9:00 a.m. to 5:00 p.m. EST, excluding State holidays.

Calendar Days: All seven days of the Week.

Calendar Years: January through December.

Capitated Service: Any Covered Service for which the Contractor receives an actuarially sound Capitation Payment.

Capitation: A Contractual arrangement through which a Contractor agrees to provide specified Health Care services to Members for a fixed amount Per Member Per Month.

Capitation Payment: A payment, fixed in advance, that DCH makes to the Contractor for each Member covered under this Contract for the provision of Covered Services. Capitation Payments are unique for each program. For instance, Capitation Payments may be referred to as P4HB Capitation Payments, Foster Care/Juvenile Justice Capitation Payments, or Adoption Assistance Capitation Payments. This payment is made regardless of whether the Member receives Covered Services or Benefits during the period covered by the payment. Payments are contingent upon the availability of appropriated funds.

Capitation Rate: The fixed monthly amount, including the Value-Based Purchasing (VBP) withhold, that the Contractor is paid by DCH for each Member to ensure that Covered Services and Benefits under this Contract are provided. Capitation Rates are unique for each program. For instance, Capitation Rates may be referred to as P4HB Capitation Rates, Foster Care/Juvenile Justice Capitation Rates or Adoption Assistance Capitation Rates. Payments are contingent upon the availability of appropriated funds.

Care Coordination: The process of actively linking a Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified.

Care Coordination Team (CCT): The team assigned to each Member to assist in navigating the health care system and coordinating with the Division of Family and Children Services (DFCS) or the Department of Juvenile Justice (DJJ) to develop work flows and processes, including those related to the transmission of clinical and non-clinical Member information. The CCT will not substitute any of the interdisciplinary teams or case management functions supporting Home- and Community-Based Services (HCBS).

Care Coordinator: The lead member of the Care Coordination Team and who serves as the key point of contact between the CMO and State agencies, the Member in Foster Care

or receiving Adoption Assistance, the Foster Parent(s), Adoptive Parent(s), Caregivers and Providers. The qualifications of the Care Coordinator will be based on the individual needs of the Member in Foster Care or receiving Adoption Assistance.

Caregiver: The DFCS-authorized caretaker for a FC Member may be the FC Member's Foster Parent(s), relative(s), or twenty-four (24)-hour childcare facility staff.

Care Management: Traditional Case Management provided to Georgia Families 360° Members.

Care Management Organization (CMO): An entity organized for the purpose of providing Health Care, with a Health Maintenance Organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers, and furnishes Health Care services on a capitated basis to Members.

Case Management: A person-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. Case Management serves as a means for achieving Member wellness and autonomy through advocacy, communication, education and identification of services and resources. Interventions are undertaken with the purpose of helping Members receive appropriate care. Case Management is distinguished from Utilization Management in that it is voluntary and it is distinguished from Disease Management by its intensity and focus on any disease(s) or condition(s) the Member has.

Category of Eligibility: Defined set of requirements used to identify individuals who are eligible for Medicaid, PeachCare for Kids and P4HB and the services the individuals are eligible for. Requirements may include age; being pregnant, disabled, or blind; meeting income and asset requirements and being a U.S. citizen or a qualified alien. Non-qualified aliens or undocumented immigrants may be eligible for emergency assistance only.

Category of Service (COS): Classifications of the service types and the Providers authorized to deliver the services as defined by DCH.

Centers for Medicare & Medicaid Services (CMS): The Agency within the U.S. Department of Health and Human Services responsible for the Medicare, Medicaid and the Children's Health Insurance Programs.

Certified Nurse Midwife (CNM): A registered professional nurse who is legally authorized under State law to practice as a nurse-midwife, and has completed a program of study and clinical experience for nurse-midwives or equivalent.

Child and Family Teams (CFT): A group of people responsible for development, coordination, and monitoring of individualized plans developed in a family-driven model. The group includes, at a minimum, the child and family, any Foster Parents, a Behavioral Health representative, and any individuals important in the child's life including both

professionals and non-professionals who are invited to participate by the child and family whose combined expertise and involvement ensures plans are individualized, culturally competent and person-centered, build upon strengths and capabilities and address youth health and safety issues.

Child Protective Services (CPS): An office within DFCS that investigates reports of child abuse or neglect and provides services to protect the child and strengthen the family.

Children 1st: A State program administered by the Department of Public Health (DPH) which identifies and screens children (birth to age 5) at risk for poor health and developmental outcomes, refers children to appropriate services, and monitors health status. The program is designed to serve as a single point of entry to a statewide collaborative system of public health and other prevention based programs and services.

Children's Health Insurance Program (CHIP formerly State Children's Health Insurance Program (SCHIP)): A joint federal-state Health Care program for targeted, low-income children, established pursuant to Title XXI of the Social Security Act. Georgia's CHIP is called PeachCare for Kids®.

Children's Intervention School Services (CISS): The Georgia Medicaid program that provides reimbursement for specified medically-necessary services that are received in schools and provided by or arranged by a Local Education Agency (LEA) for Medicaid-eligible students under the age of twenty-one (21) with an Individualized Education Program (IEP).

Children's Medical Services: Administered by the Department of Public Health, the Children's Medical Services program provides care coordination and other needed medical/health services for eligible children and their families who are not enrolled in managed care. The Children's Medical Services program may provide, arrange for and/or pay for comprehensive physical evaluations, diagnostic tests, inpatient/outpatient hospitalization, medications, and other medical treatments, therapy, Durable Medical Equipment, hearing aids related to the child's eligible condition, and genetic counseling.

Chronic Condition: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is considered Routine Care.

Claim: A bill for services, a line item of services, or all services for one recipient within a bill.

Claim Adjustment: A claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, payment amount can be changed.

Claims Administrator: The entity engaged by DCH to provide Administrative Service(s) to the CMO in connection with processing and adjudicating risk-based payment, and recording Encounter Claims Data for Members.

Clean Claim: A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: (i) A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; (ii.) A Claim for which Fraud is suspected; and (iii.) A Claim for which a Third Party Resource should be responsible.

Cold-Call Marketing: Any unsolicited contact by the CMO, with a potential Member, for the purposes of marketing a Member's selection or Enrollment in a particular CMO.

Community Mental Health Rehabilitation Services (CMHRS): Services that are intended for the maximum reduction of mental disability and restoration of an individual to his or her best possible functional level.

Completion/Implementation Timeframe: The date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the Contractor.

Complex Care Coordination: Rigorously coordinated Care Management provided to Members, which includes Care Coordination of medical and social supports for Members with multiple Chronic Conditions.

Comprehensive Child and Family Assessment (CCFA): An intake assessment provided to children in Foster Care through the Division of Family and Children Services (DFCS) which includes the following components: family assessment, Trauma Assessment, Medical Assessment, relative and non-relative home evaluation and reassessments. The Contractor will be responsible for ensuring that the Medical Assessment and Trauma Assessments are completed within the timeframes set forth in this Contract.

Comprehensive Child and Family Assessment (CCFA) Provider: A Provider that renders clinical services to Foster Care Members and their families. CCFA Providers are responsible for the submission of the Comprehensive Child and Family Assessment final report which includes the Medical Assessment and Trauma Assessment.

Condition: A disease, illness, injury, or disorder, of biological, cognitive, or psychological basis for which evaluation, monitoring and/or treatment are indicated.

Consecutive Enrollment Period: The consecutive twelve (12) month period beginning on the first day of Enrollment or the date the notice is sent, whichever is later. For Members that use their option to opt out of the GF 360° Program without cause during the first ninety (90) Calendar Days of Enrollment, the twelve-month Consecutive Enrollment Period will commence when the Member opts out. This is not to be

construed as a guarantee of eligibility during the Consecutive Enrollment Period. FC Members and DJJ Members do not have the option to opt out of the GF 360° Program.

Consulting Provider: The Provider who evaluates a Member at the request of the Member's Primary Care or referring Provider. The consultation may occur via a Telemedicine mode of delivery.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): CAHPS surveys ask Medicaid and PeachCare for Kids[®] Members or their parents/guardians to report on and evaluate their experiences with their health care. The surveys cover topics that are important to Members and focus on aspects of quality that Members and parents/guardians are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The acronym CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). DCH uses the Adult and Child CAHPS surveys.

Contested Claim: A Claim that is denied because the Claim is an ineligible Claim, the Claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the Claim requires special treatment.

Continuing Care Provider: A Provider who formally agrees: to provide to individuals enrolled in Medicaid, screening, diagnosis, and treatment for conditions identified during EPSDT screening visits (within the Provider's capacity) or referral to a Provider capable of providing the appropriate services; maintains a complete health history, including information received from other Providers; is responsible for providing needed physician services for acute, episodic and/or chronic illnesses and conditions; and ensures accountability by submitting reports reasonably required by the Contractor and/or DCH.

Contract: The written agreement between the State and the Contractor; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Award: The date upon which the Apparent Successful Vendor Letter(s) is/are issued by DOAS.

Contract Effective Date: The date upon which CMS approves the Contract.

Contractor: The Care Management Organization with a valid Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner that contracts hereunder with the State for the provision of comprehensive Health Care services to Members on a capitated basis.

Contractor's Representative: The individual legally empowered to bind the Contractor, using his/her signature block, including his/her title.

Coordination of Care: The deliberate organization of Member care activities by a CMO between two or more Providers involved in a Member's care, in order to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required Member care activities,

and is often managed by the exchange of information among participants responsible for different aspects of care.

Co-payment: The part of the cost-sharing requirement for Members in which a fixed monetary amount is paid for certain services/items received from the Contractor's Providers.

Core Provider: Those service providers that are deemed to satisfy the staffing and service scope requirements for the DJJ population. Recent changes in terminology used in the Behavioral Health Medicaid services system now refers to Core Providers as Comprehensive Community Providers.

Core Services: Those supports/services provided by outpatient Behavioral Health agencies offering a comprehensive range of Mental Health, addictive disease, and/or specialty services that meet conditions of the Medicaid program specifically under the Medicaid Rehabilitation Option. Also known as Community Behavioral Health Rehabilitation Services.

Corrective Action: A reaction to a problem, complaint or issue that has already occurred. The actions initiated are intended to fix the problem/issue and modify the quality system so that the process that caused it is monitored to prevent a recurrence. Documentation for a Corrective Action provides evidence that the problem was recognized, corrected and proper controls were implemented to make sure that it does not happen again. The process for reacting to problems, complaints or other issues includes:

- i. Reviewing and defining the problem/issue
- ii. Finding the cause of the problem/issue
- iii. Developing an action plan to correct the problem/issue and prevent a recurrence
- iv. Implementation of the action plan
- v. Evaluating the effectiveness of the correction

Corrective Action Plan: The detailed written plan required by DCH to correct or resolve a deficiency or event that may result in the assessment of a Liquidated Damage or sanction against the CMO.

Corrective Action Preventive Action (CAPA) Process: A step-by-step process for completing and documenting preventive and corrective actions. The steps assist investigators in detecting potential problems or reacting to existing problems and eliminating or correcting them. The CAPA process may be linked to liquidated damages.

Corrective Action Preventive Action (CAPA) Program: A fundamental management tool that provides a simple step by step process for completing and documenting corrective or preventive actions. The end result of implementation of this program is a complete, well documented investigation and solution that will satisfy DCH's requirements and form the basis for an effective continuous improvement plan. Liquidated damages may be linked to this program.

Cost Avoidance: A method of paying Claims in which the Provider is not reimbursed until the Provider has demonstrated that all available health insurance has been exhausted.

Court Appointed Special Advocate (CASA): National Association that supports and promotes court-appointed advocates for abused or neglected children in order to provide children with a safe and healthy environment in permanent homes.

Covered Services: Those Medically Necessary Health Care services provided to Members, the payment or indemnification of which is covered under this Contract.

Credentialing Verification Organization (CVO): An entity contracted by the State to determine the qualifications and ascribed privileges of providers to render specific Health Care services. The entity will make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families.

Crisis: A condition of instability/danger or dramatic emotional or circumstantial upheaval in a person's life requiring action or change.

Critical Access Hospital (CAH): A hospital that meets the CMS requirements to be designated as a Critical Access Hospital and that is recognized by DCH as a Critical Access Hospital for purposes of Medicaid.

Cultural Competency: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Deliverable: A document, manual or report submitted to DCH by the Contractor to fulfill requirements of this Contract.

Demonstration (also Family Planning Waiver, Planning for Health Babies, or the P4HB Program): The 1115 Demonstration waiver program in Georgia supported by CMS that expands the delivery of family planning services to uninsured women, ages eighteen (18) through forty-four (44), who have family income at or below 200 percent of the Federal Poverty Level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). Georgia's only 1115 Demonstration waiver is referred to as the Family Planning Waiver, Planning for Healthy Babies, or the P4HB Program. This Demonstration includes three distinct groups: women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the FPL and are eligible for Family Planning Only Services ("Family Planning Only P4HB Participants"); women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the FPL who have delivered a very low birth weight infant

(VLBW) and are eligible for Family Planning Services and Interpregnancy Care Services; and women ages eighteen (18) through forty-four (44) who are current Medicaid recipients, have delivered a VLBW infant and are eligible for Resource Mother services only.

Demonstration Disenrollment: The removal of a P4HB Participant from participation in the Demonstration.

Demonstration Enrollee: An individual meeting P4HB Program eligibility requirements who selects or is otherwise assigned to the Contractor in order to receive Demonstration services.

Demonstration Enrollment: The process by which an individual eligible for the P4HB program applies to utilize the Contractor to receive Demonstration services and such application is approved by DCH or its Agent.

Demonstration Period: The period from January 1, 2011 through January 31, 2015 in which the Demonstration will be effective. This period may be extended upon CMS' approval of DCH's requested extension.

Demonstration Provider: A physician, advanced practice nurse or other health care provider who meets the State's Medicaid provider enrollment requirements for the Demonstration, hospital, facility, or pharmacy licensed or otherwise authorized to provide Demonstration related Services to P4HB Participants within the State or jurisdiction in which they are furnished. Also known as a P4HB Provider.

Demonstration-Related Emergency Medical Condition: A medical condition resulting from a Demonstration-related Service and manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the woman in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. A Demonstration-related Emergency Medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

Demonstration-Related Post Stabilization Services: Covered Services related to Demonstration-related Emergency Medical Condition that are provided after a P4HB Participant is stabilized in order to maintain the stabilized condition or to improve or resolve the P4HB Participant's condition.

Demonstration-Related Services: Those Demonstration Services identified in the CMS Special Terms and Conditions and approved by CMS that are available to P4HB Participants.

Demonstration-Related Urgent Care Services: Medically Necessary treatment of a Demonstration-related injury, illness or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Dental Home: A Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the State Plan. P4HB Participants are not eligible for a Dental Home.

Dental Subspecialty Providers: Specialized dental providers including endodontists, oral pathologists, orthodontists, oral surgeons, periodontists, pedodontists, and prosthodontists.

Department of Behavioral Health and Developmental Disabilities (DBHDD): The Georgia state agency that provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD serves people of all ages with the most severe and likely to be long-term conditions, including consumers with forensic issues.

Department of Community Health (DCH): The single state Agency in the State of Georgia responsible for oversight and administration of the Medicaid program, the PeachCare for Kids® program, the Planning for Healthy Babies Program and the State Health Benefits Plan (SHBP).

Department of Community Health Performance, Quality and Outcomes Unit (DCH PQQ Unit): A unit within the DCH Medicaid Division charged with ensuring that all aspects of the department's Quality Strategic Plan are implemented, and defining enhancements to the plan that would drive health improvements for Georgia's Medicaid population served by the CMOs.

Department of Early Care and Learning (DECAL): The Georgia state agency that is responsible for meeting the child care and early education needs of Georgia's children and their families. Also known as "Bright from the Start."

Department of Juvenile Justice (DJJ): The Georgia state agency that serves the State's youthful offenders up to the age of twenty-one (21). While holding youthful offenders accountable for their actions through probation supervision and secure detention, DJJ provides youth with medical and psychological treatment, as well as specialized programs designed to equip youth with the social, intellectual and emotional tools they will need as adults.

Department of Juvenile Justice Member (DJJ Member): A Member in the custody of the Department of Juvenile Justice while residing in community residential facilities and enrolled in the Georgia Families 360° program.

Department of Public Health: The Georgia state agency with the ultimate responsibility for the health of communities and the entire population.

Diagnostic Related Group (DRG): Any of the payment categories that are used to classify patients and especially Medicare patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred. The payment category is determined primarily by the principal diagnosis, surgical procedure used, age of patient, and expected length of stay in the hospital.

Diagnostic Services: Any medical procedures or supplies recommended by a physician or other licensed medical practitioner, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature or extent of illness, injury, or other health deviation in a Member.

Discharge: Point at which Member is formally released from a hospital, by the treating physician, an authorized member of the physician's staff or by the Member after they have indicated, in writing, their decision to leave the hospital against medical advice.

Discharge Planning Pilot Program: A pilot program the Contractor will implement with hospital(s) that agree to participate to improve coordination for Members being discharged from the hospital. The intent of this program is to improve quality of care and outcomes, as well as to reduce readmissions.

Disenrollment: The removal of a Member from enrollment with a CMO, but not necessarily from the Medicaid or PeachCare for Kids® programs.

Division of Family and Children Services (DFCS): DFCS has statutory responsibility for the care of children and young adults who have been removed from the home and placed in the conservatorship of DFCS.

Division of Family and Children Services (DFCS) Case Manager: A staff professional who provides assistance to children and families by helping them address psychological and social problems related to child abuse and neglect. DFCS Case Managers provide interventions and perform duties related to various social services program areas such as Child Protective Services (CPS), Foster Care, resource development, and Adoption Assistance.

Division of Family and Children Services (DFCS) Clinical Program Specialist: DFCS region-specific staff whose responsibilities include but are not limited to, the following:

- i. Oversight of DFCS children receiving Behavioral Health Services and collaborating with the DBHDD program specialist serving specific regions.
- ii. Reviews the status of any child receiving inpatient treatment at a psychiatric residential treatment family or psychiatric hospital at least monthly.
- iii. Participates in Discharge goals and planning.
- iv. Monitors all children in Foster Care receiving psychotropic medication.
- v. Maintains a regional listing of available Behavioral Health providers.
- vi. Guides or assists DFCS Case Managers as FC Members receiving Behavioral Health Services, developmental disability services, or special medical services transition from non-Foster Care Medicaid to Foster Care Medicaid and vice versa to ensure continuity of services.

Division of Family and Children Services (DFCS) Revenue Maximization Specialist (RMS): A regional eligibility specialist trained in Title IV-E Foster Care and Adoption Assistance programs and Medicaid eligibility with data entry in SHINES and SUCCESS for child welfare funding determinations and Medicaid eligibility.

Documented Attempt: A bona fide, or good faith, attempt on the part of the Contractor to contract with a Provider. Such attempts may include written correspondence that outlines contracted negotiations between the parties, including rate and contract terms disclosure, as well as documented verbal conversations, to include date and time and parties involved.

Driver Diagrams: A road map for changes and interventions that provides a way to organize thoughts around what needs to be done in order to achieve the aim. There are two types of drivers:

- i. Primary drivers – system components that will contribute to improving outcomes; and
- ii. Secondary drivers – elements of the associated primary drivers that help create the changes. The secondary drivers are interventions expected to affect primary drivers and thus outcomes, and are evidence-based, necessary and sufficient for improvement.

Durable Medical Equipment (DME): Equipment, including assistive technology, which:

- i. Can withstand repeated use;
- ii. Is used to service a health or functional purpose;
- iii. Is ordered by a qualified practitioner to address an illness, injury or disability; and
- iv. Is appropriate for use in the home, work place, or school.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit: A comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age twenty-one (21), as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The EPSDT benefit also covers medically necessary diagnostic services. The Contractor is required to arrange for and cover, under the EPSDT benefit, any Medicaid covered service listed in Section 1905(a) of the Act if that treatment or service is determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age twenty-one (21) enrolled in the Medicaid and PeachCare for Kids® programs. P4HB Participants are not eligible for the EPSDT Benefit.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program: The program that defines the policy, reimbursement, and oversight for the EPSDT services described under the EPSDT Benefit. The goal of the EPSDT program is to ensure that individual children get the health care they need when they need it.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

Emergency Medical Screening: An examination: (i.) provided on hospital property, and provided for that patient for whom it is requested or required, (ii.) performed within the capabilities of the hospital's emergency room (ER) (including ancillary services routinely available to its ER), (iii.) the purpose of which is to determine if the patient has an Emergency Medical Condition, and (iv.) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or Physician Assistant as permitted by State statutes and regulations and hospital bylaws.

Emergency Services: Covered inpatient and outpatient services furnished by a qualified Provider needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the Prudent Layperson standard.

Encounter: A distinct set of Health Care services provided to a Member enrolled with the Contractor on the dates that the services were delivered.

Encounter Claims: Records of Claims paid by the Contractor, or by its Subcontractors, to Providers that have provided Health Care services to Members. The Contractor is required to submit Encounter Claims to the State's Fiscal Agent Contractor that include required, optional, and situational data fields as specified in the Encounter Data Companion Guides, relevant 837 and National Council for Prescription Drug Programs standards, and other Encounter Claims data reporting documentation, where applicable.

Enrollment: The process by which an individual eligible for Medicaid or PeachCare for Kids® applies (whether voluntary or mandatory) to utilize the Contractor's plan in lieu of the Fee-for-Service program and such application is approved by DCH or its Agent.

Enrollment Period: The twelve (12) month period commencing on the effective date of Enrollment.

Evaluate: The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

Expedited Review: For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision with twenty-four (24) hours and provide notice as expeditiously as the Member's health condition requires and no later than three (3) Business Days after receipt of the request for service. The Contractor may extend the twenty-four (24) hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's interest.

External Quality Review (EQR): The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the Health Care services that the Contractor or its Subcontractors furnish to Members.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, and other related activities.

Family Planning Provider: A physician advanced practice nurse, or other Health Care provider who meets the State's Medicaid provider enrollment requirements for providing family planning services to eligible Members.

Family Planning Services: Family planning services and supplies include at a minimum:

- i. Education and counseling necessary to make informed choices and understand contraceptive methods;
- ii. Initial and annual complete physical examinations;
- iii. Follow-up, brief and comprehensive visits;
- iv. Pregnancy testing;
- v. Contraceptive supplies and follow-up care;
- vi. Diagnosis and treatment of sexually transmitted diseases; and
- vii. Infertility assessment.

Family Planning Waiver: See Demonstration.

Federally Qualified Health Center (FQHC): An entity that provides outpatient health programs pursuant to Section 1905(1)(2)(B) of the Social Security Act.

Federal Financial Participation (FFP): The funding contribution that the Federal government makes to the Georgia Medicaid and PeachCare for Kids® programs.

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services. Federal Poverty Levels are used to determine eligibility for certain programs and benefits.

Fee-for-Service (FFS): A method of reimbursement based on payment for specific services rendered to eligible Medicaid and PeachCare for Kids® individuals that are not participants in the Georgia Families 360° program.

Financial Relationship: A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity that equates to at least five percent (5%) or more of the disclosing entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation arrangement with an entity. This includes a mortgage, deed of trust, note or other obligation.

Fiscal Agent Contractor (FAC) or Fiscal Agent: The entity contracted with DCH to process Medicaid and PeachCare for Kids® Claims and other non-Claim specific payments.

Foster Care: Twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the Title IV-E agency (DFCS) has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Foster Care Member (FC Member): A Member in Foster Care and enrolled in the Georgia Families 360° program.

Foster Parent: A substitute caregiver who assumes the daily caretaking responsibilities for children in DFCS custody who have been placed in their home.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law.

Full Month: All Calendar Days included in a month (i.e. all 28, 30 or 31 days of the month in consideration).

Full Quarter: Three consecutive Full Months starting with the first Full Month of the Calendar Year.

Full Time Provider: defined as a location operating for more than sixteen (16) hours in an office location each Week.

Geographic Access: A Provider Network fulfilling access criteria within set geographic restrictions.

Georgia Crisis and Access Line (GCAL): A twenty-four (24)-hour phone line sponsored by DBHDD to assist with coordinating access to care or provide support in an emergency or crisis.

Georgia Families: The risk-based managed care delivery program for Medicaid and PeachCare for Kids® in which DCH contracts with CMOs to manage the care of eligible Members.

Georgia Families 360°: The risk-based managed care delivery program for Foster Care Members, Adoption Assistance Members and Juvenile Justice Members.

Georgia Health Information Network (GaHIN): The technical infrastructure used to facilitate secure electronic exchange of electronic health records among authorized health care providers throughout the entire State of Georgia.

GaHIN Authorized User/Member Affiliate: Qualified Entities and GaHIN Member Users having authorized access to the GaHIN.

GaHIN Member Agreements: Written agreements that GaHIN and/or its Agents determine are required as a condition for a Qualified Member's participation in the network.

GaHIN Member Users/Member Affiliates: Any entity, organization or individual person who has been identified and authorized by a Qualified Member to access the GaHIN, in a manner defined by the respective Qualified Member, in compliance with an agreement between the Member User and the Qualified Member and applicable law. Member Users may include, but are not limited to, hospitals or Health Care systems, and employees, Contractors, or agents of a Qualified Member.

Georgia Pediatric Program (GAPP): The program serving medically fragile children operating in part under a Home-and-Community Based Waiver.

Georgia Technology Authority (GTA): The State agency that manages the State's information technology (IT) infrastructure, i.e. data center, network and telecommunications services and security, establishes policies, standards and guidelines for State IT, promotes an enterprise approach to State IT, and develops and manages the State portal.

Grievance: An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights.

Grievance System: The overall system that addresses the manner in which the CMO handles Grievances at the Contractor level.

Health Care: Health Care means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental Condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Healthcare Effectiveness Data and Information Set (HEDIS®): A widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA).

Health Care Professional: A physician or other Health Care Professional, including but not limited to podiatrists, optometrists, chiropractors, psychologists, dentists, physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians licensed in the State of Georgia.

Health Care Service Plan: An individualized plan developed with and for an FC Member or AA Member which includes, but is not limited to, the following:

- i. Summary of current medical and social needs and concerns;
- ii. Short and long term needs and goals;
- iii. A treatment plan to address the FC Member or AA Member; and
- iv. A description of who will provide such services.

The Health Care Service Plan will be coordinated by the CCT.

Health Check Program: The Early and Periodic Screening components of the EPSDT benefit are covered under this program pursuant to Title XIX of the Social Security Act.

Health Information Technology: Hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. Source is ARRA - H.R.1 -115 Sec. 3000 (5).

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV: Enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, the legislation was signed into law on February 17, 2009, to promote the adoption and meaningful use of Health Information Technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that includes requirements to protect the privacy of individually identified health information in any format, including written or printed, oral and electronic, to protect the security of individually identified health information in electronic format, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers. When referenced in this Contract, it includes all related rules, regulations and procedures.

Health Maintenance Organization: An entity organized for the purpose of providing Health Care and has a Health Maintenance Organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers and furnishes Health Care services on a capitated basis to Members.

Health Professional Shortage Area (HPSA): An area designated by the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental or mental health providers. These areas can be geographic, demographic or institutional in nature. A care area can be found using the following website: <http://hpsafind.hrsa.gov/>.

Health Risk Screening: The Health Risk Screening is used to collect comprehensive information on FC Members or AA Members.

High Fidelity Wraparound: According to the U. S. National Wraparound Initiative (<http://www.nwi.pdx.edu/>), an approach to Behavioral Health Services designed to meet needs that are prioritized by the youth and family, improve their ability and confidence to manage their own services and supports, develop or strengthen their natural supports, and integrate the work of all child servicing systems and natural supports into one streamlined plan.

Historical Provider Relationship: A Provider who has been the main source of Demonstration, Medicaid or PeachCare for Kids® services for the Member or P4HB Participant during the previous year (decided on by the most recent Provider on the Member's or P4HB Participant's Claim history).

Home- and Community-Based Services (HCBS): Includes all services included in a Home- and Community-Based waiver program. Georgia's HCBS programs include the Independent Care Waiver Program, the Community Based Alternatives for Youth (CBAY) Program, the New Options Waiver (NOW) Program, the Elderly and Disabled Waiver Program, and the Comprehensive Supports Waiver Program (COMP). Contractor is not required to provide HCBS, but must provide all other Medicaid State Plan services required under the Contract for any FC Member or AA Member enrolled in an HCBS waiver program.

Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)): A law enacted by the Georgia State legislature and codified as O.C.G.A. § 31-8-179 *et seq.* The Hospital Medicaid Financing Program Act establishes (i) a hospital provider fee that is assessed by the State on Hospital Medicaid Financing Program Act Providers and (ii) an additional add-on payment with each CMO Claim payment that is equal to 11.88% of the Hospital Medicaid Financing Program Act Provider's contracted reimbursement rate with the CMO.

Hospital Medicaid Financing Program Act Provider: An institution licensed pursuant to Chapter 7 of Title 31 of the Official Code of Georgia Annotated which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured,

disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, and other specialty hospitals but shall not include psychiatric hospitals as defined in paragraph (7) of Code Section 37-3-1, Critical Access Hospitals as defined in paragraph (3) of Code Section 33-21A-2, or any state owned or state operated hospitals.

Immediately: Within twenty-four (24) clock hours.

Implementation Phase: The period of time from the Contract Effective Date through the Operational Start Date.

Incentive Arrangement: Any mechanism under which a Contractor may receive additional funds over and above the Capitation Payments, excluding Provider incentive payments made under Value-Based Purchasing, for exceeding targets specified in the Contract.

Incurred-But-Not-Reported (IBNR): Estimate of unpaid Claims liability, includes received but unpaid Claims.

Individual Recovery/Resiliency Plan (IRP): The treatment plan or plan of care for individuals engaged in the Behavioral Health system that comprehensively addresses the Mental Health and/or addictive disease needs of the individual. This written plan establishes and documents treatment goals and objectives based on the most recent diagnostic assessment; specific strategies and methods for treating needs identified by the diagnostic assessment; schedule for accomplishing the goals and objectives; responsibility for providing each treatment component and responsibility of the individual to engage in recovery; and reflects the health status and progress, including changes in functioning over time. The Resiliency Plan typically is a term used to reflect a plan specifically designed for youth and adolescents.

Individualized Education Program (IEP): A mandate of the IDEA that defines the individualized objectives of a child who has been found with a disability, as defined by federal regulations. The IEP is intended to help children reach educational goals more easily than they otherwise would and refers both to the educational program to be provided to a child with a disability and to the written document that describes that educational program.

Individualized Family Service Plan (IFSP): A document developed when a child under the age of three (3) is found eligible for early-intervention services. The IFSP focuses on the child and family and the services that a family needs to help them enhance the development of their child.

Individually Identifiable Health Information: See Protected Health Information.

Individuals with Disabilities Education Act (IDEA): A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Individuals with Disabilities Education Act (IDEA) Part B: A law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to infants, toddlers, children and youth with disabilities. Part B focuses on children and youth ages three (3) to twenty-one (21) and their receipt of special education and related services. For Medicaid Members aged three (3) to twenty-one (21), the CMOs are not responsible for reimbursing Local Education Agencies for the provision of Medically Necessary IDEA Part B services, provided pursuant to an IEP in the school setting.

Individuals with Disabilities Education Act (IDEA) Part C: Part C of IDEA serves infants and toddlers through age two (2) with developmental delays or who have diagnosed physical or mental conditions with high probabilities that these conditions will result in developmental delays.

Information: (i) Structured Data: Data that adhere to specific properties and Validation criteria that is stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; and (ii.) Document: Information that does not meet the definition of Structured Data that includes, at a minimum, text, files, spreadsheets, electronic messages and images of forms and pictures.

Information System/Systems: A combination of computing hardware and software that is used in: (i.) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. Structured Data (which may include digitized audio and video) and documents; and/or (ii.) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

In-Network Provider: A Provider that has entered into a Provider contract with the Contractor to provide Health Care services.

Inpatient Facility: Hospital or clinic for treatment that requires at least one overnight stay.

Insolvent: Unable to meet or discharge financial liabilities.

Intensive Care Coordination: Care coordination provided to Members at a greater frequency, duration, and scope than traditional Case Management to support Members with managing chronic or acute conditions.

Intensive Customized Care Coordination: A provider-based High Fidelity Wraparound intervention, as defined by the U. S. National Wraparound Initiative, comprised of a team selected by the family/caregiver in which the family and team identify the goals and the appropriate strategies to reach the goals. Intensive Customized Care Coordination assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is gained. Intensive Customized Care Coordination encourages the use of community resources through referral to appropriate

traditional and non-traditional providers, paid, unpaid and natural supports. Intensive Customized Care Coordination is a set of interrelated activities for identifying, planning, budgeting, documenting, coordinating, and reviewing the delivery and outcome of appropriate services for individuals through a wraparound approach. Care Coordinators (CC), who deliver this intervention, work in partnership with the individual and their family/caregivers/legal guardians are responsible for assembling the Child and Family Team (CFT), including both professionals and non-professionals who provide individualized supports and whose combined expertise and involvement ensures plans are individualized and person-centered, build upon strengths and capabilities and address individual health and safety issues.

Intensive Family Intervention (IFI): A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic Foster Care, Psychiatric Residential Treatment Facilities, or therapeutic residential intervention services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- i. Defuse the current Behavioral Health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- ii. Ensure linkage to needed community services and resources; and
- iii. Improve the individual child's/adolescent's ability to self-recognize and self-manage Behavioral Health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

IFI services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her Behavioral Health needs/strengths and goals as identified in the Individualized Resiliency Plan.

Intensive Family Intervention Provider (IFI Provider): Those service providers that are deemed to satisfy the staffing and service scope requirements for DBHDD's core customers as defined in DBHDD's provider manual.

Interpregnancy Care (IPC): A benefit available to those P4HB Participants who meet the Demonstration's eligibility requirements and who delivered a Very Low Birth Weight baby on or after initiation of the Demonstration.

Interpregnancy Care Service Providers: Those Demonstration Providers serving the IPC P4HB Participants including Nurse Case Managers and Resource Mothers.

Interpregnancy Care Services: Services available under the Demonstration for P4HB Participants who meet the eligibility criteria for the IPC program. These services are in addition to Family Planning Services and include: limited primary care services; management and treatment of chronic diseases; Substance Abuse treatment

(detoxification and intensive outpatient rehabilitation); case management, including Resource Mothers outreach; limited dental; prescription drugs (non-family planning) for the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery and Non-Emergency Transportation.

Interpretation Services: The act or result of explaining, discovering, or ascertaining the meaning of all non-English language between speakers who speak different languages. Interpretation Services allow the transference of meaning between spoken languages. The interpreter must be fluent in both the original language and the target language and must translate the language to make it understandable. Interpretation Services are available free of charge to potential members and enrolled Members.

Interstate Compact on Adoption and Medical Assistance (ICAMA): Established in 1986, an agreement among member states to safeguard and protect the interstate interests of children covered by an Adoption Assistance agreement when they move or are adopted across state lines. ICAMA, which has the force of law within and among party states, enables the provision of medical benefits and services when a child with special needs is adopted by a family from another state, or the adoptive family moves to another state.

Interstate Compact on the Placement of Children (ICPC): Enacted by Georgia in 1977, a uniform law that has been enacted by all fifty (50) states, the District of Columbia, and U. S. Virgin Islands. It establishes orderly procedures for the interstate placement of Foster Care children and assigns responsibility for those involved in placing the child.

Juvenile Probation and Parole Specialist (JPPS): A DJJ staff professional who provides intake, informal adjustment, and probation services to youth for the Juvenile Court and aftercare and commitment services to youth under DJJ supervision. At a minimum, the JPPS will be solely responsible for coordinating youth placements in residential treatment settings, supervision in their communities, development of service plans that may consist of health care, mental health, and educational needs identified during the youth's initial assessment that may not be limited to referrals to collaborative agencies or resource providers.

Kenny A. Consent Decree: In June 2002, Children's Rights, Incorporated out of New York, filed a class action lawsuit against the State of Georgia on behalf of children in the State's legal custody. The lawsuit alleged violations of constitutional and statutory rights arising out of the operation of the State's foster care systems in Fulton and DeKalb counties. In October 2005, the plaintiffs and defendants settled the lawsuit under the Kenny A. vs. Sonny Perdue Consent Decree, which established independent accountability agents with the responsibility of monitoring the State's progress and producing public reports every six (6) months. These reports are available at: <http://aysps.gsu.edu/faculty-research/publications/kenny-a-v-perdue-monitoring-reports/>. Under the terms and conditions of the Kenny A. Consent Decree, the State is to achieve and sustain thirty-one (31) outcomes, as well as maintain certain practice standards related to service planning, placement experience, health care, investigation of maltreatment allegations concerning children in Foster Care, court reviews and reporting.

Some of these standards are new requirements for administrators and case managers, and others are existing agency policy and practice requirements receiving heightened attention. In addition, the consent decree stipulates various state and county infrastructure requirements. These stipulations pertain to automation, caseload sizes, training, supervision of private providers, Foster Parent licensing, and financing.

Key Staff: Contractor's staff which includes the Chief Executive Officer, Member Services Director, Provider Services Director, Utilization Management Director, Medical Director, Quality Management Director, Health Services Director and the Program Implementation Manager. Key Staff must be full-time employees located in Georgia with no other client responsibilities other than the Georgia Families, Georgia Families 360° or P4HB programs.

Limited-English-Proficient Population: Individuals with a primary language other than English who must communicate in that language if the individual is to have an equal opportunity to participate effectively in, and benefit from, any aid, service or benefit provided by the Health Care Provider.

Local Education Agency (LEA): The official designation for a school district in the State of Georgia.

Local Interagency Planning Teams (LIPT): A requirement of Georgia law, these teams are responsible for improving and facilitating the coordination of services for children with severe emotional disorders (SED) and/or addictive disease (AD). Team membership may include representatives from DFCS, DBHDD, DJJ, DPH, service Providers, educators, and Foster Parents or parent advocates, when their child is discussed. Teams meet as needed, usually no less than once a month, depending on the needs of the children.

Long Term: A period greater than thirty (30) Calendar Days.

Low Birth Weight (LBW): Birth weight below 2,500 grams (5.5 pounds).

Mandated Reporters: People in professions who have regular contact with vulnerable people such as children, disabled persons and senior citizens and are therefore legally required to report (or cause a report to be made) when abuse, neglect or exploitation is observed or are suspected. The specific professionals are typically named in state law. Georgia identified Mandated Reporters in the Official Code of Georgia Annotated for adults and children §§ 30-5-1 *et seq.* and 19-7-5(c)(1) which include, but are not limited to: Physicians licensed to practice medicines, interns or residents; dentists; psychologists; chiropractors; podiatrists; pharmacists; physical therapists; occupational therapists; licensed professionals and counselors; nursing personnel; social work personnel; day care personnel; employees of a public or private agency engaged in professional health-related services; and law enforcement personnel.

Mandatory Enrollment: The process whereby an individual eligible for the Demonstration, Medicaid or PeachCare for Kids® is required to enroll in a CMO, unless

otherwise exempted or excluded, to receive covered Demonstration, Medicaid or PeachCare for Kids® services.

Marketing: Any communication from the Contractor to any Demonstration, Medicaid or PeachCare for Kids® eligible individual that can reasonably be interpreted as intended to influence the individual to enroll in or remain in the Contractor's plan

Marketing Materials: Materials that are produced in any medium, by or on behalf of the Contractor, and can reasonably be interpreted as intended to market to any Member.

Material Subcontractor: A Subcontractor, excluding Providers, receiving Subcontractor payments from the Contractor in amounts equal to or greater than ten (10) million dollars annually during the State fiscal year.

Measurable: Applies to a Contractor objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.

Medicaid: The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act, which in Georgia is administered by DCH.

Medicaid Care Management Organizations Act: O.C.G.A. §33-21A-1, *et seq.* MEDICAID CARE MANAGEMENT ORGANIZATIONS ACT. A bill passed by the Georgia General Assembly, signed into law by the Governor, and effective July 1, 2008 which outlines several administrative requirements with which the administrators of the Medicaid Managed Care plan, must comply. Some of the requirements include dental Provider networks, emergency room Claims payment requirements, eligibility verification, and others.

Medicaid Eligible: An individual eligible to receive services under the Medicaid Program but not necessarily enrolled in the Medicaid Program.

Medicaid Management Information System (MMIS): Computerized system used for the processing, collecting, analysis, and reporting of Information needed to support Medicaid and CHIP functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manual.

Medical Assessment: An initial medical evaluation completed for FC Members and DJJ Members as follows:

- i. For each child newly entering or re-entering Foster Care, the Medical Assessment is part of the CCFA. These assessments must follow the requirements set forth in Georgia's Medicaid EPSDT program, and include dental, hearing and developmental screenings.
- ii. For DJJ Members, a Medical Assessment must follow the requirements set forth in Georgia's Medicaid EPSDT program, including dental, hearing and developmental screenings

Medical Director: The Georgia-licensed physician designated by the Contractor to exercise general supervision over the provision of health service Benefits by the Contractor.

Medical Home: A person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers, and where appropriate, the individual's family and other supports. A focal point for information sharing and referral to specialists and sub-specialists as well as community evaluations and interpretation of specialists.

Medical Records: The complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's participating Primary Care or Demonstration Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

Medical Screening: An examination used to identify an unrecognized or recognized disease in individuals without signs or symptoms.

Medically Necessary Services (includes concepts of Medically Necessary and Medical Necessity): Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary Services are those that are:

- i. Required to correct or ameliorate a defect, physical or mental illness, or a Condition
- ii. Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's medical Condition
- iii. Compatible with the standards of acceptable medical practice
- iv. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
- v. Not provided solely for the convenience of the Member or the convenience of the Health Provider
- vi. Not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage
- vii. Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available

Member Education and Outreach Plan (a/k/a the "Georgia Families 360° Education and Outreach Plan"): The plan detailing all education and outreach activities that the Contractor will use to reach Members. The Member Education and Outreach plan must be approved by DCH.

Members: Includes Foster Care Members, Adoption Assistance Members and Juvenile Justice Members.

Members with Special Health Care Needs (MSHCN): Any Member who:

- i. Ranges in age from birth up to but not including age twenty-one years (one (1) through < twenty-one (21));
- ii. Requires regular, ongoing therapeutic intervention and evaluation by Medicaid enrolled Health Care Professionals; and either (a) has a serious ongoing illness, a complex chronic condition, or a disability that has lasted or is anticipated to last at least twelve (12) continuous months or more; or (b) has an illness, condition or disability that significantly limits Activities of Daily Living or social roles in comparison with accepted pediatric age related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development.

Mental Health: A state of emotional and psychological well-being in which the individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.

Mental Illness: A behavioral or psychological syndrome or disorder that presents as a mental or behavioral anomaly and reflects an underlying psychobiological dysfunction the consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning).

Methodology: The planned process, steps, activities or actions taken by the Contractor to achieve a goal or objective, or to progress toward a positive outcome.

Monitoring: The process of observing, evaluating, analyzing and conducting follow-up activities.

Multidisciplinary Team (MDT): A team consisting of persons representing various disciplines associated with key components of the Foster Care assessment process. The purpose of the MDT meetings is to review the outcome and recommendations of the CCFA Provider related to the assessment of the FC Member and the Member's family.

The disciplines which may participate as part of the MDT should include, but are not limited to the following:

- i. Legal custodian (DFCS Case Manager, CPS investigator, CPS ongoing case manager, DFCS supervisor, and/or independent living coordinator for any youth fourteen (14) years or older);
- ii. CCFA Provider conducting the Trauma Assessment;
- iii. School system representative with direct knowledge of the educational status of the child;
- iv. Medical health provider with direct knowledge of the medical and dental status of the Foster Care child including the Babies Can't Wait service coordinator if applicable;
- v. Representative from the appropriate court system if the child had any court or law enforcement involvement including local law enforcement officials or a Court Appointed Special Advocate (CASA);
- vi. A mental health representative with direct knowledge of the mental health or substance abuse issues affecting the child or family;

- vii. Foster Parent(s) or Out of Home Placement provider where the child resided during the assessment process with direct knowledge of the child's behavior and activity during the assessment; and
- viii. Any other individual having appropriate information directly related to the FC Member's case.

The MDT meeting is coordinated and facilitated by the individual who completed the family assessment.

National Child Traumatic Stress Network: Established by the U.S. Congress in 2000 as part of the Children's Health Act, the National Child Traumatic Stress Network (NCTSN) is a collaborative of over one hundred fifty (150) centers in university, hospital, and diverse community-based organizations committed to raising the standard of care and improving access to services for traumatized children, their families and communities.

National Committee for Quality Assurance (NCQA): An organization that sets standards, and evaluates and accredits health plans and other managed care organizations.

National Provider Identifier (NPI): A unique ten digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). Providers must use their NPI to identify themselves in all HIPAA transactions.

Neonatal Intensive Care Unit (NICU): Hospital unit which provides intensive care services for sick and premature newborns.

Neonatal Intensive Care Unit (NICU) Supplemental Payments: Payments made to the Care Management Organizations for Georgia Families Members when those Members receive certain services in a NICU.

Net Capitation Payment: The Capitation Payment, adjusted for the applicable VBP Withhold, made by DCH to the Contractor excluding NICU Supplemental Payments, or other medical services that are on a per occurrence basis rather than a per Member basis.

Non-Capitated Services: Services not included in the Contractor's Capitation Rate.

Non-Emergency Transportation (NET): A ride, or reimbursement for a ride, provided so that a Member or P4HB Participant with no other transportation resources can receive services from a medical provider. NET does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.

Non-Institutional Claims: Claims submitted by a medical Provider other than a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF/ID).

Normal Birth Weight: Birth weight greater than or equal to 2,500 grams (5.5 pounds).

Nurse Case Manager (NCM): Contractor staff responsible for assisting Members, identified through the health assessment as Members with Special Health Care Needs, with obtaining Medically Necessary Services, health-related services and coordinating their clinical care needs with holistic consideration.

Nurse Practitioner Certified (NP-C): A registered professional nurse who is licensed by the State of Georgia and meets the advanced educational and clinical practice requirements beyond the two (2) or four (4) years of basic nursing education required of all registered nurses.

Objective: A measurable step, generally in a series of progressive steps, to achieve a goal.

Office of Insurance and Safety Fire Commissioner: The Agency in the State of Georgia responsible for licensing, overseeing, regulating, and certifying insuring entities.

Ombudsman Coordinator: An employee of the Contractor who is responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that Members have access to Covered Services and non-Covered Services. The Ombudsman Coordinator is also responsible for interacting with DCH's equivalent ombudsman staff and submitting reports to DCH.

Ombudsman Liaison: An employee of the Contractor who is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to Health Care services, and identifying the communication and education needs of Members, Providers and caregivers. The Ombudsman Liaison must assist Members and Providers in coordinating services with local community organizations and working with advocacy organizations. The Ombudsman Liaison is also responsible for interacting with DCH's equivalent ombudsman staff and submitting reports to DCH.

Operational Start Date: The date upon which the Contractor begins providing services to Members under the Contract.

Ordering Prescribing Referring (OPR) Provider: Pursuant to the Patient Protection and Affordable Care Act and resulting regulations at 42 CFR 455.410(b), a physician or non-physician practitioner that orders, prescribes or refers services for a Member. OPR providers must be enrolled in Medicaid as either a participating Medicaid Provider or as an OPR Provider and his or her National Provider Identifier (NPI) number must be included on submitted claims.

Out of Home Placement: The separation of a child from his/her parent or legal guardian because of abuse and/or neglect or special medical circumstances. The child may be placed in a variety of placement settings including, but not limited to, the home of a relative, a DFCS or Child Placing Agency (CPA) family foster home, or a twenty-four (24) hour child care institution.

Out-of-Network Provider: A Provider of services that does not have a Provider contract with the Contractor.

Parent Company: A company which owns and controls other companies, usually known as subsidiaries.

Part Time Provider: A location operating for less than sixteen (16) hours in an office location each Week.

Participating Provider: A Provider that has signed a contract with the Contractor to provide services to Members.

Patient Centered Medical Home (PCMH): Georgia recognizes Providers as PCMHs if they have received NCQA PCMH recognition. A Patient-Centered Medical Home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The PCMH is intended to result in more personalized, coordinated, effective and efficient care. A PCMH achieves these goals through a high level of accessibility, providing excellent communication among patients, physicians and staff and taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.

Patient Protection and Affordable Care Act (PPACA): The Patient Protection and Affordable Care Act is a federal statute, signed into law on March 23, 2010. The law includes numerous health-related provisions that will take effect over a four year period, including expanding Medicaid eligibility, subsidizing insurance premiums, establishing health insurance exchanges and support of medical research. Also known as ACA.

PeachCare for Kids®: The State of Georgia's Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act.

Peer Support Services: An evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. Designed and delivered by peers who have been successful in the recovery process, peer supports extend the reach of treatment beyond the clinical setting and help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services are provided by Certified Peer Specialists (CPS), peer support providers who have graduated with a certificate from a state approved CPS training. CPS can be provided by an adult peer specialist certified to those with mental illness and/or addictive disease, a youth peer specialist certified to support peers with mental illness and/or addictive disease, or a family peer specialist to support parents with children with serious emotional disturbance.

Performance Improvement Project (PIP): A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have

a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy benefit management services including but not limited to claims processing and maintenance of associated systems and related processes.

Physical Health: The treatment focused on the care and oversight of the general medical Condition of a person and related Physical Health Care services.

Physician Assistant (PA): A trained, licensed individual who performs tasks that might otherwise be performed by physicians or under the direction of a supervising physician.

Physician Incentive Plan: Any compensation arrangement between a Contractor and a Provider that is designed to identify and reward desired behavior or outcomes.

Physician Practice Connections-Patient Centered Medical Home (PPC®-PCMH): The PPC-PCMH is a Recognition Program that emphasizes systematic use of patient-centered, coordinated Care Management processes. In order to obtain the PPC-PCMH Recognition, the entity must meet specific elements in the following categories: (1) Access and Communication, (2) Patient Tracking and Registry Functions, (3) Care Management, (4) patient Self-Management and Support, (5) Electronic Prescribing, (6) Test Tracking, (7) Referral Tracking, (8) Performance Reporting and Improvement, and (9) Advanced Electronic Communication.

Planning for Healthy Babies Program (P4HB): The name of the 1115 Family Planning Demonstration Waiver Program in Georgia. See definition of Demonstration.

Population Health Management (PHM): The management, integration and outcome measurement of any program affecting the health and productivity of the Georgia Families 360° population, i.e. corporate wellness, disease management, catastrophic case management, Utilization Management, Employee Assistance Program (EAP), disability, and/or worker's compensation programs.

Post-Stabilization Services: Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

Potential P4HB Participant: An individual meeting the eligibility requirements for the Demonstration who is subject to mandatory Enrollment in a CMO but is not yet enrolled in a specific CMO.

Pre-Certification: Review conducted prior to a Member's admission, stay or other service or course of treatment in a hospital or other facility.

Preconception Health Care: The primary prevention of maternal and perinatal morbidity and mortality comprised of interventions that identify and modify biomedical, behavioral and social risks to pregnancy outcomes for women and their offspring. To

have maximal impact on pregnancy outcomes, strategies to address risks must occur before conception or before prenatal care is typically initiated.

Preferred Health Organization (PHO): A coordinated care plan that: (i.) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (ii.) provides for reimbursement for all covered benefits regardless of whether the benefits are provided with the network of providers; and (iii.) is offered by an organization that is not licensed or organized under State law as an health maintenance organization.

Pregnancy Rate: The number of pregnancies occurring to females in a specified age group per 1,000 females in the specified age group. The rate is calculated by using the following formula: $\text{Pregnancy rate} = [\text{Number of pregnancies in age group} / \text{Female population in age group}] * 1000$. Rates that use Census Population Estimates in the denominator are unable to be calculated when the selected population is unknown.

Preliminary Protective Hearing (also known as 72-Hour Hearing or Probable Cause Hearing): An informal hearing within seventy-two (72) hours of a child's removal from the home is required when the juvenile court or the court intake officer has not released the child to the custody of his or her parents after removal from the home. If the seventy-two (72)-hour period expires on a Saturday, Sunday, or legal holiday, the hearing must be held on the next day of business which is not a Saturday, Sunday, or legal holiday. (See O.C.G.A. § 15-11-145). At the seventy-two (72)-hour hearing, the judge will determine whether it is safe to return the child to the home or if the child should be detained until a full hearing can be held to determine whether the child is deprived.

Prevalent Non-English Language: A language other than English, spoken by a significant number or percentage of Potential Members or P4HB Participants.

Preventive Action: An intervention initiated to stop a potential problem from occurring. A Preventive Action assumes that adequate monitoring and controls are in place in the Quality system to assure that potential problems are identified and eliminated before they happen. If something in the Quality system indicates that a possible problem is or may develop, a Preventive Action must be implemented to avert and then eliminate the potential situation. Documentation for a Preventive Action provides evidence that an effective Quality system has been implemented that is able to anticipate, identify and eliminate potential problems. The process for detecting potential problems/issues and eliminating them includes:

- i. Identifying the potential problem/issue
- ii. Finding the cause of the potential problem/issue
- iii. Developing a plan to prevent the occurrence of the problem/issue
- iv. Implementing the plan
- v. Reviewing the actions taken and the effectiveness in preventing the problem

Preventive Services: Services provided by a physician or other licensed health practitioner within the scope of his or her practice under State law to: prevent disease, disability, and other health Conditions or their progression; treat potential secondary

Conditions before they happen or at an early remediable stage; prolong life; and promote physical and mental health and efficiency.

Primary Care: All Health Care services and laboratory services, including periodic examinations, preventive Health Care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of Referrals to specialty Providers described in this Contract, and for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner or alternative Provider types such as specialists to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP): A licensed health care practitioner, usually a doctor, nurse practitioner, or physician assistant who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required Primary Care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, OB/GYNs, Physicians' Assistants, or nurse practitioners. The PCP's role is to:

- i. Provide preventive care and teach healthy lifestyle choices
- ii. Identify and treat common medical conditions
- iii. Assess the urgency of an individual's medical problems and direct him/her to the best place for that care
- iv. Make referrals to medical specialists when necessary

Primary Dental Provider (Dentist): A licensed dentist who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required general dental services to Georgia Families 360° Members. A Dentist shall include general dental practitioners provided that the Dentist is able and willing to carry out all Dentist responsibilities in accordance with these Contract provisions and licensure requirements. The Dentist is responsible for coordinating referrals, as needed, with Dental Subspecialty Providers and all subsequent dental care.

Prime Contractor: Primary Contractor of the Contract who holds full responsibility of the completion of the job. The Contractor, regardless of use of Subcontractors, is the Prime Contractor of this Contract.

Prior Authorization: Authorization granted in advance of the rendering of a service after appropriate medical review. Also known as Pre-Authorization or Prior Approval.

Prior Authorization Portal: The electronic web-based system through which Providers and the Contractor communicate about Prior Authorization requests submitted by Providers.

Proposed Action: The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or

termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the Contractor to act within the timeframes provided in 42 CFR 438.408(b).

Prospective Payment System (PPS): A method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Protected Health Information (PHI): A subset of health information, including demographic information collected from an individual and (1) created or received by a health care provider, health plan, employer, or health care clearinghouse, and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) is a reasonable basis to believe the information can be used to identify the individual. This information is (i) transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health information (i) in education records covered by the Family Educational Rights and Privacy Act, (ii) in employment records held by a covered entity in its role as employer; (iii) regarding persons who have been deceased for more than fifty (50) years; and (iv) in records described at 20 U.S.C. § 1232g (a) (4) (B) (iv).

Provider: Any person (including physicians or other Health Care Professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide Health Care Services that has contracted with a Care Management Organization to provide health care services to Members.

Provider Complaint: A written expression by a Provider, which indicates dissatisfaction or dispute with the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.

Provider Contract: Any written contract between the Contractor and a Provider that requires the Provider to perform specific parts of the Contractor's obligations for the provision of Health Care services under this Contract.

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

Provider Number (or Provider Billing Number): An alphanumeric code utilized by health care payers to identify providers for billing, payment, and reporting purposes.

Provider Withhold: A percentage of payments or set dollar amounts that a Contractor deducts from a Provider's payment or fee, or salary payment, and that may or may not be returned to the Provider, depending on specific predetermined factors.

Prudent Layperson: A person with average knowledge of health and medicine who could reasonably expect the absence of immediate medical attention to result in an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that could cause:

- i. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- ii. Serious impairment to bodily functions; or
- iii. Serious dysfunction of any bodily organ or part.

Psychiatric Residential Treatment Facility (PRTF): A separate, standalone entity providing a range of comprehensive psychiatric services to treat the psychiatric condition of residents under age twenty-one (21) years on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed. (42 CFR §483.352, subpart D of part 441)

Qualified Electronic Health Record: "An Electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists; and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relevant to health care quality; and to exchange electronic health information with and integrate such information from other sources." Source is ARRA - H.R.1 -115 Sec. 3000 (13)

Qualified Entities (QEs): Entities that have permission from DCH and/or its designee to access services available on the GaHIN Network and meet a set of DCH-established criteria, have completed an approval process, and have signed participation documentation with Contractor. QEs ensure that GaHIN Participant Users and/or vendors with which they have agreements comply with the applicable terms of participation and related policy documentation.

Qualified Member: Individuals who meet a set of established criteria, successfully complete the approval process, and sign agreements to abide by GaHIN policies. GaHIN Member Users have permission to access, consume, and make available data transport services on the statewide health information network.

Quality: The degree to which the Contractor increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

Query-Based Exchange: Technology and functionality that GaHIN Authorized Users/Member Affiliates will use to search for and locate individual Member records.

Rapid Cycle Process Improvement: A quality improvement method that identifies, implements and measures changes made to improve a process or a system. Rapid-cycle improvement implies that changes are made and tested over short time frames (weeks to months) rather than years.

Re-admission: Subsequent admissions of a patient to a hospital or other health care institution for treatment within thirty (30) Calendar Days of the date of Discharge.

Recoupment: The recovery by the Contractor of any Medicaid debt by reducing present or future Medicaid payments and applying the amount withheld to the indebtedness.

Referral: A request by a PCP for a Member to be evaluated and/or treated by a different physician, usually a specialist.

Referral Services: Those Health Care services provided by a Health Care Professional other than the Primary Care Provider and which are ordered and approved by the Primary Care Provider or the Contractor.

Referring Provider: The Provider who has evaluated the Member, determined the need for a consultation (or other service), and has arranged the services of the consulting provider for the purpose of diagnosis and/or treatment.

Regional Interagency Action Team (RIAT): These teams provide feedback from each of DBHDD's five (5) regions for collaborative learning regarding the operation of the LIPT. The RIAT addresses service gaps, barriers, fragmentation and duplication across partners at the regional level, as well as other issues relating to children's Behavioral Health. Membership includes the chairpersons of the LIPTs located within the region, regional representation by mandated agencies, LIPT trainers, and a Member's family representative. These teams are not required by law.

Reinsurance: An agreement whereby the Contractor transfers risk or liability for losses, in whole or in part, sustained under this Contract. A reinsurance agreement may also exist at the Provider level.

Remedial Action: Action required immediately to remedy a situation until a thorough investigation and a permanent solution is implemented. When remedial actions are necessary, the actions and the resources required must be listed and the steps that must be taken immediately to avoid any further adverse effects are explained. All actions taken are documented and become part of the 'Action Plan' section of the Corrective Action/Preventive Action actions. If a remedial action is all that is needed, a rationale for that decision and appropriate follow up must be documented.

Remedy: The State's means to enforce the terms of the Contract through performance guarantees and other actions.

Reprocessing (Claims): Upon determination of the need to correct the outcome of one or more Claims processing transactions, the subsequent attempt to process a single Claim or batch of Claims.

Requirements Analysis Documents (RADs): A set of documents that describe the technical and business process requirements of each Deliverable identified in the Contract. Each requirement is defined in such way that its achievement is capable of being objectively verified by a prescribed method (for example inspection, demonstration, analysis, or test) and serves as a contractual basis between DCH and Contractor. DCH shall post such RADs on the DCH website and the Contractor shall access this information as determined by DCH. DCH reserves the right to modify the RADs as needed. The initial RADs will be developed by DCH during the Implementation Phase.

Residential Placement: An Out of Home Placement setting designed to meet the needs of children and youth with behavioral, emotional and mental health needs that prevent them from being able to reside in a less structured family home setting. A residential treatment facility offers a structured physical environment and a treatment program designed to help children improve their ability to function in multiple areas of life. For DJJ Members, Residential Placement may also be referred to as Room Board and Watchful Oversight (RBWO).

Residential Placement Provider: A Provider contracted with DFCS or DJJ providing Residential Placements.

Resource Mother: A paraprofessional that provides a broad range of services to P4HB IPC Participants and their families.

Resource Mother Outreach: Service under the P4HB program made available to women who receive Medicaid benefits and give birth to a VLBW baby. The Resource Mother Outreach section offers support to mothers and provides them with information on parenting, nutrition, and healthy lifestyles. Details pertaining to Resource Mothers Outreach are incorporated in **Attachment N** to this Contract.

Responsible Health Organization: Includes CMOs and FFS and is the party stated on the DCH MMIS portal as evidenced by the Provider's screen print out when the service is rendered within seventy-two (72) hours of that screen shot.

Revenue Codes: A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).

Routine Care: Treatment of a Condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physicians' office) or by the patient.

Rural Health Clinic (RHC): A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to Primary Care

in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, Physician Assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least fifty percent (50%) of the time with a mid-level practitioner. RHCs may also provide other Health Care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs.

Rural Health Services: Medical services provided to rural sparsely populated areas isolated from large metropolitan counties.

Security Rule: Establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic Protected Health Information. Ref. 45 CFR Part 160 and Subparts A and C of Part 164.

Service Authorization: A Provider's request for services for Members.

Service Region: A geographic area defined by the State that is used for reporting and analytical purposes.

SHINES: A web-based, statewide automated child welfare information system (SACWIS) that offers DFCS child welfare professionals a comprehensive case management tool.

Short Term: A period of thirty (30) Calendar Days or less.

Span of Control: Information systems and telecommunications capabilities that the Contractor operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The Contractor span of control also includes Information Systems and telecommunications capabilities outsourced by the Contractor.

Special Health Needs Care Managers: Provides clinical service to facilitate development of a Foster Care Member or AA Member Health Care Service Plan and coordination of clinical services among PCPs and specialty providers to ensure Members with Special Health Care Needs have access to, and appropriately utilize, Medically Necessary Covered Services.

Stabilized: With respect to an Emergency Medical Condition; that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, the woman has delivered (including the placenta).

State: The State of Georgia.

State Fair Hearing: See Administrative Law Hearing.

State Health Benefit Plan (SHBP): The health benefit plan administered by the Georgia Department of Community Health covering State employees, public school teachers, public school employees, retirees and their eligible dependents, and other entities under the Official Code of Georgia for health insurance.

State Plan: A comprehensive written statement submitted by DCH describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal Financial Participation (FFP) in the State program.

State-Vaccine-Eligible Child: With respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B) of the Social Security Act.

Subcontract: Any written contract between the Contractor and a third party, including a Provider, to perform a specified part of the Contractor's obligations under this Contract.

Subcontractor: Any third party who has a written Contract with the Contractor that have been assigned delegated functions and who have interactions with Members' Coordination of Care or the delivery of care.

Subcontractor Payments: The all-inclusive amount the Contractor pays a Subcontractor for services rendered.

Substance Abuse: Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. The term may also reference the field of clinical study and treatment of individuals who have experienced chronic disease related to substance abuse.

Substantiated Maltreatment: A disposition of a Child Protective Services (CPS) investigation which concludes that child maltreatment, as defined by federal and state law, and CPS policy, has occurred as supported by a preponderance of the evidence.

System Access Device: A device used to access Information System functions; can be any one of the following devices if it and the System are so configured: (i.) Workstation (stationary or mobile computing device), (ii.) Network computer/"winter" device, (iii.) "Point of Sale" device, (iv.) Phone, or (v.) Multi-function communication and computing device, e.g. Personal Digital Assistant (PDA).

System for the Uniform Calculation and Consolidation of Economic Support Services (SUCCESS): An integrated computer system utilized by DFCS and DCH to record information and generate benefits to assistance units (group or individual(s) applying for or receiving benefits).

System Function Response Time: Based on the specific sub-function being performed:

- i. Record Search Time: The time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
- ii. Record Retrieval Time: The time elapsed after the retrieve command is entered until the record data begins to appear on the monitor.
- iii. Print Initiation Time: The elapsed time from the command to print a screen or report until it appears in the appropriate queue.
- iv. On-line Claims Adjudication Response Time: The elapsed time from the receipt of the transaction by the Contractor from the Provider and/or switch vendor until the Contractor hands-off a response to the Provider and/or switch vendor.

System of Care: A spectrum of effective, highly-coordinated community-based services and supports for children and youth with or at risk for mental health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families' and youths' needs to help them to function better at home, in school, in the community, and throughout life.

System of Care core values and philosophy include an expectation that services and supports: are culturally and linguistically competent; ensure availability and access to effective traditional and nontraditional services as well as natural and informal supports that address physical, emotional, social, and educational needs; are planned in true partnership with the child and family and a family peer professional representative; and include intensive Care Management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

This definition is culled from an Issue Brief by the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, <http://gucchdtacenter.georgetown.edu/resources/>. The Contractor will reference and incorporate revised definitions, protocol, and operations as indicated according to published updates issued by the National Technical Assistance Center for Children's Mental Health.

System Unavailability: Failure of the system to provide a designated user access based on service level agreements or software/hardware problems within the Contractor's Span of Control.

Telecommunication Device for the Deaf (TDD): Special telephony devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones.

Telemedicine: Delivery of medical or other health services provided to a patient utilizing real-time interactive communication equipment to exchange the patient's information from one site to another via an electronic communication system.

Third Party Resource: Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a Member.

Transition of Care: The movement of patients between health care practitioners and/or settings as their condition and care needs change during the course of a chronic or acute illness. For FC Members, DJJ Members and AA Members, Transition of Care planning may involve activities or needs related to a Member's placement in DFCS custody or under DJJ supervision, transition from FFS Medicaid or commercial health plans to the Georgia Families 360° program; transition from a CMO to the Georgia Families 360° CMO, changes in Residential Placement, aging out of Foster Care or exiting DJJ supervision.

Translation Services: The act or process of changing or converting one language to another language. The translator must be fluent in both the original source language and the target language and must translate the language to make it understandable. Translation Services may also include the use of computer tools or technology. Translation Services are available free of charge to potential members and enrolled Members.

Trauma Assessment: A component of the CCFA provided to FC Members placed in DFCS custody. The comprehensive Trauma Assessment involves an in-depth exploration of the nature and severity of the traumatic events experienced directly or witnessed by the child, the sequence of those events, and the current trauma-related symptoms to determine the best type of treatment for that specific child. A CCFA Provider must use an assessment tool approved by DCH to identify the types and severity of symptoms the child is experiencing. The comprehensive Trauma Assessment must provide recommendations to coordinate services and meet the child's needs.

Trauma Screening: A brief, focused inquiry to determine the specific traumatic events experienced by the child. A Trauma Screening is conducted to direct the Trauma Assessment.

Unique Provider: A provider who furnishes, bills, or is paid for health care services provided to Members and who has been assigned a designated National Provider Identifier (NPI). The provider is identified utilizing the designated NPI number. Multiple practice locations are not taken into consideration when identifying the provider

Unique Provider Identifier: The National Provider Identifier (NPI) number assigned to an individual provider notwithstanding the provider's multiple office or practice locations.

Urgent Care: Medically Necessary treatment for an injury, illness, or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Utilization: The rate patterns of service usage or types of service occurring within a specified time.

Utilization Management (UM): A service performed by the Contractor which seeks to assure that Covered Services provided to Members are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established or administered by DCH.

Utilization Review (UR): Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of Health Care services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, Care Management, Discharge Planning, or retrospective review.

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Value-Based Purchasing: An enhanced approach to purchasing and program management that focuses on value over volume. It is part of a comprehensive strategy that aligns incentives for Members, Providers, Contractor and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.

Value-Based Purchasing (VBP) Performance Management Team (PMT): Monitors CMO performance on VBP initiatives. Members of the VBP Performance Management Team include:

- i. Medicaid Director
- ii. DCH senior level employee(s)
- iii. Leadership from Georgia healthcare departments that support Medicaid: quality management, provider networks, medical management, member services, community outreach and finance
- iv. Contract Liaisons
- v. Representatives from DCH and Contractor's legal departments, as appropriate
- vi. As appropriate, management from enterprise functions (e.g., communications, information technology)
- vii. Key leadership from the Contractor (e.g., Medical Director Chief Operating Officer or other designee approved by DCH)
- viii. As appropriate, operational-level Contractor staff

Value-Based Purchasing Withhold: DCH will withhold five percent (5%) of the Contractor's Capitation Payments for the Value-Based Purchasing program. DCH may return all, part or none of the withheld funds to the Contractor as incentive payments

based on the Contractor achieving identified VBP performance targets. The maximum incentive payment to the Contractor will be the full five percent (5%) VBP Withhold.

Very Low Birth Weight (VLBW): Birth weight below 1,500 grams (3.3 pounds).

Virtual Health Record (VHR): A virtual view of many data sources that contain patient health records. The VHR enables authorized users to query Georgia Families 360° Member health information.

Week: The traditional seven-day week, Sunday through Saturday.

Work Week: The traditional work week, Monday through Friday.

Working Days: Monday through Friday but shall not include Saturdays, Sundays, or State and Federal holidays.

1.5 ACRONYMS

For purposes of this Contract the following terms, abbreviations, and acronyms are defined as follows:

AA Member – Adoption Assistance Member

AAPD – American Academy of Pediatric Dentistry

ABD – Aged Blind Disabled

ACE – Administrative Claiming for Education

ACIP – Advisory Committee on Immunization Practices

AD – Addictive Disease

ADL – Activities of Daily Living

AFDC – Aid to Families with Dependent Children

AHRQ – Agency for Healthcare Research and Quality

AICPA – American Institute of Certified Public Accountants

BHH - Behavioral Health Home

BIN – Bank Identification Number

CAH – Critical Access Hospital

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CAPA – Corrective Action Preventive Action

CAPTA – Child Abuse Prevention and Treatment Act

CASA – Court Appointed Special Advocate

CBAY – Community-Based Alternatives for Youth

CCFA – Comprehensive Child and Family Assessment

CCT – Care Coordination Team

CCP – Comprehensive Community Providers

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CFT – Child and Family Team

CHIP – Children’s Health Insurance Program – formerly known as the State Children’s Health Insurance Program (SCHIP)

CISS – Children’s Intervention School Services

CLIA – Clinical Laboratory

CMHRS – Community Mental Health Rehabilitation Services

CMO – Care Management Organization

CMP – Community Medicaid Providers

CMS – Centers for Medicare & Medicaid Services

CNM – Certified Nurse Midwives

COMP – Comprehensive Supports Waiver Program

COS – Category of Service

CPS – Child Protective Services

CSB – Community Service Boards

CVO – Credentialing Verification Organization

DBHDD – Department of Behavioral Health and Developmental Disabilities

DCH – Department of Community Health

DECAL – Department of Early Care and Learning

DFCS – Division of Family and Children Services

DJJ – Department of Juvenile Justice

DJJ Member – Department of Juvenile Justice Member

DMAP – Division of Medical Assistance Plans

DME – Durable Medical Equipment

DO – Doctor of Osteopathy

DOE – Department of Education

DPH – Department of Public Health

DRG – Diagnostic Related Group

EB – Enrollment Broker

ED – Emergency Department

EDI – Electronic Data Interchange

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ER – Emergency Room

eRFP –electronic Request for Proposal

eRFQC – electronic Request for Qualified Contractors

EVS - Eligibility Verification System

FAC - Fiscal Agent Contractor

FC Member – Foster Care Member

FFP – Federal Financial Participation

FFS – Fee-for-Service

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

GaHIN – Georgia Health Information Network

GAPP – Georgia Pediatric Program

GCAL – Georgia Crisis and Access Line

GEPS – Georgia Enterprises for Products and Services

GF – Georgia Families

GF 360° – Georgia Families 360°

GFMOG – Georgia Families Monitoring and Oversight Committee

GTA - Georgia Technology Authority

HCBS – Home- and Community-Based Services

HEDIS – Healthcare Effectiveness Data and Information Set

HHS – US Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Maintenance Organization

HPSA – Health Professional Shortage Area

IBNR – Incurred-But-Not-Reported

ICAMA – Interstate Compact on Adoption and Medical Assistance

ICF/ID – Intermediate care facility for the intellectually disabled

ICPC – Interstate Compact on the Placement of Children

ICWP – Independent Care Waiver Program

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IFI – Intensive Family Intervention

IFSP – Individualized Family Service Plan

INS – U.S. Immigration and Naturalization Services

IPC – Interpregnancy Care component of the 1115 Demonstration Waiver

JPPS – Juvenile Parole/Probation Specialist

LBW – Low Birth Weight

LEAs – Local Education Agencies

LIM – Low-Income Medicaid

LIPT – Local Interagency Planning Team

MDT – Multidisciplinary Team

MMIS – Medicaid Management Information System

MSHCN – Members with Special Health Care Needs

NAIC – National Association of Insurance Commissioners

NCM – Nurse Case Manager

NCQA – National Committee for Quality Assurance

NCTSN – National Child Traumatic Stress Network

NET – Non-Emergency Transportation

NICU – Neonatal Intensive Care Unit

NOIA – Notice of Intent to Award

NOW – New Options Waiver Program

NP-C – Certified Nurse Practitioners

NPI – National Provider Identifier

O.C.G.A. – Official Code of Georgia Annotated

OSAH – Office of State Administrative Hearings

P4HB – Planning for Healthy Babies 1115 Demonstration Waiver

PA – Physician Assistant

PBM – Pharmacy Benefit Manager

PCMH - Patient Centered Medical Home

PCP – Primary Care Provider

PDF – Portable Document Format file

PDSA – Plan Do Study Act

PHI – Protected Health Information

PHM – Population Health Management

PHO - Preferred Health Organization

PIP – Performance Improvement Project

PMPM – Per Member Per Month

PPACA – Patient Protection and Affordable Care Act

PPC®-PCMH - Physician Practice Connections-Patient Centered Medical Home

PPS – Prospective Payment System

PQO - Performance, Quality and Outcomes

PRTF – Psychiatric Residential Treatment Facility

QAPI – Quality Assessment Performance Improvement

QEs – Qualified Entities

RBWO – Room Board and Watchful Oversight

RFP – Request for Proposal

RHC – Rural Health Clinic

RIAT – Regional Interagency Team

RSM – Right from the Start Medicaid

SED – Severe Emotional Disorder

SHBP – State Health Benefits Plan

SHD – Systems Help Desk

SP – Specialty Providers

SSA – Social Security Act

SSI – Supplemental Security Income

SUD – Substance use Disorder

SUCCESS – System for the Uniform Calculation and Consolidation of Economic Support

TANF – Temporary Assistance for Needy Families

TCN – Transaction Control Number

TDD – Telecommunication Device for the Deaf

UM – Utilization Management

UPIN – Unique Provider Identifier Number

UR – Utilization Review

VBP – Value-Based Purchasing

VFC – Vaccines for Children

VHR – Virtual Health Record

VLBW – Very Low Birth Weight

W3C – World Wide Web Consortium

2.0 **DCH RESPONSIBILITIES**

2.1 **GENERAL PROVISIONS**

- 2.1.1 DCH is responsible for administering the GF 360° program. The Department will administer the Contract, monitor Contractor performance, and provide oversight in all aspects of the Contractor operations.

2.2 LEGAL COMPLIANCE

- 2.2.1 DCH will comply with, and will monitor Contractor's compliance with, all applicable State and federal laws and regulations, including but not limited to, implementing and abiding by all requirements established by CMS.

2.3 ELIGIBILITY AND ENROLLMENT

- 2.3.1 The State of Georgia has the sole authority for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for Enrollment in GF. DCH or its Agent will determine eligibility for PeachCare for Kids® and will collect applicable premiums. DCH or its Agent will continue responsibility for the electronic eligibility verification system (EVS).
- 2.3.2 DCH or its Agent will issue a daily notice of all Enrollments to the Contractor. Members shall be enrolled in the GF 360° CMO within forty-eight (48) hours of DCH's receipt of the Member's eligibility file from DFCS.
- 2.3.3 DCH or its Agent will be responsible for the consecutive Enrollment period and re-Enrollment functions.
- 2.3.4 In accordance with current operations, the State or its Agent will issue a Medicaid number to a newborn upon notification from the hospital, or other authorized Medicaid Provider.
- 2.3.5 DCH will notify Contractor that a Foster Care Member, Adoptive Assistance Member or Juvenile Justice Member is an expectant mother based on the pregnancy Category of Service. Upon notification from DCH, the CMO shall mail a newborn enrollment packet to the DFCS Case Manager, Adoptive Parent or JPPS. This packet shall include information that the newborn will be Auto-Assigned to a Georgia Families CMO and, if desired, select a PCP for the newborn prior to the birth by contacting the Georgia Families CMO. The DFCS Case Manager, Adoptive Parent or JPPS shall have ninety (90) Calendar Days from the day a Medicaid number was assigned to the newborn to choose a different CMO.
- 2.3.6 DCH may, at its sole discretion, elect to modify the Auto-Assignment threshold and/or use quality, cost, or other measures to conduct auto-assignments for reasons it deems necessary and proper.

2.4

DISENROLLMENT

- 2.4.1 DCH or its Agent will process all CMO Disenrollments. This includes AA Member Disenrollments due to loss of eligibility for GF 360° and all Disenrollment requests Members or the Contractor submits via telephone, surface mail, internet, facsimile, and in person.
- 2.4.2 DCH or its Agent will make final determinations about granting Disenrollment requests and will notify the Contractor via file transfer and the Member via surface mail of any Disenrollment decision within five (5) Calendar Days of making the final determination.
- 2.4.3 If a Member is hospitalized in an acute inpatient facility on the first day of the month their Disenrollment is to be effective, the Member will remain enrolled until the end of the month of their Discharge from the inpatient facility. When Disenrollment is necessary due to a change in eligibility category, or eligibility for GF 360°, the Member will be disenrolled according to the timeframes identified in Section 2.4.7.
- 2.4.5 When Disenrollment is necessary because a Member loses Medicaid or PeachCare for Kids® eligibility (for example, he or she has died, been incarcerated, or moved out-of-state), Disenrollment shall be immediate.
- 2.4.6 AA Members enrolled in the GF 360° CMO may elect to disenroll from the GF 360° CMO without cause within the first ninety (90) Calendar Days following the date of the AA Member's initial enrollment in the GF 360° CMO or the date DCH sends the AA Member notice of the Enrollment, whichever is later ("AA Member Fee-For-Service Selection Period"). AA Members disenrolling from the GF 360° CMO shall return to the Medicaid Fee-For-Service delivery system. The change in CMO enrollment will be reflected in the updated GF Member eligibility roster and associated change in AA Member Capitation Rate. The disenrollment from the GF 360° CMO will be processed within two (2) Business Days of the date that the AA Member completes the requirements for disenrolling from the GF 360° CMO and the effective date of such change will be date the disenrollment requirements were met by the AA Member.
- 2.4.6.1 If an AA Member does not elect to disenroll from the GF 360° CMO during the AA Member Fee-For-Service Selection Period, such AA Member shall remain in the GF 360° CMO until the end of the AA Member's Consecutive Enrollment Period, subject to eligibility and Sections 4.2.2 and Sections 4.2.3 of the Contract.
- 2.4.6.1.1 DCH or its Agent will notify AA Members at least once every twelve (12) months, and at least sixty (60) Calendar Days prior to the date upon which the AA Member Consecutive Enrollment period ends (the annual Enrollment opportunity), that they have the opportunity to

disenroll from the GF 360° CMO without cause and return to the Medicaid Fee-For-Service delivery system. AA Members who do not make a choice to return to the Medicaid Fee-For-Service delivery system during this thirty (30) Calendar Day period will be deemed to have chosen to remain enrolled in the GF 360° CMO until the AA Member's next AA Member Consecutive Enrollment Period.

2.4.6.2 AA Members who disenrolled from the GF 360° CMO pursuant to Sections 4.2.1.1 and 4.2.1.2 may request to re-enroll in the GF 360° CMO at any time, subject to eligibility and Sections 4.2.2 and 4.2.3 of the Contract. The change in Georgia Families 360° CMO enrollment will be reflected in the updated Member eligibility roster and associated change in AA Member Capitation Rate. The re-enrollment in the GF 360° CMO will be processed within two (2) Business Days of the date that the AA Member completes the requirements for re-enrollment into the GF 360° CMO and the effective date of such change will be the date the re-enrollment requirements were met by the AA Member.

2.4.7 If an AA Member is hospitalized in an inpatient facility on the first day their Disenrollment from the FCAA CMO is to be effective pursuant to Sections 4.2.1.1 and 4.2.1.2, the AA Member will remain enrolled in the GF 360° CMO until the date Discharged from the inpatient facility. If an AA Member is hospitalized in an inpatient facility on the first day their Disenrollment from the Fee-For-Service delivery system and return to the FCAA CMO is to be effective pursuant to Section 2.4.8, the AA Member will remain enrolled in the Fee-For-Service delivery system until the date Discharged from the inpatient facility.

2.5 MEMBER SERVICES AND MARKETING

2.5.1 DCH will provide to the Contractor its methodology for identifying the prevalent non-English languages spoken. For the purposes of this Section, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State.

2.5.2 DCH will review and prior approve all marketing materials.

2.5.3 DCH will provide the Contractor with DCH logos and designs when such logos and designs are appropriate to the written materials being produced.

2.6 COVERED SERVICES & SPECIAL COVERAGE PROVISIONS

2.6.1 For Members, Medically Necessary Services and Benefits pursuant to the Georgia State Medicaid and CHIP State Plans, and the Georgia Medicaid

Policies and Procedures Manuals are covered. Such Medically Necessary Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

2.6.2 Specific services available under the P4HB Demonstration are outlined in **Attachment L** to this Contract.

2.7 **NETWORK**

2.7.1 DCH will provide to the Contractor up to date changes to the State's list of excluded Providers, as well as any additional information that will affect the Contractor's Provider network.

2.7.1.1 DCH may consider Contractor's requests to waive network geographic access requirements in rural areas with insufficient potential Providers. All such requests shall be submitted in writing.

2.7.1.2 DCH will provide the State's Provider Credentialing policies and processes to the Contractor upon execution of this Contract.

2.8 **QUALITY MONITORING**

2.8.1 General Provisions

2.8.1.1 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor. In accordance with 42 CFR 438.204, this strategy will, at a minimum, monitor:

2.8.1.1.1 The availability of services;

2.8.1.1.2 The adequacy of the Contractor's capacity and services;

2.8.1.1.3 The Contractor's coordination and continuity of care for Members;

2.8.1.1.4 The coverage and authorization of services;

2.8.1.1.5 The Contractor's policies and procedures for selection and retention of Providers;

2.8.1.1.6 The Contractor's compliance with Member information requirements in accordance with 42 CFR §438.10;

2.8.1.1.7 The Contractor's compliance with State and federal privacy laws and regulations relative to Member's confidentiality;

- 2.8.1.1.8 The Contractor's compliance with Member Enrollment and Disenrollment requirements and limitations;
- 2.8.1.1.9 The Contractor's Grievance System;
- 2.8.1.1.10 The Contractor's oversight of all Subcontractor relationships and delegations;
- 2.8.1.1.11 The Contractor's adoption of practice guidelines, including the dissemination of the guidelines to Providers and Providers' application of them;
- 2.8.1.1.12 The Contractor's quality assessment and performance improvement program; and
- 2.8.1.1.13 The Contractor's health information systems.
- 2.8.1.1.14 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor for the Demonstration and the outcomes resulting from those services. This strategy is incorporated in **Attachment M**.

2.8.2 Value-Based Purchasing

- 2.8.2.1 Prior to the Operations Start Date, DCH will establish the VBP Performance Management Team, which will be responsible for planning, implementing and executing the VBP initiative. Key responsibilities include:
 - 2.8.2.1.1 Overseeing execution of the VBP model;
 - 2.8.2.1.2 Working collaboratively with the Contractor to meet identified performance measures and targets;
 - 2.8.2.1.3 Reviewing Contractor progress monthly, quarterly and annually;
 - 2.8.2.1.4 Identifying lessons learned and necessary adjustments;
 - 2.8.2.1.5 Determining incentive payouts;
 - 2.8.2.1.5 Assessing liquidated damages; and
 - 2.8.2.1.6 Communicating results to stakeholders.

- 2.8.2.2 DCH will publish a VBP Operations Manual and will be responsible for updates to such manual as determined by DCH.

2.9 COORDINATION WITH CONTRACTOR'S KEY STAFF

- 2.9.1 DCH will make diligent good faith efforts to facilitate effective and continuous communication and coordination with the Contractor in all areas of GF 360° operations.
- 2.9.2 Specifically, DCH will designate individuals within the Department who will serve as a liaison to the corresponding individual on the Contractor's staff, including:
 - 2.9.2.1 A program integrity staff member;
 - 2.9.2.2 A quality oversight staff member;
 - 2.9.2.3 A Grievance System staff member who will also ensure that the State Administrative Law Hearing process is consistent with the Rules of the Office of the State Administrative Hearings Chapter 616-1-2 and with any other applicable rule, regulation, or procedure whether State or federal;
 - 2.9.2.4 An information systems coordinator; and
 - 2.9.2.4 A contract compliance staff member.

2.10 FORMAT STANDARDS

- 2.10.1 DCH will provide to the Contractor its standards for formatting all Reports requested of the Contractor. DCH will require that all Reports be submitted electronically.

2.11 FINANCIAL MANAGEMENT

- 2.11.1 In order to facilitate the Contractor's efforts in using Cost Avoidance processes to ensure that primary payments from the liable third party are identified and collected to offset medical expenses; DCH will include information about known Third Party Resources on the electronic Enrollment data given to the Contractor.
- 2.11.2 DCH will monitor Contractor compliance with federal and State physician and member incentive plan rules and regulations.

2.12 INFORMATION SYSTEMS

- 2.12.1 DCH will supply the following information to the Contractor:

- 2.12.1.1 Application and database design and development requirements (standards) that are specific to the State of Georgia.
- 2.12.1.2 Networking and data communications requirements (standards) that are specific to the State of Georgia.
- 2.12.1.3 Specific information for integrity controls and audit trail requirements.
- 2.12.1.4 State web portal (Georgia.gov) integration standards and design guidelines.
- 2.12.1.5 Specifications for data files to be transmitted by the Contractor to DCH and/or its agents.
- 2.12.1.6 Specifications for point-to-point, uni-directional or bi-directional interfaces between Contractor and DCH systems.
- 2.12.2 DCH and/or its designee will develop and maintain Virtual Health Records (VHR) for Members to ensure that health information provided to DCH Staff, DFCS, DJJ, other state agencies as appropriate, network Providers, and other GaHIN Network Authorized Users is timely, portable and readily accessible. The VHR will provide data sharing capabilities between the Contractor, DCH, state agencies, Providers, Foster Parents, Adoptive Parents, and Members.
- 2.12.3 DCH and/or its designee will structure the Virtual Health Record in a manner to provide the data in a summarized, user friendly, printable format and shall employ hierarchical security measures to limit access to designated persons as defined by DCH.
- 2.12.4 The VHR will be available twenty-four (24) hours per day, seven (7) days per week, except during limited scheduled system downtime. DCH and/or its designee will post routine scheduled downtime on its website. DCH shall make reasonable attempts to communicate non-routine scheduled downtime to Contractor before the scheduled downtime occurs.

2.13 READINESS AND ANNUAL REVIEW

2.13.1 Project Plan

- 2.13.1.2 Within thirty (30) Calendar Days of the Contract Effective Date, the Contractor shall submit a detailed project plan (“Project Plan”), including a project schedule, to DCH outlining the proposed, specific timeframes associated with Contract requirements, and identifying dedicated Contractor staff. The Project Plan should address the planning, implementation and deployment phases of the Contract. The format for the Project Plan shall be in a version

of Microsoft Excel and Microsoft Project agreed upon by DCH. DCH shall have five (5) Calendar Days to review the Project Plan and project schedule, and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized Project Plan and project schedule to DCH.

2.13.2.2 Within ten (10) Calendar Days of the Contract Effective Date, the Contractor must designate a dedicated project manager "CMO Project Manager" and CMO project management team ("CMO Project Management Team"). The CMO Project Manager must be stationed at the CMO's metropolitan Atlanta headquarters. The CMO Project Manager must also be onsite at the DCH offices in Atlanta, Georgia during times specified by DCH during the planning, implementation and deployment phases of the Contract.

2.13.2.3 The Contractor must continue to submit revised Project Plans and project schedules throughout the planning, implementation and deployment phases based upon requested updates or revisions from DCH.

2.13.3 Staffing Plan

2.13.3.1 Within thirty (30) Calendar Days of the Contract Effective Date, the Contractor must submit a staffing plan ("Staffing Plan") to DCH, specifically addressing anticipated timeframes for hiring and staff training; the proposed organizational chart, reporting responsibilities, Contractor staff to Member ratios, and the physical location of staff for each functional area referenced in the Contract. DCH shall have five (5) Calendar Days to review the Staffing Plan and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized Staffing Plan to DCH.

2.13.4 Subcontractors

2.13.4.1 Within thirty (30) Calendar Days of the Contract Effective Date, the Contractor must provide a listing, including detailed contact information, for all of its Subcontractors involved in the execution of this Contract, including a description of the Subcontractor's organization and the responsibilities that are delegated to the Subcontractor. Contractor will not contract or permit the performance of any work or services by Subcontractors without prior written consent of DCH.

2.13.5 Transition of Care Plan

2.13.5.1 Within thirty (30) Calendar Days of the Contract Effective Date, the Contractor must provide a high-level draft of the Transition of Care plan for those Members enrolled in Medicaid prior to the

Operations Start Date and who will transition to the Contractor's GF 360° Plan on the Operations Start Date ("Transition of Care Plan"). At a minimum, this plan shall address the data and claims requirements, data analysis methodology, communications and outreach, specific timeframes for executing the Transition of Care Plan, dedicated Contractor staff involvement in the Transition of Care Plan, approach and involvement with sister agencies, ensuring continuity of care and plans for conducting all applicable health and trauma assessments, if applicable. DCH shall have fifteen (15) Calendar Days to review the draft Transition of Care Plan and Contractor shall have fifteen (15) Calendar Days from completion of DCH's review to submit the finalized Transition of Care Plan to DCH.

2.13.6 Dental Home

2.13.6.1 The Contractor shall submit policies and procedures for providing a Dental Home for Members to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the policies and procedures and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized policies and procedures to DCH.

2.13.7 Health Risk Screening

2.13.7.1 The Contractor shall submit policies and procedures for conducting the Health Risk Screening and the tools that will be used to conduct the screenings to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the policies and procedures and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized policies and procedures to DCH.

2.13.8 Readiness Reviews

2.13.8.1 DCH or its Agent will conduct a readiness review of Contractor at least ninety (90) Calendar Days prior to Enrollment of Members in the CMO. DCH or its Agent will conduct the reviews to provide assurances that the Contractor is able and prepared to perform all administrative functions and is providing high quality of services to Members.

Specifically, DCH's review will document the status of the Contractor with respect to meeting program standards set forth in the Contract. A multidisciplinary team appointed by DCH will conduct the readiness and annual review. The scope of the reviews

will include, but not be limited to, review and/or verification of:

- 2.13.8.1.1 Network Provider composition and access with specific focus on providers with experience in trauma-informed care, pediatricians, primary care providers, specialists, Behavioral Health providers, CCFA Providers, and dental providers;
- 2.13.8.1.2 Staffing Plan and staffing levels dedicated to the requirements set forth in this Contract for the GF 360° population with special emphasis on Care Coordinators, Nurse Case Managers, staff with System of Care knowledge and experience, quality management and utilization management personnel, and ombudsman staff;
- 2.13.8.1.3 Progress and status in hiring and training staff, and cross-training staff;
- 2.13.8.1.4 Transition of Care Plan for Members enrolled in Medicaid prior to the Operations Start Date and who will transition to the Contractor's GF 360° Plan on the Operations Start Date;
- 2.13.8.1.5 Contractor's plans for building relationships with DFCS staff at the regional and county level and the DFCS units designated for Kenny A., ICAMA and ICPC services, and such plans shall address education, training and process development;
- 2.13.8.1.6 Contractor's plans for building relationships with DJJ staff at the regional level, and such plans shall address education, training and process development;
- 2.13.8.1.7 Activities related to the System of Care approach in the delivery of physical and behavioral health care services to Members;
- 2.13.8.1.8 Ability to provide all required health screenings and assessments set forth in this Contract within the prescribed timeframes;
- 2.13.8.1.9 Activities detailed in the Member Education and Outreach Plan;
- 2.13.8.1.10 Training of providers, CMO staff, court personnel, law enforcement and others on trauma-informed care, the System of Care approach; new policies and procedures; Care Coordination Teams, Virtual Health Records, privacy

requirements and other activities or requirements specific for Members;

- 2.13.8.1.11 Implementation of a dental home including provider education and outreach, and any applicable system changes required by the CMO and DCH;
- 2.13.8.1.12 Readiness to participate in the GaHIN;
- 2.13.8.1.13 Privacy policies and procedures for the GF 360° population, including staff and provider training and re-training protocols;
- 2.13.8.1.14 Detailed policies and procedures for the ombudsman staff;
- 2.13.8.1.15 Ability to share care coordination and case management information electronically with DFCS staff;
- 2.13.8.1.16 Development of policies and procedures required under the terms of this Contract;
- 2.13.8.1.17 Educational and outreach materials;
- 2.13.8.1.18 Content of Provider agreements;
- 2.13.8.1.19 Member services capability, including 24/7 Call Center;
- 2.13.8.1.20 Development of policies with protocols with GCAL;
- 2.13.8.1.21 Comprehensiveness of quality and Utilization Management strategies;
- 2.13.8.1.22 Participation in the Georgia Families 360° Monitoring and Oversight Committee;
- 2.13.8.1.23 Policies and procedures for the Grievance System and Complaint System;
- 2.13.8.1.24 Financial solvency; and
- 2.13.8.1.25 Information systems' capabilities including the ability to process eligibility, conduct enrollment activities, process prior authorizations and claims payments, etc.

2.13.9 The Readiness Reviews will assess the Contractor's ability to meet any requirements set forth in this Contract and the documents referenced herein.

- 2.13.10 Members will not be enrolled in the Contractor's GF 360° Plan until DCH has determined that the Contractor is capable of meeting these requirements. The Contractor's failure to pass the final Readiness Review thirty (30) Calendar Days prior to the Operational Start Date may result in the assessment and payment of liquidated damages against Contractor, delayed operations and/or immediate termination of the Contract. Contractor's failure to pass the annual review may result in liquidated damages, corrective action and/or Contract termination.
- 2.13.11 DCH will provide the Contractor with a summary of the findings as well as areas requiring remedial action after each Readiness Review.

3.0 GENERAL CONTRACTOR RESPONSIBILITIES

- 3.0.1 Contractor shall promptly deliver all required goods and services in a professional and workmanlike manner according to the Contract including all applicable professional standards.
- 3.0.2 Contractor shall maintain qualified staff and any other necessary business resources throughout the duration of the Contract to meet scheduled deadlines and all other performance requirements.
- 3.0.3 Comply with all State and DCH policies and standards in effect during the performance of the Contract, including but not limited to DCH's policies and standards relating to personnel conduct, security, safety, confidentiality, privacy and ethics.
- 3.0.4 Contractor shall immediately notify DCH of any of the following changes with respect to Contractor:
- 3.0.4.1 Change in business address, telephone number, facsimile number or e-mail address;
 - 3.0.4.2 Change in entity status or nature;
 - 3.0.4.3 Change in business location;
 - 3.0.4.4 Change to a condition of insolvency (i.e. a state in which Contractor is unable to meet or discharge financial liabilities);
 - 3.0.4.5 Change in entity officers, executive employees, or entity structure;
 - 3.0.4.6 Material change in ownership or control (i.e. more than 5%);
 - 3.0.4.7 Change in federal employee identification number or federal tax identification number;

- 3.0.4.8 Change in current litigation, audits and other governmental investigations, both in Georgia and in other states as well as at the federal level.
- 3.0.5 Contractor shall notify DCH of any of the following changes with respect to any Subcontractor(s):
 - 3.0.5.1 Change in entity status or nature;
 - 3.0.5.2 Change in solvency; or
 - 3.0.5.3 Material change in ownership or control (i.e. more than 5%).
- 3.0.6 Contractor shall request and receive DCH's prior written consent (which shall not be unreasonably withheld) before taking any of the following actions:
 - 3.0.6.1 Change its legal status;
 - 3.0.6.2 Change its legal structure; or
 - 3.0.6.3 Sell, transfer, convey, or assign more than 5% ownership interest in the Contractor.
- 3.0.7 Should DCH not consent to any of the actions set forth in Section 3.0.6 and the Contractor desires to proceed with such action, then DCH may, at its option, elect to terminate this Contract at such date as determined by DCH.

4.0 SPECIFIC CONTRACTOR RESPONSIBILITIES

The Contractor shall complete the following actions, tasks, obligations, and responsibilities:

4.1 ENROLLMENT

4.1.1 Enrollment Procedures

4.1.1.1. DCH or its Agent is responsible for Enrollment, including Disenrollment for Members, education on enrollment options, and outreach activities. The Contractor shall coordinate with DCH and its Agent as necessary for all Enrollment and Disenrollment for Member functions.

4.1.1.2 DCH or its Agent will make every effort to ensure that individuals who are ineligible for Enrollment are not enrolled in GF 360°. However, to ensure that such individuals are not enrolled in GF 360°, the Contractor shall assist DCH or its Agent in the

identification of individuals who are ineligible for Enrollment in GF 360°, as set forth in Section 1.2.3, should such individuals inadvertently become enrolled in GF 360°.

4.1.1.3 The Contractor shall assist DCH or its Agent in the identification of individuals that become ineligible for Medicaid, PeachCare for Kids® and P4HB (for example, those who have died, been incarcerated, or moved out-of-state).

4.1.1.4 The Contractor shall accept all eligible individuals for Enrollment as identified by DCH or its Agent without restrictions. The Contractor shall not discriminate against individuals on any basis, including but not limited to religion, gender, race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on any basis, including but not limited to religion, gender, race, color, or national origin or on the basis of health, health status, pre-existing Condition, or need for Health Care services.

4.1.1.5 The Contractor shall enroll Members in the GF 360° program and immediately begin Care Coordination upon the receipt of an electronic notification from DCH, DFCS or DJJ stating that the Member is eligible for the GF 360° program.

4.1.2 Selection of a Primary Care Provider (PCP)

4.1.2.1 The Contractor shall provide all Members access to a Primary Care Provider (PCP), also referred to as a Medical Home, that serves as the single point of accountability and coordination—primarily for primary care. A PCP Model/ Medical Home:

4.1.2.1.1 Is essentially a person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers and, when appropriate, the individual's family and other supports;

4.1.2.1.2 Serves as a focal point for information sharing and Referral to specialists and sub-specialists, as well as communication, evaluation and interpretation of specialist recommendations;

4.1.2.1.3 Typically relies on advanced health information systems to support evidence-based care and includes resources to support the Coordination of Care; and

4.1.2.1.4 Will allow better access to health care, increased satisfaction with the care process and improved health and health outcomes.

4.1.2.2. The Contractor shall allow for PCPs to include not only traditional provider types that have historically served as PCPs but also alternative provider types such as specialists and Medical Homes with documented physician oversight and meaningful physician engagement. Assignment should be based on a Member's identified needs and preference as well as Provider agreement. For example, Behavioral Health providers may act as the PCP, if clinically appropriate and agreeable to both the Provider and the Member. PCPs shall:

4.1.2.2.1 Supervise, coordinate, and provide all Primary Care to each assigned Member.

4.1.2.2.2 Coordinate and/or initiate Referrals for specialty care (both in and out of network) for Members.

4.1.2.2.3 Maintain continuity of each Member's Health Care and maintain the Member's Medical Record, which includes documentation of all services provided by the PCP as well as other providers.

4.1.2.3 The Contractor shall work with DCH and Providers identify and address gaps and implement innovative solutions to decrease potentially preventable admissions and Re-admissions and avoidable use of the emergency department. The Contractor shall send PCPs a monthly list of Members with potentially preventable admissions or Re-admissions and avoidable use of the emergency department.

4.1.2.4 The Contractor shall offer its Members the freedom of selecting a PCP to serve as a Medical Home. DCH or its Agent will encourage self-selection of a PCP and continuation of any existing satisfactory Provider relationship with the current PCP if the PCP participates in the Contractor's Network. Upon request from a Member, DCH or its Agent will provide counseling or assistance in selecting a PCP. If a Member fails to select a PCP, the Contractor shall Auto-Assign Members to a PCP based on the following Algorithm.

4.1.2.4.1 Auto-assign Member to a Provider with whom, based on FFS Claims history, the Member has a Historical Provider Relationship, provided that the geographic access requirements are met.

4.1.2.4.2 If no Historical Provider Relationship exists, Auto-Assign Member to the assigned PCP an immediate family member enrolled in the CMO, if the Provider is an appropriate Provider based on the age and gender of the Member.

- 4.1.2.4.3 If other immediate family members do not have an assigned PCP, Auto-Assign Member to a Provider with whom a family member has a Historical Provider Relationship if the Provider is an appropriate Provider based on the age and gender of the Member.
- 4.1.2.4.4 If no Member or family member has a relationship with a Provider, Auto-Assign Member to a PCP, using an algorithm developed by the Contractor and approved by DCH, based on the age and sex of the Member, and geographic proximity.
- 4.1.2.4.5 Pregnant Members may also select an obstetrician as their assigned PCP. If a pregnant Member fails to select an obstetrician, the Contractor may Auto-Assign the Member to an obstetrician, using an algorithm developed by the Contractor and approved by DCH, based on geographic proximity.
- 4.1.2.5 The PCP auto-assignment process included in Section 4.1.2.3 is as follows when a PCP is not selected upon enrollment.
- 4.1.2.5.1 GF 360° Members in Foster Care
- 4.1.2.5.1.1 If the DFCS Case Manager, Caregiver, Foster Parent or FC Member does not voluntarily select a PCP upon enrollment in the GF 360° program, the Contractor shall Auto-Assign the FC Member a PCP within two (2) Business Days of receipt of notification of the FC Member's enrollment in the GF 360° program.
- 4.1.2.5.1.2 An eligibility file or electronic notification from DCH or DFCS will serve as notification.
- 4.1.2.5.2 Members receiving Adoption Assistance:
- 4.1.2.5.2.1 If an AA Member or Adoptive Parent does not voluntarily select a PCP upon enrollment in the GF 360° program, the Contractor shall Auto-Assign the AA Member a PCP within two (2) Business Days of receipt of notification of the AA Member's enrollment in the CMO.
- 4.1.2.5.2.2 An eligibility file or electronic notification from DCH will serve as notification.

4.1.2.5.3 Members in the Juvenile Justice System:

4.1.2.5.3.1 If the Residential Placement Provider's identified Core Provider does not voluntarily select a PCP upon enrollment in the GF 360° program, the Contractor shall Auto-Assign the DJJ Member a PCP within two (2) Business Days of receipt of notification of the DJJ Member's enrollment in the CMO.

4.1.2.5.3.2 An eligibility file or electronic notification from DCH or DJJ will serve as notification.

4.1.2.5.4 To ensure continuity of care when an FC Member changes placement, the Contractor must assess the FC Member's PCP access and assign the FC Member to a new PCP as necessary, according to the following process:

4.1.2.5.4.1 Member in Foster Care is relocated.

4.1.2.5.4.2 The Contractor will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DFCS.

4.1.2.5.4.3 The Contractor must assess the FC Member's access to the currently assigned PCP within one (1) Business Day of receipt of notification.

4.1.2.5.4.4 The Contractor must notify within the same Business Day the DFCS Case Manager, Caregiver, Foster Parent or FC Member if the PCP no longer meets the geographic access standards as defined in Section 4.8.17.

4.1.2.5.4.5 The DFCS Case Manager, Caregiver, Foster Parent or FC Member must select a new PCP within two (2) Business Days of the Contractor's notification. Contractor shall auto-assign a new PCP if no selection is made during this timeframe.

4.1.2.5.4.6 This full process must be complete within three (3) Business Days of the Contractor's receipt of notification of the FC Member's relocation.

4.1.2.5.5 To ensure continuity of care when a DJJ Member involved with the Department of Juvenile Justice changes placement, the Contractor must assess the DJJ Member's PCP access

and assign the DJJ Member to a new PCP as necessary, according to the following process:

- 4.1.2.5.5.1 DJJ Member is relocated.
- 4.1.2.5.5.2 The Contractor will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DJJ.
- 4.1.2.5.5.3 The Contractor must assess the DJJ Member's access to the currently assigned PCP within one (1) Business Day of receipt of notification and must notify the Residential Placement Provider's identified Core Provider if the PCP no longer meets the geographic access standards as defined in Section 4.8.17.2.
- 4.1.2.5.5.4 The Residential Placement Provider's identified Core Provider must select a new PCP within two (2) Business Days of the Contractor's notification. Contractor shall auto-assign a new PCP if no selection is made within this timeframe.
- 4.1.2.5.5.5 This full process must be complete within three (3) Business Days of the Contractor's receipt of notification of the DJJ Member's relocation.
- 4.1.2.5.6 For FC Members, the Contractor shall allow the FC Member, DFCS staff, Caregiver or Foster Parent to change the designation based on the needs of a child. For AA Members, the Contractor shall allow the AA Member or Adoptive Parent to change the PCP designation based on the needs of a child. For DJJ Members, the Contractor shall allow the JPPS or Residential Placement Provider's designated Core Provider to change a PCP designation based on the needs of the youth.
- 4.1.2.6 PCP assignment shall be effective immediately. The Contractor shall notify the Member via surface mail of his/her Auto-Assigned PCP within ten (10) Calendar Days of Auto-Assignment.
- 4.1.2.7 The Contractor shall submit its PCP Auto-Assignment Policies and Procedures during the Readiness Review for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter.

4.1.2.8 The Contractor shall require that Members are assigned to the same PCP for a period of up to six (6) months, except for the following exceptions:

4.1.2.8.1 Members shall be allowed to change PCPs without cause during the first ninety (90) Calendar Days following PCP selection

4.1.2.8.2 Members shall be allowed to change PCPs with cause at any time. The following constitute cause for change:

4.1.2.8.2.1 The PCP no longer meets the geographic access standards as defined in this Contract;

4.1.2.8.2.2 The PCP does not, because of moral or religious objections, provide the Covered Service(s) the Member seeks; or

4.1.2.8.2.3 The Member requests to be assigned to the same PCP as other family members.

4.1.2.8.3 Members shall be allowed to change PCPs every six (6) months.

4.1.2.9 Primary Care services are not Covered Services under the Demonstration for Family Planning Only P4HB Participants. However, Contractor shall encourage Family Planning Only P4HB Participants to choose a Primary Care Provider. The Contractor shall maintain an up-to-date list of available Providers affiliated with the Georgia Association for Primary Health Care and other Providers serving the uninsured and underinsured populations who are available to provide primary care services. The Contractor must not use Demonstration funds to reimburse for Primary Care services delivered to Family Planning Only P4HB Participants.

4.1.3 Dental Home

4.1.3.1 All Members shall have access to a Dentist within thirty (30) minutes or thirty (30) miles of the Member's home address for urban areas and within forty-five (45) minutes or forty-five (45) miles for rural areas who will serve as the Members' Dental Home. The Dental Home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. The Dental Home is the Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the Medicaid State Plan.

4.1.3.2 Upon request from a Member, DCH or its Agent will provide counseling or assistance in selecting a Dental Home. DCH or its Agent will encourage self-selection of a Dentist and continuation of any existing satisfactory relationship with a Member's current Dentist if the Dentist participates in the Contractor's network. If the Member fails to select a Dentist, the Contractor shall Auto-Assign the Member to a Dental Home using an algorithm developed by the Contractor and approved by DCH, based on geographic proximity. The Dental Home auto-assignment process is as follows when a Dental Home is not selected upon enrollment:

4.1.3.2.1 Members in Foster Care

4.1.3.2.1.1 If the DFCS Case Manager, Caregiver, Foster Parent or FC Member does not voluntarily select a Dentist upon enrollment, the Contractor shall assign the FC Member to a Dentist within five (5) Business Days of receipt of notification of the FC Member's enrollment.

4.1.3.2.1.2 The eligibility file from DCH or written notification from DCH or DFCS will serve as notification of the FC Member's enrollment.

4.1.3.2.2 Members receiving Adoption Assistance

4.1.3.2.2.1 If an AA Member or Adoptive Parent does not voluntarily select a Dentist upon enrollment, the Contractor shall assign the AA Member a Dentist within five (5) Business Days of receipt of notification of the AA Member's enrollment.

4.1.3.2.2.2 The eligibility file from DCH or written notification from DCH will serve as notification of the AA Member's enrollment.

4.1.3.2.3 Members in the Juvenile Justice System:

4.1.3.2.3.1 If the Residential Placement Provider's identified Core Provider does not voluntarily select a Dentist upon enrollment, the Contractor shall assign the DJJ Member a Dentist within five (5) Business Days of receipt of notification of the DJJ Member's enrollment.

4.1.3.2.3.2 The eligibility file from DCH or written notification from DCH or DJJ will serve as notification of the

DJJ Member's enrollment.

4.1.3.2.4 Re-Assignment of Dental Home

4.1.3.2.4.1 To ensure continuity of care when a Member changes placement, the Contractor must assess the Member's Dental Home access and assign the Member to a new Dental Home as necessary, according to the following process:

4.1.3.2.4.1.1 Member in Foster Care is relocated

4.1.3.2.4.1.1.1 When an FC Member is relocated, the Contractor will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DFCS.

4.1.3.2.4.1.1.2 The Contractor must assess the FC Member's access to the currently assigned Dentist within two (2) Business Days of receipt of notification.

4.1.3.2.4.1.1.3 The Contractor must notify, within two (2) Business Days, the DFCS Case Manager, Caregiver, Foster Parent or FC Member if the Dentist no longer meets the geographic access standards as defined in Section 4.8.17.

4.1.3.2.4.1.1.4 The DFCS Case Manager, Caregiver, Foster Parent or FC Member must select a new Dentist within five (5) Business Days of the Contractor's notification or the FC Member's relocation.

4.1.3.2.4.1.1.5 This full process must be complete within five (5) Business Days of the Contractor's receipt of notification of the FC Member's relocation.

4.1.3.2.4.1.2 Member in the Juvenile Justice System is

relocated:

- 4.1.3.2.4.1.2.1 The Contractor will be notified through the daily eligibility file provided by DCH or through written or telephonic notification from DCH or DFCS.
- 4.1.3.2.4.1.2.2 The Contractor must assess the DJJ Member's access to the currently assigned Dentist within two (2) Business Days of receipt of notification.
- 4.1.3.2.4.1.2.3 The Contractor must notify within two (2) Business Days the Residential Placement Provider's identified Core Provider if the PCP no longer meets the geographic access standards as defined in Section 4.8.17.
- 4.1.3.2.4.1.2.4 The Residential Placement Provider's identified Core Provider must select a new PCP within two (2) Business Days of the Contractor's notification or the DJJ's relocation.
- 4.1.3.2.4.1.2.5 This full process must be complete within five (5) Business Days of the Contractor's receipt of notification of the DJJ Member's relocation.

4.1.3.3 For FC Members, the Contractor shall allow the FC Member, DFCS staff, Caregiver or Foster Parent to change the Dentist designation based on the needs of a child. For AA Members, the Contractor shall allow the AA Member or Adoptive Parent to change the Dentist designation based on the needs of a child. For DJJ Members, the Contractor shall allow the JPPS or Residential Placement Provider's designated Core Provider to change a Dentist designation based on the needs of the youth.

4.1.3.4 The Contractor shall notify the Member via surface mail of his/her Dental Home Assignment within ten (10) Calendar Days of Auto-Assignment.

4.1.3.5 The Contractor shall submit its Dental Home Auto-Assignment Policies and Procedures to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter. The Dental Home auto-assignment process must address those instances when a Dental Home is not selected upon enrollment.

4.1.3.6 IPC P4HB Participants are not eligible for a Dental Home. IPC P4HB Participants are eligible for limited dental services which include emergency dental services.

4.1.4 Newborn Enrollment

4.1.4.1 All newborns shall be Auto-Assigned by DCH or its Agent to the mother's CMO. The Contractor shall notify DCH or its Agent of newborns born to enrolled Members who do not appear on the monthly roster.

4.1.4.2 The Contractor shall provide assistance to any Member who is an expectant mother who contacts them wishing to make a PCP selection for her newborn and record that selection.

4.1.4.3 Within twenty-four (24) hours of the birth, the Contractor shall ensure the submission of a newborn notification form to DCH or its Agent. If the mother has not made a PCP selection, the Contractor shall Auto-Assign the newborn to a PCP within thirty (30) Calendar Days of the birth. Auto-Assignment shall be made using the algorithm described in Section 4.1.2.3. Notice of the PCP Auto-Assignment shall be mailed to the mother within twenty-four (24) hours of assignment.

4.1.6 Reporting Requirements

4.1.6.1 The Contractor shall submit to DCH monthly Member Data Conflict Report as described in the Requirements Analysis Documents (RADs), as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.1.6.2 The Contractor shall submit to DCH monthly Eligibility and Enrollment Reconciliation Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.2 **DISENROLLMENT**

4.2.1 Disenrollment Initiated by the Adoption Assistance Member

4.2.1.1 AA Members enrolled in GF 360° may elect to disenroll from the program without cause during the AA Member Fee-for-Service Selection Period. AA Members disenrolling from the Contractor's GF 360° Plan shall return to the Medicaid Fee-For-Service delivery system. AA Members may disenroll from the CMO for cause at any time and return to the Medicaid Fee-for-Service delivery system. An AA Member may request Disenrollment without cause during the ninety (90) Calendar Days following the date of the Member's initial Enrollment with the CMO or the date DCH or its Agent sends the Member notice of the Enrollment, whichever is later. An AA Member may request Disenrollment without cause every twelve (12) months thereafter.

4.2.1.2 AA Members may request Disenrollment from the CMO for cause at any time. The following constitutes cause for requesting Disenrollment:

4.2.1.2.1 The CMO does not, because of moral or religious objections, provide the Covered Service the Member seeks;

4.2.1.2.2 The Member needs related services to be performed and not all related services are available within the Network. The Member's or P4HB Participant's Provider or another Provider have determined that receiving related services from In-Network and Out-Of-Network Providers would subject the Member to unnecessary risk; and

4.2.1.2.3 Other reasons for Disenrollment initiated by the Member, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of Providers experienced in addressing the Member's Health Care needs. (DCH or its Agent shall make determination of these reasons).

4.2.1.3 The Contractor shall provide assistance to Members seeking to disenroll. This assistance shall consist of providing Disenrollment forms to the Member and referring the Member to DCH or its Agent who will make Disenrollment determinations.

4.2.1.4 Change in Enrollment Status of a Member

4.2.1.4.1 In the event a Member's eligibility category changes to a category ineligible for the GF 360° Plan and the Member remains eligible for Medicaid and Georgia Families, the Member shall remain enrolled with the Contractor's Georgia Families Plan as a Member until the Member's next Enrollment Period with the exception of youth

enrolled in Supplemental Security Income (SSI) who will return to the Medicaid Fee-For Service delivery system. The change in CMO enrollment will be reflected in the updated GF Member eligibility roster and associated change in Capitation Rate. The disenrollment from the GF 360° program and Enrollment in the Georgia Families program will be processed within three (3) Business Days of the date that the Member's eligibility category actually changes and will not be made retroactive.

4.2.1.4.2 The Contractor shall be responsible for issuing new Member enrollment materials pursuant to Section 4.31.1.

4.2.2 Disenrollment Initiated by the Contractor

4.2.2.1 The Contractor shall complete all Disenrollment paperwork for Members it is seeking to disenroll.

4.2.2.2 The Contractor shall notify DCH or its Agent upon identification of a Member who it knows or believes meets the criteria for Disenrollment as defined in Section 4.2.2.2.

4.2.2.2 The Contractor may request Disenrollment if:

4.2.2.2.1 The Member's Utilization of services is Fraudulent or abusive.

4.2.2.2.2 The Member is placed in a long-term care nursing facility, State institution, or intermediate care facility for individuals with intellectual disabilities.

4.2.2.2.3 The Member's Medicaid eligibility category changes to a category ineligible for GF 360°. In such event, the Member will remain in GF 360° pursuant to Section 4.2.1.4.

4.2.2.2.4 The Member has died, been incarcerated, or moved out of State, thereby making him or her ineligible for Medicaid.

4.2.2.3 Prior to requesting Disenrollment of a Member, the Contractor shall document at least three (3) interventions over a period of ninety (90) Calendar Days that occurred through treatment, Case Management, and Care Coordination to resolve any difficulty leading to the request. The Contractor shall provide at least one (1) written warning to the Member, certified return receipt requested, regarding implications of his or her actions. This notice must be delivered within ten (10) Business Days of the Member's action.

4.2.2.4 The Contractor shall cite to DCH or its Agent at least one (1) acceptable reason for Disenrollment before requesting Disenrollment of the Member.

4.2.2.5 The Contractor shall submit Disenrollment requests to DCH or its Agent and the Contractor shall honor all Disenrollment determinations made by DCH or its Agent. DCH's decision on the matter shall be final, conclusive and not subject to appeal.

4.2.3 Unacceptable Reasons for Disenrollment Requests by Contractor

4.2.3.1 The Contractor shall not request Disenrollment of a Member for discriminating reasons, including but not limited to:

4.2.3.1.1 Adverse changes in a Member's health status;

4.2.3.1.2 Missed appointments;

4.2.3.1.3 Utilization of medical services;

4.2.3.1.4 Diminished mental capacity;

4.2.3.1.5 Pre-existing medical condition;

4.2.3.1.6 Uncooperative or disruptive behavior resulting from his or her special needs; or

4.2.3.1.7 Lack of compliance with the treating physician's plan of care.

4.2.3.2 The Contractor shall not request Disenrollment because of the Member's attempt to exercise his or her rights under the Grievance System.

4.2.3.3 The request of one PCP to have a Member assigned to a different Provider shall not be sufficient cause for the Contractor to request that the Member be disenrolled from the plan. Rather, the Contractor shall utilize its PCP assignment process to assign the Member to a different and available PCP.

4.2.3.4 Change in Enrollment Status of a FC Member or DJJ Member

4.2.3.4.1 In the event a Member's eligibility category changes to a category ineligible for GF 360° and remains eligible for Medicaid and Georgia Families:

4.2.3.4.1.1 The Member shall remain enrolled with the Contractor under its Georgia Families program until the Member's next Enrollment Period.

4.2.3.4.1.2 The change in enrollment will be reflected in the updated Georgia Families and Georgia Families 360° Member eligibility roster and associated change in Capitation Rate.

4.2.3.4.1.3 The disenrollment from the GF 360° program and enrollment in the Georgia Families program will be processed within three (3) Business Days of the date that the FC or DJJ Member eligibility category actually changes and will not be made retroactive. (Note exception when Members become eligible and enrolled in any retro-active program, such as SSI, after the date of an inpatient hospitalization.)

4.2.3.4.1.4 The Contractor must issue Georgia Families Member enrollment materials pursuant to Section 4.3

4.2.3.4.2 In the event a FC or DJJ Member's eligibility category changes to a category ineligible for Georgia Families and the youth is enrolled in Supplemental Security Income (SSI), the youth will return to the Medicaid Fee-for-Service delivery system.

4.3 GEORGIA FAMILIES 360° MEMBER SERVICES

4.3.1 General Provisions

4.3.1.1 The Contractor shall ensure that Members are aware of the following:

4.3.1.1.1 Member rights and responsibilities

4.3.1.1.2 The role of PCPs and Dental Home

4.3.1.1.3 How to obtain care

4.3.1.1.4 What to do in an emergency or urgent medical situation

4.3.1.1.5 How to request a Grievance, Appeal, or Administrative Law Hearings

4.3.1.1.6 How to report suspected Fraud and Abuse

4.3.1.1.7 Providers who have been terminated from the Contractor's network

4.3.1.2 The Contractor must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting; and email. These communication options shall allow Members to submit questions and receive responses from the Contractor while protecting the confidentiality and PHI of the Members in all instances. The Contractor shall attempt to obtain Member email addresses from Members. Upon request, the Contractor must provide materials in the format preferred by the Member.

4.3.1.3 The Contractor must provide DCH a Member Education and Outreach Plan (hereinafter "Outreach Plan") no later than one hundred fifty (150) Calendar Days prior to the Operational Start Date and shall adhere to all requirements included in Section 4.3. DCH shall have at least ten (10) Calendar Days to review the Outreach Plan and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized Outreach Plan to DCH. In addition to the other requirements included in Section 4.3, the Member Education and Outreach Plan shall address the development of the following:

4.3.1.3.1 Member Information Packet;

4.3.1.3.2 Member Handbook;

4.3.1.3.3 Member Identification Card;

4.3.1.3.4 Twenty-four (24) hour Call Center; and

4.3.1.3.5 Other outreach or education activities identified by the GF 360° Contractor and approved by DCH.

4.3.2 Requirements for Written Materials

4.3.2.1 The Contractor shall make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. The Contractor shall notify all Members that information is available in alternative formats and how to access those formats.

4.3.2.2 The Contractor shall make all written information available in English, Spanish and all other prevalent non-English languages, as defined by DCH. For the purposes of this Contract, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH.

4.3.2.3 All written materials distributed to Members shall include a language block, printed in Spanish and all other prevalent non-English languages, that informs the Member that the document contains important information and directs the Member to call the Contractor to request the document in an alternative language or to have it orally translated.

4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5th) grade level. Suggested reference materials to determine whether this requirement is being met are:

4.3.2.4.1 Fry Readability Index;

4.3.2.4.2 PROSE The Readability Analyst (software developed by Education Activities, Inc.);

4.3.2.4.3 Gunning FOG Index;

4.3.2.4.4 McLaughlin SMOG Index;

4.3.2.4.5 The Flesch-Kincaid Index; or

4.3.2.4.6 Other word processing software approved by DCH.

4.3.2.5 The Contractor shall provide written notice to DCH of any changes to any written materials provided to the Members. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.

4.3.2.6 The Contractor must submit all written materials, including information for the Contractor's Web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the Member materials within thirty (30) Calendar Days of submission. DCH reserves the right to require the discontinuation of any Member materials that violate the terms of this Contract.

4.3.3 Member Information Packet

4.3.3.1 The Contractor shall send electronically via secure portal on the Contractor's web site an FC Member to the DFCS Case Managers for FC Members and a DJJ Member information packet to the Juvenile Probation and Parole Specialist (JPPS) for DJJ Members who are newly enrolled in the CMO within five (5) Calendar Days of receipt of the eligibility file from DCH. Upon request from the DFCS Case Manager or JPPS, the Contractor will mail the Member

information packet to the Foster Parent, Caregiver, Residential Placement Provider or State agency staff. The Contractor shall mail an AA Member information packet to the AA Member or Adoptive Parent for AA Members who are newly enrolled in the CMO within five (5) Calendar Days of receipt of the eligibility file from DCH. The member information packets shall include but not be limited to the following:

- 4.3.3.1.1 A welcome letter that includes the name and contact information for the Member's Care Coordinator;
- 4.3.3.1.2 A Member Handbook;
- 4.3.3.1.3 A new member ID card;
- 4.3.3.1.4 Information about changing the Members' Medical and Dental Home Dentist
- 4.3.3.1.5 A form requesting information about any special health care needs and specific services for which the Contractor may need to coordinate services;
- 4.3.3.1.6 Information for Members about the roles of the Care Coordination Team and how to seek help in scheduling appointments, and accessing Care Coordination services;
- 4.3.3.1.7 Information for Members about the role of the GF 360° Call Center and how to access the Call Center;
- 4.3.3.1.8 Explanation of the disenrollment procedures for AA Members in Section 4.1;
- 4.3.3.1.9 Information about seventy-two (72) hour emergency prescription drug supply;
- 4.3.3.1.10 For FC Members in DFCS custody in DeKalb and Fulton counties only, information on the Kenny A. health care requirements; and
- 4.3.3.1.11 Information about the Ombudsman Liaison.

4.3.4 Member Handbooks

- 4.3.4.1 No later than one hundred twenty (120) Calendar Days prior to the Operations Start Date, the Contractor shall develop a member handbook specific to the needs of the GF 360° population (hereinafter "Handbook") and shall adhere to all requirements included in Section 4.3. DCH shall have fifteen (15) Calendar Days to review the Handbook and the Contractor shall have five

(5) Calendar Days from completion of DCH's review to submit the finalized Handbook to DCH.

4.3.4.2 The Contractor shall provide a Member Handbook and other programmatic information to Members. The Contractor shall make the Member Handbook available to Members through the Contractor's web site. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households.

4.3.4.3 The Member Handbook shall include all requirements set forth in 42 CFR 438.10, and the Member Handbook shall include, but not be limited to:

4.3.4.3.1 A table of contents;

4.3.4.3.2 Information about the roles and responsibilities of the Member (this information to be supplied by DCH);

4.3.4.3.3 At a minimum, the Member Handbook shall address the following topics:

4.3.4.3.3.1 Roles of DFCS and DJJ in consenting to the FC Members' and DJJ Members' health care services;

4.3.4.3.3.2 Role of Care Coordination Team related to coordination of care and services;

4.3.4.3.3.3 How to access the Care Coordination Team; and

4.3.4.3.3.4 Continuity of care and transition issues.

4.3.4.3.4 Information about the role of the PCP, including services provided and the role of the Medical Home;

4.3.4.3.5 Information about choosing a PCP;

4.3.4.3.6 Information about the Dental Home, including services provided and how a Member can select a Dental Home;

4.3.4.3.7 Information about what to do when family size change;

4.3.4.3.8 Appointment procedures;

4.3.4.3.9 Information on the benefits and services including a description of all available GF 360° Benefits and Services;

- 4.3.4.3.10 Information on how to access services including a description of all available Georgia Family Benefits and Services;
- 4.3.4.3.11 Information on how to access services, including EPSDT services, non-emergency transportation (NET) services, and maternity and family planning services
- 4.3.4.3.12 Information about the GaHIN including how information will be used by the CMOs and DCH and procedures to opt out of the GaHIN;
- 4.3.4.3.13 An explanation of any service limitations or exclusions from coverage;
- 4.3.4.3.14 Information about services that can be obtained through telemedicine;
- 4.3.4.3.15 A notice stating that the Contractor shall be liable only for those services authorized by the Contractor;
- 4.3.4.3.16 Information on where and how Members may access Benefits not available from or not covered by the Contractor;
- 4.3.4.3.17 The Medical Necessity definition used in determining whether services will be covered;
- 4.3.4.3.18 A description of Utilization Review policies and procedures used by the Contractor;
- 4.3.4.3.19 A description of all Pre-Certification, Prior Authorization or other requirements for treatments and services;
- 4.3.4.3.20 The policy on Referrals for specialty care and for other Covered Services not furnished by the Member's PCP;
- 4.3.4.3.21 Information on how to obtain services when the Member is out of the Service Region and for After-Hours coverage;
- 4.3.4.3.22 Cost-Sharing;
- 4.3.4.3.23 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the Contractor's toll-free telephone line and Web site;
- 4.3.4.3.24 A description of Member rights and responsibilities

- 4.3.4.3.25 The policies and procedures for Disenrollment
- 4.3.4.3.26 Information on Advance Directives
- 4.3.4.3.27 A statement that additional information, including information on the structure and operation of the CMO and physician incentive plans, shall be made available upon request;
- 4.3.4.3.28 Information on the extent to which, and how, After-Hours and emergency coverage are provided, including the following:
 - 4.3.4.3.28.1 What constitutes an Urgent and Emergency Medical Condition, Emergency Services, and Post-Stabilization Services;
 - 4.3.4.3.28.2 The fact that Prior Authorization is not required for Emergency Services;
 - 4.3.4.3.28.3 The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent;
 - 4.3.4.3.28.4 The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered herein; and
 - 4.3.4.3.28.5 The fact that a Member has a right to use any hospital or other setting for Emergency Services.
- 4.3.4.3.29 Information about the Grievance Systems policies and procedures, as set forth in Section 4.14, which must include the following:
 - 4.3.4.3.29.1 The right to file a Grievance and Appeal with the Contractor;
 - 4.3.4.3.29.2 The requirements and timeframes for filing a Grievance or Appeal with the Contractor;
 - 4.3.4.3.29.3 The availability of assistance in filing a Grievance or Appeal with the Contractor;
 - 4.3.4.3.29.4 The toll-free numbers Members can use to file a Grievance or an Appeal with the Contractor by phone;

- 4.3.4.3.29.5 The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing; and
- 4.3.4.3.29.6 Notice that if a Member files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the Member may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Member.
- 4.3.4.3.30 The geographic boundaries of the Service Regions.
- 4.3.4.3.31 Information on the availability of telemedicine services.
- 4.3.4.3.32 A statement that additional information, including information on the structure and operation of the CMO and physician incentive plans, shall be made available upon request.
- 4.3.4.4 The Contractor shall submit to DCH for review and approval initial versions, any changes and edits to the Member Handbook and all other Member materials the Contractor plans to distribute at least thirty (30) Calendar Days before the effective date of change.
- 4.3.5 Member Rights
 - 4.3.5.1 The Contractor shall have written policies and procedures regarding the rights of Members and shall comply with any applicable federal and State laws and regulations that pertain to Member rights. These rights shall be included in the Member Handbook. At a minimum, said policies and procedures shall specify the Member's right to:
 - 4.3.5.1.1 Receive information pursuant to 42 CFR 438.10;
 - 4.3.5.1.2 Be treated with respect and with due consideration for the Member's dignity and privacy;
 - 4.3.5.1.3 Have all records and medical and personal information remain confidential;
 - 4.3.5.1.4 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's Condition and ability to understand;

- 4.3.5.1.5 Participate in decisions regarding his or her Health Care, including the right to refuse treatment;
- 4.3.5.1.6 Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- 4.3.5.1.7 Request and receive a copy of his or her Medical Records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the records as specified in 45 CFR 164.524 and 164.526;
- 4.3.5.1.8 Be furnished Health Care services in accordance with 42 CFR 438.206 through 438.210;
- 4.3.5.1.9 Freely exercise his or her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the Member is treated;
- 4.3.5.1.10 Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the Covered Services provided to the Member for which DCH does not pay the Contractor; not be held liable for Covered Services provided to the Member for which DCH or the CMO does not pay the Health Care Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, Referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the services directly; and
- 4.3.5.1.11 Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60 and **Attachment J** of this Contract.

4.3.6 Provider Directory

- 4.3.6.1 The Contractor shall make the Provider Directory available to Members through the Contractor's web site. Upon request, the Contractor shall mail via surface mail a hard copy of the Provider Directory to enrolled Member households within three (3) Business Days of receipt of the request whether verbally or in writing. Hard copy Provider Directories shall include a statement indicating that changes to the Provider Network will occur and that Members are encouraged to review the online Provider Directory or contact the Contractor for current information as needed.

- 4.3.6.2 The electronic Provider Directory, at a minimum, shall be searchable by Provider name, Provider type/specialty and location (to include city, zip code, physical address, and county).
- 4.3.6.3 The Provider Directory shall include current names, locations, office hours, telephone numbers of and non-English language(s) spoken by, contracted Providers. This includes, at a minimum, information on PCPs, specialists, Family Planning Providers, dentists, pharmacies, vision providers, FQHCs and RHCs, mental health and substance abuse Providers, physical therapists, occupational therapists, speech therapists, and hospitals. The Provider Directory shall identify Providers that are not accepting new patients for any provided services and/or Providers that are only accepting specialty populations. The Provider Directory shall also identify if the location is a telemedicine presentation site. The online Provider Directory shall be updated within five (5) Business Days upon any change in the Provider network, open and closed panels and Provider service offerings.
- 4.3.6.4 The Contractor shall submit an updated version to DCH of the Provider Network Listing spreadsheet for all requested Provider types upon request. DCH may require the Contractor to include in the submission executed Signature Pages of Provider Contracts and written acknowledgements from all Providers who are part of a Preferred Health Organization (PHO), IPA, or other network stating that they know they are in the CMO's network, know they are accepting Medicaid Members, any restrictions on which Members the Provider is seeing, and that they are accepting the terms and conditions of the Provider Contract.
- 4.3.6.5 The Contractor must submit the Provider Directory template and specifications for the Directory that will be provided on the Contractor's web site to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated, thereafter. The Contractor shall not use the new template until notification of approval from DCH.
- 4.3.7 Member Identification (ID) Card
- 4.3.7.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes:
- 4.3.7.1.1 Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP.

- 4.3.7.2 The Member ID Card must, at a minimum, include the following information:
- 4.3.7.2.1 The Member's name;
 - 4.3.7.2.2 The Member's Medicaid number;
 - 4.3.7.2.3 The PCP's name, address, and telephone numbers (including After-Hours number if different from business hours number);
 - 4.3.7.2.4 Dental Home name, address and telephone number, including after-hours telephone number (if the Member is eligible for a Dental Home);
 - 4.3.7.2.5 The name and telephone number(s) of the Contractor;
 - 4.3.7.2.6 The Contractor's twenty-four (24) hour, seven (7) day a week toll-free Member services telephone number;
 - 4.3.7.2.7 Instructions for emergencies;
 - 4.3.7.2.8 Minimum instructions to facilitate the submission of a claim by a Provider;
 - 4.3.7.2.9 Processor Control Number and Bank Identification Number (BIN) Number for pharmacy claims submission; and
 - 4.3.7.2.10 Toll free phone numbers for provider call centers to assist providers with claims adjudication questions or issues.
- 4.3.7.3 The Contractor shall reissue the FC Member ID card under the following circumstances:
- 4.3.7.3.1 An FC Member, DFCS Staff, Caregiver or Foster Parent reports a lost card;
 - 4.3.7.3.2 An FC Member has a name change;
 - 4.3.7.3.3 An FC Member, DFCS staff, Caregiver or Foster Parent requests a new PCP;
 - 4.3.7.3.4 The FC Member moves to a new placement;
 - 4.3.7.3.5 Any other reason that results in a change to the information disclosed on the FC Member's ID card.

4.3.7.4 The Contractor shall reissue the AA Member ID card under the following circumstances

4.3.7.4.1 AA Member or Adoptive Parent reports a lost card;

4.3.7.4.2 AA Member has a name change

4.3.7.4.3 AA Member or Adoptive Parent requests a new PCP; or for

4.3.7.4.4 Any other reason that results in a change to the information disclosed on the AA Member's ID card.

4.3.7.5 The Contractor shall reissue the DJJ Member ID card under the following circumstances:

4.3.7.5.1 DJJ Member, the JPPS or Residential Placement Provider reports a lost card;

4.3.7.5.2 DJJ Member has a name change;

4.3.7.5.3 DJJ Member, the JPPS or Residential Placement Provider requests a new PCP;

4.3.7.5.4 DJJ Member moves to a new placement; and

4.3.7.5.5 Any other reason that results in a change to the information disclosed on the DJJ Member's ID card.

4.3.7.6 All ID cards shall be issued initially within five (5) Calendar Days of receipt of the eligibility file from DCH and reissued within five (5) Calendar Days of a request for reissue based on the events named above.

4.3.7.7 The Contractor shall submit a front and back sample Member ID Card to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter.

4.3.8 Toll-free Member Call Center

4.3.8.1 The Contractor must provide a twenty-four (24) hour call center staffed with experienced personnel familiar with GF 360°, Georgia child-serving agencies and the Georgia provider community.

4.3.8.2 The Call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.

- 4.3.8.3 The call center staff shall be trained to accurately assist Members with general inquiries, identify the need for Crisis intervention and provide referrals to Georgia Crisis and Access Line (GCAL) or other appropriate resources for emergency and crisis needs. The Contractor shall work with GCAL to develop Crisis protocols. The Contractor shall submit such protocols to DCH for review and approval no later than ninety (90) Calendar Days of the Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the protocols and the Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized protocols to DCH.
- 4.3.8.4 The Contractor must develop appropriate, interactive scripts for call center staff to use during initial welcome calls when making outbound calls to new Members and to respond to Member calls. The Contractor's call center staff must also use a DCH-approved script to respond to Members who call to request assistance with PCP selection. The Contractor must develop special scripts for emergency and unusual situations, as requested by DCH. All scripts must be clear and easily understood. The Contractor must review the scripts annually to determine any necessary revisions. DCH reserves the right to request and review call center scripts at any time. The Contractor's call center job descriptions must detail the level and type of training related to crisis calls, including how personnel are trained to recognize callers in Crisis and then manage triage. The Contractor must have an operational process through which emergency and Crisis calls are prioritized over routine calls, protocols that support warm transfers and technology that enables direct telephonic/computer connectivity to emergent and Crisis intervention resources.
- 4.3.8.5 The Contractor shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.
- 4.3.8.6 The Contractor shall submit these call center policies and procedures, including performance standards, to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter.
- 4.3.8.7 The Contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, the Contractor shall have an automated system available between the hours of

7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.

4.3.8.8 The Contractor shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities. The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for review and approval annually. At a minimum, the standards shall require that, on a Calendar month basis:

4.3.8.8.1 Average Speed of Answer: Eighty percent (80%) of calls shall be answered by a person within thirty (30) seconds by a live operator measured weekly. "Answer" shall mean each caller who elects to speak is connected to a live representative. The caller shall not be placed on hold immediately by the live representative. The remaining twenty percent (20%) of calls shall be answered by a person within one (1) minute of the call.

4.3.8.8.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.

4.3.8.8.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).

4.3.8.8.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a live Call Center Representative.

4.3.8.8.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.

4.3.8.8.6 Accurate Response to Call Center Phone Inquiries: Call center representatives' accuracy rate must be ninety percent (90%) or higher.

4.3.8.9 The Contractor shall establish remote phone monitoring capabilities for at least five (5) DCH staff. DCH or its Agent shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress and to identify the number of call center staff answering calls and the identity of the individual call center staff answering the calls.

4.3.9 Member Web Site

4.3.9.1 The Contractor shall develop and maintain a Program web site on which the Contractor will provide a Member webpage that provides general and up-to-date information about the Contractor's GF 360° Plan, including but not limited to the following:

4.3.9.1.1 A searchable Member Handbook.

4.3.9.1.2 All Member Information materials.

4.3.9.1.3 A portal that allows Members to access a searchable Provider Directory.

4.3.9.1.4 Information about how limited English speaking persons as well as those who are hearing impaired can access interpreter services.

4.3.9.1.5 Pharmacy Preferred Drug List.

4.3.9.1.6 Pharmacy Conditions for Coverage and Utilization Limits.

4.3.9.1.7 What's New items.

4.3.9.1.8 Frequently asked questions and answers.

4.3.9.1.9 Reminder information about Medicaid eligibility redeterminations.

4.3.9.1.10 General and up to date information about the Demonstration that incorporates DCH's messaging regarding the Demonstration.

4.3.9.1.11 Link to the DCH Medicaid web site.

4.3.9.1.12 Link to the DCH Enrollment Broker website.

- 4.3.9.2 The Web site must have the capability for Members to submit questions and comments to the Contractor and for Members to receive responses. The Contractor shall respond to Member inquiries within one (1) Business Day of receipt and resolve the issue within seventy-two (72) Clock Hours of receipt. The Contractor shall refer any inquiries to DCH that are not within the Contractor's scope of services (e.g., inquiries about the Fee-for-Service delivery system).
- 4.3.9.3 The Web site must comply with the marketing policies and procedures and with requirements for written materials described in this Contract and must be consistent with applicable State and federal laws. Information provided on the Member webpages must be written at no higher than a 5th grade reading level.
- 4.3.9.4 The Contractor must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Contractor must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades which support the ordinary operation, administration, and maintenance of the web site, the Contractor shall not modify the web site prior to receipt of DCH approval.
- 4.3.9.5 The web site must comply with DCH's requirements for information systems and webpage development, including but not limited to security controls that meet the requirements of this Contract. The Contractor's web site shall also be functionally equivalent, with respect to functions described in this Contract, to the web site maintained by the State's Medicaid Fiscal Agent. See <https://www.mmis.georgia.gov/portal/>.

4.3.10 Cultural Competency

- 4.3.10.1 In accordance with 42 CFR 438.206, the Contractor shall have a comprehensive written Cultural Competency Plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency, hearing impairment, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The Cultural Competency Plan must describe how the Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each. The cultural Competency Plan must:

- 4.3.10.1.1 Include training to Member services staff and Contract Providers, including PCPs and Contractor staff at all levels, to receive ongoing education and training in culturally and linguistically appropriate service delivery;
- 4.3.10.1.2 Include a plan for interpretive services and written materials, consistent with Section 4.3.11 to meet the needs of Members whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member oriented materials, including the posting of signage in locations approved by DCH in the languages of the commonly encountered group and/or groups represented in the service area;
- 4.3.10.1.3 Identify community advocates and agencies that could assist Limited-English Proficiency and/or that provide other Culturally Competent services, which include methods of Outreach and referral;
- 4.3.10.1.4 Incorporate Cultural Competence into Utilization Management, quality improvement and planning for the course of treatment;
- 4.3.10.1.5 Identify resources and interventions for high-risk health conditions found in certain cultural groups;
- 4.3.10.1.6 Include a plan to recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State
- 4.3.10.2 The Contractor shall submit the Cultural Competency Plan to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval as updated thereafter.
- 4.3.10.3 The Contractor may distribute a summary of the Cultural Competency Plan to the In-Network Providers if the summary includes information on how the Provider may access the full Cultural Competency Plan on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.

4.3.11 Interpretation Services

- 4.3.11.1 The Contractor shall provide oral interpretation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor

shall notify its Members of the availability of oral interpretation services and inform them of how to access oral interpretation services. There shall be no charge to the Member for interpretation services.

4.3.12 Translation Services

4.3.12.1 The Contractor shall provide translation services to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor shall notify its Members of the availability of oral translation services and inform them of how to access oral translation services. There shall be no charge to the Member for translation services.

4.3.13 Reporting Requirements

4.3.13.1 The Contractor shall submit monthly Telephone and Internet Activity Reports to DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.4 MARKETING

4.4.1 Prohibited Activities

4.4.1.1 The Contractor is prohibited from engaging in the following activities:

4.4.1.1.1 Directly or indirectly engaging in door-to-door, telephone, or other Cold-Call Marketing activities to Potential Members

4.4.1.1.2 Offering any favors, inducements or gifts, promotions, and/or other insurance products worth more than \$15.00 at one time and not more than \$50 annually per Member;

4.4.1.1.3 Providing meals for Potential Members, regardless of value;

4.4.1.1.4 Distributing plans and materials that contain statements that DCH determines are inaccurate, false or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that AA Members must enroll in the Contractor's plan within the first ninety (90) Calendar Days in order to obtain Benefits or in order to not lose Benefits or that the

Contractor's plan is endorsed by the federal or State government, or similar entity; and

- 4.4.1.1.5 Distributing information or materials that, according to DCH, mislead or falsely describe the Contractor's Provider network, the participation or availability of network Providers, the qualifications and skills of network Providers (including their bilingual skills); or the hours and location of network services.

4.4.2 Allowable Activities

4.4.2.1 The Contractor shall be permitted to perform the following marketing activities:

4.4.2.1.1 Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);

4.4.2.1.2 Distribute general information through the use of social media platforms to contact a greater proportion of the Members served by the Contractor. Content intended for use on social media platforms must be approved by DCH prior to publication;

4.4.2.1.3 Make telephone calls, mailings and home visits only to Members currently enrolled in the Contractor's plan, for the sole purpose of educating the Member about services offered by or, available through the Contractor.

4.4.2.1.4 Reach out to former Members via telephone calls, mailings, and home visits for a period of up to forty-five (45) Calendar Days from the date the Member is disenrolled from the Contractor's plan for the sole purpose of surveying the former Member about services received while the Member was enrolled with the Contractor.

4.4.2.1.5 Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the CMO's Provider network, provided that all CMOs in which the Provider participates have an equal opportunity to be represented; and

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

4.4.2.2 If the Contractor performs an allowable activity, the Contractor shall conduct these activities statewide.

4.4.2.3 All materials shall comply with the information requirements in 42 CFR 438.10 and detailed in Section 4.3.2 of this Contract.

4.4.3 State Approval of Materials

4.4.3.1 The Contractor shall submit to DCH for review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter a detailed description of its Marketing Plan and copies of all Marketing Materials (written and oral) it or its Subcontractors plan to distribute.

4.4.3.2 This requirement includes, but is not limited to posters, brochures, Web sites, and any materials that contain statements regarding the benefit package and Provider network-related materials. Neither the Contractor nor its Subcontractors shall distribute any marketing materials without prior, written approval from DCH.

4.4.3.3 The Contractor shall submit any changes to previously approved Marketing Materials and receive approval from DCH of the changes sixty (60) Calendar Days before distribution.

4.5 **GEORGIA FAMILIES 360° COVERED BENEFITS AND SERVICES**

4.5.1 Included Services

4.5.1.1 The Contractor shall at a minimum provide Medically Necessary services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals. Such Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

4.5.1.2 All benefits and services should be provided in the most appropriate service location for the service rendered based on the Members' individual needs at a specific point in time.

4.5.1.3 The Contractor shall provide all Medicaid State Plan services required by Section 4.5.1.1 for Members enrolled in an HCBS waiver program except any services provided under the applicable 1915(c) waiver, which shall remain available to such Members via the Fee-for-Service program. DCH shall have the final

determination as to which services are covered under the waiver and which services are the responsibility of the Contractor.

4.5.2 Individuals with Disabilities Education Act (IDEA) Services

4.5.2.1 For Members up to and including age two (2), the Contractor shall be responsible for Medically Necessary IDEA Part C services provided pursuant to an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).

4.5.2.2 For Members ages three (3) to twenty-one (21), the Contractor shall not be responsible for Medically Necessary IDEA Part B services provided pursuant to an IEP or IFSP. Such services shall remain in FFS Medicaid.

4.5.2.2.1 The Contractor shall be responsible for all other Medically Necessary covered services.

4.5.3 Enhanced Services

4.5.3.1 In addition to the Covered Services provided above, the Contractor shall provide enhanced services to educate Members. The Contractor shall provide such services in a manner that will increase a Member's understanding of the availability of Covered Services, the importance of seeking and receiving such services and how doing so may help to improve outcomes. For example, the Contractor shall do the following

4.5.3.1.1 Place strong emphasis on programs to enhance the general health and well-being of Members;

4.5.3.1.2 Make health promotion materials available to Members;

4.5.3.1.3 Participate in Medicaid fairs and community-sponsored health fairs;

4.5.3.1.4 Coordinate with community resources to facilitate a holistic approach to Member care; and

4.5.3.1.5 Provide education to Members, families and other Health Care Providers about early intervention and management strategies for various illnesses.

4.5.3.2 The Contractor shall not charge a Member for participating in health education services that are defined as either enhanced or Covered Services.

4.5.4 Medical Necessity

4.5.4.1 Contractor must ensure Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services available through the Georgia Medicaid State Plan. Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:

4.5.4.1.1 Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;

4.5.4.1.2 Compatible with the standards of acceptable medical practice in the community;

4.5.4.1.3 Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;

4.5.4.1.4 Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and

4.5.4.1.5 Not primarily custodial care unless custodial care is a Covered Service or benefit under the Members evidence of coverage.

4.5.4.2 There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

4.5.4.3 For Medicaid children under twenty-one (21) years of age, the Contractor is required to provide Medically Necessary Services to correct or ameliorate physical and behavioral health disorders, a defect, or a condition identified during an EPSDT screening or preventive visit, regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905(a) of the Social Security Act.

4.5.5 Experimental, Investigational or Cosmetic Procedures, Drugs, Services, or Devices

4.5.5.1 Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manuals, in no instance shall the Contractor cover experimental, investigational or cosmetic procedures, drugs, services or devices or those not recognized by the Federal Food and Drug Administration, the United States Public Health Service, Medicaid and/or the Department's

contracted peer review organization as universally accepted treatment.

4.5.6 Moral or Religious Objections

4.5.6.1 The Contractor is required to provide and reimburse for all Covered Services. If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, reimburse for, or provide coverage of a counseling or Referral service because of an objection on moral or religious grounds, the Contractor shall notify:

4.5.6.1.1 DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;

4.5.6.1.2 Members within sixty (60) Calendar Days before adopting the policy with respect to any service; and

4.5.6.1.3 Members before and during Enrollment.

4.5.6.2 The Contractor shall provide information to the DCH Enrollment Broker for use in Member CMO selection counseling with respect to any counseling or Referral service the Contractor elects not to provide, reimburse for or provide coverage for because of an objection on moral or religious grounds.

4.5.6.3 The Contractor acknowledges that such objection will be grounds for recalculation of rates paid to the Contractor by DCH.

4.6 **SPECIAL COVERAGE PROVISIONS**

4.6.1 Emergency Services

4.6.1.1 Emergency Services shall be available without Prior Authorization or approval twenty-four (24) hours a day, seven (7) Days a week to treat an Emergency Medical Condition.

4.6.1.2 An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

4.6.1.2.1 Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- 4.6.1.2.2 Serious impairment to bodily functions;
 - 4.6.1.2.3 Serious dysfunction of any bodily organ or part;
 - 4.6.1.2.4 Serious harm to self or others due to an alcohol or drug abuse emergency;
 - 4.6.1.2.5 Injury to self or bodily harm to others; or
 - 4.6.1.2.6 With respect to a pregnant woman having contractions: i. That there is inadequate time to effect a safe transfer to another hospital before delivery, or ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.
- 4.6.1.3 The Contractor shall provide payment for Emergency Services when furnished to a Member by a qualified Provider, regardless of whether that Provider is in the Contractor's Provider Network. These services shall not be subject to Prior Authorization requirements. The Contractor shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Contractor shall also pay for any screening examination services conducted on a Member to determine whether an Emergency Medical Condition exists.
- 4.6.1.4 The Contractor shall provide payment for Demonstration related Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements. The Contractor shall be required to pay all Demonstration related Emergency Services that are Medically Necessary until the P4HB Participant is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether a Demonstration related Emergency Medical Condition exists.
- 4.6.1.5 The Contractor may not deny or inappropriately reduce payment to a Provider of Emergency Services for any evaluation, diagnostic testing, or treatment provided to a Member for an emergency condition or make payment for Emergency Services contingent on the Member or Provider of Emergency Services providing any notification, either before or after receiving Emergency Services.
- 4.6.1.6 In processing claims for Emergency Services, the Contractor shall consider, at the time that a claim is submitted, at least the following criteria:

- 4.6.1.6.1 The age of the patient;
 - 4.6.1.6.2 The time and day of the week the patient presented for services;
 - 4.6.1.6.3 The severity and nature of the presenting symptoms;
 - 4.6.1.6.4 The patient's initial and final diagnosis; and
 - 4.6.1.6.5 Any other criteria prescribed by the Department, including criteria specific to patients under eighteen (18) years of age.
- 4.6.1.7 The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a Prudent Layperson.
- 4.6.1.8 The attending emergency room physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or Discharge, and that determination is binding on the Contractor, who shall be responsible for coverage and payment.
- 4.6.1.9 The Contractor shall not retroactively deny a Claim for an emergency screening examination because the Condition, which appeared to be an Emergency Medical Condition under the Prudent Layperson standard, turned out to be non-emergency in nature. Likewise, the Contractor shall not routinely or arbitrarily employ the practice of paying a triage rate that reduces reimbursement and places an administrative burden on the Provider to appeal such a payment. If an emergency screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, the Contractor shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid program.
- 4.6.1.10 The Contractor may establish guidelines and timelines for submittal of notification regarding provision of Emergency Services, but, the Contractor shall not refuse to cover an Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, Contractor's representative, or DCH of the Member's screening and treatment within said timeframes.
- 4.6.1.11 When a representative of the Contractor instructs the Member to seek Emergency Services, the Contractor shall be responsible for

payment for the Medical Screening examination and for other Medically Necessary Emergency Services, without regard to whether the Condition meets the Prudent Layperson standard.

4.6.1.12 The Member who has an Emergency Medical Condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific Condition or stabilize the patient.

4.6.1.13 Once the Member's Condition is stabilized, the Contractor may require Pre-Certification for hospital admission or Prior Authorization for follow-up care.

4.6.2 Post-Stabilization Services

4.6.2.1 The Contractor shall be responsible for providing access to and payment for Post-Stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain the stabilized Condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the Member's Condition.

4.6.2.2 The Contractor shall be responsible for payment for Post-Stabilization Services that are Prior Authorized or Pre-Certified by a Provider or organization representative, regardless of whether they are provided within or outside the Contractor's network of Providers.

4.6.2.3 The Contractor is financially responsible for Post-Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network that are administered to maintain the Member's stabilized Condition for one (1) hour while awaiting response on a Pre-Certification or Prior Authorization request.

4.6.2.4 The Contractor is financially responsible for Post-Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network, that are not prior authorized by the Contractor or Contractor's representative but are administered to maintain, improve or resolve the Member's stabilized Condition if:

4.6.2.4.1 The Contractor does not respond to the Provider's request for Pre-Certification or Prior Authorization within one (1) hour;

4.6.2.4.2 The Contractor cannot be contacted; or

4.6.2.4.3 The Contractor's Representative and the attending physician cannot reach an agreement concerning the Member's care and the Contractor's physician (i.e. a Chief Medical Officer or Medical Director) is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with the Contractor's physician and the treating physician may continue with care of the Member until the Contractor's physician is reached or one of the criteria in Section 4.6.2.5 is met.

4.6.2.5 The Contractor's financial responsibility for Post-Stabilization Services it has not approved will end when:

4.6.2.5.1 An In-Network Provider with privileges at the treating hospital assumes responsibility for the Member's care;

4.6.2.5.2 An In-Network Provider assumes responsibility for the Member's care through transfer;

4.6.2.5.3 The Contractor's Representative and the treating physician reach an agreement concerning the Member's care; or

4.6.2.5.4 The Member is Discharged.

4.6.2.6 In the event the Member receives Post-Stabilization Services from a Provider outside the Contractor's network, the Contractor shall reimburse the non-contracted Provider for the Post-Stabilization services at a rate equal to the rate paid by the Department for claims that it reimburses directly. The Contractor is prohibited from billing the Member for Post-Stabilization services.

4.6.3 Urgent Care Services

4.6.3.1 The Contractor shall provide Urgent Care services to Members as necessary. Such services shall not be subject to Prior Authorization or Pre-Certification.

4.6.4 Family Planning Services

4.6.4.1 The Contractor shall provide access to Family Planning Services within the network to Members and P4HB Participants. In meeting this obligation, the Contractor shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act, for the provision of Family Planning Services. The Contractor shall verify its efforts and Documented Attempts to contract with Title X Clinics by maintaining records of communication. The Contractor shall not

limit Members' or P4HB Participants' freedom of choice for family planning services to In-Network Providers and the Contractor shall cover services provided by any qualified Provider regardless of whether the Provider is In-Network. The Contractor shall not require a Referral if a Member or P4HB Participant chooses to receive Family Planning services and supplies from outside of the network.

4.6.4.2 The Contractor shall inform Members and P4HB Participants of the availability of family planning services and must provide services to Members and P4HB Participants wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy.

4.6.4.3 Family Planning Services and supplies for Members and P4HB Participants include at a minimum:

4.6.4.3.1 Education and counseling necessary to make informed choices and understand contraceptive methods;

4.6.4.3.2 Initial and annual complete physical examinations including a pelvic examination and Pap test;

4.6.4.3.3 Follow-up, brief and comprehensive visits;

4.6.4.3.4 Pregnancy testing;

4.6.4.3.5 Contraceptive supplies and follow-up care;

4.6.4.3.6 Diagnosis and treatment of sexually transmitted infections with the following exceptions – P4HB Participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration.

4.6.4.3.7 For P4HB Participants: Drugs, supplies, or devices related to the women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirement; (subject to the national drug rebate program requirements); and

4.6.4.3.8 Infertility assessments with the following exception –P4HB Participants are excluded from receiving this benefit.

4.6.4.4 The Contractor shall furnish all services on a voluntary and confidential basis, even if the Member is less than eighteen (18) years of age.

4.6.5 Sterilizations, Hysterectomies and Abortions

4.6.5.1 In compliance with 42 C.F.R. § § 441.251 through 441.258, the Contractor shall cover sterilizations and hysterectomies, only if all of the following requirements are met:

4.6.5.1.1 The Member is at least twenty-one (21) years of age at the time consent is obtained;

4.6.5.1.2 The Member is mentally competent;

4.6.5.1.3 The Member voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Services. This includes the completion of all applicable documentation;

4.6.5.1.4 At least thirty (30) Calendar Days, but not more than one hundred and eighty (180) Calendar Days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. A Member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least seventy-two (72) hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty (30) Calendar Days before the expected date of delivery (the expected date of delivery must be provided on the consent form);

4.6.5.1.5 An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a Member who is visually impaired, hearing impaired or otherwise disabled; and

4.6.5.1.6 The Member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

4.6.5.2 A hysterectomy shall be considered a Covered Service only if the following additional requirements are met:

4.6.5.2.1 The Member must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and

4.6.5.2.2 The Member must sign and date the Georgia Families 360° Sterilization Request Consent form prior to the

hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

4.6.5.4 Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

4.6.5.4.1 If it is performed solely for the purpose of rendering a Member permanently incapable of reproducing;

4.6.5.4.2 If there is more than one (1) purpose for performing the hysterectomy, but the primary purpose was to render the Member permanently incapable of reproducing; or

4.6.5.4.3 If it is performed for the purpose of cancer prophylaxis.

4.6.5.5 Abortions or abortion-related services performed for family planning purposes are not Covered Services. Abortions are Covered Services if a Provider certifies that the abortion is Medically Necessary to save the life of the mother or if pregnancy is the result of rape or incest. The Contractor shall cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies.

4.6.5.6 The Contractor shall maintain documentation of all sterilizations, hysterectomies and abortions consistent with requirements in 42 CFR 441.206 and 42 CFR 441.256. The Contractor shall not accept documentation for informed consent completed or altered after the service was rendered. All documentation pertaining to sterilizations, hysterectomies, and abortions must be provided to DCH upon request.

4.6.6 Pharmacy

4.6.6.1 The Contractor is permitted to establish a Maximum Allowable Cost (MAC) schedule. However, the Contractor must ensure the MAC pricing schedule is evaluated for pricing appropriateness and updated as appropriate no less frequently than every two (2) weeks.

4.6.6.1.1 The MAC must be reviewed no less frequently than every two (2) weeks to ensure:

4.6.6.1.1.1 Appropriateness of pricing;

4.6.6.1.1.2 MAC pricing schedule does not create a barrier to access to the medication; and

- 4.6.6.1.1.3 Each medication represented on the MAC schedule has at least two (2) A-rated generic equivalents available in the Georgia marketplace.
- 4.6.6.1.2 The MAC pricing schedule must be posted on the Contractor's website.
- 4.6.6.1.3 The Contractor must make available an inquiry and appeal process for Provider disputes over the MAC schedule or individual drugs subject to the MAC pricing with all inquiries and appeals being addressed within five (5) calendar days of the receipt of the Provider inquiry or appeal.
- 4.6.6.2 The Contractor shall provide pharmacy services either directly or through a Pharmacy Benefits Manager (PBM). The Contractor or its PBM may establish a preferred drug list if the following minimum requirements are met:
- 4.6.6.2.1 Appropriate selection of drugs from therapeutic drug classes are accessible and are sufficient in amount, duration, and scope to meet Members' medical needs;
- 4.6.6.2.2 The only excluded drug categories are those permitted under Section 1927(d) of the Social Security Act;
- 4.6.6.2.3 A Pharmacy & Therapeutics Committee that advises and/or recommends preferred drug list decisions is established and maintained; and
- 4.6.6.2.4 Over the counter medications specified in the Georgia State Medicaid Plan are included in the formulary.
- 4.6.6.3 The Contractor shall make the preferred drug list, utilization limits and conditions for coverage for prior authorized drugs available through its website and provide such documentation to DCH upon request.
- 4.6.6.4 The Contractor shall have an automated electronic Prior Authorization portal for the submission of Prior Authorization requests and encourage adoption by Providers. Regardless of whether Providers submit Prior Authorization requests manually or through the portal, the Contractor shall:
- 4.6.6.4.1 Provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization.

4.6.6.4.2 Provide for the dispensing of at least a seventy-two (72)-hour supply of a covered outpatient prescription drug in an emergency situation.

4.6.6.4.3 Resolve all pharmacy Prior Authorization requests within twenty-four (24) hours unless additional information is required from the prescriber. If additional information is needed from the prescriber, documented telephonic or other telecommunication contact with the prescriber must be made every twenty-four (24) hours up to a final disposition within seventy-two (72) hours of receipt of the request.

4.6.6.5 If the Contractor chooses to implement a mail-order pharmacy program, any such program must be established and maintained in accordance with State and federal law. The Contractor shall not require Members to use a mail-order pharmacy to receive covered pharmacy benefits, but may allow Members to use a mail-order pharmacy if:

4.6.6.5.1 Mail-order delivery is clinically appropriate;

4.6.6.5.2 The pharmacy is willing to accept payments and terms as described in this Contract;

4.6.6.5.3 Cost sharing is no more than it is for Members utilizing services by retail pharmacy;

4.6.6.5.4 The Member expressed desire to receive pharmacy services by mail-order; and

4.6.6.5.5 The Member is allowed to cease mail-order pharmacy services and utilize retail pharmacies at any time.

4.6.7 Immunizations

4.6.7.1 The Contractor shall provide all Members less than twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. See: <http://www.cdc.gov/vaccines/schedules/hcp/index.html>.

4.6.7.2 The Contractor shall collaborate with the Department of Public Health to ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccines for Children (VFC) program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with Well-

Child/preventive care. See <http://dph.georgia.gov/vaccines-children-program> for additional information.

4.6.7.3 The Contractor shall collaborate with the Department of Public Health to ensure that all Providers use vaccines which have been made available, free of cost, under the VFC program for Members eighteen (18) years of age and younger. The Contractor shall develop a policy for collaborating with DPH. The Contractor shall work with DCH to address challenges in providing vaccines under the VFC program.

4.6.7.4 The Contractor shall provide all adult immunizations specified in the Georgia Medicaid Policies and Procedures Manuals.

4.6.7.5 The Contractor shall report all immunizations to the DPH Georgia Registry of Immunization Transactions and Services (GRITS) in a format to be determined by DCH.

4.6.7.6 The Contractor shall enter into an agreement with the Georgia Department of Public Health recognizing a Member of PeachCare for Kids® as a “State Vaccine Eligible Child ” as permitted under Section 1928(b)(3) of the Social Security Act. At a minimum, this agreement shall permit the State to enjoy the discounted purchasing of vaccines for children covered under PeachCare for Kids® permitted under said Section and provide appropriate reimbursement to DPH for such vaccines utilized by the CMO’s membership.

4.6.8 Transportation

4.6.8.1 The Contractor shall provide emergency transportation and shall not retroactively deny a Claim for emergency transportation to an emergency Provider because the Condition, which appeared to be an Emergency Medical Condition under the Prudent Layperson standard, turned out to be non-emergency in nature.

4.6.8.2 The Contractor is not responsible for providing non-emergency transportation (NET) for its Members. Eligible Medicaid Members are to contact the assigned NET Broker for the county they live in to arrange for transportation. The Contractor is encouraged to collaborate with the NET Brokers and assist both the NET brokers and assigned Members with the coordination of NET services for assigned Members.

4.6.8.3 The Contractor may, however, coordinate other transportation for those Medicaid Members not eligible for transportation under the NET Broker contract. In the event Contractor performs such coordination, DCH shall not be responsible for any payment

resulting from such services. The following Categories of Aid are not eligible for Non-Emergency Transportation:

- 4.6.8.3.1 177 – Family Planning Waiver
- 4.6.8.3.2 181 - P4HB Family Planning (only)
- 4.6.8.3.3 460 – SSI Qualified Medicare Beneficiary
- 4.6.8.3.4 466 - Specified Low Income Medicare Beneficiary
- 4.6.8.3.5 660 – Qualified Medicare Beneficiary
- 4.6.8.3.6 661 – Specified Low Income Medicare Beneficiary
- 4.6.8.3.7 662 – Q11 Beneficiary
- 4.6.8.3.8 664 – Qualified Working Disabled individuals
- 4.6.8.3.9 790 – PeachCare 101-150% FPL
- 4.6.8.3.10 791 – PeachCare 151-200% FPL
- 4.6.8.3.11 792 – 201-235% FPL
- 4.6.8.3.12 793 – PeachCare > 235% FPL
- 4.6.8.3.13 815 – Aged Inmate
- 4.6.8.3.14 817- Disabled Inmate
- 4.6.8.3.15 870 – Emergency Alien – Adult
- 4.6.8.3.16 873 – Emergency Alien - Child

4.6.9 Perinatal Services

4.6.9.1 The Contractor shall ensure that appropriate perinatal care is provided to women and newborn Members. The Contractor shall have adequate capacity such that any new Member who is pregnant is able to have an initial visit with her Obstetric Provider within fourteen (14) Calendar Days of Enrollment. The Contractor shall have in place a system that provides, at a minimum, the following services:

- 4.6.9.1.1 Pregnancy planning and perinatal health promotion and education for reproductive-age women;

- 4.6.9.1.2 Perinatal risk assessment of non-pregnant women, pregnant and post-partum women, and newborns and children up to five (5) months of age. The Contractor must have the capacity to electronically accept, in a timely manner, Perinatal Case Management Initial Assessments from local public health departments completing these assessments following the presumptive eligibility determination;
- 4.6.9.1.3 Childbirth education classes to all pregnant Members and their chosen partner. Through these classes, expectant parents shall be encouraged to prepare themselves physically, emotionally, and intellectually for the childbirth experience. The classes shall be offered at times convenient to the population served, in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation services if necessary pursuant to Section 4.3.10 and 4.3.11 of this Contract;
- 4.6.9.1.4 Access to appropriate levels of care based on risk assessment, including emergency care;
- 4.6.9.1.5 Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
- 4.6.9.1.6 Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
- 4.6.9.1.7 Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery.

4.6.10 Parenting Education

- 4.6.10.1 In addition to individual parent education and anticipatory guidance to parents and guardians at EPSDT preventive visits, the Contractor shall offer or arrange for parenting skills education to expectant and new parents, at no cost to the Member.

4.6.10.2 The Contractor shall create effective ways to deliver this education, whether through classes, as a component of post-partum home visiting, or other such means. The educational efforts shall include topics such as bathing, feeding (including breast feeding), injury prevention, sleeping, illness, when to call the doctor, when to use the emergency room, etc. DCH shall approve education content, class schedule and locations. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation services if necessary pursuant to Section 4.3.10 and 4.3.11 of this Contract.

4.6.11 Mental Health and Substance Abuse

4.6.11.1 The Contractor shall provide integrated behavioral and physical health care for Members with mental illness including for those with dual-diagnoses. Integrated health care for Members with mental illness shall be focused equally on prevention and intervention utilizing predictive modeling to identify Members at risk as well as innovative and best-practice methods to encourage Member engagement in self-care behaviors. The Contractor shall provide a full range of recovery-based services and engage non-medical services and supports as indicated to provide holistic care focused on whole-health wellness, long-term independence, and skills building. This includes access to Certified Peer Supports for youth, adults and parents of youth with mental illness.

4.6.11.2 The Contractor shall have written Mental Health and Substance Abuse Policies and Procedures that explain how they will arrange or provide for covered mental health and substance abuse services. Such policies and procedures shall include Advance Directives. The Contractor shall assure timely delivery of mental health and substance abuse services and coordination with other acute care services.

4.6.11.3 Mental Health and Substance Abuse Policies and Procedures shall be submitted to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter.

4.6.11.4 The Contractor shall permit Members to self-refer to an In-Network Provider for an initial mental health or substance abuse assessment.

4.6.11.5 The Contractor shall permit all initial outpatient behavioral health (mental health and substance abuse) evaluation, diagnostic testing, and assessment services to be provided without Prior Authorization. The Contractor shall permit up to three (3) initial

evaluations per year for Members younger than twenty-two (22) years of age without requiring additional Prior Authorization.

4.6.11.6 Following an initial evaluation, the Contractor shall permit up to twelve (12) outpatient counseling/therapy visits to be provided without Prior Authorization.

4.6.11.7 The Contractor shall promote the delivery of behavioral health services in the most integrated and person-centered setting including in the home, school or community, for example, when identified through care planning as the preferred setting by the Member. The delivery of home and community based behavioral health services shall be incentivized by the Contractor for Providers who engage in this person-centered service delivery.

4.6.11.8 The Contractor shall provide emergency services diversion techniques and interventions (including but not limited to SBIRT-Screening, Brief Intervention and Referral to Treatment) for Members with mental illness and/or substance use.

4.6.11.9 The Contractor shall provide scalable intensity of Care Management, disease management, Care Coordination, and Complex Care Coordination based on the intensity of the Members need, as described in Section 4.11.8.

4.6.12 Advance Directives

4.6.12.1 In compliance with 42 CFR 438.6 (i) (1)-(2) and 42 CFR 422.128, the Contractor shall maintain written policies and procedures for Advance Directives, including mental health advance directives. Such Advance Directives shall be included in each Member's medical record. The Contractor shall provide these policies to all Members eighteen (18) years of age and older and shall advise Members of:

4.6.12.1.1 Their rights under the law of the State of Georgia, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; and

4.6.12.1.2 The Contractor's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

4.6.12.2 The information must include a description of State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) Calendar Days after the effective change.

- 4.6.12.3 The Contractor's information must inform Members that complaints may be filed with the Healthcare Facility Regulation Division, the State's Survey and Certification Agency.
- 4.6.12.4 The Contractor shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Members, and their responsibility to educate Members about this tool and assist them to make use of it.
- 4.6.12.5 The Contractor shall educate Members about their ability to direct their care using this mechanism and shall specifically designate which staff Members and/or network Providers are responsible for providing this education.
- 4.6.13 Member Cost-Sharing
- 4.6.13.1 The Contractor shall ensure that Providers assess Member Co-payments consistent with those specified in **Attachment J**.
- 4.6.13.2 The Contractor shall ensure that Providers do not refuse to render services based on a Member's inability to pay the Member cost-share.
- 4.6.13.3 The Contractor shall ensure that Providers do not utilize other methods post-delivery of services (such as but not limited to collection agency) to fulfill Member cost-sharing responsibility.
- 4.6.14 Value Added Services
- 4.6.14.1 The Contractor is permitted to provide value added services that address the complex health care needs of Members and improve health outcomes. Value added services exceed Georgia State Plan benefits and are designed to improve Members' wellbeing, encourage prudent use of health care benefits, and enhance the cost effectiveness of the GF 360° program. DCH encourages the Contractor to consider the challenges in improving Member health outcomes in developing Value Added services. For example, the Contractor may consider the provision of respite services to give caregivers rest and relief while providing a safe and supportive environment for Members to reduce the risk of out-of home placement at a higher level of care for the Member.
- 4.6.14.2 Value added services cannot be discontinued once implemented without prior approval from DCH. Should DCH approve the Contractor's request for discontinuation of value added services, DCH reserves the right to initiate an open enrollment period for the

Members assigned to the Contractor if value added benefits are discontinued.

4.6.14.3 Value added services are not considered during the Capitation Rate development process.

4.7 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) BENEFIT

4.7.1 General Provisions

4.7.1.1 The Contractor must ensure that Medicaid and PeachCare for Kids® children younger than twenty-one (21) years of age receive the services available under the federal EPSDT benefit.

4.7.1.2 The Contractor shall comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, diagnostic and treatment services. The Contractor shall comply with all EPSDT Program requirements pursuant to the Georgia Medicaid Policies and Procedures Manuals.

4.7.1.3 The Contractor shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the EPSDT Program. The EPSDT Plan shall emphasize outreach and compliance monitoring for children and adolescents (young adults), taking into account the multi-lingual, multi-cultural nature of the GF 360° population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for ensuring compliance with DCH's EPSDT periodicity schedule, follow-up of missed appointments, including missed Referral appointments for problems identified through preventive screens and exams. The EPSDT Plan shall also include procedures for referral, tracking and follow up for annual dental examinations and visits. The Contractor shall submit its initial EPSDT Plan to DCH for review and approval no later than one hundred twenty (120) Calendar Days prior to the Operational Start Date and shall submit proposed updated drafts of the EPSDT Plan thereafter. The Contractor shall submit to DCH annually a report and evaluation of its EPSDT Plan according to DCH specifications.

4.7.1.4 The Contractor shall ensure Providers perform all components of the EPSDT preventive health visit according to the requirements documented in the DCH approved periodicity schedule. The visit must include: (i) a comprehensive health and developmental history (including assessment of both physical and mental health

development); (ii) comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam); (iii) appropriate immunizations (according to the schedules established by the ACIP for individuals 0 – 18 years of age and nineteen (19) and older); (iv) laboratory tests (including blood lead level assessment appropriate to age and risk); and (v) health education (including anticipatory guidance.) All five (5) components must be performed for the visit to be considered an EPSDT preventive health visit.

4.7.2 Outreach and Informing

4.7.2.1 The Contractor's EPSDT outreach and informing process shall include:

4.7.2.1.1 The importance of preventive care;

4.7.2.1.2 The periodicity schedule and the depth and breadth of services;

4.7.2.1.3 How and where to access services, including necessary transportation and scheduling services; and

4.7.2.1.4 A statement that services are provided without cost.

4.7.2.2 The Contractor shall inform its newly enrolled families with EPSDT eligible children about the EPSDT benefit within thirty (30) Calendar Days of Enrollment with the EPSDT Plan. This requirement includes informing pregnant women and new mothers, either before or within seven (7) days after the birth of their children, that Health Check services are available.

4.7.2.3 The Contractor shall provide to each PCP, on a monthly basis, a list of the PCP's EPSDT eligible Members who appear not to have had an encounter during the initial ninety (90) Calendar Days of CMO enrollment, and/or who are not in compliance with the EPSDT periodicity schedule. The Contractor shall require its Providers to contact the Members' parents or guardians to schedule an appointment for those screens and services that appear not to be in compliance with the EPSDT periodicity schedule. If the PCP has medical record evidence that appropriate screens have occurred for the Member, the Contractor must incorporate these visits into its tracking system and remove the Member from the PCP's list of Members who are non-compliant with the EPSDT periodicity schedule.

4.7.2.4 Informing of the Health Check Program may be oral (on the telephone, face-to-face, or via films/tapes) or written and may be

done by Contractor personnel or Health Care Providers. At a minimum, the Contractor shall provide written notification to its families with Health Check eligible children when appropriate periodic assessments or needed services are due. The Contractor shall conduct all outreach and informing in non-technical language at or below a fifth (5th) grade reading level. The Contractor shall use accepted methods for informing persons who are blind or deaf, or who cannot read or understand the English language, in accordance with requirements for written material as described in Section 4.2.3. The Contractor shall document all outreach efforts it makes to inform Members (or their parents/guardians) regarding Health Check services.

4.7.2.5 The Contractor may provide incentives to Members and/or Providers to encourage compliance with the periodicity schedules as described in Section 4.12.5.

4.7.3 Early and Periodic Screenings – the Preventive Health Visit

4.7.3.1 PCPs within the Contractor's network are responsible for providing, at the time of the Member's preventive visit, all of the EPSDT required components along with those identified in the State's periodicity schedule. The required EPSDT components include:

4.7.3.1.1 A comprehensive health and developmental history (including assessment of both physical and mental health development);

4.7.3.1.2 A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam);

4.7.3.1.3 Appropriate immunizations (according to the schedule established by ACIP for individuals eighteen (18) years of age and younger and individuals nineteen (19) years of age and older;

4.7.3.1.4 Certain laboratory tests (including the federally required blood lead level assessment appropriate to age and risk screening);

4.7.3.1.5 Health Education (including anticipatory guidance);

4.7.3.1.6 Measurements (including head circumference for infants and body mass index);

4.7.3.1.7 Sensory screening (vision and hearing);

- 4.7.3.1.8 Oral health assessment; and
- 4.7.3.1.9 Sexually Transmitted Infection/ Human Immunodeficiency Virus (STI/HIV) screening.
- 4.7.3.2 The Contractor's contracts with its network hospitals/birthing centers shall ensure the EPSDT initial newborn preventive visit occurs in the hospital/birthing center. The newborn preventive visit should be completed within twenty-four (24) hours after birth and prior to Discharge of the infant.
- 4.7.3.3 The Contractor shall provide for a blood lead screening test for all EPSDT eligible children at twelve (12) and twenty-four (24) months of age. Children between thirty-six (36) months of age and seventy-two (72) months of age should receive a blood lead screening test if there is no record of a previous test.
- 4.7.3.4 The Contractor shall have a lead case management program for EPSDT eligible children and their households when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter. The lead case management program shall include education, a written case management plan that includes all necessary referrals, coordination with other specific agencies, environmental lead assessments, and aggressive pursuit of non-compliance with follow-up tests and appointments. The Contractor must ensure reporting of all blood lead levels to the Department of Public Health.
- 4.7.3.5 The Contractor shall have procedures for Referral of Members who are eligible for the Health Check Program to oral health professionals, including annual dental examinations and services by an oral health professional. Dental visits must be performed by a dentist, or other licensed dental professionals working under the supervision of a dentist according to the provisions of Georgia's scope of practice laws, and can occur in settings other than a dentist's office, such as a clinic or a school. The Contractor's oral health providers must follow the American Academy of Pediatric Dentistry's (AAPD) Periodicity Schedule. Dental preventive services that carry a limitation per year shall be limited to a 12-rolling month period.
- 4.7.3.6 The Contractor shall provide inter-periodic screens, which are screens that occur between the complete periodic screens and are Medically Necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes, at a minimum, vision and hearing services. An inter-periodic visit may be performed only for vision or hearing services.

4.7.3.7 The Contractor shall allow Referrals for further diagnostic and/or treatment services to correct or ameliorate defects, and physical and mental illnesses and Conditions discovered during the Health Check EPSDT preventive health visit. The PCP may make such Referrals and follow up pursuant to the PCP's contract with the Contractor, as appropriate.

4.7.3.8 The Contractor shall ensure an initial health and screening visit is performed, as appropriate, for all newly enrolled GF 360° EPSDT eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth for all newborns. If the Member's PCP provides medical record evidence to the Contractor that the initial health and screening visit have already taken place, this evidence will meet this Contract requirement. The Contractor should incorporate this evidence for this Member in its tracking system. The Contractor shall share EPSDT health check screening results with PCPs.

4.7.3.9 Minimum Contractor compliance with the Health Check screening requirements is an eighty percent (80%) screening ratio for the periodic preventive health visits, using the methodology prescribed by CMS to determine the screening ratio. This requirement and screening percentage is related to the CMS-416 Report requirements.

4.7.4 Diagnostic and Treatment Services

4.7.4.1 If a suspected problem is detected by a preventive health screening examination as described above, the Member shall be evaluated as necessary for further diagnosis. This diagnosis will be used to determine treatment needs.

4.7.4.2 EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a physical or mental illness or condition discovered or shown to have increased in severity during an EPSDT preventive health visit. Such Medically Necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-Covered Services as defined in Title XIX of the Social Security Act. The Contractor shall provide Medically Necessary, Medicaid-covered diagnostic and treatment services.

4.7.4.3 When a preventive health screening examination indicates the need for further evaluation of a Member's health, the referral for diagnosis must be made without delay. Follow-up is required to

ensure that the Member receives a complete diagnostic evaluation. If the Member is receiving care from a Continuing Care Provider, diagnosis may be part of the screening and examination process.

4.7.4.4 Continuing Care Providers may have to arrange for certain specialty services that are beyond the scope of their practice (e.g. cardiology or ophthalmology); and may agree, at their option, to make direct dental Referrals.

4.7.4.5 The Contractor must provide for EPSDT Diagnostic and Treatment Services, which must include:

4.7.4.5.1 Vision Services: At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.

4.7.4.5.2 Dental Services: At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health, at as early an age as necessary. Also included are emergency dental services, such as those services necessary to control bleeding, relieve pain, eliminate acute infection, etc. Dental services may not be limited to emergency services.

4.7.4.5.3 Hearing Services: At a minimum, include diagnosis and treatment for defects in hearing, and include hearing aids.

4.7.4.5.4 Developmental Assessment: Include structured tests and instruments administered by the professional to whom the Member has been referred after potential problems have been identified by the screening process.

4.7.4.5.5 Diagnosis, Treatment, and Follow-Up for Lead Toxicity: If a child is found to have blood lead levels equal to or greater than 10 ug/dL, Providers are to use their professional judgment regarding patient management and treatment.

4.7.4.5.6 Other Necessary Health Care: Provide other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

4.7.5 Tracking

4.7.5.1 The Contractor shall establish a tracking system that provides information on compliance with EPSDT requirements. This system shall track, at a minimum, the following areas:

- 4.7.5.1.1 Initial newborn EPSDT visit occurring in the hospital;
- 4.7.5.1.2 Periodic and preventive/well child screens and visits as prescribed by the periodicity schedule;
- 4.7.5.1.3 Diagnosis and treatment services, including Referrals;
- 4.7.5.1.4 Immunizations, lead, tuberculosis and dental services;
- 4.7.5.1.5 Missed periodic and preventive/visits and Notification to Members of missed visits; and
- 4.7.5.1.6 Activities listed in the CMS-416 Report. The Contractor must submit to DCH a report, using the CMS 416 Report's template that is specific to its Member population on a quarterly basis.
- 4.7.5.2 The Contractor shall establish a reminder/notification system that must be integrated with its tracking system allowing timely notifications of preventive visits coming due and missed appointments. The system must also interface with the Providers' notifications to the Contractor of the Members' missed appointments.
- 4.7.5.3 All information generated and maintained in the tracking system shall be consistent with Encounter Claims requirements as specified elsewhere herein.
- 4.7.6 Reporting Requirements
 - 4.7.6.1 The Contractor shall submit all required EPSDT-related reports as described in the CMO Report Schedule. The Contractor must utilize the templates and specifications provided by DCH when submitting reports to DCH. From time to time, DCH may modify the reports' specifications and templates in response to federal and state needs. The reports' specifications and templates must not be altered by the Contractor prior to submission to DCH. Each EPSDT report must include an analysis of the report's findings along with planned interventions to drive further improvements in the outcomes documented in the report. The report template along with the quality analysis report must be reviewed, approved, and signed by the Contractor's Chief Medical Officer prior to submission to DCH.

4.7.7 Assessments and Screenings

4.7.7.1 The Contractor shall at a minimum provide Medically Necessary Services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals.

4.7.7.2 Contractor must ensure Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services available through the Georgia Medicaid State Plan. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

4.7.7.3 Required Assessments and Screenings

4.7.7.3.1 A critical component of the success of the Contractor depends upon the Contractor's ability to conduct and report required assessments and screenings upon Member enrollment. These tools are used to identify immediate needs of Members transitioning into and out of GF 360°. Required assessments and screening vary by population type and include:

4.7.7.3.1.1 Comprehensive Child & Family Assessment (CCFAs)

4.7.7.3.1.1.1 The CCFA is used by DFCS to assist in developing case plans, making placement decisions, expediting permanency and planning for effective service intervention. The Contractor shall be responsible for ensuring that the Medical and Trauma Assessments required for the FC Members as part of the CCFA are conducted and reported in a timely manner as set forth herein. Each instance of failure to meet a timeframe specified in this Section shall constitute a Category 4 event as set forth in Section 25.5.

4.7.7.3.1.1.2 Includes all EPSDT periodicity schedule requirements relevant to the Member's age. The Contractor shall ensure Providers conducting the Medical Assessment provide outcomes of the Assessment to the Contractor within twenty (20) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH. The Contractor must provide outcomes of the

Medical Assessments to the DFCS-contracted CCFA Provider within twenty (20) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH.

4.7.7.3.1.2 Trauma Assessment Screenings

4.7.7.3.1.2.1 The Trauma Assessment Screening, at a minimum, shall include:

4.7.7.3.1.2.1.1 A trauma history with information about any trauma that the child may have experienced or been exposed to as well as how they have coped with that trauma in the past and present.

4.7.7.3.1.2.1.2 Completion of the age appropriate assessment tool.

4.7.7.3.1.2.1.3 A summary of assessment results and recommendations for treatment (if needed).

4.7.7.3.1.2.2 The Contractor shall contract with CCFA Providers for the provision of CCFA Trauma Assessment Screenings for the following Members:

4.7.7.3.1.2.2.1 Members Newly Entering or Re-entering Foster Care

4.7.7.3.1.2.2.1.1 The Contractor shall ensure that the CMO-contracted CCFA Provider has initiated contact with or visit(s) with the Member newly entering or re-entering Foster Care as a FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's seventy-two (72)-hour hearing. The Contractor must coordinate all necessary visits with the CMO-contracted CCFA Provider to ensure that the final Trauma Assessment is completed within the timeframes referenced in this Contract.

4.7.7.3.1.2.2.1.2 The CMO-contracted CCFA Provider must prepare a written Trauma Assessment report and submit such report to the Contractor. The Contractor must then submit the written Trauma Assessment report to the DFCS-contracted CCFA provider preparing the final CCFA report within twenty (20) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's seventy-two (72)-hour hearing. If the CMO contracted CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CMO-contracted CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment during the FC Member's multidisciplinary team meeting. In the case of a verbal report, the Contractor shall be responsible for assuring the CMO-contracted CCFA Provider submits the final written Trauma Assessment report to the DFCS-contracted CCFA provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's seventy-two (72)-hour hearing.

4.7.7.3.1.2.2.2 Trauma Assessments for AA Members and Enrolled FC Members

4.7.7.3.1.2.2.2.1 Trauma Assessments may be required for AA Members in the event of abuse or neglect as reported by a Provider, Adoptive Parent or others. Trauma Assessments may also be required for a Member who has been an FC Member for a period of twelve (12) or more months and whose completed CCFA is more than twelve (12) months old. Under these two (2) circumstances, the Contractor shall:

4.7.7.3.1.2.2.2.1.1 Ensure that the CMO-contracted CCFA Provider has initiated contact

with or visit(s) with the AA or FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Contractor's receipt of written notification from DFCS. The Contractor must coordinate all necessary visits with the CMO-contracted CCFA Provider to ensure that the final Trauma Assessment is completed within the timeframes referenced in the RFP and this Contract.

4.7.7.3.1.2.2.2.1.2 The CMO-contracted CCFA Provider must prepare a written Trauma Assessment report and submit such report to the DFCS-contracted CCFA provider preparing the final CCFA report within twenty (20) Calendar Days of the Contractor's receipt of written notification from DFCS.

4.7.7.3.1.2.2.2.1.3 If the CMO-contracted CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CMO-contracted CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment. In the case of a verbal report, the Contractor shall be responsible for assuring the CMO-contracted CCFA Provider submits the final written Trauma Assessment report to the DFCS-contracted CCFA provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Contractor's receipt of written notification from DFCS.

4.7.7.3.1.2.2 The Contractor shall coordinate for and ensure that FC or AA Members follow up on and receive any care specified within the Trauma and Medical Assessments in accordance with the following timeliness requirements. The Contractor shall:

4.7.7.3.1.2.2.1 Provide follow up for dental treatment within thirty (30) Calendar Days of the EPSDT dental

visit if the dental screening yields any concerns or the need for dental treatment.

4.7.7.3.1.2.2.2 Obtain an audiological assessment and treatment or prescribed corrective devices initiated within thirty (30) Calendar Days of the screening, based on the results of the hearing screening.

4.7.7.3.1.2.2.3 Provide a developmental assessment if the developmental screening completed as part of the EPSDT visit yields any developmental delays or concerns. The EPSDT provider is responsible for making a referral for the assessment, and the Contractor is responsible for ensuring the child has the assessment within thirty (30) Calendar Days of the screening.

4.7.7.3.1.2.2.4 Ensure that Providers refer FC Members ages three (3) years and under who are exposed to Substantiated Maltreatment to the Children 1st program for a developmental screening as required by the Child Abuse Prevention and Treatment Act (CAPTA).

4.7.7.3.1.3 Medical Assessments for DJJ Members

4.7.7.3.1.3.1 The Contractor shall be responsible for assuring the Medical Assessments for DJJ Members are completed within ten (10) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH whichever comes first for a Member newly entering or re-entering as a DJJ Member.

4.7.7.3.1.3.2 Providers conducting the assessment must provide outcomes to the Contractor and the Contractor shall send the outcome of the Medical Assessment to the DJJ Member's Residential Placement Provider within fifteen (15) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DJJ, whichever comes first, for a Member newly entering or re-entering as a DJJ Member.

4.7.7.3.1.3.3 The medical components of the Medical Assessment for the DJJ Member shall include an

initial medical evaluation that includes all components of the EPSDT periodicity schedule relevant for the age of the DJJ Member.

4.7.7.3.1.4 Health Risk Screening

4.7.7.3.1.4.1 The Contractor shall provide a Health Risk Screening within thirty (30) days of receipt of the eligibility file from DCH. The Health Risk Screening is used to develop a comprehensive understanding of the Members' health status and will be used by the Contractor to develop the Health Care Service Plan and used by the Care Coordination Team to determine the Member's Care Coordination needs.

4.7.7.3.1.4.2 The Health Risk Screening is independent of the assessments conducted for the CCFA; however, the Contractor may utilize the information from the CCFA assessments it coordinates to further inform the comprehensive understanding of the Member's health.

4.7.7.3.1.4.3 The Contractor must assess the need to complete a new Health Risk Screening each time a Member moves to a new placement or based on a change in the Member's medical or behavioral health as identified by Providers.

4.7.7.3.1.4.4 The Contractor shall submit policies and procedures for conducting the Health Risk Screening and the tools that will be used to conduct the screenings to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operations Start Date.

4.7.7.4 Value Added Services

4.7.7.4.1 The Contractor may provide value added services that address the complex health care needs of Members and improve health outcomes.

4.7.7.5 Kenny A. Consent Decree

4.7.7.5.1 The Contractor shall review the Kenny A. Consent Decree.

4.7.7.5.2 Members in custody of Fulton and DeKalb counties are required to receive services within the timeframe identified

in the Kenny A. Consent Decree (**Attachment X**). The Contractor must provide all Medical Services and adhere to timeliness requirements defined in the Kenny A. Consent decree for FC Members in custody of Fulton and DeKalb counties.

4.7.7.6 State Plan Services for Members Enrolled in an HCBS Waiver Program

4.7.7.6.1 The Contractor must provide all Medicaid State Plan services required by Section 4.5 for Members enrolled in an HCBS waiver program except any services provided under the applicable 1915(c) waiver, which shall remain available to such Members via the Fee-for-Service program. DCH shall have the final determination as to which services are covered under the waiver and which services are the responsibility of the Contractor.

4.8 GEORGIA FAMILIES 360° PROVIDER NETWORK AND ACCESS

4.8.1 General Provisions

4.8.1.1 The Contractor shall develop and maintain a network of Providers and facilities adequate to deliver Covered Services as described in the RFP and this Contract while ensuring adequate and appropriate provision of services to Members in rural areas which may include the use of telemedicine when appropriate to the condition and needs of the Member. The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other health care Providers through whom it provides the items and services included in Covered Services.

4.8.1.2 The Contractor must expand upon its Georgia Families Provider network to meet the unique needs of the Members. The Contractor shall employ innovative solutions for providing access in underserved areas. For example, the Contractor may consider the provision of physical health and behavioral health telemedicine services in local schools. The Provider network must, at a minimum, include the following:

4.8.1.2.1 Primary care and specialist providers who are trained or experienced in trauma-informed care and in treating individuals with complex special needs, including the population which comprises the Members;

4.8.1.2.2 Providers who have knowledge and experience in identifying child abuse and neglect;

- 4.8.1.2.3 Providers who render Core Services and Intensive Family Intervention (IFI) services.
- 4.8.1.2.4 Providers recommended by DCH to ensure network access for Members, including independent behavioral health providers and non-traditional providers. Such providers must meet the State's credentialing requirements.
- 4.8.1.3 The Contractor is encouraged to contract with the Community Service Boards to provide Core Services.
- 4.8.1.4 Such Providers must meet the GF 360° State's Credentialing requirements.
 - 4.8.1.4.1 The Contractor is also expected to form productive relationships with provider associations with experience serving the population which comprises the Members.
 - 4.8.1.4.2 The Contractor shall provide the option for Providers to enroll for the purposes of serving the GF 360° population only rather than the universe of all Medicaid Members associated with all Georgia Families enrollees in the Contractor's plan.
- 4.8.1.5 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent, that maintain current license(s), and that have appropriate locations to provide the Covered Services.
- 4.8.1.6 The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.
- 4.8.1.7 The Contractor shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network enrollment for new Provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.
- 4.8.1.8 The Contractor shall not include any Providers who have been excluded from participation by the United States Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor shall check the exclusions list on a monthly basis and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.

4.8.2 Provider Selection and Retention Policies and Procedures

4.8.2.1 The Contractor shall have written Provider Selection and Retention Policies and Procedures. In selecting and retaining Providers in its network the Contractor shall consider the following:

4.8.2.1.1 The anticipated GF 360° Enrollment;

4.8.2.1.2 The expected Utilization of services, taking into consideration the characteristics and Health Care needs of its Members;

4.8.2.1.3 The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the Covered Services;

4.8.2.1.4 The numbers of network Providers who are not accepting new GF 360° patients; and

4.8.2.1.5 The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

4.8.2.2 If the Contractor declines to include individual Providers or groups of Providers in its network, the Contractor shall give the affected Providers written notice of the reason(s) for the decision. These provisions shall not be construed to:

4.8.2.2.1 Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members;

4.8.2.2.2 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs that are consistent with its responsibilities to Members.

4.8.2.3 The Contractor shall ensure that all network Providers have knowingly and willfully agreed to participate in the Contractor's network. The Contractor shall not acquire established networks without contacting each individual Provider to ensure knowledge of the requirements of this Contract and the Provider's complete understanding and agreement to fulfill all terms of the Provider Contract, as outlined in Section 4.10. DCH reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and on-site visits to

network Providers, the existence of a direct relationship between the Contractor and the network Providers.

4.8.2.4 The Contractor shall send all newly contracted Providers a written network participation welcome letter that includes a contract effective date for which Providers are approved to begin providing medical services to Members.

4.8.2.5 The Contractor shall survey all Providers who chose to exit the network and use the results of Provider exit surveys to improve Provider retention and recruitment. The Contractor shall provide DCH with the Provider exit survey template initially and when updated thereafter. The Contractor shall provide DCH with results of the Provider exit surveys upon request.

4.8.3 Provider Network Compositions

4.8.3.1 The Contractor shall maintain an online Provider Directory and Network Listing.

4.8.3.2 The Contractor shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted Providers which shall include the use of access and availability audits described in Section 4.8.19.6. Failure to conduct quarterly validation and provide a clean file after determining errors through validation may result in liquidated damages up to \$5,000 per day against the Contractor.

4.8.3.3 The Contractor shall ensure that all Provider network data files are tested and validated for accuracy prior to Contractor deliverable submissions, which shall include the use of access and availability audits described in Section 4.8.19.6. The Contractor shall scrub data to identify inconsistencies such as duplicate addresses; mismatched cities, counties, and regions; and incorrectly assigned specialties. The Contractor shall be responsible for submission of attestations for each network report. All reports are to be submitted in the established DCH format with all required data elements. Failure to submit all attestations and complete reports in the established DCH format with all required data elements may result in liquidated damages up to \$5,000 per day against the Contractor.

4.8.3.4 The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented in record. The Contractor will emphasize to Providers the need for a unique GA Medicaid number for each practice location unless DCH changes this requirement at a future date.

4.8.4 Primary Care Providers (PCPs)

4.8.4.1 The Contractor shall allow for PCPs to include not only traditional provider types that have historically served as PCPs but also alternative provider types such as specialists and patient-centered medical homes (PCMHs) with documented physician oversight and meaningful physician engagement.

4.8.4.2 The Contractor shall include in its network as PCPs the following:

4.8.4.2.1 Physicians who routinely provide Primary Care services in the areas of:

4.8.4.2.1.1 Family Practice;

4.8.4.2.1.2 General Practice;

4.8.4.2.1.3 Pediatrics;

4.8.4.2.1.4 Internal Medicine; or

4.8.4.2.1.5 Obstetrics and Gynecology.

4.8.4.2.2 Nurse Practitioners Certified (NP-C) specializing in:

4.8.4.2.2.1 Family Practice; or

4.8.4.2.2.2 Pediatrics.

4.8.4.2.2.3 NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who is a network Provider, who has hospital admitting privileges and oversees the provision of services furnished by NP-Cs.

4.8.4.2.3 Psychiatrists who agree to serve as PCPs for Members who have a primary diagnosis of a Severe Persistent Mental Illness.

4.8.4.2.4 Physicians who provide medical services at FQHCs and RHCs. The Contractor shall maintain an accurate list of all Providers rendering care at these facilities.

4.8.4.2.5 Providers who practice at Public Health Department clinics and Hospital Outpatient clinics may be included as PCPs if they agree to the requirements of the PCP role, including the following conditions:

- 4.8.4.2.5.1 The practice must routinely deliver Primary Care as defined by the majority of the practice devoted to providing continuing comprehensive and coordinated medical care to a population undifferentiated by disease or organ system. If deemed necessary, a Medical Record audit of the practice will be performed by the Contractor. Any exceptions to this requirement will be considered by DCH on a case-by-case basis.
- 4.8.4.2.5.2 Any Referrals for specialty care to other Providers of the same practice may be reviewed for appropriateness.
- 4.8.4.2.5.3 Members who have a primary diagnosis of a Severe Persistent Mental Illness may be permitted to have any physician including a psychiatrist as their PCP assuming the physician or psychiatrist agrees to serve in this role.
- 4.8.4.2.6 Physician's assistants (PAs); however, the physician should be listed as the Member's PCP.
- 4.8.4.3 The Contractor may allow Members with Chronic Conditions to select a specialist with whom he or she has an on-going relationship to serve as a PCP.
- 4.8.4.4 The Contractor is encouraged to promote and facilitate the capacity of all PCP practices to meet the recognition requirements of a NCQA PCMH™ as jointly defined by NCQA. The Contractor shall report to DCH those PCP practices that achieve recognition or meet the requirements of the NCQA for PCMH™ or TJC PCH Accreditation. The Contractor shall collaborate with other CMOs to coordinate efforts when PCPs are contracted with one or more plans so that efforts are not duplicated.
- 4.8.4.5 The Contractor will include Behavioral Health Homes in its Medical Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated. The number of Behavioral Health Homes proposed in the network should be responsive to the prevalence of members with severe and persistent mental illness or chronic behavioral health conditions. The proposed algorithm along with assignment of Behavioral Health Homes shall be included in a Medical Home implementation plan.

4.8.4.6 The Contractor shall provide a Medical Home implementation plan within ninety (90) days of the Operational Start Date for DCH review and approval that identifies the methodology for promoting and facilitating NCQA PCMH recognition and/or TJC PCH accreditation. The implementation plan shall include, but not be limited to:

4.8.4.6.1 Payment methodology for payment to primary care practices;

4.8.4.6.2 Provision of technical support, to assist in their transformation to PPC®-PCMH recognition or TJC PCH accreditation (e.g., education, training, tools, and provision of data relevant to patient clinical Care Management);

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

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

4.8.5 Direct Access

4.8.5.1 The Contractor shall provide female Members with direct In-Network access to a women's health specialist for covered care necessary to provide her routine and preventive Health Care services. This access is in addition to the Member's designated source of Primary Care if that Provider is not a women's health specialist.

4.8.5.2 The Contractor shall have a process in place that ensures that Members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the Member's condition and identified needs. The Contractor's Medical Director shall be responsible for overseeing this process.

4.8.5.3 The Contractor shall have a procedure by which the PCP in consultation with the Contractor's Medical Director and specialists, if appropriate, may request that a Member who needs ongoing care from a specialist receive a standing referral to such specialist. The Contractor shall not be required to permit a Member to elect to have a non-participating specialist if a network Provider is available. Such referral shall be pursuant to a treatment plan approved by the Contractor in consultation with the PCP, the specialist, and the Care Coordinator, or, where applicable, DFCS, DJJ, the Foster or Adoptive Parent or Caregiver, FC Member or AA Member or DJJ Member. Such treatment plan may limit the number of visits or the period during which such visits are

authorized and may require the specialist to provide the PCP with regular treatment updates and demonstrate medical necessity.

4.8.5.4 The Contractor shall provide for a review by a specialist of the same or similar specialty with experience as the type of physician or provider to whom a referral is requested before the Contractor may deny a request for referral to a specialist provider.

4.8.6 Pharmacies

4.8.6.1 The Contractor shall maintain a comprehensive Provider network of pharmacies that ensures pharmacies are available and geographically accessible to all Members.

4.8.7 Hospitals

4.8.7.1 The Contractor shall have a comprehensive Provider network of hospitals such that they are available and geographically accessible to all Members. This includes, but is not limited to tertiary care facilities and facilities with neo-natal, intensive care, burn, and trauma units.

4.8.7.2 The Contractor shall include in its network all Critical Access Hospitals (CAHs).

4.8.7.2.1 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include CAHs in its network. This documentation shall be provided to DCH upon request.

4.8.8 Laboratories

4.8.8.1 The Contractor shall maintain a comprehensive Provider network of laboratories that ensures laboratories are accessible to all Members. The Contractor shall ensure that all laboratory testing sites providing services under this contract have either a clinical laboratory (CLIA) certificate or a waiver of a certificate of registration, along with a CLIA number, pursuant to 42 CFR 493.3.

4.8.9 Mental Health/Substance Abuse

4.8.9.1 The Contractor shall include in its network the three tiers of community Behavioral Health Providers listed below that meet the requirements of the Department of Behavioral Health and Developmental Disabilities, provided they have been credentialed to participate in Medicaid for that provider type and agree to the Contractor's terms and conditions as well as rates. Additional information about these provider types and related policies and

standards are available at <https://gadbhdd.policystat.com/policy/1038203/latest/>.

4.8.9.1.1 Tier 1: Comprehensive Community Providers (CCPs)

4.8.9.1.1.1 CCPs function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The standards and requirements for CCPs are found in CCP Standards for Georgia's Tier 1 Behavioral Health Safety Net, 01-200.

4.8.9.1.2 Tier 2: Community Medicaid Providers (CMPs)

4.8.9.1.2.1 CMPs provide behavioral health services and supports identified in the Medicaid State Plan for Serious Emotional Disturbance (SED) youth, young adults, Serious and Persistent Mental Illness (SPMI) Adults, and individuals with Substance Use Disorders (SUDs). CMPs must competently serve children, adolescents, emerging adults, and/or adults and have the capacity and infrastructure to provide all of the services in the core benefit package:

4.8.9.1.3 Tier 3: Specialty Providers (SPs) that offer an array of specialty services including but not limited to:

4.8.9.1.3.1 Intensive Family Intervention providers for children who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.

4.8.9.1.3.2 Certified Peer Specialists (CPS) with lived experience for both young adults and adults to include CPS-Parents who are associated with a Family Support Organization (i.e. Federation of Families), CPS-Addiction and CPS Whole Health and Wellness.

4.8.9.1.3.3 Care Management Entities to provide intensive, customized, Complex Care Coordination for children, youth, and young adults who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.

4.8.9.1.3.4 Assertive Community Treatment for adults with SPMI.

4.8.9.2 Additionally, the Contractor shall include in its Provider network Providers who are enrolled as psychologists under the State Plan.

4.8.9.3 The Contractor shall maintain copies of all letters and other correspondence related to the inclusion of Community Behavioral Health Providers in its network. This documentation shall be provided to DCH upon request.

4.8.10 Federally Qualified Health Centers (FQHCs)

4.8.10.1 The Contractor shall include in its Provider network all FQHCs and utilize the PPS rates for reimbursement.

4.8.10.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include FQHCs in its network. This documentation shall be provided to DCH upon request.

4.8.10.3 The FQHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for FQHC (the Manual). Services and supplies deemed necessary for the provision of a Core service as described in §901.2 of the Manual are considered part of the FQHC service. In addition, an FQHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:

4.8.10.3.1 EPSDT [Health Check (COS 600)];

4.8.10.3.2 Mental Health (COS 440);

4.8.10.3.3 Dental Services (COS 450 and 460);

4.8.10.3.4 Refractive Vision Care services (COS 470); and

4.8.10.3.5 Podiatry (COS 550).

4.8.11 Rural Health Clinics (RHCs)

4.8.11.1 The Contractor shall include in its Provider network all RHCs in its Service Region based on PPS rates.

4.8.11.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include RHCs in its network. This documentation shall be provided to DCH upon request.

4.8.11.3 The RHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for RHC (the Manual). Services and supplies deemed necessary for the provision of a Core service as described in §901.2 of the Manual are considered part of the RHC service. In addition, an RHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:

- 4.8.11.3.1 EPSDT [Health Check (COS 600)];
- 4.8.11.3.2 Mental Health (COS 440);
- 4.8.11.3.3 Dental Services (COS 450 and 460);
- 4.8.11.3.4 Refractive Vision Care services (COS 470); and
- 4.8.11.3.5 Podiatry (COS 550).

4.8.12 Telemedicine

4.8.12.1 Telemedicine allows Provider-to-Provider and Provider-to-Member live interactions, and is especially useful in situations where Members do not have easy access to a Provider, such as for Members in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of treating Members. DCH does not currently recognize provider-to-provider live interactions without a Member present. Further, DCH does not currently recognize Store-and-Forward interactions of any kind. DCH reserves the right to modify this policy decision in the future, acknowledging that such a change would require a review of the appropriateness of the Capitation Rates. However, nothing in this Contract prevents Contractor from offering Store-and-Forward use of Telemedicine or Provider-to-Provider interactions without a Member present as an additional service not subject to consideration in the Capitation Rate setting process.

4.8.12.2 The Contractor shall provide telemedicine services to increase access to primary and specialty care as appropriate. Telemedicine presentation sites shall receive a telemedicine presentation site facility fee consistent with the Georgia Medicaid FFS program unless otherwise negotiated. The Contractor must include in its Provider Directory information on Providers with telemedicine capabilities and telemedicine presentation sites. The Contractor must:

- 4.8.12.2.1 Promote and employ broad-based utilization for access to HIPAA-compliant Telemedicine service systems

4.8.12.2.2 Follow accepted HIPAA and 42 C.F.R. Part 2 regulations that affect Telemedicine transmission, including but not limited to staff and Provider training, room setup, security of transmission lines, etc. The Contractor shall have and implement policies and procedures that follow all federal and State security and procedure guidelines.

4.8.12.2.3 Identify, develop, and implement training for accepted Telemedicine practices.

4.8.12.2.4 Participate in the needs assessment of the organizational, developmental, and programmatic requirements of Telemedicine programs.

4.8.12.3 A health-care facility that receives reimbursement under this section for consultations provided by a Medicaid-participating provider who practices in that facility and a health professional who obtains a consultation under this section shall establish quality-of-care protocols and patient confidentiality guidelines to ensure that telehealth consultations meet all requirements and patient care standards as required by law.

4.8.12.4 The Contractor shall determine the exact number and locations of all telemedicine presentation sites and the number of Providers who will commit to providing telemedicine consultations.

4.8.13 Family Planning Clinics

4.8.13.1 The Contractor shall make a reasonable effort to subcontract with all family planning clinics, including those funded by Title X of the Public Health Services Act.

4.8.13.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include Title X Clinics in its network. This documentation shall be provided to DCH upon request.

4.8.14 Nurse Practitioners Certified (NP-Cs) and Certified Nurse Midwives (CNMs)

4.8.14.1 The Contractor shall ensure that Members have appropriate access to NP-Cs and CNMs, through either Provider contracts or Referrals. This provision shall in no way be interpreted as requiring the Contractor to provide any services that are not Covered Services.

4.8.15 Dental Practitioners

4.8.15.1 The Contractor shall not deny any dentist from participating in its GF 360° dental program if the dentist meets the below criteria:

4.8.15.1.1 Such dentist has obtained a license to practice in this State and is an enrolled Provider who has met all of the requirements of DCH for participation in the Medicaid and PeachCare for Kids® program;

4.8.15.1.2 Licensed dentist will provide dental services to Members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, the Contractor shall be required to offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the service region who participate in the Contractor's Medicaid and PeachCare for Kids® dental programs; and

4.8.15.1.3 The geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by DCH, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services.

4.8.15.2 The Contractor must establish a sufficient number of general dentists and specialists as specified by Geographic Access Requirements, specified in Section 4.8.17, to provide covered dental services to Members. The Contractor may cover certain dental services provided by a dental hygienist in a Public Health setting in accordance with all applicable laws and rules. The Contractor may also provide for services in a school environment by mobile dentistry providers.

4.8.15.3 Should the Contractor find that the Provider does not meet the provisions set forth in Section 4.8.15.1 and elects to deny participation, the Contractor's denial letter of a credentialed Provider's request to contract must include specific information regarding the basis for denial and how to file an appeal.

4.8.15.4 The Contractor must report to DCH the number of dental application appeals, and appeal outcomes on a Calendar month basis.

4.8.16 Dental Home

4.8.16.1 The Contractor shall provide all Members under age twenty-one (21) a Dentist who will serve as the Members' Dental Home. The Contractor shall have written Selection Policies and Procedures describing how Members select or are assigned to a Dental Home.

4.8.17 Geographic Access Requirements

4.8.17.1 In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the following geographic access standards for all Members as outlined in Figure 1. The Contractor shall utilize the most recent Geo Access program versions available and update periodically as appropriate. The Contractor shall use GeoCoder software along with the Geo Access application package.

4.8.17.2 Beginning on the Operational Start Date, the Contractor's Geographic Access analysis must include the below data standards and reporting specifications. However, DCH reserves the right to modify the data standards and report specifications at any time in its discretion. The Contractor can submit recommendations for differing data standards and report specifications for DCH consideration and approval. With this submission, the Contractor must include its rationale for requesting the change. DCH's prior written approval of the change is required.

4.8.17.2.1 Data Standards:

4.8.17.2.1.1 The Contractor shall use the most recent eligibility files provided by DCH.

4.8.17.2.1.2 The Contractor shall use the most recent Member data to geocode each Member by street address. Identifying Members at zip code centroids or randomly within zip codes is not acceptable.

4.8.17.2.1.3 All Contractors' network Provider Street addresses should be exactly geocoded. For any address that cannot be exactly geocoded, the address should be geocoded using a technique that takes into account population density. Placing Providers at zip code centroids or randomly within zip codes is not acceptable.

4.8.17.2.1.4 If more than one Provider is located at the same address, all Providers at that address should have the same geographic coordinates.

4.8.17.2.1.5 Physicians should be classified based on their primary specialty only. For example, a pediatric cardiologist should be classified as cardiologist, not a pediatrician.

4.8.17.2.1.6 The Provider file must include the capacity for each PCP and general dentist.

4.8.17.2.1.7 The Contractor shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider location. For purposes of this requirement, a Full-Time Provider location is defined as a location operating for sixteen (16) or more hours in an office location each week. For Providers who have more than one (1) office location, the Contractor must indicate each location by a separate record in the Provider file and divide the capacity of the Provider by the number of locations. For example, if the Provider capacity is one hundred fifty (150), and the Provider has two (2) offices, each office would have a capacity of seventy-five (75). The “individual capacity” option should be used when reporting PCPs.

4.8.17.2.1.8 For calculating distance (miles) the Contractor must use the maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider. DCH recognizes that transportation with NET vendors may not always follow direct routes due to multiple passengers.

4.8.17.2.2 Report Specifications

4.8.17.2.2.1 The Contractor must prepare separate Geographical Access reports for each county, addressing all Provider types included in Figure 1. Additionally, the Contractor shall prepare separate analyses for the following:

- 4.8.17.2.2.1.1 Adult PCPs for ages twenty-one (21) and over
- 4.8.17.2.2.1.2 Pediatric PCPs for children under the age of twenty-one (21)
- 4.8.17.2.2.1.3 General Dentist
- 4.8.17.2.2.1.4 Telemedicine Presentation Sites
- 4.8.17.2.2.1.5 Provider specialist shortages as identified by DCH or the Contractor including but not limited to OB Providers
- 4.8.17.2.2.2 The Contractor must prepare separate Geographical Access reports showing Providers with open panels only and showing all open and closed panels.

Figure 1. Geographic Access Standards by Provider Type

Provider Type	Urban	Rural
PCPs*	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Obstetric Providers	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

Provider Type	Urban	Rural
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles
Therapy : (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

*PCPs not including practitioners listed below in Table.

4.8.18 Other Reports

4.8.18.1 In addition to the Geographic Access data reports, the Contractor shall submit the following separate reports:

4.8.18.1.1 Providers and associated locations with closed panels (any Provider which the Contractor recognizes as no longer accepting new Members) and those Providers and associated locations with less than Full-Time Provider hours. The separate reports must include a listing of the Providers by name and location, Provider type and an analysis of the total number of Providers with closed panels or less than Full-Time Provider hours expressed as a percentage of the Contractor's total contracted Providers for the state and then for each Service Region.

4.8.18.3.1.2 The percent of Members who do not have Provider access as defined in Figure 1.

4.8.18.3.1.3 Plans or corrective actions to enhance access of the Providers included in these separate reports. If enhanced access is not possible (i.e., no Providers available for contracting or available Providers only practice part-time), the Contractor must describe the limitations to enhancing access. The Contractor may indicate whether a Provider's office is a primary, secondary, tertiary, etc. location

4.8.18.3.1.4 Report monthly the total number of Provider requests to contract received, the total number of Providers referred to

DCH or its Agent for credentialing, the total number of contracts pending a determination, and the total of each of the approved and denied contract requests by Provider type and in aggregate.

4.8.18.2 The Contractor shall ensure that all executed Provider contracts are processed and loaded into all systems including but not limited to the Contractor’s claims processing system, within thirty (30) Calendar Days of receipt by the Contractor or its designated subcontracted vendor.

4.8.19 Waiting Maximums and Appointment Requirements

4.8.19.1 The Contractor shall require that all network Providers offer hours of operation that are no less than the hours of operation offered to commercial and Fee-for-Service patients. The Contractor shall encourage its PCPs to offer After-Hours office care in the evenings and on weekends.

4.8.19.2 The Contractor shall have in its network the capacity to ensure that waiting times for appointments do not exceed those outlined in Figure 2:

Figure 2. Waiting Times by Provider Type

Provider Type	Waiting Time
PCPs (routine visits)	Not to exceed fourteen (14) calendar days
PCP (adult sick visit)	Not to exceed twenty-four (24) clock hours
PCP (pediatric sick visit)	Not to exceed twenty-four (24) clock hours
Maternity Care	First Trimester – Not to exceed fourteen (14) Calendar Days Second Trimester – Not to exceed seven (7) Calendar Days Third Trimester – Not to exceed three (3) Business Days
Specialists	Not to exceed thirty (30) Calendar Days
Therapy: Physical Therapists, Occupational Therapists, Speech Therapists, Aquatic Therapists	Not to exceed thirty (30) Calendar Days

Provider Type	Waiting Time
Vision Providers	Not to exceed thirty (30) Calendar Days
Dental Providers (routine visits)	Not to exceed twenty-one (21) Calendar Days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) Calendar Days
Mental health Providers	Fourteen (14) Calendar Days
Urgent Care Providers	Not to exceed twenty-four (24) clock hours
Emergency Providers	Immediately (twenty-four (24) clock hours a day, seven (7) days a week) and without prior authorization

4.8.19.3 The Contractor shall have in its network the capacity to ensure that waiting times in the Provider office does not exceed those outlined in Figure 3 for pediatrics and adults.

Figure 3. Waiting Times by Appointment Type

Appointment Type	Waiting Time
Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed ninety (90) minutes. After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

4.8.19.4 Providers shall track waiting times by appointment to be reviewed by DCH upon request.

4.8.19.5 The Contractor shall ensure that Provider response times for returning calls After-Hours do not exceed those outlined in Figure 4:

Figure 4. Returned Call Response Times

Call Type	Response Time
Urgent Calls	Shall not exceed twenty (20) minutes
Other Calls	Shall not exceed one (1) hour

4.8.19.6 The Contractor shall conduct access and availability audits at least quarterly to validate Provider network access (outreach phone calls, emails) of individual Providers within the Contractor’s primary care, specialty, dental, pediatric and obstetrical Provider Network. The Contractor may coordinate with other CMOs to conduct these audits to avoid duplicate contacts to Providers. The Contractor shall conduct a review of twenty-five percent (25%) of its combined GF 360° Provider Network. Reviews shall include the use of “secret shopper” calls during which the caller pretends to be a Member to confirm specific information including but not limited to the following:

- 4.8.19.6.1 Contact information, such as address, phone, email, web site and fax numbers.
- 4.8.19.6.2 Provider is participating in the Network.
- 4.8.19.6.3 Open/Closed panel status.
- 4.8.19.6.4 Appointment availability and how far in advance the Member can schedule an appointment.

4.8.19.7 The Contractor shall provide DCH with results of all access and availability audits upon request. The Contractor shall take corrective action to remediate instances of identified non-compliance with the standards above and report all non-compliance to DCH within thirty (30) Calendar Days of the audit. Should DCH identify and notify the Contractor of non-compliance with the standards listed above, the Contractor shall provide to DCH a corrective action plan within thirty (30) Calendar Days of receipt of such notice.

4.8.20 Mainstreaming

4.8.20.1 The Contractor shall encourage that all In-Network Providers accept Members for treatment, unless they have a full panel and are accepting no new Georgia Families 360° or commercial patients. The Contractor shall ensure that In-Network Providers do

not intentionally segregate Members in any way from other persons receiving services.

4.8.20.2 The Contractor shall ensure that Members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.

4.8.21 Provider Credentialing

4.8.21.1 DCH is contracting with a single Credentialing Verification Organization (CVO) to conduct credentialing and re-credentialing of Providers for Medicaid and the contracted CMOs. Providers must enroll with Medicaid and/or Georgia Families or Georgia Families 360° by submitting an electronic application and supporting documentation through the CVO's web-based Provider Credentialing Portal. The Contractor will not conduct its own Credentialing processes and shall accept the CVO's credentialing and recredentialing determinations. The Contractor cannot appeal the CVO credentialing decision. The Contractor cannot require Providers to submit supplemental or additional information for purposes of conducting a second credentialing process by the Contractor. See **Attachment V, Provider Credentialing Process**.

4.8.21.2 The Contractor shall coordinate with DCH's contracted CVO to confirm the status of Providers who are requesting to enroll with the Contractor and to confirm recredentialing status. The Contractor shall report to DCH any instances of which it is informed a determination has not been made by the CVO within thirty (30) Calendar Days of application. See **Attachment W, Provider Credentialing Timelines**. DCH reserves the right to modify the credentialing timelines as needed.

4.8.21.3 The Contractor shall include Providers recommended by DFCS, DBHDD, DJJ, DOE, DECAL or DPH in its Provider network if the Provider or agency meets the enrollment criteria for Georgia Fee-for-Service Medicaid and are credentialed by DCH's contracted CVO, as described in Section 4.8.21 and are able to negotiate a Provider Agreement.

4.8.21.4 The Contractor shall refer providers to the CVO website to complete the credentialing process prior to enrolling with a CMO. The Contractor shall also provide information about the re-credentialing process to all network Providers. The Contractor will refer all Providers to the CVO who are not Medicaid providers and requesting to enroll.

- 4.8.21.5 The CVO updates the Provider Credentialing Portal and notifies DCH of the Credentialing status. If Credentialing is successful, the application is sent to DCH for final disposition. For approved applications, the CVO sends a file with all of the Provider's enrollment data to the Fiscal Agent to update the MMIS to include the necessary Provider information. The Fiscal Agent will send the Provider a welcome letter, and notify any CMO in which the Provider has requested to also enroll.
- 4.8.21.6 In the event the State decides not to contract with a single CVO, the Contractor shall be responsible for all credentialing and re-credentialing of its network providers. The Contractor would be required to submit a credentialing and re-credentialing plan to DCH for review and approval prior to beginning these processes, and updates thereto.

4.8.22 Network Changes

- 4.8.22.1 The Contractor shall notify DCH within seven (7) Business Days of any significant changes to the Provider network or, if applicable, to any Subcontractors' Provider network. A significant change is defined as:
- 4.8.22.1.1 A decrease in the total number of PCPs by more than five percent (5%);
 - 4.8.22.1.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within the geographic access standards as defined in Section 4.8.17;
 - 4.8.22.1.3 A loss of specialty Providers in a Health Professional Shortage Areas including but not limited to Obstetric Providers;
 - 4.8.22.1.4 A loss of a hospital in an area where another contracted hospital of equal service ability is not available within the geographic access standards as defined in Section 4.8.17; or
 - 4.8.22.1.5 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to In-Network Providers including closed Provider panels.
- 4.8.22.2 The Contractor shall have procedures to address changes in the Contractor's Provider network that negatively affect the ability of Members to access services, including access to a culturally diverse Provider network. Failure to adequately address significant changes in network composition that negatively impact Member

access to services may be grounds for Contract termination or State determined remedies.

4.8.22.3 If a PCP ceases participation in the Contractor's Provider network, the Contractor shall send written notice to the Members who have chosen the Provider as their PCP. The notice shall encourage the Member to select a new PCP as soon as possible to limit disruption in care, and explain that the DCH Enrollment Broker will assign a new PCP if the Member does not choose a new PCP within thirty (30) Calendar Days. This notice must contain contact information to assist the Member in selecting a new PCP. This notice shall be issued no less than thirty (30) Calendar Days prior to the effective date of the termination and no more than ten (10) Calendar Days after receipt or issuance of the termination notice. This notice must contain contact information to assist the member in selecting a new PCP.

4.8.22.4 If a Member is in a prior authorized ongoing course of treatment with any other participating Provider who becomes unavailable to continue to provide services, the Contractor shall notify the Member in writing within ten (10) Calendar Days from the date the Contractor becomes aware of such unavailability.

4.8.22.5 These requirements to provide notice to the Member prior to the effective dates of Provider termination shall be waived in instances where a Provider becomes physically unable to care for Members due to illness, a Provider dies, the Provider moves from the Service Region and fails to notify the Contractor, or when a Provider fails Credentialing. Under these circumstances, notice shall be issued immediately upon the Contractor becoming aware of the circumstances, along with contact information to assist the Member in selecting a new PCP.

4.8.22.6 The Contractor shall submit a Continuity of Care plan to DCH sixty (60) Calendar Days prior to the anticipated mass Network changes, as defined in this section that will impact membership. DCH may require the Continuity of Care Plan drill down to the individually affected member level depending upon the situation.

4.8.23 Out-of-Network Providers

4.8.23.1 If the Contractor's network is unable to provide Medically Necessary Covered Services to a particular Member, the Contractor shall adequately and timely cover these services Out-of-Network for the Member. The Contractor must inform the Out-of-Network Provider that the Member cannot be balance billed.

4.8.23.2 The Contractor shall coordinate with Out-of-Network Providers regarding payment. For payment to Out-of-Network, or non-participating Providers, the following guidelines apply:

4.8.23.2.1 If the Contractor offers the service through an In-Network Provider(s), and the Member chooses to access the service (i.e., it is not an emergency) from an Out-of-Network Provider, the Contractor is not responsible for payment.

4.8.23.2.2 If the service is not available from an In-Network Provider and the Member requires the service and is referred for treatment to an Out-of-Network Provider, the payment amount is a matter between the CMO and the Out-of-Network Provider.

4.8.23.2.3 If the service is not available from an In-Network Provider, but the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).

4.8.23.2.4 If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition standard, and the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).

4.8.23.2.5 When paying out of state Providers in an emergency situation, Contractor shall not allow a Member to be held accountable for payment.

4.8.23.3 In the event that needed services are not available from an In-Network Provider and the Member must receive services from an Out-of-Network Provider, the Contractor must reimburse the Provider. In this instance, Contractor is prohibited from billing the Member.

4.8.24 Shriners Hospitals for Children

4.8.24.1 The Contractor shall comply with the responsibilities outlined in the “Memorandum of Understanding for the PeachCare Partnership Program” executed on February 18, 2008, as amended from time to time, and attached to this Contract as **Attachment T** and expressly incorporated into this Contract as if completely restated herein.

4.8.24.2 The Contractor shall cooperate with DCH in making any updates or revisions to the Memorandum, as necessary.

4.8.25 Reporting Requirements

4.8.25.1 The Contractor shall submit to DCH quarterly Provider Network Adequacy and Capacity Reports (including Policies and Procedures) as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.8.25.2 The Contractor shall submit to DCH quarterly Timely Access Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.9 **PROVIDER SERVICES**

The Contractor shall establish and maintain a Provider services function to act as the point of contact for its Providers. As such, the Contractor will provide educational material, operate a provider services line, facilitate Provider complaints and timely address Provider contract and payment issues. The Contractor must staff its provider services department with personnel qualified to fulfill the requirements as described in this Section.

4.9.1 General Provisions

4.9.1.1 The Contractor shall provide information to all Providers about Georgia Families 360° in order to operate in full compliance with the Georgia Families 360° Contract and all applicable federal and State regulations.

4.9.1.2 The Contractor shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.

4.9.1.3 The Contractor shall submit to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter, all materials and information to be distributed and/or made available to Providers about Georgia Families 360°.

4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.

4.9.1.5 Contractor must seek DCH's written approval of the Contractor's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider contracts or

communications. DCH's review and response will be completed within sixty (60) Calendar Days of the Contractor's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Contractor misinterprets a Medicaid policy which is communicated to Providers, the Contractor must submit a written corrective action plan to DCH within three (3) Business Days of notice from DCH. Contractor will be required to retroactively correct and adjust any previously adjudicated claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) calendar days of approval of the corrective action plan.

4.9.2 Provider Handbooks

4.9.2.1 The Contractor shall develop and provide to DCH within one hundred twenty (120) Calendar Days of the Operations Start Date a GF 360° Provider Handbook specific to the needs of the Members. DCH shall have at least ten (10) Calendar Days to review the handbook and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized handbook to DCH.

4.9.2.2 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the GF 360° Provider Handbook must contain special requirements for the Members, including:

4.9.2.2.1 How Members, Caregivers, Foster and Adoptive Parents, DFCS staff and DJJ staff may access Care Management;

4.9.2.2.2 Requirements that Behavioral Health Providers and PCPs shall coordinate care for Members;

4.9.2.2.3 The requirement that PCPs providing CCFA assessments must provide timely assessment results to the Contractor as detailed in Section 4.9 and requirements included in the Kenny A. Consent Decree;

4.9.2.2.4 Requirements and legal obligations for providing medical information as required by DFCS and DJJ, and/or necessary for court hearings;

- 4.9.2.2.5 GF 360° Covered Services;
- 4.9.2.2.6 Member eligibility categories;
- 4.9.2.2.7 Medical Necessity standards and practice guidelines;
- 4.9.2.2.8 Role of the PCP;
- 4.9.2.2.9 Link to the NCQA and Joint Commission web sites;
- 4.9.2.2.10 Role of the Dental Home;
- 4.9.2.2.11 Emergency Service responsibilities;
- 4.9.2.2.12 Health Check/EPSTD Benefit;
- 4.9.2.2.13 Prior Authorization, Pre-Certification, and Referral procedures;
- 4.9.2.2.14 Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
- 4.9.2.2.15 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers;
- 4.9.2.2.16 Provider Complaint System Policies and Procedures, including, but not limited to, specific instructions for contacting the Contractor's Provider services to file a complaint and which individual(s) have the authority to review a complaint;
- 4.9.2.2.17 Policies and procedures for the Provider Grievance and Appeals process;
- 4.9.2.2.18 Information on the Member Grievance System, including the Member's right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the right to request continuation of Benefits while utilizing the Grievance System;
- 4.9.2.2.19 The role of the CVO and link to the CVO web site;
- 4.9.2.2.20 Information about the HIE/GaHIN including how information will be used by the CMOs and DCH and an

explanation of any service limitations or exclusions from coverage;

- 4.9.2.2.21 Link to the DCH web site;
- 4.9.2.2.22 Role of the DCH fiscal agent and link to the fiscal Agent's web site;
- 4.9.2.2.23 Information about the Georgia Families 360° Value-based Purchasing;
- 4.9.2.2.24 Transition of Care Planning;
- 4.9.2.2.25 Care Coordination Policies;
- 4.9.2.2.26 Protocol for Encounter Claims element reporting/records;
- 4.9.2.2.27 Medical Records standards;
- 4.9.2.2.28 Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;
- 4.9.2.2.29 Payment policies;
- 4.9.2.2.30 The Contractor's Cultural Competency Plan;
- 4.9.2.2.31 Member rights and responsibilities; and
- 4.9.2.2.32 Other Provider or Subcontractor responsibilities.

4.9.2.3 The Contractor shall disseminate bulletins as needed to incorporate any needed changes to the Provider Handbook. These bulletins can be mailed hard copy or can be disseminated via email, provided hard copies are available and Providers are informed of how to request in hard copy.

4.9.2.4 The Contractor shall submit the Provider Handbook to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter. Any updates or revisions shall be submitted to DCH for review and approval at least thirty (30) Calendar Days prior to distribution.

4.9.3 Education and Training

4.9.3.1 The Contractor shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Contractor shall conduct initial training within

thirty (30) Calendar Days of executing a contract with a newly Contracted Provider. The Contractor shall also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Contractor or DCH in order to ensure compliance with program standards and this Contract and meet the needs of Providers.

4.9.3.2 The Contractor shall also provide Provider workshops, data, trainings and technical assistance, webinars and web-based tutorials about the emergence and ongoing operations of Medical Homes and other service delivery innovations, evidence-based and emergency best practices, delivering a person-centered approach to care and the System of Care approach to care delivery.

4.9.3.3 The Contractor shall provide training to all Demonstration Family Planning and IPC service Providers and their staff regarding the requirements of the Demonstration and the Contract provisions related to the Demonstration and special needs of the P4HB Participants. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or DCH in order to ensure compliance with the Demonstration's standards and the Contract.

4.9.3.4 The Contractor's Demonstration Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling available at <http://fpm.emory.edu/preventive/research/projects/index.html>.

4.9.3.5 The Contractor shall develop and submit the Provider Training Manual and Training Plan, including topics, schedule and languages spoken, to DCH for initial review and approval at least thirty (30) Calendar Days prior to any scheduled trainings and as updated thereafter.

4.9.3.6 DCH may attend any training sessions specific to this Contract at its discretion.

4.9.3.7 The Contractor shall submit to DCH a Provider education and training approach within one hundred fifty (150) Calendar Days of the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH. The education and outreach approach must include, at a minimum:

- 4.9.3.7.1 Obtaining recommendations from experts in the field including DFCS, DBHDD, DOE, DPH, DECAL and DJJ to identify relevant training modules;
- 4.9.3.7.2 Initial and ongoing training of Contractor staff and the Provider network as applicable that addresses, but is not limited to, the following issues:
 - 4.9.3.7.2.1 The roles and responsibilities of DCH, DFCS, DBHDD, DOE, DCH, DECAL and DJJ with regard to the GF 360° program and how DCH and partner agencies will coordinate with the Contractor;
 - 4.9.3.7.2.2 Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules;
- 4.9.3.7.3 Coordinating care utilizing a System of Care approach between: Foster Parents and Caregivers; DFCS Case Managers, JPPS or other involved case managers; attorneys; guardians ad litem; judges; law enforcement officials; Adoptive Parents; and other involved parties from State agencies;
- 4.9.3.7.4 Requirements for providing Health Care Services to the Member, including:
 - 4.9.3.7.4.1 Medical consent requirements;
 - 4.9.3.7.4.2 Required timelines for services and assessments;
 - 4.9.3.7.4.3 Specific medical information required for court requests and judicial review of medical care;
 - 4.9.3.7.4.4 Appropriate utilization of psychotropic medications;
 - 4.9.3.7.4.5 Evidence-based Behavioral Health treatment interventions; and
 - 4.9.3.7.4.6 Specific behavioral health and physical health needs of the children and young adults who comprise the GF 360° population.
- 4.9.3.7.5 Training in trauma-informed care;
- 4.9.3.7.6 The effect of abuse and neglect on the developing brain;

- 4.9.3.7.7 The effect of intrauterine assault, fetal alcohol syndrome and shaken baby syndrome;
- 4.9.3.7.8 How to screen for and identify Behavioral Health disorders;
- 4.9.3.7.9 The Contractor's referral process for Behavioral Health services; and
- 4.9.3.7.10 The availability of a Care Coordination Team for Members and how to access the Care Coordinator.

4.9.3.8 Training for Law Enforcement Officials and Judges

- 4.9.3.8.1 The Contractor shall provide one (1) training per quarter of the Contract for law enforcement officials, judges, district and county attorneys representing DFCS and DJJ about the requirements of the Contract and needs of the Members. DCH, DFCS, DJJ and other sister agencies may also participate in these trainings. The Contractor shall provide multiple methods of training to engender the most participation. Examples of training methods include but are not limited to face-to-face; workshops; Internet-based (webinars or other tutorials); etc.

4.9.3.9 Trainings for DCH Sister Agencies

- 4.9.3.9.1 The Contractor shall prepare trainings and educational materials for use by DCH and the Contractor to educate DCH staff, sister agencies and HCBS Case Managers about the GF 360° program and the necessity of collaboration and coordination. DCH encourages the Contractor to collaborate with DCH sister agencies to improve staff training rates and shall incorporate innovative approaches to training sister agencies which may include co-locating Contractor staff with sister agency staff.

- 4.9.3.9.2 The Contractor shall submit a training plan that includes proposed locations, dates of trainings and training materials to DCH sixty (60) Calendar Days prior to the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH. The Contractor shall update training materials annually, at a minimum, and more often if a change in law or policy alters the content of the training materials.

4.9.3.10 Children 1st and Babies Can't Wait (BCW)

4.9.3.10.1 The Contractor shall educate network Providers about the federal laws on child find (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) and require network Providers to identify and refer any FCAAP Member birth through thirty-five (35) months of age suspected of having a developmental delay or disability, or who is at risk of delay, to the designated Children 1st program for assessment and evaluation.

4.9.3.10.2 Evidence of this education shall be documented and available to DCH or its designee.

4.9.3.10.3 The Contractor shall send appropriate staff to attend Local Interagency Planning Team (LIPT) and Regional Interagency Action Team (RIAT) meetings when its enrolled FC Member or DJJ Member is on the agenda.

4.9.3.11 The Contractor shall submit the Provider Rep Field Visit Report Ad-Hoc as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.9.4 Provider Relations

4.9.4.1 The Contractor shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. The Contractor shall implement policies addressing the compliance of Providers with the requirements included in this RFP and institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.

4.9.4.2 The Contractor shall provide for at least one (1) Provider Relations Liaison per Service Region to Conduct the Provider Relations functions.

4.9.5 Provider Services Call Center

4.9.5.1 The Contractor shall operate a toll-free Call Center to respond to Provider questions, comments and concerns.

4.9.5.2 The Contractor shall develop Call Center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

- 4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.
- 4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in **Attachment K**.
- 4.9.5.5 Pursuant to OCGA 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00 am and 7:00 pm EST Monday through Friday, excluding State holidays. The Contractor shall ensure that after regular business hours the non-Prior Authorization/ Pre-Certification line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition. The call center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Contractor shall provide information to Providers on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.
- 4.9.5.6 The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for initial review and approval and as updated thereafter. At a minimum, the standards shall require that, on a calendar month basis:
- 4.9.5.6.1 Average Speed of Answer: Eighty percent (80%) of calls shall be answered by a person within thirty (30) seconds. "Answer" shall mean each caller who elects to speak is connected to a live representative. The caller shall not be placed on hold immediately by the live representative. The remaining twenty percent (20%) of calls are answered within one (1) minute of the call
- 4.9.5.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (1) not permitted access to that option or (2) the system disconnects the call while the Member is on hold.

- 4.9.5.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).
- 4.9.5.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a live Call Center Representative.
- 4.9.5.6.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of “closed” for this performance measure.
- 4.9.5.6.6 Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.
- 4.9.5.7 The Contractor shall set up remote phone monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer or phone, to monitor call Center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Contractor will facilitate bi-annual calibration sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.
- 4.9.6 Provider Web Site
- 4.9.6.1 The Contractor shall dedicate a section of its Web Site to Provider services and provide general up-to date information about the Contractor’s program. At minimum, the website must have the capability for Providers to make inquiries and receive responses through the Medicaid fiscal agent Web Site (www.mmis.georgia.gov) and must:
- 4.9.6.1.1 Include a searchable Provider Handbook;
- 4.9.6.1.2 Include a searchable Provider Directory that the Contractor updates immediately within five (5) Business Days of a change;
- 4.9.6.1.3 Include Customer services, including the capability for Providers to submit questions and comments to the Contractor and receive responses. The Contractor shall respond to Provider inquiries within one (1) Business Day

of receipt. The Contractor shall refer any inquiries to DCH that are not within the Contractor's scope of services (e.g., inquiries about the Fee-for-Service delivery system);

4.9.6.1.4 Include the capability for Providers to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate claims electronically and consistent with the Contractor's policies and procedures for Provider Claims activities. To the extent a Provider has the capability, the Contractor shall submit payments to Providers electronically and submit remittance advices to Providers electronically within one (1) Business Day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, *et seq.*, then those transactions also shall be conducted in accordance with applicable federal requirements;

4.9.6.1.5 Provide information about the following:

4.9.6.1.5.1 Grievance and Appeals Systems

4.9.6.1.5.2 Pharmacy Preferred Drug List

4.9.6.1.5.3 Pharmacy Conditions for Coverage and Utilization Limits

4.9.6.1.5.4 Member rights and responsibilities

4.9.6.1.5.5 DCH's Value-based Purchasing

4.9.6.1.5.6 Information about the GaHIN including how information will be used by the CMOs and DCH and procedures to opt out of the GaHIN

4.9.6.1.5.7 PCP/Medical Home responsibilities;

4.9.6.1.5.8 Dental Home responsibilities

4.9.6.1.5.9 Planning for Healthy Babies 1115 Demonstration;

4.9.6.1.6 Link to the DCH CVO web site;

4.9.6.1.7 Link to the DCH Fiscal Agent web site;

4.9.6.1.8 Link to the NCQA accreditation recognition web site;

4.9.6.1.9 Include What's New items;

- 4.9.6.1.10 Include frequently asked questions and answers; and
- 4.9.6.1.11 Link to the DCH Medicaid web site, DCH P4HB web site and the Enrollment Broker web site.

4.9.6.2 The Contractor must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Contractor must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades which support the ordinary operation, administration, and maintenance of the web site, the Contractor shall not modify the web site prior to receipt of DCH approval.

4.9.6.3 The Contractor's Web Site shall be functionally equivalent, with respect to functions described in this Contract, to the Web Site maintained by the State's Medicaid fiscal agent <https://www.mmis.georgia.gov/portal/default.aspx/> and consistent with the standards established by the Georgia Technology Authority (GTA) as published at <http://gta.georgia.gov/psg/> and amended periodically.

4.9.7 Provider Complaint System

4.9.7.1 The Contractor shall establish a Provider Complaint system that permits a Provider to dispute the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.

4.9.7.2 The Contractor shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and annually and as updated thereafter. The Contractor shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor's Provider services to file a Provider complaint and which individual(s) have the authority to review a Provider complaint.

4.9.7.3 The Contractor shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers with the remittance advice of the processed Claim. The Contractor may distribute a summary of these Policies and Procedures if the summary includes information on how the Provider may access the full Policies and Procedures on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.

4.9.7.4 As a part of the Provider Complaint System, the Contractor shall:

4.9.7.4.1 Allow Providers thirty (30) Calendar Days from the date of issue or incident to file a written complaint;

4.9.7.4.2 Allow Providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal;

4.9.7.4.3 Require that Providers' complaints are clearly documented;

4.9.7.4.4 Allow a Provider that has exhausted the Contractor's internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal the option either to pursue the administrative appeals process described in O.C.G.A. § 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A. § 33-21A-7. If the Contractor and the Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties;

4.9.7.4.5 For all claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from fifteen (15) Calendar Days after the date the claim was submitted. The Contractor shall pay all interest required to be paid under this provision or Code Section O.C.G.A. 33-21A-7 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment;

- 4.9.7.4.6 Accurately identify all interest payments on the associated remittance advice submitted by the Contractor to the Provider;
 - 4.9.7.4.7 Require that Providers exhaust the Contractor's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);
 - 4.9.7.4.8 Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems;
 - 4.9.7.4.9 Identify a staff person specifically designated to receive and process Provider Complaints;
 - 4.9.7.4.10 Thoroughly investigate each Provider Complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and
 - 4.9.7.4.11 Ensure that Contractor plan executives with the authority to require corrective action are involved in the Provider Complaint process.
- 4.9.7.6 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers may request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.
- 4.9.7.7 The Contractor shall notify the Providers that a request for an Administrative Law Hearing must include the following information:
- 4.9.7.7.1 A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;
 - 4.9.7.7.2 Identification of the Action being appealed and the issues that will be addressed at the hearing;
 - 4.9.7.7.3 A specific statement of why the Provider believes the Contractor's Action is wrong; and
 - 4.9.7.7.4 A statement of the relief sought.
- 4.9.7.8 DCH has delegated its statutory authority to receive hearing requests to the Contractor. The Contractor shall include with the

Notice of Adverse Action the Contractor's address where a Provider's request for an Administrative Law Hearing should be sent in accordance with O.C.G.A. § 49-4-153(e).

4.9.8 Claims Adjustment Requests/Claim Payment Disputes

4.9.8.1 If the amount reimbursed by the Contractor to an enrolled Provider is not correct, a positive or negative adjustment may be necessary. Such request for claims adjustment shall be included in the Contractor's internal appeals process and shall not negate a Provider's right to appeal pursuant to O.C.G.A. §49-4-153(e). The Contractor shall develop a procedure to address claims adjustment requests that meet the following minimum requirements:

4.9.8.1.1 Contractor Positive Adjustments

4.9.8.1.1.1 When a Provider can substantiate that additional reimbursement is appropriate, the Provider may adjust and resubmit a claim. Provider shall be given the option to submit the written request, Explanation of Payment and all claims related documentation either electronically or by U.S. mail. All documentation must be received within three (3) months from the end of the month of payment. The adjustment request must include sufficient documentation to identify each claim identified in the request. The Contractor may return incomplete requests without further action provided it notifies the Provider of the basis for the incomplete status and allows the Provider ten (10) calendar days to resubmit the adjustment request. The Provider shall be required to submit documentation that supports the requested claims adjustment. If a positive adjustment is warranted, the Contractor shall make additional reimbursement upon processing of the request. If an adjustment is not warranted, the Provider will be notified via written correspondence from the Contractor.

4.9.8.1.2 Contractor Negative Adjustments

4.9.8.1.2.1 When a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim. Provider shall be given the option to submit the written request, Explanation of Payment and all claims related documentation either electronically or by U.S. mail. If a negative adjustment is warranted, Contractor may either deduct the

payment from future reimbursement or request reimbursement from the Provider as required by the Provider's contract with the Contractor.

4.9.8.1.3 The Contractor shall respond to all adjustment requests within fifteen (15) Calendar Days of receipt.

4.9.8.1.4 Contractor shall maintain a website that allows Providers to submit, process, edit, rebill, and adjudicate claims electronically.

4.9.8.1.5 Contractor shall include recoupment information to be combined within the remittance where the recoupment occurs.

4.9.9 Reporting Requirements

4.9.9.1 The Contractor shall submit to DCH monthly Telephone and Internet Activity Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.9.9.2 The Contractor shall submit to DCH monthly Provider Complaints Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.10 **PROVIDER CONTRACTS AND PAYMENTS**

4.10.1 Provider Contracts

4.10.1.1 The Contractor shall submit to DCH for initial review and approval and as updated thereafter a model for each type of Provider Contract and shall comply with all DCH procedures for contract review and approval submission. Memoranda of Agreement (MOA) shall not be permitted.

4.10.1.2 Any significant changes to the model Provider Contract shall be submitted to DCH for review and approval no later than thirty (30) Calendar Days prior to use of the revised Provider Contract.

4.10.1.3 Upon request, the Contractor shall provide DCH with copies of all executed Provider Contracts at no cost.

4.10.1.4 In addition to addressing the CMO licensure requirements, the Contractor's Provider Contracts shall:

- 4.10.1.4.1 Not require Providers to participate or accept other plans or products offered by the Contractor unrelated to providing Covered Services to Members. The Contractor shall be subject to a penalty of \$1,000.00 per violation if this prohibition is violated;
- 4.10.1.4.2 Prohibit the Contractor from entering into any exclusive contracts agreements with providers that exclude other health care providers from contract agreements for network participation;
- 4.10.1.4.3 Prohibit the Contractor from entering into a contract with or without the Provider's consent that prohibits the Provider from contracting with another CMO as a condition of the Contract;
- 4.10.1.4.4 Prohibit the health care provider from, as a condition of contracting with the Contractor, requiring the Contractor to contract with or not contract with another health care provider;
- 4.10.1.4.5 Prohibit the Provider from seeking payment from the Member for any Covered Services provided to the Member within the terms of the Contract and require the Provider to look solely to the Contractor for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Georgia Medicaid or CHIP State Plans, the Georgia State Medicaid Policies and Procedures Manuals, and this Contract.
- 4.10.1.4.6 Require the Provider to cooperate with the Contractor's Quality improvement and Utilization Review and management activities.
- 4.10.1.4.7 Include provisions for the immediate transfer to another PCP if the Member's health or safety is in jeopardy.
- 4.10.1.4.8 Not prohibit a Provider from discussing treatment or non-treatment options with Members that may not reflect the Contractor's position or may not be covered by the Contractor;
- 4.10.1.4.9 Not prohibit a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;

- 4.10.1.4.10 Not prohibit a Provider from advocating on behalf of the Member in any Grievance System or Utilization Review process, or individual authorization process to obtain necessary Health Care services;
- 4.10.1.4.11 Require Providers to meet appointment waiting time standards pursuant to Section 4.8.19.2;
- 4.10.1.4.12 Provide for continuity of treatment in the event a Provider's participation terminates during the course of a Member's treatment by that Provider;
- 4.10.1.4.13 Prohibit discrimination with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely based on such license or certification. This provision should not be construed as any willing provider law, as it does not prohibit the Contractor from limiting Provider participation to the extent necessary to meet the needs of the Members. Additionally, this provision shall not preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. This provision also does not interfere with measures established by the Contractor that are designed to maintain Quality and control costs;
- 4.10.1.4.14 Prohibit discrimination against Providers serving high-risk populations or those that specialize in Conditions requiring costly treatments;
- 4.10.1.4.15 Specify that CMS and DCH or its Agent will have the right to inspect, evaluate, and audit any pertinent books, financial records, documents, papers, and records of any Provider involving financial transactions related to this Contract;
- 4.10.1.4.16 Specify Covered Services and populations;
- 4.10.1.4.17 Require Provider submission of timely, complete and accurate Encounter Data;
- 4.10.1.4.18 Include the definition and standards for Medical Necessity, pursuant to the definition in Sections 1.4 and 4.5.4;
- 4.10.1.4.19 Specify rates of payment. The Contractor ensures that Providers will accept such payment as payment in full for

Covered Services provided to Members, less any applicable Member cost sharing pursuant to this Contract;

- 4.10.1.4.20 Provide for timely payment to all Providers for Covered Services to Members. Pursuant to O.C.G.A. 33-24-59.5(b) (1) once a Clean Claim has been received, the CMO(s) will have fifteen (15) Business Days within which to process and either transmit funds for payment electronically for the Claim or mail a letter or notice denying it, in whole or in part giving the reasons for such denial;
- 4.10.1.4.21 Specify acceptable billing and coding requirements;
- 4.10.1.4.22 Require that Providers comply with the Contractor's Cultural Competency plan;
- 4.10.1.4.23 Require that any marketing materials developed and distributed by Providers to Members be submitted to the Contractor to submit to DCH for prior approval;
- 4.10.1.4.24 Specify that in the case of newborns the Contractor shall be responsible for any payment owed to Providers for services rendered prior to the newborn's Enrollment with the Contractor;
- 4.10.1.4.25 Specify that the Contractor shall not be responsible for any payments owed to Providers for services rendered prior to a Member's Enrollment with the Contractor, even if the services fell within the established period of retroactive eligibility;
- 4.10.1.4.26 Comply with 42 CFR 434 and 42 CFR 438.6;
- 4.10.1.4.27 Require Providers to attempt to collect Member Co-payments;
- 4.10.1.4.28 Prohibit Providers from refusing to treat a Member on the basis of inability to pay Co-payments;
- 4.10.1.4.29 Not employ or subcontract with individuals on the State or Federal Exclusions list;
- 4.10.1.4.30 Prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a member of the Provider's family has a Financial Relationship;

- 4.10.1.4.31 Require Providers of transitioning Members to cooperate in all respects with Providers of other CMOs to assure maximum health outcomes for Members;
- 4.10.1.4.32 Contain a provision stating that in the event DCH is due funds from a Provider, who has exhausted or waived the Administrative Review process, if applicable, the Contractor shall reduce payment by one hundred percent (100%) to that Provider until such time as the amount owed to DCH is recovered;
- 4.10.1.4.33 Contain a provision giving notice that the Contractor's negotiated rates with Providers shall be adjusted in the event the Commissioner of DCH directs the Contractor to make such adjustments in order to reflect budgetary changes to the Medical Assistance program;
- 4.10.1.4.34 Require the Contractor to notify the Provider in writing no less than thirty (30) Calendar Days prior to any adjustments to the Provider's contracted reimbursement rates and receive written notification from the Provider of acceptance of the new reimbursement rates;
- 4.10.1.4.35 Allow for the Contractor to recoup or withhold reimbursement made or due to a Provider, as required by and upon receipt of notice by DCH that the Provider has an outstanding balance that is owed to DCH as the result of an identified overpayment for Fee-for-Service Claims. Contractor must transfer all funds withheld or recouped to DCH;
- 4.10.1.4.36 Prohibit Providers from requiring a pre-service consultation prior to providing care; and
- 4.10.1.4.37 Require that Providers participate in all DCH and CMO driven Quality improvement, performance measurement activities and Program Integrity operations.

4.10.2 Provider Termination

- 4.10.2.1 The Contractor shall comply with all State and federal laws regarding Provider termination. In its Provider Contracts the Contractor shall:
 - 4.10.2.1.1 Specify that in addition to any other right to terminate the Provider Contract, and notwithstanding any other provision of this Contract, DCH may require Provider termination immediately, or the Contractor may immediately terminate

on its own, a Provider's participation under the Provider Contract if a Provider fails to abide by the terms and conditions of the Provider Contract, as determined by DCH, or, in the sole discretion of DCH, fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from the Contractor specifying such failure and requesting such Provider to abide by the terms and conditions hereof; and

4.10.2.1.2 Specify that any Provider whose participation is terminated under the Provider Contract for any reason shall utilize the applicable appeals procedures outlined in the Provider Contract. No additional or separate right of appeal to DCH or the Contractor is created as a result of the Contractor's act of terminating, or decision to terminate any Provider under this Contract. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, this Contract shall remain in full force and effect with respect to all other Providers.

4.10.2.2 The Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network. If the termination was "for cause", the Contractor may terminate, suspend, or withdraw the Provider immediately and shall notify DCH in writing within one (1) Business Day of the termination with the reasons for termination. If a Member is receiving ongoing care, the Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal..

4.10.3 Provider Insurance

4.10.3.1 The Contractor shall require each Provider (with the exception of Section 4.10.3.2, and FQHCs that are section 330 grantees) to maintain, throughout the terms of the Contract, at its own expense, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written contract with the Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars (\$1,000,000) per occurrence, and three million dollars (\$3,000,000) annual aggregate. Providers may be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve. DCH reserves the right to waive the insurance requirement if necessary for business need.

4.10.3.2 The Contractor shall require allied mental health professionals to maintain, throughout the terms of the Contract, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written contract with Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars (\$1,000,000) per occurrence, and one million dollars (\$1,000,000) annual aggregate. These Providers may also be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve.

4.10.3.3 In the event any such insurance is proposed to be reduced, terminated or canceled for any reason, the Contractor shall provide to DCH and Department of Insurance (DOI) at least thirty (30) Calendar Days prior written notice of such reduction, termination or cancellation. Prior to the reduction, expiration and/or cancellation of any insurance policy required hereunder, the Contractor shall require the Provider to secure replacement coverage upon the same terms and provisions so as to ensure no lapse in coverage, and shall furnish DCH and DOI with a Certificate of Insurance indicating the receipt of the required coverage at the request of DCH or DOI.

4.10.3.4 The Contractor shall require Providers to maintain insurance coverage (including, if necessary, extended coverage or tail insurance) sufficient to insure against claims arising at any time during the term of this Contract, even though asserted after the termination of this Contract. DCH or DOI, at its discretion, may request that the Contractor immediately terminate the Provider from participation in the program upon the Provider's failure to abide by these provisions. The provisions of this Section shall survive the expiration or termination of this Contract for any reason.

4.10.4 Provider Payment

4.10.4.1 With the exceptions noted below, the Contractor shall negotiate rates with Providers and such rates shall be specified in the Provider contract. The Contractor shall also develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The Contractor is required to submit to DCH timely, complete and accurate Encounter Claims for all services, including Claims from those Providers that may be paid a Capitation Payment by the Contractor. The Contractor must require all providers to submit detailed Encounter data.

- 4.10.4.2 If a Provider submits a claim to the Contractor for services rendered within seventy-two (72) clock hours after the Provider verifies the eligibility of the patient with Contractor, the Contractor shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Contractor made payment for a patient for whom it was not responsible, then the Contractor may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.
- 4.10.4.3 The Contractor shall be responsible for issuing an IRS Form (1099) in accordance with all federal laws, regulations and guidelines.
- 4.10.4.4 When the Contractor negotiates a contract with a Critical Access Hospital (CAH), the Contractor shall pay the CAH a payment rate based on one hundred and one percent (101%) allowable costs incurred by the CAH. DCH may require the Contractor to adjust the rate paid to CAHs if so directed by the State of Georgia's Appropriations Act.
- 4.10.4.4.1 A CAH must provide notice to the Contractor and DCH of any alleged breaches in its contract by the Contractor.
- 4.10.4.4.2 If a CAH satisfies the requirement of Title 33 of the Official Code of Georgia Annotated (Medicaid Care Management Organizations Act), and if DCH concludes, after notice and hearing, that a the Contractor has substantively and repeatedly breached a term of its contract with a CAH, DCH is authorized to require the Contractor to pay damages to the CAH in an amount not to exceed three times the amount owed. Notwithstanding the foregoing, nothing in said Act shall be interpreted to limit the authority of DCH to establish additional penalties or fines against a CMO for failure to comply with the contract between the Contractor and DCH.
- 4.10.4.5 When the Contractor negotiates a contract with a FQHC and/or a RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act, the Contractor shall pay the PPS rates for Core Services and other ambulatory services per Encounter. The rates are established as described in §1001.1 of the Manual. At Contractor's discretion, it may pay more than the PPS rates for these services. Payment Reports must consist of all covered service claim types each month, inclusive of all services provided by the Contractor.

4.10.4.6 Upon receipt of notice from DCH that it is due funds from a Provider, who has exhausted or waived the Administrative Review process, if applicable, the Contractor shall reduce payment to the Provider for all claims submitted by that Provider by one hundred percent (100%), or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered. The Contractor shall promptly remit any such funds recovered to DCH in the manner specified by DCH. To that end, the Contractor's Provider contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the contract shall constitute agreement with the Contractor's obligation to DCH.

4.10.4.7 The Contractor shall adjust its negotiated rates with Providers to reflect budgetary changes to the Medical Assistance program, as directed by the Commissioner of DCH, to the extent such adjustments can be made within funds appropriated to DCH and available for payment to the Contractor. The Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the contract shall constitute agreement with the Contractor's obligation to DCH. Change in the terms of the Provider's reimbursement rate methodology must be agreed to by the Provider. The Contractor is not permitted to simply send a notice advising as to a reimbursement rate methodology change. This does not prevent routine and necessary adjustments to Maximum Allowable Charge rates.

4.10.4.8 The Contractor shall recognize and honor for payment consideration any Provider's claims with dates of service on or after the Provider credentialing date or the Provider contract effective date, whichever is later, irrespective of the date the Contractor loads the Provider into its claims processing system.

4.10.5 Administrative Review Process/Law Hearing

4.10.5.1 The Contractor shall offer the opportunity for Administrative Review to any Provider against whom it proposes to take an adverse action or denial of payment unless otherwise authorized to by law to take such action without Administrative Review. The Contractor shall develop policies and procedures which outline the Administrative Review process.

4.10.5.2 For a Provider to obtain an Administrative Review, a written request must be received at the address identified by the Contractor within thirty (30) Calendar Days of the date of the notification of

the denial or reduction in payment, initial determination, or other adverse action. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation.

4.10.5.3 The Contractor shall issue an Administrative Review Response within thirty (30) Calendar Days of receipt of the request for Administrative Review. If the Contractor upholds the Proposed Action, the Contractor shall issue a Notice of Adverse Action which informs the Provider of their right to a hearing before an Administrative Law Judge at the Office of State Administrative Hearings (OSAH).

4.10.5.4 The Contractor shall offer Provider the opportunity for an Administrative Hearing after the Administrative Review has been completed and upon receipt of a written request from the Provider. The Request for an Administrative Hearing must be submitted within thirty (30) Calendar Days of the date of the Administrative Review response. The Request for Hearing must be accompanied by a copy of the Administrative Review Response.

4.10.5.5 All Provider Administrative Appeals shall be transmitted to the Office of State Administrative Hearings.

4.10.6 Reporting Requirements

4.10.6.1 The Contractor shall submit to DCH monthly FQHC and RHC Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.10.7 Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)).

4.10.7.1 The Contractor shall increase benefit payments to Providers in an amount consistent with the Provider rate increases included in the State of Georgia's fiscal year budget. This enhanced rate shall be effective for all dates of service for which the Hospital Medicaid Financing Program Act is in place or until or modified by legislative action or DCH policy changes.

4.10.7.2 The Contractor will provide reports as requested by DCH to enable DCH to determine the amount of the increase in benefit payments to Providers as referenced in Section 4.10.7.1. The report will include, but not be limited to monthly reports, by hospital, that provide the following data for each claim paid:

4.10.7.2.1 Claim Number;

- 4.10.7.2.2 Date of Service;
- 4.10.7.2.3 Date of Payment;
- 4.10.7.2.4 Base Paid Amount;
- 4.10.7.2.5 Add-on Paid Amount;
- 4.10.7.2.6 Interest Paid Amount; and
- 4.10.7.2.7 Total Paid Amount.

4.11 UTILIZATION MANAGEMENT AND COORDINATION AND CONTINUITY OF CARE RESPONSIBILITIES

4.11.1 Utilization Management

4.11.1.1 The Contractor shall implement innovative and effective Utilization Management processes to ensure a high quality, clinically appropriate yet highly efficient and cost-effective delivery system. The Contractor shall continually evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Contractor must apply objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account when determining the medical appropriateness of Health Care services.

4.11.1.2 The Contractor shall enable Pre-Certification of service requests when required and direct Providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Contractor must evaluate all review requests for Medical Necessity and make recommendations that are more appropriate and more cost-effective. The Contractor should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.

4.11.1.3 The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:

- 4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.
- 4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.
- 4.11.1.3.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.
- 4.11.1.3.4 Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Sections 1.4 and 4.5.4.
- 4.11.1.3.5 Provide for the appeal by Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.
- 4.11.1.4 Contractor must consider the role of non-medical factors (ex. Placement changes, involvement with the juvenile justice system, etc.) that may drive inappropriate Utilization of medical resources when developing Utilization Management Policies and Procedures.
- 4.11.1.5 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval annually and as changed. Nothing in this Section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures in so far as that decision is accompanied by the clinical rationale for such a decision.
- 4.11.1.6 Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.
- 4.11.1.6.1 Utilization Management Committee
- 4.11.1.6.1.1 The Contractor shall establish a Utilization Management Committee. The Utilization Management committee is accountable to the Medical Director and governing body of the

Contractor. The Utilization Management Committee shall meet no less frequently than a quarterly basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.

4.11.1.6.2 Emergency Room (ER) Diversion Pilot

4.11.1.6.2.1 The Contractor shall develop and implement an ER diversion pilot program with hospital(s) that agree to participate to reduce inappropriate utilization of ERs for non-emergent conditions. The Contractor shall submit to DCH ninety (90) Calendar Days prior to beginning the ER Diversion Pilot program a detailed plan describing how the Contractor will work with providers to reduce inappropriate utilization of ERs for non-emergent conditions. The diversion pilot shall not prohibit or delay a Member's access to ER services.

4.11.1.7 The Contractor, and any delegated Utilization Review agent, shall not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

4.11.1.7.1 Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or

4.11.1.7.2 Any other method that encourages the rendering of a Proposed Action.

4.11.2 Prior Authorization and Pre-Certification

4.11.2.1 The Contractor shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services, as described in Section 4.6.1, 4.6.2, and 4.6.3, Special Coverage Provisions.

4.11.2.2 The Contractor shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.

4.11.2.3 The Contractor may require Prior Authorization and/or Pre-Certification for all non-emergent, Out-of-Network services.

- 4.11.2.4 Prior Authorization and Pre-Certification shall be conducted by a currently Georgia licensed, registered or certified Health Care Professional who is appropriately trained in the principles, procedures and standards of Utilization Review.
- 4.11.2.5 The Contractor and its network Providers (except: Pharmacy Providers) shall use DCH's central Prior Authorization Portal for communicating Prior Authorization and Pre-Certification requests and their disposition. The Contractor shall establish an interface with the Prior Authorization Portal that allows the Contractor to receive and submit required data. The Prior Authorization and Pre-Certification process shall be one hundred percent (100%) paperless. The Contractor shall conduct outreach to and educate network Providers about use of the Portal and submission of all required documentation through the Portal.
- 4.11.2.6 The Contractor will retain authority for reviewing requests and making Prior Authorization and Pre-Certification determinations. The Contractor shall implement policies and procedures that incorporate how the Contractor will conduct the following activities:
- 4.11.2.6.1 Accept Prior Authorization and Pre-Certification requests that Providers submit on a standardized form developed by DCH through the Prior Authorization Portal.
 - 4.11.2.6.2 Communicate requests for additional information from the Provider through the Prior Authorization Portal. The Contractor may directly contact the Provider with questions, but the Contractor shall communicate the same information through the Prior Authorization Portal.
 - 4.11.2.6.3 Review requests when a Member has an outstanding Prior Authorization and transitions enrollment to the Contractor. The Contractor may not require the requesting Provider to re-submit the Prior Authorization request. The Contractor may make its own determination regarding approval of the request.
- 4.11.2.7 The Contractor shall notify the Provider of Prior Authorization determinations via the Prior Authorization Portal in accordance with the following timeframes.
- 4.11.2.7.1 Standard Service Authorizations. Prior Authorization decisions for non-urgent services shall be made within three (3) Business Days, or other established timeframe, of the request (generally submitted one week prior to the service or procedure). An extension may be granted for an

additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's best interest.

4.11.2.7.2 Expedited Service Authorizations. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision with twenty-four (24) clock hours and provide notice as expeditiously as the Member's health condition requires and no later than three (3) Business Days after receipt of the request for service. The Contractor may extend the twenty-four (24) clock hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's best interest.

4.11.2.7.3 Authorization for Services that have been Delivered. Determinations for authorization involving health care services that have been delivered shall be made within thirty (30) Calendar Days of receipt of the necessary information.

4.11.2.8 The Contractor's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.

4.11.2.9 The Contractor may require that the prescriber's office request Prior Authorization as a condition of coverage or payment for a prescription drug provided that a decision whether to approve or deny the prescription is made within twenty-four (24) clock hours of the Prior Authorization request. If a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the Contractor must allow the pharmacist to dispense a seventy two (72) hour emergency supply of the prescribed. The Contractor must reimburse the pharmacy for the temporary supply of medication and contracted dispensing fee. The Contractor's Prior Authorization processes for Behavioral Health Services shall recognize the intensive and/or ongoing need for these services often present among the Members, and should not be unnecessarily burdensome to Providers or the Members. For example, Medical Necessity reviews for Member stays in a Psychiatric Residential Treatment Facility (PRTF) must account for the high level needs of the Members and must not be unnecessarily burdensome for Providers or the CMO. DCH recommends that the Contractor does

not conduct Medical Necessity reviews for Members in a PRTF more frequently than every seven (7) Calendar Days.

- 4.11.2.10 Prior Authorization will not be required for the first twelve (12) individual or group outpatient psychotherapy sessions provided by a contracted Behavioral Health provider, per twelve (12)-month rolling period. Such sessions may include the initial evaluation. Additional visits will be reviewed and approved based on a Medical Necessity review conducted by the Contractor.

4.11.3 Referral Requirements

- 4.11.3.1 The Contractor may require that Members obtain a Referral from their PCP prior to accessing non-emergency specialized services.

- 4.11.3.2 In the Utilization Management Policies and Procedures discussed in Section 4.11.1, the Contractor shall address:

- 4.11.3.2.1 When a Referral from the Member's PCP is required;

- 4.11.3.2.2 How a Member obtains a Referral to an In-Network Provider or an Out-of-Network Provider when there is no Provider within the Contractor's network that has the appropriate training or expertise to meet the particular health needs of the Member;

- 4.11.3.2.3 How a Member with a Condition which requires on-going care from a specialist may request a standing Referral; and

- 4.11.3.2.4 How a Member with a life-threatening Condition or disease, which requires specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.

- 4.11.3.3 The Contractor shall prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a member of the Provider's family has a Financial Relationship.

- 4.11.3.4 The Contractor shall develop electronic, web-based Referral processes and systems. In the event a Referral is made via the telephone, the Contractor shall ensure that the Contractor, the Provider and DCH maintain Referral data, including the final decision, in a data file that can be accessed electronically.

- 4.11.3.5 In conjunction with the other Utilization Management policies, the Contractor shall submit the Referral processes to DCH for review and approval.

4.11.4 Transition of Members

4.11.4.1 The Contractor shall coordinate the transfer of information when Members transition from one CMO to another, to the Fee-for-Service system or private insurance.

4.11.4.2 Inpatient Acute Coverage Responsibility

4.11.4.2.1 Members enrolled in a Georgia Families CMO that are hospitalized in an acute inpatient hospital facility and are placed in Foster Care during the inpatient stay will be disenrolled from the Georgia Families CMO and enrolled in the Georgia Families 360° CMO on the date the Member's 834 file is transferred to the Georgia Families 360° CMO. The Contractor is not required to cover services for an individual that has no Medicaid benefits, if the Member individual remains an acute inpatient and loses Medicaid eligibility during the stay; the Contractor is only responsible for payment until the last day of Medicaid eligibility.

4.11.4.2.2 Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned CMO.

4.11.4.2.3 The Contractor shall remain responsible for Members that become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization until they are Discharged from inpatient acute hospital care. These Members will remain the responsibility of the Contractor for all Covered Services, even if the start date for SSI eligibility is made retroactive to a date prior to the inpatient acute hospitalization.

4.11.4.2.4 Upon notification that a hospitalized Member will be transitioning to a new CMO, or to Fee-for-Service Medicaid, the current CMO will work with the new CMO or Fee-for-service Medicaid or private insurance to ensure that Coordination of Care and appropriate Discharge Planning occurs.

4.11.4.3 Relinquishment of Members

4.11.4.3.1 When relinquishing Members, the Contractor shall cooperate with the receiving CMO, Fee for Service Medicaid or private insurance regarding the course of on-going care with a specialist or other Provider.

4.11.4.3.2 Contractor must identify and facilitate Coordination of Care for all Members during changes or transitions between CMOs, as well as transitions to FFS Medicaid or private insurance. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations. Special circumstances include Members designated as having “special Health Care needs”, as well as Members who have medical conditions or circumstances such as:

4.11.4.3.2.1 Pregnancy (especially women who are high risk and in third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date)

4.11.4.3.2.2 Major organ or tissue transplantation services which are in process, or have been authorized

4.11.4.3.2.3 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities, and/or

4.11.4.3.2.4 Significant medical conditions, (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments

4.11.4.3.2.5 Members who are in treatment such as:

4.11.4.3.2.5.1 Chemotherapy and/or radiation therapy; or

4.11.4.3.2.5.2 Dialysis.

4.11.4.3.2.6 Members with ongoing needs such as:

4.11.4.3.2.6.1 Durable medical equipment including ventilators and other respiratory assistance equipment;

4.11.4.3.2.6.2 Home health services;

4.11.4.3.2.6.3 Medically Necessary transportation on a scheduled basis; or

4.11.4.3.2.6.4 Prescription medications.

4.11.4.3.2.7 Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible Members

4.11.4.3.2.8 Members who are currently hospitalized.

4.11.4.4 Long-Term Care Coverage Responsibility

4.11.4.4.1 Members enrolled in a CMO that are receiving services in a long-term care facility will remain the responsibility of the admitting CMO until disenrolled from the CMO by DCH.

4.11.4.4.2 For the purposes of this requirement, long-term care facilities include Nursing Homes, Skilled Nursing Facilities, Psychiatric Residential Treatment Facilities and other facilities that provide long-term non-acute care.

4.11.4.4.3 Upon disenrollment from the CMO, the financial responsibility for services provided to the Member transitions to the Member's new CMO or Fee for Service Medicaid.

4.11.4.4.4 Members that are in ongoing non acute treatment in an inpatient facility that has been covered by DCH prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary Transition of Care. The CMO will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days.

4.11.5 Back Transfers

4.11.5.1 The Contractor shall permit transfers from a higher level of care back to a lower level (referred to as a back transfer). The transfer is subject to Medical Necessity review and the payment policies outlined in the contract with the payer.

4.11.5.2 Each request will be reviewed on an individual basis to determine if the transfer is appropriate. The length of stay for the transferring hospital and for the return to the originating hospital will also be evaluated to determine if the transfer is appropriate.

4.11.5.3 If a transfer back to a hospital that provides a lower level of care does occur, the facility receiving the back-transfer will be eligible for reimbursement if Prior Authorization is obtained from the applicable payer and according to the payment agreement of that payer.

4.11.5.4 The Contractor shall make available Provider education and clear policies regarding the “back transfer” Pre-Certification requirements along with the billing procedures.

4.11.6 Court-Ordered Evaluations and Services

4.11.6.1 In the event a Member requires Medicaid-Covered Services ordered by a State or federal court, the Contractor shall fully comply with all court orders while maintaining appropriate Utilization Management practices.

4.11.7 Second Opinions

4.11.7.1 The Contractor shall provide for a second opinion in any situation when there is a question concerning a diagnosis or the options for surgery or other treatment of a health Condition when requested by any Member of the Health Care team, a Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

4.11.7.2 The second opinion must be provided by a qualified Health Care Professional within the network, or the Contractor shall arrange for the Member to obtain one outside the Provider network, if an appropriate Provider is unavailable in the Contractor’s network.

4.11.7.3 The second opinion shall be provided at no cost to the Member.

4.11.8 Coordination and Continuity of Care Responsibilities

4.11.8.1 The Contractor is responsible for employing a System of Care approach to Care Coordination and Continuity of Care. Care Coordination is a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely, and cost effective manner. Care Coordination includes Case Management, Disease Management, Transition of Care and Discharge Planning.

4.11.8.2 The Contractor must develop and implement Care Coordination and continuity of care. Policies and procedures are designed to accommodate the specific cultural and linguistic needs of the Contractor’s Members and include, at a minimum, the following elements:

4.11.8.2.1 The provision of an individual needs assessment and diagnostic assessment; the development of an individualized treatment plan, as necessary, based on the needs assessment; the establishment of treatment

objectives; the monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary;

- 4.11.8.2.2 Includes a patient-centered approach to meet the needs of Members, addressing both developmental and chronic conditions;
- 4.11.8.2.3 Ensures that Members who are determined to need a course of treatment or regular care monitoring have a treatment plan. This treatment plan shall be developed by the Member's PCP with Member participation, and in consultation with any specialists caring for the Member. This treatment plan shall be approved in a timely manner by the Medical Director and in accordance with any applicable State quality assurance and Utilization Review standards;
- 4.11.8.2.4 A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning or regular Care Management;
- 4.11.8.2.5 A strategy to ensure the timely provision of services;
- 4.11.8.2.6 A strategy to ensure that the Contractor works with Members and Providers to implement an integrated approach to meeting physical health and behavioral health needs of the Member;
- 4.11.8.2.7 Use of data analytics to identify patterns of care. DCH encourages the use of predictive modeling to identify high risk Members;
- 4.11.8.2.8 Procedures and criteria for making Referrals to specialists and sub-specialists;
- 4.11.8.2.9 Procedures and criteria for maintaining treatment plans and Referral Services when the Member changes PCPs;
- 4.11.8.2.10 Capacity to implement, when indicated, Case Management functions such as individual needs assessment, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plan;
- 4.11.8.11 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and
- 4.11.8.12 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other

support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP.

- 4.11.8.3 The Contractor must consider the role of non-medical factors (ex. Placement changes, involvement with the juvenile justice system, etc.) that may create challenges to Coordination of Care when developing Coordination and Continuity of Care policies.
- 4.11.8.4 The Contractor shall submit Care Coordination and continuity of care Policies and Procedures to DCH for review and approval within ninety (90) Calendar Days of Contract Award and as updated thereafter.
- 4.11.8.5 The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities. This includes: Transition of Care, Discharge Planning, Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management.
- 4.11.8.6 Transition of Care
 - 4.11.8.5.1 Contractors shall identify and facilitate transitions for Members that are moving from the Contractor's GF 360° Plan to another CMO or from the Contractor's GF 360° Plan to a Fee-for Service provider or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing Members, the Contractor shall cooperate with the receiving CMO or FFS Medicaid regarding the course of on-going care with a specialist or other Provider. Priority will be given to Members who have medical conditions or circumstances such as:
 - 4.11.8.5.1.1 Members who are currently hospitalized;
 - 4.11.8.5.1.2 Pregnant women who are high risk and in their third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date;
 - 4.11.8.5.1.3 Major organ or tissue transplantation services which are in process, or have been authorized;

- 4.11.8.5.1.4 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities;
- 4.11.8.5.1.5 Members who are in treatment such as Chemotherapy, radiation therapy, or Dialysis;
- 4.11.8.5.1.6 Members with ongoing needs such as Specialized Durable medical equipment, including ventilators and other respiratory assistance equipment;
- 4.11.8.5.1.7 Current Home health services;
- 4.11.8.5.1.8 Medically Necessary transportation on a scheduled basis;
- 4.11.8.5.1.9 Prescription medications requiring Prior Authorizations;
- 4.11.8.5.2 The Contractor will monitor Providers to ensure transition of care from one entity to another to include Discharge Planning as appropriate. Members with Procedures that are scheduled to occur after the transition effective date, but that have been authorized by either DCH or the Member's original CMO prior to their new CMO transition effective date will be covered by the Member's new CMO for thirty (30) Calendar Days; and
- 4.11.8.5.3 Members that are in ongoing outpatient treatment or that are receiving medication that has been covered by DCH or another entity prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary transition of care. The Contractor will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days.
- 4.11.8.6 The Contractor shall employ System of Care principles in the coordination and delivery of services to ensure coordinated planning across and between multiple child-serving agencies which also serve the Members. The Contractor will coordinate with DCH, DFCS, DPH, DJJ, DOE, DBHDD and DECAL as needed when a Member transitions into or out of the CMO to maintain continuity of care and services and minimize disruptions to the Member including: When a FC Member or DJJ Member is transitioning from another CMO or from private insurance, the Contractor shall contact the FC Member's or DJJ Member's prior

CMO or other insurer and request information about the FC Member's or DJJ Member's needs, current Medical Necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH or electronic notification from DFCS, DCH or DJJ and receipt of a signed release of information form from DFCS or DJJ;

4.11.8.7 When an AA Member is transitioning from another CMO or from private insurance, the Contractor shall contact the AA Member's prior CMO or other insurer and request information about the AA Member's needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent;

4.11.8.8 When a Member is transitioning from Fee-for-Service Medicaid, the Contractor shall coordinate with DCH staff designated to coordinate administrative services for the Member, and contact the FC Member's or DJJ Member's prior Service Providers including but not limited to PCPs, specialists and dental providers, and request information about the FC Member's or DJJ Member's needs, current Medical Necessity determinations, and authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH or electronic notification from DFCS, DJJ or DCH and receipt of a signed release of information form from DFCS or DJJ; and

4.11.8.9 When an AA Member is transitioning from Fee-for-Service Medicaid, the Contractor shall coordinate with DCH staff designated to coordinate administrative services for the AA Member, and contact the AA Member's prior Service Providers including but not limited to PCPs, specialists and dental providers, and request information about the AA Member's needs, current Medical Necessity determinations, authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent.

4.11.8.10 The Contractor must authorize all services included in treatment plans by prior CMOs, private insurers or Fee-for-Service Medicaid for Members transitioning from another CMO, private insurance or Fee-for-Service Medicaid. The Contractor must authorize the Member to continue care with his or her providers and current services, including the issuance of an Out-of-Network authorization to ensure the Member's condition remains stable and services are consistent to meet the Member's needs. All such authorizations or allowances will continue for the later of a period

of at least thirty (30) Calendar Days or until the Contractor's authorized Health Care Service Plan is completed.

4.11.8.11 The Contractor shall provide additional coordination to ensure continuity of care for Members with Special Health Care Needs as detailed in Section 4.11.4.

4.11.8.12 When Members disenroll from the GF 360° program, the Contractor is responsible for transferring to the DCH the Member's Care Management history, six (6) months of claims history, and pertinent information related to any special needs of transitioning Members.

4.11.8.13 Discharge Planning

4.11.8.13.1 The Contractor shall maintain and operate a formalized Discharge Planning program that includes a comprehensive evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following Discharge from an institutional clinical setting.

4.11.8.13.2 The Contractor shall implement a Discharge Planning Pilot Program with hospital(s) that agree to participate to improve coordination for Members when being Discharged from the hospital. The intent of this program is to improve Quality of care and outcomes, as well as to reduce readmissions. The Contractor will place a nurse onsite in the hospital to serve as an onsite resource for Members and to provide support to Members such as patient education and care planning, reviewing medications and how to take those medications, identifying community resources that may be beneficial to the Member, assuring follow-up care is arranged for when Members leave the hospital and regularly contacting Members after Discharge to confirm they have received follow up care.

4.11.8.13.3 The Contractor shall submit its plan for a Discharge Planning Pilot Program to DCH for initial review and approval prior to implementation and any updates thereto. The plan shall include, for example, information about the hospital(s) that will participate, Member eligibility for the program, services that will be provided, and the approach to coordinating with hospital staff to supplement the care and education they are providing. The Contractor shall submit monthly reports to DCH that provide information that will track results to help identify initiatives that improve quality of care and outcomes.

4.11.8.14 Transition of Members

4.11.8.14.1 DFCS Transitional Round Tables

4.11.8.14.1.1 The Contractor will support DFCS and participate in DFCS transitional roundtables in transition planning for FC Members turning eighteen (18) years of age and exiting Foster Care. DFCS will begin transition planning one (1) year prior to a FC Member reaching their eighteenth (18th) birthday and aging out of Foster Care and will repeat the planning process one (1) year prior to the twenty first (21st) birthday if the youth elects to continue services to age twenty one (21). For FC Members electing to continue services to age twenty six (26), the Contractor shall offer transition planning services to the FC Member at age twenty five (25), but shall not be required to provide such services if the FC Member declines to receive them. Transition planning for Members entering the CMO on or after their seventeenth (17th) birthday shall start within one (1) month of entry into the CMO. A youth exiting FC due to age should not need to transition to a nursing facility or institution because they lacked a plan for continued support. Transition planning activities may include but are not limited to:

4.11.8.14.1.1.1 Working with DFCS to assess the FC Member's home and community support needs to remain in the community and maintain stability through the transition out of foster care including but not limited to the following:

4.11.8.14.1.1.1.1 Determining and identifying the array of services needed and providers of these services; and

4.11.8.14.1.1.1.2 Assessing needs and providing recommendations for access for specialized supports including but not limited to positive behavioral supports, medication support, Durable Medical Equipment, communication

devices or vehicle or home adaptations.

- 4.11.8.14.1.1.2 Reviewing the FC Member's health status and other appropriate factors to determine if the FC Member meets the general eligibility criteria for entering a HCBS waiver program.
- 4.11.8.14.1.1.3 Initiating the waiver application processes and if necessary, placing youth on waiver waiting list(s).
- 4.11.8.14.1.1.4 In collaboration with DFCS, educating FC Members about options for services and supports available after eligibility terminates. Such options may include Independence Plus, IDEA participation, and application for post-secondary options. Education shall include information on accessing disability services available from educational institutions and employers where appropriate.

4.11.8.14.2 DJJ Transitional Round Tables

4.11.8.14.2.1 The Contractor will support DJJ and participate in DJJ transitional roundtables in transition planning for DJJ Members returning to their homes. The transition planning will begin upon the DJJ Member's enrollment in the CMO and the transitional roundtable will be initiated by DJJ. Transition planning activities may include but are not limited to:

- 4.11.8.14.2.1.1 Assessing the DJJ Member's home and community support needs to remain in the community and maintain stability through the transition out of the juvenile justice system including but not limited to the following:

- 4.11.8.14.2.1.1.1 Determining and identifying the array of services needed and providers of these services; and

4.11.8.14.2.1.1.2 Assessing needs and providing recommendations for access for specialized supports including but not limited to positive behavioral supports, medication support, Durable Medical Equipment, communication devices or vehicle or home adaptations.

4.11.8.14.2.1.2 Reviewing the DJJ Member's health status and other appropriate factors to determine if the DJJ Member meets the general eligibility criteria for entering a HCBS waiver program.

4.11.8.14.2.1.3 Initiating the waiver application processes and if necessary, placing youth on waiver waiting list(s).

4.11.8.14.2.1.4 In collaboration with DJJ, educating DJJ youth about options for services and supports available after eligibility in the CMO terminates. Such options may include Independence Plus, IDEA participation, application for post-secondary options, housing and vocational opportunities. The DJJ and CMO education shall include information on accessing disability services available from educational institutions and employers where appropriate.

4.11.8.15 Care Coordination

4.11.8.15.1 The Contractor shall implement an approach to coordination that employs person-centered strategies, collaboration with DCH and sister agencies, and does not focus solely on the Member's immediate health care needs. The following approach to person-centered care shall be incorporated into the Contractor's Care Coordination program:

4.11.8.15.2 The Contractor shall provide Care Coordination services which shall:

- 4.11.8.15.2.1 Be comprehensive: All services a Member receives are to be coordinated;
- 4.11.8.15.2.2 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions;
- 4.11.8.15.2.3 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP;
- 4.11.8.15.2.4 Uses the person's own situation and experiences as a starting point based upon information gathered during outreach and Health Risk Assessment activities and the individual's Claims history;
- 4.11.8.15.2.5 Strives to understand behaviors, clinical symptoms and clinical, as well as non-clinical, drivers of utilization from the perspective of the person;
- 4.11.8.15.2.6 Tailors care and treatment to each individual;
- 4.11.8.15.2.7 Promotes both empowerment of the person and shared decision-making;
- 4.11.8.15.2.8 Involves the person and/or caregiver as an active, collaborative partner; and
- 4.11.8.15.2.9 Strives to involve the person's social network in his/her care.

4.11.8.15.3 The Contractor's ability to provide rigorous and immediate Care Coordination to meet individual needs of Members will be a key indicator of success. Care planning for Members must begin immediately upon the Contractor's receipt of the eligibility file or electronic notification from DCH, DFCS or DJJ.

4.11.8.16 Health Care Service Plans

- 4.11.8.16.1 The Contractor shall use the results of all assessments and screenings to develop a Health Care Service Plan which identified the Member's Care Coordination needs for all

new Members within thirty (30) Calendar Days of Member Enrollment. The Contractor must document the involvement of the Member's PCP, dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan and provide evidence of such documentation to DCH, DFCS and DJJ.

4.11.8.16.2 The Contractor shall develop a process by which the Contractor will regularly review and update the Members' Health Care Service Plans, which shall include:

4.11.8.16.2.1 The detailed description of the involvement of the Member's PCP, dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan;

4.11.8.16.2.2 The approach for updating or revising the Health Services Plan; and

4.11.8.16.2.3 Details on the monitoring and follow-up activities conducted by the Contractor with the Members' Providers.

4.11.8.16.3 Such process shall be submitted to DCH for review and approval within ninety (90) Calendar Days of the Operational Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.8.16.4 The Contractor is responsible for ensuring that the Health Care Service Plan for Members with Severe Emotional Disturbance (SED) shall include a safety and contingency Crisis plan. The development of such a plan will be coordinated between the Contractor, Core Services Providers and/or IFI Providers.

4.11.8.17 Care Coordination Teams

4.11.8.17.1 All Members will have access to Care Coordination services and an interdisciplinary Care Coordination Team. The Care Coordination Team will include a Care Coordinator and clinical representatives to meet the individual needs of Members. The Care Coordination team will:

4.11.8.17.1.1 Coordinate with DFCS and DJJ to develop work flows and processes, including those related to the

transmission of clinical and non-clinical Member information. These workflows and processes shall be subject to the approval of DCH;

- 4.11.8.17.1.2 Provide information to and assist Providers, Members, Foster Parents, Adoptive Parents, Caregivers, DFCS Staff, DJJ, JPPS and Residential Placement Providers with access to care and coordination of services;
- 4.11.8.17.1.3 Ensure access to primary, dental and specialty care and support services, including assisting Members, Caregivers, Foster and Adoptive Parents, DFCS staff and DJJ Staff with locating Providers, and scheduling and obtaining appointments as necessary;
- 4.11.8.17.1.4 Expedite the scheduling of appointments for Medical Assessments and facilitating Providers' timely submittal of Assessment results used to determine Residential Placements as requested by DFCS and DJJ. The Contractor must give high priority to this function in its Care Coordination operations;
- 4.11.8.17.1.5 Compile Assessment results used to determine Residential Placements as requested by DFCS and DJJ and submitting those results to the appropriate DFCS or DJJ entity within the timeframes identified in this Contract;
- 4.11.8.17.1.6 Assist with coordinating non-emergent transportation for Members as needed for Provider appointments and other Health Care Services;
- 4.11.8.17.1.7 Broker community supports for Members and arrange for referrals to community-based resources as necessary;
- 4.11.8.17.1.8 Document efforts to obtain Provider appointments, arrange transportation, establish meaningful contact with the Members' PCP, Dentists, specialists and other Providers, and arrange for referrals to community-based resources. Such documentation shall include details on any barriers or obstacles to obtaining appointments, arranging transportation, establishing meaningful contact with Providers or arranging referrals to community-based resources;

4.11.8.17.1.9 Provide Members with access to information about the Prior Authorization processes of the Contractor and its business partners;

4.11.8.17.1.10 Define program requirements and processes, including the Member Appeals processes and how the Contractor will provide assistance to Providers and Members with navigating these processes;

4.11.8.17.1.11 Educate the Contractor's staff about coordinating with DFCS and DJJ as identified in the Contractor's DFCS and DJJ Communication Plan. The Plan should include, but not be limited to, when medical information is required by DFCS and DJJ and/or is necessary for court hearings;

4.11.8.17.1.12 Educate Providers about providing medical information to DFCS or DJJ as requested, including but not limited to medical information necessary for court hearings. If the Provider has not timely responded to a DFCS or DJJ request and/or a court's subpoena or request for such information, the Contractor must timely contact the Provider in question to require him or her to provide the requested information. The Contractor shall remind the Provider of his or her legal obligations to produce such information, including those obligations arising out of the Network Provider agreement with the Contractor, including those obligations arising out of the Network Provider agreement with the Contractor;

4.11.8.17.1.13 Work with PCPs and specialists of prior health plans to ensure continuity of care for Members with Special Health Care Needs (MSHCN) receiving services authorized in a treatment plan by their prior health plan, to address issues that will help the Member's condition remain stable and services are consistent to meet the Member's ongoing needs; and

4.11.8.17.1.14 Provide application assistance to MSHCN who may qualify for Supplemental Security Income (SSI) benefits.

4.11.8.17.2 The Care Coordinator will ensure the Care Coordination Team has the information it needs to make timely and

appropriate authorizations and referrals to meet Member needs. This includes, but is not limited to, contacting prior health plans and Providers for information the Care Coordination Team may need to work with current Providers to develop treatment plans. The Care Coordinator will ensure that approved care plans and authorizations are communicated timely to treating Providers, DFCS, DJJ and other agencies as required, whether via the Virtual Health Record (VHR) or by direct communications. The Care Coordinator will ensure that Members, Providers, Caregivers, Foster and Adoptive Parents, DFCS, DJJ, Residential Placement Providers and other agencies also have the most current information regarding community resources available to assist Members with meeting their needs and assist Members with connecting with these resources.

4.11.8.17.3 The Care Coordination Teams must include an interdisciplinary group of professionals identified specifically to meet the needs of each individual Member.

4.11.8.17.4 Based on information identified through required assessments, the Contractor shall stratify Members according to their risk(s), costs and impactability. The level of intensity of Care Management services provided by Care Coordination Teams must be tailored in intensity to meet the needs of each individual Member as identified in section 1.4. Members may receive the following level of Care Management services:

4.11.8.17.5 Care Management services;

4.11.8.17.6 Intensive Care Coordination, which must include the following monthly contacts:

4.11.8.17.6.1 One (1) Face-to-face visit;

4.11.8.17.6.2 One (1) weekly contact;

4.11.8.17.6.3 One (1) Child and Family Team Meeting; and

4.11.8.17.6.4 One (1) care plan update

4.11.8.17.7 Complex Care Coordination including Members with a previous Mental Health inpatient stay or an inpatient stay for a psychosocial disorder and Members with Special Health Care Needs. Care Coordinators must provide the

following monthly contacts to Members receiving Complex Care Coordination:

4.11.8.17.7.1 Two (2) face-to-face visits;

4.11.8.17.7.2 One (1) weekly contact;

4.11.8.17.7.3 A minimum of two (2) hours per week Care Coordination;

4.11.8.17.7.4 One (1) Child and Family Team Meeting; and

4.11.8.17.7.5 One (1) health care service plan update.

4.11.8.18 Members identified as needing Complex Care Coordination services due to Behavioral Health needs must receive Care Coordination services provided by Coordinators who have been certified and trained in the delivery of High Fidelity Wrap Around Care. The Contractor shall include a Nurse Case Manager (NCM) to assist Members identified through the health assessment as Members with Special Health Care Needs. The NCM will help Members with Special Health Care Needs obtain Medically Necessary care, health-related services and coordinate clinical care needs with holistic consideration. The Contractor's NCM must coordinate across a Member's Providers and health systems. The Contractor must have a process to facilitate, maintain and coordinate both care and communication with State agency staff, Providers, Caregivers, Foster or Adoptive Parents, Service Providers, and Members.

4.11.9 Coordination with Other Entities

4.11.9.1 The Contractor shall coordinate and work collaboratively with all divisions within DCH, as well as with other State agencies, and with other CMOs for administration of the GF 360° program.

4.11.9.2 The Contractor shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children's Intervention School Services provided by the LEAs to ensure Medical Necessity and prevent duplication of services.

4.11.9.3 The Contractor shall coordinate the services furnished to its Members with the services the Member receives outside the CMO, including services received through any other managed care entity.

4.11.9.4 The Contractor shall coordinate with all DCH-contracted entities involved in providing care to the Member or administering program services that also impact the CMO's services.

Coordination with other contracted-entities includes, but is not limited to, the following:

- 4.11.9.4.1 NET vendors to ensure Members are able to access Medically Necessary services in a timely manner.
- 4.11.9.4.2 DCH's Pharmacy Rebate Services Vendor for the purposes of processing pharmacy rebates. The Contractor shall regularly submit data, such as Omnibus Budget Reconciliation Act (OBRA) and J-Code claims feed to the Fee-for-Service Pharmacy Rebate Services Vendor. Prior to program launch, the Contractor will accept the Fee-for-Service Pharmacy Rebate Services Vendor's file format for data feeds and for testing interface capabilities. The Contractor shall respond to and resolve all inquiries and requests from the Pharmacy Rebate Vendor within thirty (30) Calendar Days of receipt of such inquiry or request.
- 4.11.9.4.3 DCH's CVO as set forth in Section 4.8.21.
- 4.11.9.4.4 DCH's Fiscal Agent Contractor.
- 4.11.9.4.5 The State Health Benefit Plan
- 4.11.9.4.6 Vendors identified by DCH to complete DCH required audits, reviews and special projects.
- 4.11.9.4.7 Other DCH vendors to complete statewide initiatives.
- 4.11.9.4.8 Private insurance and Fee-for-Service providers.
- 4.11.9.5 The Contractor shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 45 CFR 164.
- 4.11.9.6 The Contractor shall implement a systematic administrative process to coordinate with DFCS, including providing DFCS with requested information and coordinating with PCPs or specialists for medical information when required by DFCS and/or necessary for court hearings for FC Members. A coordination plan shall be due within one hundred fifty (150) Calendar Days prior to the Operational Start Date. DCH shall have at least fourteen (14) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.9.7 The Contractor shall implement a systematic administrative process to coordinate with DJJ, including providing DJJ with requested information and coordinating with PCPs or specialists for medical information when required by DJJ and/or necessary for court hearings for DJJ Members. A DJJ coordination plan shall be due within one hundred fifty (150) Calendar Days prior to the Operational Start Date. DCH shall have at least fourteen (14) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.9.8 The Contractor shall have documented Member Care Coordination policies and procedures for coordinating care and creating linkages with external organizations, including but not limited to school districts, child protective service agencies, early intervention agencies, behavioral health, and developmental disabilities service organizations. Such policies and procedures must include details on the Contractor's approach for documenting care coordination activities and creating linkages with external organizations for each Member. The Contractor shall submit the policies and procedures to DCH for review within one hundred twenty (120) Calendar Days of the Operational Start Date and within ten (10) Calendar Days of any subsequent updates. In all instances, DCH shall have at least fourteen (14) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.9.9 Integration of Physical and Behavioral Health Services

4.11.9.9.1 The Contractor shall develop an innovative approach to encourage PCPs, Behavioral Health Providers, and dental Providers to effectively and efficiently share behavioral and physical health clinical Member information, including how the Contractor will notify Behavioral Health Providers and PCPs after an inpatient mental health stay.

4.11.9.9.2 The Contractor must require Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks.

4.11.9.9.3 The Contractor shall submit an annual Health Coordination and Integration Report to the Department due June 30th of each calendar year for the prior calendar year beginning

2017. This report is subject to approval by the Department.
At a minimum, this report shall include:

- 4.11.9.9.3.1 Program Goals and Objectives
- 4.11.9.9.3.2 Summary of activities and efforts to integrate and coordinate behavioral and physical health;
- 4.11.9.9.3.3 Effectiveness measures with clear metrics;
- 4.11.9.9.3.4 Successes (e.g., exceeding performance targets) and opportunities for improvement;
- 4.11.9.9.3.5 Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and
- 4.11.9.9.3.6 Roadmap of activities planned for the next reporting.

4.11.10 Disease Management

- 4.11.10.1 The Contractor shall develop a minimum of three (3) disease management programs for Members with Chronic Conditions. These programs must target the prevalent chronic diseases within the Contractor's population, as specified by DCH.
- 4.11.10.2 Disease Management functions include, but are not limited to:
 - 4.11.10.2.1 Incorporating evidence-based guidelines or standards of care in program development.
 - 4.11.10.2.2 Utilizing clinical data to stratify Members for enrollment based on levels of service intensity.
 - 4.11.10.2.3 Encouraging the Member's active participation and adherence to interventions.
 - 4.11.10.2.4 Educating the Member on their disease or condition to facilitate self-management.
 - 4.11.10.2.5 Consistently informing the Member on progress in the achievement of goals and about the areas that require further improvement.
 - 4.11.10.2.6 Promoting Coordination of Care by collaborating and communicating with Providers and other health care resources to improve Member outcomes.

4.11.10.3 The Contractor must notify DCH of the disease management programs it initiates and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members. The Contractor is encouraged to align disease management programs with Quality initiatives.

4.11.10.4 The Contractor must submit Quarterly status reports to DCH which include specified Disease Management Program data as listed in Section 5.71 in addition to the annual report.

4.11.11 Case Management

4.11.11.1 The Contractor's Case Management program shall emphasize prevention, Continuity of Care, and coordination and integration of care. The program shall link Members to services.

4.11.11.2 Case Management functions include, but are not limited to:

4.11.11.2.1 Early identification of Members who have or may potentially have special needs by receiving referrals, reviewing medical records, claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An initial assessment of pregnant women may be performed by a local public health agency at the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO;

4.11.11.2.2 Assessment of a Member's risk factors such as an over- or under-utilization of services, inappropriate use of services, non-adherence to established plan of care or lack thereof, lack of education or understanding of current condition, lack of support system, financial barriers that impede adherence to plan of care, compromised patient safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities;

4.11.11.2.3 Development of a personalized, patient-centered plan of care which is consistent with evidence-based guidelines and includes established goals that are specific and measurable, with emphasis on Member education of disease or condition to facilitate shared decision making and self-management;

4.11.11.2.4 Coordination of Care, as previously described;

- 4.11.11.2.5 Monitoring to ensure the plan of care and interventions continue to be appropriate or revised as needed based on changes in the Member's condition or lack of positive response to the plan of care;
- 4.11.11.2.6 Continuity of care which includes collaboration and communication with other Providers involved in the Member's transition to another level of care to optimize outcomes and resources while eliminating fragmentation of care;
- 4.11.11.2.7 Follow up which includes assessing the achievement of established goals and identifying the overall impact of the plan of care;
- 4.11.11.2.8 Documentation which includes adherence to Member privacy and confidentiality standards, evidence of Member's progress and effectiveness of the plan of care, evaluation of Member satisfaction; and
- 4.11.11.2.9 When appropriate, Disenrollment from Case Management when the goals have been achieved and the Member is able to self-manage, or the needs and desires of the Member change.

4.11.11.3 Levels of Case Management for the GF 360° Program include:

- 4.11.11.3.1 Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem and a plan of care that has been developed which provides for health and social problem follow-up as indicated.
- 4.11.11.3.2 Level II - Services that ensure necessary Member services are available. Case managers will arrange for appointments and transportation to the Member's appointments and referrals and verify that the referral site is available and appropriate for the Member's needs.
- 4.11.11.3.3 Level III - Services defined in Level I and Level II plus assisting the Member to complete forms, accompanying the Member to their appointments to provide introductions and support as well as contacting the Member to schedule additional appointments. Visits to the Member's residence are included in Level III Case Management. This level of Case Management services ensures the Member successfully negotiates any transitions in care. Level III

Case Management may be reserved for certain high risk Members who require special assistance to negotiate complex or highly structured health or social systems.

4.11.11.3.4 The Contractor shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have catastrophic or other high-cost or high-risk Conditions including pregnant women under twenty-one (21) years of age, high risk pregnancies and infants and toddlers with established risk for developmental delays.

4.11.11.4 The Contractor must notify DCH of the specific Case Management programs it initiates (i.e. OB case management, Behavioral Health case management, etc.) and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members.

4.11.11.5 The Contractor will submit quarterly reports to DCH which include specified Case Management Program data as listed in Section 5.71 in addition to the annual report.

4.11.12 Reporting Requirements

4.11.12.1 The Contractor shall submit to DCH quarterly Case Management and Disease Management Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.11.12.2 The Contractor shall submit to DCH quarterly Prior Authorization and Pre-Certification Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.11.12.3 The Contractor shall submit to DCH all reports as outlined in the Demonstration Quality Strategy identified in **Attachment M** of this Contract in addition to the annual report.

4.11.13 Health Outcomes

4.11.13.1 The Contractor shall submit written policies and procedures for tracking and reporting individual Member health outcomes, including the mechanism for reporting whether a Member's health outcomes improved as a result of the CMO's Care Coordination activities. The Contractor shall submit such policies and procedures to DCH for review within ninety (90) Calendar Days of the Operational Start Date and within ten (10) Calendar Days of

any subsequent updates. In all instances, DCH shall have at least ten (10) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.14 Medication Management

4.11.14.1 The Contractor shall develop a medication management program specific to the needs of the Members. At a minimum, the medication management program must assess prescribing patterns and treatment plans for psychotropic medications, medications at risk of abuse and other medications identified by DCH or the Contractor. Contractor must submit to DCH an annual report describing activities and the effectiveness of the efforts over the reporting period and the future efforts and activities planned for the next reporting period.

4.12 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

4.12.1 General Provisions

4.12.1.1 The Contractor shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions, and designation of adequate resources to support the intervention(s).

4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers, community resources, and agencies to actively improve the Quality of care provided to Members.

4.12.1.3 National Committee for Quality Assurance (NCQA) Accreditation

4.12.1.3.1 The Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date. Contractors shall apply for NCQA accreditation, or at other times as required by DCH as follows:

4.12.1.3.1.1 July 1, 2016: Apply for NCQA Interim Status

4.12.1.3.1.2 July 1, 2017: Apply for provisional status (first survey)

4.12.1.3.1.3 December 31, 2017: Notify NCQA of intent to submit data

4.12.1.3.1.4 June 15, 2018: Submit CY 2017 data

4.12.1.3.2 The Contractor shall achieve NCQA Commendable or Excellent accreditation status within two (2) years after the Operational Start date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.

4.12.1.4 Quality Oversight Committee

4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following:

4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director;

4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization;

4.12.1.4.1.3 A senior executive who is responsible for program implementation;

4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and

4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

4.12.1.4.2 The Quality Management Committee must:

4.12.1.4.2.1 Maintain Records that document the committee's activities, findings, recommendations, actions, and results; and

4.12.1.4.2.2 Obtain DCH's approval of membership of the Quality Oversight Committee.

4.12.2 DCH Quality Strategic Plan Requirements

4.12.2.1 The Contractor shall support and comply with the DCH Quality Strategic Plan. The DCH Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to GF and Members as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).

4.12.2.2 The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to enrolled Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit are responsible for oversight of the Contractor's Quality program including:

4.12.2.2.1 Monitoring and evaluating the Contractor's service delivery system and Provider network, as well as its own processes for quality management and performance improvement;

4.12.2.2.2 Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members;

4.12.2.2.3 Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.;

4.12.2.2.4 Monitoring compliance with Federal, State and DCH requirements;

4.12.2.2.5 Ensuring the Contractor's coordination with State registries;

4.12.2.2.6 Ensuring Contractor executive and management staff participation in the Quality management and performance improvement processes;

4.12.2.2.7 Ensuring that the development and implementation of Quality management and performance improvement activities includes Provider participation and information provided by Members, their families and guardians; and

4.12.2.2.8 Identifying the Contractor's best practices for performance and Quality improvement.

4.12.3 Performance Measures

- 4.12.3.1 The Contractor shall comply with the GF 360° DCH Quality Strategic Plan requirements to improve the health outcomes for all Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS[®]) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measures and incent Contractor improvement through the Value-based Purchasing program.
- 4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS[®] measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirements for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure.
- 4.12.3.3 DCH established Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at <http://dch.georgia.gov/medicaid-quality-reporting>. Performance targets are based on national Medicaid Managed Care HEDIS[®] percentiles as reported by NCQA or other benchmarks as established by DCH.
- 4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.
- 4.12.3.5 The performance measures apply to the Member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or

specifications may change annually to comply with industry standards and updates.

- 4.12.3.6 The Contractor must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.

4.12.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

- 4.12.4.1 The Contractor shall deliver to DCH the results of CAHPS Surveys conducted by an NCQA certified CAHPS survey vendor. The survey report must include but not be limited to the following items:

- 4.12.4.1.1 An Executive Summary with the description of the survey process conducted according to the CAHPS Health Plan Survey guidelines of the HEDIS protocol;

- 4.12.4.1.2 Protocols for the administration of the survey via mail, telephone or mixed mode;

- 4.12.4.1.3 Definition of the sample size, number of completed surveys and response dates achieved. Response rates should, at a minimum, be no less than the NCQA average Medicaid response rates for the period; and

- 4.12.4.1.4 Detailed survey results and trend analysis.

- 4.12.4.2 The Contractor shall submit, on an annual basis to DCH, Adult and Child CAHPS Survey reports as stated in Section 4.12.16.

4.12.5 Member and Provider Incentives

- 4.12.5.1 The Contractor shall implement Member and Provider incentives to increase Member and Provider participation in reaching program goals. The Contractor may provide:

- 4.12.5.1.1 Incentives to Members and/or Providers to encourage compliance with periodicity schedules. Such incentives shall be established in accordance with all applicable State and federal laws, rules and regulations. Member incentives must be of nominal value (\$10.00 or less per item and \$50.00 in the aggregate on an annual basis per Member) and may include gift cards so long as such gift cards are not redeemable for cash or Co-payments. The Contractor shall submit the proposed incentive methods to DCH for review and receive DCH approval prior to implementation. Upon request by DCH, the Contractor shall provide DCH with reports detailing incentives provided to Members and/or

Providers and illustrating efficacy of incentive programs. In accordance with 42 CFR 1003.101, the Nominal Value requirement stated herein is not applicable where the incentive is offered to promote the delivery of preventive care services, provided:

- 4.12.5.1.1.1 The delivery of the preventive services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or Medicaid;
- 4.12.5.1.1.2 The incentive is not cash or an instrument convertible to cash; and
- 4.12.5.1.1.3 The value of the incentive is not disproportionately large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future Health Care costs reasonably expected to be avoided as a result of the preventive care).
- 4.12.5.2 Provider incentives for the specific purpose of supporting necessary costs to transform and sustain NCQA PCMH recognition or TJC PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters
- 4.12.5.3 Provider incentive strategies to improve Provider compliance with clinical practice guidelines and ensure consistent application of the guidelines.
- 4.12.6 Quality Assessment Performance Improvement (QAPI) Program
 - 4.12.6.1 The Contractor shall have in place an ongoing QAPI program consistent with 42 CFR 438.240. The program must be established utilizing strategic planning principles with defined goals, objectives, strategies and measures of effectiveness for the strategies implemented to achieve the defined goals.
 - 4.12.6.2 The Contractor's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include:
 - 4.12.6.2.1 A method of monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over Utilization of services), including those with special Health Care needs;

- 4.12.6.2.2 Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy;
- 4.12.6.2.3 A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data;
- 4.12.6.2.4 Designated staff with expertise in Quality assessment, Utilization Management and Care Coordination;
- 4.12.6.2.5 Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to Providers and Members;
- 4.12.6.2.6 A methodology and process for conducting and maintaining Provider profiling;
- 4.12.6.2.7 Ad-Hoc Reports to the Contractor's multi-disciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations and implemented system changes; and annual Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas;
- 4.12.6.2.8 Integration of the results from annual Performance Improvement Projects (PIPs), performance measure rate monitoring, and compliance with federal and state standards;
- 4.12.6.2.9 The impact of the Contractor's Member demographics on their ability to improve health outcomes; and
- 4.12.6.2.10 A process for evaluation of the impact and assessment of the Contractor's QAPI program.

4.12.6.3 The Contractor shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCP's or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.

4.12.6.4 The Contractor's QAPI Program Plan must be submitted to DCH for initial review and approval and as updated thereafter.

- 4.12.6.5 The Contractor shall submit any changes to its QAPI Program Plan to DCH for review and prior approval sixty (60) Calendar Days prior to implementation of the change.
- 4.12.6.6 Upon the request of DCH, the Contractor shall provide any information and documents related to the implementation of the QAPI program.
- 4.12.6.7 Annually, the Contractor shall submit to DCH a comprehensive QAPI Report, utilizing the report template that integrates all aspects of the QAPI Plan and tells the story of the effectiveness of the Contractor's QAPI Plan in meeting defined goals and objectives and achieving improved health outcomes for the Contractor's Members. DCH may require interim reports more frequently than annually to demonstrate progress.
- 4.12.7 Performance Improvement Projects
- 4.12.7.1 As part of its QAPI program, the Contractor shall conduct clinical and non-clinical Performance Improvement Projects in accordance with DCH and federal protocols. In designing its performance improvement projects, the Contractor shall:
- 4.12.7.1.1 Show that the selected area of study is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale);
 - 4.12.7.1.2 Establish clear, defined and measurable goals and objectives that the Contractor shall achieve in each year of the project;
 - 4.12.7.1.3 Utilize Rapid Cycle Process Improvement and Plan Do Study Act (PDSA) processes;
 - 4.12.7.1.4 Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;
 - 4.12.7.1.5 Implement interventions designed to achieve Quality improvements;
 - 4.12.7.1.6 Evaluate the effectiveness of the interventions;
 - 4.12.7.1.7 Establish standardized performance measures (such as HEDIS® or another similarly standardized product);
 - 4.12.7.1.8 Plan and initiate activities for increasing or sustaining improvement; and

- 4.12.7.1.9 Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.
- 4.12.7.2 Each performance improvement project must be completed in a period determined by DCH, to allow information on the success of the project in the aggregate to produce new information on Quality of care each year.
- 4.12.7.3 The Contractor shall perform the required performance improvement projects (PIPs), as specified by DCH and agreed upon by the Parties, on an annual basis. Plan Do Study Act cycles must be incorporated into each PIP process.
- 4.12.7.4 Each PIP will use a study period approved by DCH.
- 4.12.7.5 Each PIP must include AIM statements and Driver Diagrams and align with the EQRO prepared PIP template. PIP components will be included as agreed upon by DCH and the CMO.
- 4.12.7.6 The Contractor shall submit the designated PIPs to the EQRO Contractor using the DCH specified template and format as defined in the PIP protocol approved by DCH.
- 4.12.7.7 The EQRO will evaluate the CMO's PIPs performance, using CMS approved Rapid Cycle PIP and/or other EQRO protocols. DCH reserves the right to request modification of the PIPs based on this evaluation. Modifications will be discussed with the CMO prior to implementation.
- 4.12.7.8 The Contractor shall submit PIP documentation to DCH and/or the EQRO using the DCH specified template and format as specified in the CMS approved Rapid Cycle PIP and/or other EQRO protocols.
- 4.12.7.9 The Contractor shall submit a PIP Annual Improvement Strategy Plan to DCH and/or the EQRO using the DCH specified template and format by October 31st of each contract year. This Plan will describe the improvement strategies to be implemented in the upcoming plan year (January 1st – December 31st).
- 4.12.8 Clinical Practice Guidelines (CPGs)
- 4.12.8.1 The Contractor shall adopt a minimum of three (3) evidence-based clinical practice guidelines. Such guidelines shall:
- 4.12.8.1.1 Be based on the health needs and opportunities for improvement identified as part of the QAPI program;

- 4.12.8.1.2 Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;
- 4.12.8.1.3 Consider the needs of the Members;
- 4.12.8.1.4 Be adopted in consultation with network Providers; and
- 4.12.8.1.5 Be reviewed and updated periodically as appropriate.

4.12.8.2 The Contractor shall submit to DCH for review and prior approval and as updated thereafter all Clinical Practice Guidelines in use, which shall include a methodology for measuring and assessing compliance as part of the QAPI program plan.

4.12.8.3 The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members.

4.12.8.4 The Contractor shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

4.12.8.5 To ensure consistent application of the guidelines, the Contractor shall require Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Contractor will conduct this review on a quarterly basis. The Contractor may use Provider incentive strategies to improve Provider compliance with guidelines.

4.12.8.6 To further ensure consistent application of the Clinical Practice Guidelines, the Contractor shall perform a review of a minimum random sample of fifty (50) Members' medical records per evidence-based CPG, each quarter.

4.12.8.7 The Contractor shall submit quarterly to DCH reports regarding their provider network's adherence to the Clinical Practice Guidelines as stated in Section 5.7.1.

4.12.9 Focused Studies

4.12.9.1 Focused Studies examine a specific aspect of health care (such as prenatal care) for a defined point in time. These studies are usually based on information extracted from medical records or Contractor administrative data such as Enrollment files and Encounter/claims

data. Steps that may be taken by the Contractor when conducting focused studies are:

- 4.12.9.1.1 Selecting the Study Topic(s)
- 4.12.9.1.2 Defining the Study Questions or Aim Statement
- 4.12.9.1.3 Selecting the Study Indicator(s)
- 4.12.9.1.4 Identifying a representative and generalizable study population
- 4.12.9.1.5 Documenting sound sampling techniques utilized (if applicable)
- 4.12.9.1.6 Collecting reliable data
- 4.12.9.1.7 Analyzing data and interpreting study results

4.12.9.2 The Contractor may perform, at DCH's discretion, a Focused Study to examine a specific aspect of health care (such as prenatal care) for a defined point in time. The Focused Study will have a calendar year study period and the results will be reported to DCH by June 30th following the year of the study. DCH shall retain the right to approve or disapprove all proposed Focus Studies.

4.12.10 Patient Safety Plan

4.12.10.1 The Contractor shall have a structured Patient Safety Plan, Report, and Analysis to address incidents and concerns regarding clinical care. This plan must include written policies and procedures for processing Member complaints regarding the care received and addressing incidents and concerns with clinical care. Such policies and procedures shall include:

- 4.12.10.1.1 A system of classifying incidents, concerns, and complaints according to severity;
- 4.12.10.1.2 A review by the Medical Director and a mechanism for determining which incidents will be forwarded to Peer Review and
- 4.12.10.1.3 A summary of incident(s), including the final disposition, included in the Provider profile.

4.12.10.2 At a minimum, the Patient Safety Program process shall:

- 4.12.10.2.1 Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals;
 - 4.12.10.2.2 Report and analyze Medication recalls;
 - 4.12.10.2.3 Report and analyze Medication errors;
 - 4.12.10.2.4 Describe the results of site Inspections; and
 - 4.12.10.2.5 Report and analyze Patient Quality of Care Concerns, including those arising from patient grievances.
- 4.12.10.3 The Contractor shall submit the Patient Safety Plan to DCH for initial review and approval and as updated and submit to DCH on an annual basis no later than June 30 of the Contract year a Patient Safety Program Report inclusive of the program components described in 4.12.10.1 and 4.12.10.2.
- 4.12.11 External Quality Review
- 4.12.11.1 DCH will contract with an External Quality Review Organization (EQRO) to conduct independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Contractor shall collaborate with DCH and its EQRO to develop studies, surveys and other analytic activities to assess the Quality of care and services provided to Members and to identify opportunities for CMO improvement. To facilitate this process the Contractor shall supply data, as requested by DCH or its EQRO, to the EQRO.
- 4.12.12 Value-Based Purchasing (VBP) Program
- 4.12.12.1 The Contractor shall collaborate with DCH to implement a Value-Based Purchasing (VBP) model. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, Contractors and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.
 - 4.12.12.2 Prior to the Operational Start Date, DCH will establish a VBP performance management team ("VBP Performance Management Team"). The VBP Performance Management Team will have responsibility for planning, implementing, and executing the VBP initiative. The Team will work collaboratively with the Contractor to review the Contractor's progress on a monthly, quarterly and/or

annual basis, determine incentive payments, and determine the need to modify priority areas, measures and targets.

4.12.12.3 In addition to DCH staff, key leadership from the Contractor such as the Medical Director, Chief Operating Officer, or other designee approved by DCH will provide input and feedback on planned priorities and initiatives. As appropriate, DCH will engage operational-level Contractor staff.

4.12.12.4 Through the VBP Performance Management Team, the Contractor and DCH shall meet at least quarterly to discuss progress on initiatives. Rapid cycle feedback is key to the success of a VBP model. The Contractor shall regularly review and provide real-time information focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis to DCH. The Contractor shall provide ongoing and ad hoc reports to DCH to highlight status and progress of initiatives, as well as successes and challenges. Regularly reviewing data is necessary for DCH and the Contractor to identify where initiatives are not resulting in improvements necessitating adjustments to the implemented approach. When adjustments are necessary, the Contractor shall report to DCH changes the Contractor will make to continually work towards improvements.

4.12.12.5 **Attachment U** outlines the performance measures and related targets that the Contractor must achieve under the VBP model. The Contractor must establish in collaboration with DCH initiatives that it will undertake to achieve the specified targets. Such initiatives may differ from or include other required initiatives, such as Performance Improvement Projects (PIPs) and Focused Studies. Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold") from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.

4.12.12.6 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the eighteen (18) performance measures. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold.

Contractor Payout Amount = (Number of Performance Targets Achieved/Total Number of Performance Targets) x Total VBP Withhold

4.12.12.7 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to a methodology for quantifying the Contractor's success in achieving targets and payments for each measure.

4.12.12.8 The Contractor shall incentivize Providers to participate in VBP and may also incentivize Members. The Contractor shall develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize Providers on a more frequent schedule than DCH's schedule for payment to the Contractor). The Contractor shall submit the plan to DCH for prior approval. The Contractor shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date. The plan shall include details of how the Contractor will collaborate with Providers to determine the frequency of incentive payments to Providers and how the Contractor will encourage participation in the program.

4.12.12.9 The Contractor shall comply with the requirements set forth in the VBP Operations Manual.

4.12.13 Monitoring and Oversight Committee

4.12.13.1 The Contractor shall participate in the Georgia Families Monitoring and Oversight Committee ("GFMO") and associated subcommittees as requested by DCH. The GFMO and associated subcommittees will assist DCH in assessing the performance of the Contractor and developing improvements and new initiatives specific to the GF 360° program. The GFMO will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration among State agencies, the Contractor and external stakeholders. Members of the GFMO will be appointed by the DCH Commissioner or his designee. The GFMO meetings must be attended by the Contractor decision makers defined as one or more of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position, and Chief Medical Officer.

4.12.14 Member Advisory Committee

4.12.14.1 The Contractor shall establish and maintain a Member Advisory Committee consisting of persons served by the Contractor including current and past Members and/or authorized representatives, and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of members. The Committee shall meet at least quarterly, and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct on-site reviews of the Committee meetings to ensure:

4.12.14.1.1 The Committee is discussing issues pertinent to the Member population;

4.12.14.1.2 The Committee is meeting as scheduled; and

4.12.14.1.3 The Committee members are in attendance.

4.12.15 Provider Advisory Committee

4.12.15.1 The Contractor shall establish and maintain a Provider Advisory Committee consisting of Providers contracted with the Contractor to serve Members. At least two (2) Providers on the Committee shall maintain health care practices that predominantly serve Medicaid beneficiaries. The Committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct on-site reviews of the Committee meetings to ensure:

4.12.15.1.1 The Committee is discussing issues pertinent to the Member population;

4.12.15.1.2 The Committee is meeting as scheduled; and

4.12.15.1.3 The Committee members are in attendance.

4.12.16 Reporting Requirements

4.12.16.1 Contractors must submit the following data reports as indicated.

REPORT	DUE DATE	REPORTS DIRECTED TO:
Performance Improvement Project Proposal(s) 4	Annually October 31	DCH PQO Unit
Quality Assurance Performance Improvement Plan	Annually June 30	DCH PQO Unit
Quality Assessment Performance Improvement Program Evaluation	Annually June 30	DCH PQO Unit
Performance Improvement Project Report 2	Annually June 30	EQRO vendor
Performance Measures Report 1	Annually June 30	DCH PQO Unit
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	Annually July 31	DCH PQO Unit

2 If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the DCH PQO Unit.

4.12.16.3 The Contractor's Quality Oversight Committee shall submit to DCH Quality Oversight Committee Reports - Ad Hoc as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.12.16.4 The Contractor shall submit to DCH Performance Improvement Project Reports no later than June 30 of the Contract year or per protocol described in Section 4.12.7.

4.12.16.5 The Contractor shall submit to DCH Focused Studies Reports no later than June 30 of the Contract year as described in Section 4.12.9.

4.12.16.6 The Contractor shall submit to DCH annual Patient Safety Plan Reports no later than June 30 of the Contract year as described in Section 4.12.10.

4.13 FRAUD, WASTE AND ABUSE

4.13.1 Program Integrity

4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services under this Contract.

4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below.

4.13.1.3 The Contractor shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and provider type within 7 Business Days of the settlement.

4.13.2 Compliance Plan

4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following:

4.13.2.1.1 The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed;

4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud, Waste and Abuse violations, including specific methodologies for such monitoring and auditing;

4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;

4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;

4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;

4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;

4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse plan and other compliance responsibilities;

4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following:

4.13.2.1.8.1 Prepayment review of claims;

- 4.13.2.1.8.2 Claims edits;
- 4.13.2.1.8.3 Post-processing review of Claims;
- 4.13.2.1.8.4 Provider profiling;
- 4.13.2.1.8.5 Quality Control; and
- 4.13.2.1.8.6 Utilization Management.

- 4.13.2.1.9 Written standards for organizational conduct;
- 4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board members, and Subcontractors;
- 4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;
- 4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;
- 4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovering any overpayments identified; and
- 4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.

4.13.2.2 As part of the Program Integrity Program, the Contractor may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures described in Section 4.13.1. The pharmacy lock-in program shall:

- 4.13.2.2.1 Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;

- 4.13.2.2.2 Provide Case Management and education reinforcement of appropriate medication use;
- 4.13.2.2.3 Annually assess the need for lock in for each Member; and
- 4.13.2.2.4 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH.
- 4.13.2.2.5 Not allow a Member to transfer to another pharmacy or PCP while enrolled in the CMO's pharmacy lock-in program.

4.13.3 Coordination with DCH and Other Agencies

- 4.13.3.1 The Contractor shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.
- 4.13.3.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.
- 4.13.3.3 The Contractor shall inform DCH immediately about known or suspected Fraud cases and it shall not investigate or resolve the suspicion without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.

4.13.4 Reporting Requirements

- 4.13.4.1 The Contractor shall submit to DCH a quarterly Fraud and Abuse Report, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.20.

4.14

INTERNAL GRIEVANCE/APPEALS SYSTEM

4.14.1 General Requirements

4.14.1.1 The Contractor's Grievance System shall include a process to receive, track, resolve and report on Grievances from its Members. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing. See O.C.G.A. §49-4-153.

4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.

4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal laws and regulations, the provisions of this Contract, and the Contractor's written policies and procedures as approved by DCH. Pertinent facts from all parties must be collected during the investigation.

4.14.1.4 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.

4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.

4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision-making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:

4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;

4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and

4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.

4.14.2 Member Medical Review Process for PeachCare for Kids®

4.14.2.1 DCH also allows a state review on behalf of PeachCare for Kids® Members. If the Member, parent or other authorized representative of the Member believes that a denied service should be covered, the parent or such representative must send a written request for review to the Contractor.

4.14.2.2 If the decision of the Contractor review maintains the denial of service, a letter will be sent to the parent or representative detailing the reason for denial. If the parent or representative elects to dispute the decision, the parent or representative will have the option of having the decision reviewed by the Formal Grievance Committee. The request should be sent to:

Department of Community Health
PeachCare for Kids®
Administrative Review Request
2 Peachtree Street, NW, 37th floor
Atlanta, GA 30303-3159

4.14.2.3 The decision of the Formal Grievance Committee will be the final recourse available to the Member. In reference to the Formal Grievance level, the State assures:

4.14.2.3.1 Enrollees receive timely written notice of any documentation that includes the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which Enrollment may continue, pending review.

4.14.2.3.2 Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, or termination of health services, or failure to approve or provide payment for health services in a timely manner. The independent review is available at the Formal Grievance level.

- 4.14.2.3.3 Decisions are written when reviewed by DCH and the Formal Grievance Committee.
- 4.14.2.3.4 Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.
- 4.14.2.3.5 Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, Members will be notified of the timeframes for the appeals process once an appeal is filed with the Formal Grievance Committee.
- 4.14.2.3.6 Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.
- 4.14.2.3.7 Reviews that are not expedited due to an enrollee's medical condition will be completed within ninety (90) Calendar Days of the date of a request is made.
- 4.14.2.3.8 Reviews that are expedited due to an enrollee's medical condition shall be completed within seventy-two (72) clock hours of the receipt of the request.

4.14.3 Grievance Process

4.14.3.1 A Member or Member's Authorized Representative may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.

4.14.3.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making.

4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.

4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.

4.14.4 Proposed Action

4.14.4.1 All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member's Condition or disease.

4.14.4.2 In the event of a Proposed Action, the Contractor shall notify the Member in writing. The Contractor shall also provide written notice of a Proposed Action to the Provider. This notice must meet the language and format requirements in accordance with Section 4.3.2 of this Contract and be sent in accordance with the timeframes described in Section 4.14.3.4.

4.14.4.3 The notice of Proposed Action must contain the following:

4.14.4.3.1 The Action the Contractor has taken or intends to take, including the service or procedure that is subject to the Action;

4.14.4.3.2 Additional information, if any, that could alter the decision;

4.14.4.3.3 The specific reason used as the basis of the Action;

4.14.4.3.4 The reasons for the Action must have a factual basis and legal/policy basis;

4.14.4.3.5 The Member's right to file an Administrative Review through the Contractor's internal Grievance System;

4.14.4.3.6 The Provider's right to file a Provider Complaint as described in Section 4.9.7;

4.14.4.3.7 The requirement that a Member exhaust the Contractor's internal Administrative Review Process;

4.14.4.3.8 The procedures for exercising the rights outlined in this Section;

4.14.4.3.9 The circumstances under which expedited review is available and how to request it; and

4.14.4.3.10 The Member's right to have Benefits continue pending resolution of the Administrative Review with the

Contractor, Member instructions on how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

4.14.4.4 The Contractor shall mail the Notice of Proposed Action within the following timeframes:

4.14.4.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of one of the following exceptions:

4.14.4.4.1.1 The Contractor has factual information confirming the death of a Member.

4.14.4.4.1.2 The Contractor receives a clear written statement signed by the Member that

4.14.3.4.1.2.1 he or she no longer wishes services; or

4.14.3.4.1.2.2 gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.

4.14.4.4.1.3 The Contractor establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

4.14.4.4.1.4 The Member has been admitted to an institution where he is ineligible under the plan for further services.

4.14.4.4.1.5 The post office returns Contractor mail directed to the Member indicating no forwarding address and the Member's whereabouts are unknown (refer to 42 CFR 431.231(d) for procedures if the Member's whereabouts become known).

4.14.4.4.1.6 The Member's Provider prescribes an immediate change in the level of medical care.

4.14.4.4.1.7 The date of Action will occur in less than ten (10) Calendar Days, in accordance with 42 C.F.R. §483.12(a) (5) (ii), which provides exceptions to the

thirty (30) Calendar Days' notice requirements of 42 C.F.R. § 483.12(a) (5) (i).

4.14.4.4.2 For Standard Service Authorization decisions that deny or limit services, within the timeframes required in Section 4.11.2.7.1.

4.14.4.4.3 If the Contractor extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.7, the Contractor shall give the Member written notice of the reasons for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.

4.14.4.4.4 For authorization decisions not reached within the timeframes required in Section 4.11.2.7 for either standard or expedited Service Authorizations (which constitutes a denial and is thus an adverse action), notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.

4.14.4.5 Notice in Case of Probable Fraud

4.14.4.5.1 The Contractor may shorten the period of advance notice to five (5) Calendar Days before date of Action if the Contractor has facts indicating that Action should be taken because of probable Member Fraud and the facts have been verified, if possible, through secondary sources.

4.14.5 Administrative Review Process

4.14.5.1 An Administrative Review is the request for review of a "Proposed Action". The Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review either orally or in writing. Unless the Member or Provider requests expedited review, the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's or written consent, must follow an oral filing with a written, signed, request for Administrative Review.

4.14.5.2 The Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review with the

Contractor within thirty (30) Calendar Days from the date of the notice of Proposed Action.

4.14.5.3 Administrative Reviews shall be filed directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Administrative Review committee, but the delegation must be in writing.

4.14.5.4 The Contractor shall ensure that the individuals who make decisions on Administrative Reviews are individuals who were not involved in any previous level of review or decision-making, and who are Health Care Professionals who have the appropriate clinical expertise in treating the Member's Condition or disease if deciding any of the following:

4.14.5.4.1 An Administrative Review of a denial that is based on lack of Medical Necessity.

4.14.5.4.2 An Administrative Review that involves clinical issues.

4.14.5.5 The Administrative Review process shall provide the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The Contractor shall inform the Member of the limited time available to provide this in case of expedited review.

4.14.5.6 The Administrative Review process must provide the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, opportunity, before and during the Administrative Review process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Administrative Review process.

4.14.5.7 The Administrative Review process must include as parties to the Administrative Review the Member, the Member's Authorized Representative, the Provider acting on behalf of the Member with the Member's written consent, or the legal representative of a deceased Member's estate.

4.14.5.8 The Contractor shall resolve each Administrative Review and provide written notice of the resolution, as expeditiously as the Member's health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Contractor receives the Administrative Review. For expedited reviews and notice to affected parties, the Contractor has no longer than three (3)

Working Days or as expeditiously as the Member's physical or mental health condition requires, whichever is sooner. If the Contractor denies a Member's request for expedited review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) Calendar Days with a written notice. The Contractor shall also make reasonable efforts to provide oral notice for resolution of an expedited review of an Administrative Review.

4.14.5.9 The Contractor may extend the timeframe for standard or expedited resolution of the Administrative Review by up to fourteen (14) Calendar Days if the Member, Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, requests the extension or the Contractor demonstrates (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the Member's interest. If the Contractor extends the timeframe, it must, for any extension not requested by the Member, give the Member written notice of the reason for the delay.

4.14.6 Notice of Adverse Action

4.14.6.1 If the Contractor upholds the Proposed Action in response to an Administrative Review filed by the Member the Contractor shall issue a Notice of Adverse Action within the timeframes described in Sections 4.14.5.8 and 4.14.5.9.

4.14.6.2 The Notice of Adverse Action shall meet the language and format requirements as specified in Section 4.3 and include the following:

4.14.6.2.1 The results and date of the Adverse Action including the service or procedure that is subject to the Action.

4.14.6.2.2 Additional information, if any, that could alter the decision.

4.14.6.2.3 The specific reason used as the basis of the Action.

4.14.6.2.4 The right to request a State Administrative Law Hearing within thirty (30) Calendar Days from the date of the Notice of Adverse Action. The time for filing will begin when the filing is date stamped.

4.14.6.2.5 The right to continue to receive Benefits pending a State Administrative Law Hearing.

4.14.6.2.6 How to request the continuation of Benefits.

- 4.14.6.2.7 Information explaining that the Member may be liable for the cost of any continued Benefits if the Contractor's Action is upheld in a State Administrative Law Hearing.
- 4.14.6.2.8 Circumstances under which expedited resolution is available and how to request it.

4.14.7 Administrative Law Hearing

- 4.14.7.1 The State will maintain an independent Administrative Law Hearing process as defined in O.C.G.A. §49-4-153 and as required by federal law, 42 CFR 431.200. The Administrative Law Hearing process shall provide Members an opportunity for a hearing before an impartial Administrative Law Judge. The Contractor shall comply with decisions reached as a result of the Administrative Law Hearing process.
- 4.14.7.2 The Contractor is responsible for providing counsel to represent its interests. DCH is not a party to the case and will only provide counsel to represent its own interests.
- 4.14.7.3 A Member or Member's Authorized Representative may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by the Contractor. The parties to the Administrative Law Hearing shall include the Contractor as well as the Member, Member's Authorized Representative, or authorized representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member. DCH reserves the right to intervene on behalf of the interest of either party.
- 4.14.7.4 The hearing request and a copy of the adverse action letter must be received by the Contractor within thirty (30) Calendar Days or less from the date that the notice of Action was mailed.
- 4.14.7.5 A Member may request a Continuation of Benefits as described in Section 4.14.8 while an Administrative Law Hearing is pending.
- 4.14.7.6 The Contractor shall make available any records and any witnesses at its own expense in conjunction with a request pursuant to an Administrative Law Hearing.

4.14.8 Continuation of Benefits while the Contractor Appeal and Administrative Law Hearing are Pending

4.14.8.1 As used in this Section, “timely” filing means filing on or before the later of the following:

4.14.8.1.1 Within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Action.

4.14.8.1.2 The intended effective date of the Contractor’s Proposed Action.

4.14.8.2 The Contractor shall continue the Member’s Benefits if the Member or the Member’s Authorized Representative files the Appeal timely; the Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized Provider; the original period covered by the original authorization has not expired; and the Member requests extension of the Benefits.

4.14.8.3 If, at the Member’s request, the Contractor continues or reinstates the Member’s Benefits while the Appeal or Administrative Law Hearing is pending, the Benefits must be continued until one of the following occurs:

4.14.8.3.1 The Member withdraws the Appeal or request for the Administrative Law Hearing.

4.14.8.3.2 Ten (10) Calendar Day pass after the Contractor mails the Notice of Adverse Action, unless the Member, within the ten (10) Calendar Day timeframe, has requested an Administrative Law Hearing with continuation of Benefits until an Administrative Law Hearing decision is reached.

4.14.8.3.3 An Administrative Law Judge issues a hearing decision adverse to the Member.

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

4.14.8.4 If the final resolution of Appeal is adverse to the Member, that is, upholds the Contractor’s Action, the Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal is pending, to the extent that they were furnished solely because of the requirements of this Section.

4.14.8.5 If the Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member’s health condition requires.

- 4.14.8.6 If the Contractor or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Contractor shall pay for those services.

4.15 ADMINISTRATION AND MANAGEMENT

4.15.1 General Provisions

- 4.15.1.1 The Contractor shall be responsible for the administration and management of all requirements of this Contract. All costs related to the administration and management of this Contract shall be the responsibility of the Contractor.

4.15.2 Place of Business and Hours of Operation

- 4.15.2.1 The Contractor shall maintain a place of business in the metropolitan Atlanta Area within thirty-five (35) miles of 2 Peachtree Street, NW Atlanta, GA 30303. The Contractor must have at least one (1) satellite office serving no less than two (2) contiguous Service Regions. The central business office must be accessible for foot and vehicle traffic.

- 4.15.2.2 All documentation must reflect the address of the location identified as the legal, duly licensed, central business office. This business office must be open at least between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday with the exception of State holidays. The Contractor shall ensure that the office(s) are adequately staffed to ensure that Members and Providers receive prompt and accurate responses to inquiries.

- 4.15.2.3 The Contractor shall provide access twenty-four (24) clock hours a day, seven (7) days per week to its Web site. The Contractor shall provide seventy-two (72) clock hours advance notice of web site upgrades, servicing and updates.

4.15.3 Training

- 4.15.3.1 The Contractor shall conduct on-going training for its entire staff, in all departments, to ensure appropriate functioning in all areas and to ensure that staff is aware of all programmatic changes. The Contractor must train its staff using a curriculum specific to their areas of responsibility. The training program must include, for example, training about the Georgia Medicaid program, Medicaid regulations, issues specific to the enrolled populations and managed care operations. Staff must receive training about the functionality of Information Systems so that they are fully capable

of using the systems to complete their job functions. The Contractor shall also ensure that staff have the necessary qualifications and education to perform their assigned jobs. The Contractor and its staff shall attest that staff have received required trainings and have necessary qualifications and education.

4.15.3.2 The Contractor shall submit a staff-training plan to DCH for initial review and approval and as updated thereafter.

4.15.3.3 The Contractor designated staff are required to attend DCH in-service training on an ad-hoc basis. DCH will determine the type and scope of the training.

4.15.3.4 DCH may attend any training sessions conducted by or on behalf of the Contractor specific to this Contract at its discretion.

4.15.4 Data and Report Certification

4.15.4.1 The Contractor shall certify all data pursuant to 42 CFR 438.606. The data that must be certified include, but are not limited to, Enrollment information, Encounter Data, Contractual Reports, inclusive of all Quality management reports, and other information required by the State and contained in Contracts, proposals and related documents. The data must be certified by one of the following: the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for, and who Reports directly to the Contractor's Chief Executive Officer or Chief Financial Officer. Specific to the Quality management reports, the Chief Medical Officer or other delegated physician must review and attest to the accuracy of all Quality management reports submitted to DCH. The signature of the Chief Medical Officer or other delegated physician is required on all Quality management reports.

4.15.4.1.1 By virtue of submission, the Contractor attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.

4.15.4.1.2 Inaccurate data, reports, and other documents provided to the State by the Contractor are subject to applicable Liquidated Damages.

4.15.4.2 The Contractor shall submit the certification concurrently with the certified data.

4.15.5 Turnover Planning

4.15.5.1 No later than thirty (30) Calendar Days after the Contract Effective Date, the Contractor must submit a detailed turnover plan (“Turnover Plan”) to DCH. The Turnover Plan must:

4.15.5.1.1 Specify how the Contractor will turn over any and all records, files, methodologies, data and any supplemental documentation which DCH would require for DCH or another contractor to take over operation of the GF 360° program in the event of Contract expiration or termination for any reason;

4.15.5.1.2 Include all elements of turnover phases, including specific schedule;

4.15.5.1.3 Include a statement of resources and training that would be necessary to facilitate and efficiently turnover the GF 360° program to the State or another contractor; and

4.15.5.1.4 Include a statement of commitment to maintain the level of resources dedicated to full-program operations through the contract termination.

4.15.5.2 Any Turnover Plan revisions required by DCH must be finalized within five (5) Calendar Days of DCH’s feedback.

4.16 CLAIMS MANAGEMENT

The Contractor shall have adequate systems and staff in place to ensure that the provision of Health Care services under this Contract is properly documented, accounted for, and reported.

4.16.1 General Provisions

4.16.1.1 The Contractor shall adhere to the time frames and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid Claims outlined in the DCH Policy Manuals. The Contractor shall administer an effective, accurate and efficient Claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by DCH (see Part I. Policy and Procedures for Medicaid/PeachCare for Kids® Manual) and in compliance with all applicable State and federal laws, rules and regulations. Any claims processing issues caused by the Contractor will be resolved within a forty-five (45) Calendar Day limit. The Contractor shall contact Providers within fifteen (15) Calendar Days to resolve claims processing issues. For all Claims that are initially denied or

underpaid by the Contractor and are eventually determined or agreed to have been owed by the Contractor, the Contractor shall pay interest in the amount of twenty percent (20%) annum, calculated from fifteen (15) Calendar Days after the date the Claim was submitted. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum, calculated from fifteen (15) Calendar Days after the date the Claim was submitted.

- 4.16.1.2 The Contractor shall maintain a Claims management system that can identify date of receipt (the date the Contractor receives the Claim as indicated by the date-stamp), real-time-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, Appealed, etc.), and date of payment (the date of the check or other form of payment).
- 4.16.1.3 At a minimum, the Contractor shall run one (1) Provider payment cycle per week, on the same day each week, as determined by DCH.
- 4.16.1.4 The Contractor shall support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of Claims payments.
- 4.16.1.5 The Contractor shall encourage its Providers, as an alternative to the filing of paper-based Claims, to submit and receive Claims information through electronic data interchange (EDI), i.e. electronic Claims. Electronic Claims must be processed in adherence to information exchange and data management requirements specified in the Information Management and Systems section of this Contract, Section 4.17. As part of this Electronic Claims Management (ECM) function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status information.
- 4.16.1.6 The Contractor shall generate explanation of Benefits and remittance advices in accordance with State standards for formatting, content and timeliness and will verify that Members have received the services indicated on the explanation of Benefits received and the remittance advices.
- 4.16.1.7 The Contractor shall issue a formal tracking number for Claims inquiries and shall tie any recoupment to the original payment on the remittance advice. The Contractor shall provide the ability to separate provider remittance advice by location identified through the location-specific provider number.

- 4.16.1.8 The Contractor shall not pay any Claim submitted by a Provider who is excluded or suspended from the Medicare, Medicaid or CHIP programs for Fraud, Waste or Abuse or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or who employs someone on this list. The Contractor shall not pay any Claim submitted by a Provider that is on payment hold under the authority of DCH or its Agent(s).
- 4.16.1.9 Not later than the fifteenth (15) Business Day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO web site/Provider Portal or an interim explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO shall complete processing of the Claim within fifteen (15) Business Days.
- 4.16.1.10 Responsible Health Organization. For services rendered within seventy-two (72) hours after the Provider verifies the eligibility of the patient with the Contractor, the Contractor shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Contractor made payment for a patient for whom it was not responsible, then the Contractor may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.
- 4.16.1.11 The Contractor shall not apply any penalty for failure to file Claims in a timely manner, for failure to obtain Prior Authorization, or for the Provider not being a participating Provider in the Contractor's network. The amount of reimbursement shall be that Provider's applicable rate for the service provided by an In Network or Out of Network Provider.
- 4.16.1.12 The Contractor shall inform all network Providers about the information required to submit a Clean Claim as a provision within the Contractor/Provider Contract. The Contractor shall make available to network Providers Claims coding and processing guidelines for the applicable Provider type. The Contractor shall notify Providers ninety (90) Calendar Days before implementing significant changes to Claims coding and processing guidelines. DCH's definition of 'significant' shall be binding.

- 4.16.1.13 The Contractor shall perform and submit to DCH Quarterly scheduled Global Claims Analyses to ensure an effective, accurate, and efficient claims processing function that adjudicates and settles Provider Claims. In addition, the Contractor shall assume all costs associated with Claims processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor's Span of Control. If, based on its review of such analysis, DCH finds the Contractor's Claims management system and/or processes to be insufficient, DCH may require from the Contractor a Corrective Action Plan outlining how it will address the identified issues.
- 4.16.1.14 The Contractor's web site shall be functionally equivalent to the web site maintained by the State's Medicaid Fiscal Agent Contractor.
- 4.16.2 Other Considerations
- 4.16.2.1 An adjustment to a paid Claim shall not be counted as a Claim for the purposes of reporting.
- 4.16.2.2 Electronic Claims shall be treated as identical to paper-based Claims for the purposes of reporting.
- 4.16.3 Encounter Claims Submission Requirements
- 4.16.3.1 The GF 360^o program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor to provide timely, complete and accurate information. Encounter data from the Contractor also allows DCH to budget available resources, set Contractor capitation rates, monitor utilization, follow public health trends and detect potential Fraud. Most importantly, it allows the Division of Managed Care and Quality to make recommendations that can lead to the improvement of healthcare outcomes.
- 4.16.3.2 The Contractor shall work with all contracted Providers to implement standardized billing requirements to enhance the quality and accuracy of the billing data submitted to the health plan.
- 4.16.3.3 The Contractor shall instruct contracted Providers that the State of Georgia Medicaid ID number is mandatory, until such time as otherwise determined by DCH. The Contractor will emphasize to Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.

4.16.3.4 The Contractor shall submit to DCH's Fiscal Agent Contractor weekly cycles of data files. All identified errors shall be submitted to the Contractor from the Fiscal Agent Contractor each week. The Contractor shall address identified issues and resubmit the corrected file to the Fiscal Agent Contractor within seven (7) Business Days of receipt.

4.16.3.5 The Contractor is required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, NPI numbers, SSN numbers, Member Name, and DOB. These items must match the states eligibility and provider file.

4.16.3.6 The Contractor's submitted Claims must include:

4.16.3.6.1 Patient name;

4.16.3.6.2 Date of birth;

4.16.3.6.3 Place of service;

4.16.3.6.4 Date of service;

4.16.3.6.5 Type of service;

4.16.3.6.6 Units of service;

4.16.3.6.7 Diagnostic related groupings (DRGs);

4.16.3.6.8 Treating Provider;

4.16.3.6.9 NPI number of rendering Provider;

4.16.3.6.10 NPI number of OPR Provider;

4.16.3.6.11 Tax Identification Number;

4.16.3.6.12 Facility code;

4.16.3.6.13 A unique TCN;

4.16.3.6.14 All additionally required CMS 1500 or UB 04 codes; and

4.16.3.6.15 CMO Paid Amount.

4.16.3.7 For each submission of claims per 4.16.3.5 and 4.16.3.6, Contractor must provide via DCH's required electronic format the following Cash Disbursements data elements:

- 4.16.3.7.1 Provider/Payee Number;
- 4.16.3.7.2 Name;
- 4.16.3.7.3 Address;
- 4.16.3.7.4 City;
- 4.16.3.7.5 State;
- 4.16.3.7.6 Zip;
- 4.16.3.7.7 Check date;
- 4.16.3.7.8 Check number;
- 4.16.3.7.9 Check amount; and
- 4.16.3.7.10 Check code (i.e. EFT, paper check, etc.).

4.16.3.8 Contractor will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.

4.16.3.9 The Contractor shall submit ninety-nine percent (99) of Encounter Data within thirty (30) Calendar Days of Claims payment – both for the original Claim and any adjustment. DCH or its Agent will validate Encounter Data submission according to the Cash Disbursement journal of the Contractor and any of its applicable Subcontractors.

4.16.3.10 The Contractor shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the Fiscal Agent Contractor and DCH. The Encounter Error Rate is the occurrence of a single error in any Transaction Control Number (TCN) or Encounter claim counts as an error for that Encounter (this is regardless of how many other errors are detected in the TCN.)

4.16.3.11 The Contractor's failure to comply with defined standard(s) will be subject to a Corrective Action Plan and the Contractor may be liable for liquidated damages.

4.16.4 Emergency Services

4.16.4.1 The Contractor shall not deny or inappropriately reduce payment to a provider of Emergency Services for any evaluation, diagnostic

testing, or treatment provided to a Member for an emergency condition; or

4.16.4.2 The Contractor shall not make payment for Emergency Services contingent on the Member or provider of Emergency Services providing any notification, either before or after receiving Emergency Services.

4.16.4.3 In processing claims for Emergency Services, the Contractor shall consider, at the time that a Claim is submitted, at least the following criteria:

4.16.4.3.1 The age of the patient;

4.16.4.3.2 The time and day of the week the patient presented for services;

4.16.4.3.3 The severity and nature of the presenting symptoms;

4.16.4.3.4 The patient's initial and final diagnosis; and

4.16.4.3.5 Any other criteria prescribed by DCH, including criteria specific to patients under eighteen (18) years of age.

4.16.4.4 The Contractor shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for Claims presented for Emergency Services.

4.16.4.5 If a provider that has not entered into a contract with the Contractor provides Emergency Services or post-stabilization services to that Contractor's Member, the Contractor shall reimburse the non-contracted provider for such Emergency Services and post-stabilization services at a rate equal to the rate paid by DCH for Medicaid claims that it reimburses directly.

4.16.5 Reporting Requirements

4.16.5.1 The Contractor shall submit to DCH monthly Claims Processing Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.17 **INFORMATION MANAGEMENT AND SYSTEMS**

The Contractor shall develop, maintain and update, at no cost to DCH or Providers, an information management system for the purpose of integrating all components of the delivery of care to its Members. The system shall have the

capability to securely store and transmit information, interface with other relevant systems and report data in a format specified by DCH. The Contractor shall ensure the system is available and accessible to users at times and in a format that encourages meaningful use by stakeholders.

4.17.1 General Provisions

4.17.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GF 360° requirements, State and federal reporting requirements, all other Contract requirements and any other applicable State and federal laws, rules and regulations, as amended, including HIPAA.

4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.

4.17.1.2 The Contractor is responsible for maintaining Systems that shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.

4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.

4.17.1.4 The Contractor shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its Agents and the Contractor.

4.17.1.5 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with the State. This system shall be:

4.17.1.5.1 Available from the workstations of the designated Contractor contacts; and

4.17.1.5.2 Capable of attaching and sending documents created using software products other than Contractor Systems, including

the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

4.17.1.6 By no later than the 30th of April of each year, the Contractor will provide DCH with an annual progress/status report of the Contractor's Systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Contractor's Span of Control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The Systems refresh plan will also indicate how the Contractor will ensure that the version and/or release level of all of its Systems' components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the Systems' components.

4.17.1.7 The Contractor is responsible for all costs associated with the Contractor's Systems refresh plan.

4.17.2 Health Information Technology and Exchange

4.17.2.1 The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased information on cost and Quality of care through health information technology.

4.17.2.2 The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the Quality and cost of health care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Contractor shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers.

4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).

4.17.2.3.1 If not already participating in the GaHIN, the Contractor shall sign and execute all required GaHIN participation documentation within ten (1010) Calendar Days of the Contract Effective Date (or an alternative date approved in

writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process;

4.17.2.3.2 The Contractor shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;

4.17.2.3.3 DCH and/or its designee shall provide detailed on-boarding information for use by the Contractor to establish interoperability with the GaHIN; and

4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.

4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.

4.17.2.5 Through their system and interoperability with the GaHIN, the Contractor shall provide the following types of patient health information on Members including, but not limited to:

4.17.2.5.1 Member-specific information including, but not limited to name, address of record, and date of birth, race/ethnicity, gender and other demographic information, as appropriate, for each Member;

4.17.2.5.2 Name and address of each Member's PCP and Caregiver;

4.17.2.5.3 Name and contact information of each Member's DFCS Case Manager, JPPS or Residential Placement Provider, as well as non-medical personnel such as the CMO Care Coordinator, as appropriate;

4.17.2.5.4 Acquisition and retention of the Member or DJJ Member's Medicaid ID is required, but due to a lag in the assignment of the Medicaid ID number, the Contractor shall utilize and retain the Member's DFCS personal identification number ("Person ID") to identify and link each Member to a unique Medicaid ID after it has been assigned. Both of these values shall be available and distinguishable in the VHR. The Contractor may choose to assign an additional unique identifier for each internal use, if appropriate;

- 4.17.2.5.5 Description and quarterly update of each Member's individual Health Care Service Plan, including the plan of treatment to address the Member's physical, psychological, and emotional health care problems and needs;
- 4.17.2.5.6 Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;
- 4.17.2.5.7 Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnoses, and treatment given, including drugs prescribed;
- 4.17.2.5.8 Record of future scheduled service appointments, if available, and referrals;
- 4.17.2.5.9 Record of all diagnoses applicable to the Member, with emphasis on Behavioral Health diagnoses utilizing either the DSM IV-R or ICD-9 or ICD-10 national code sets as based on claims submitted;
- 4.17.2.5.10 Record of current and/or past medications and doses (including psychoactive medications), and where available, the prescribing physician, date of prescription(s) and target symptoms;
- 4.17.2.5.11 Monthly progress notes from Behavioral Health exams or treatments. A Provider must submit notes at more frequent intervals if necessary to document significant changes in a Georgia Families 360° Member's treatment or progress. Notes should include the following:
- 4.17.2.5.11.1 Primary and secondary (if present) diagnosis; assessment information, including results of a mental status exam, history or assessments used for Residential Placement purposes;
 - 4.17.2.5.11.2 Brief narrative summary of a Member's progress or status;
 - 4.17.2.5.11.3 Scores on each outcome rating form(s);
 - 4.17.2.5.11.4 Referrals to other providers or community resources; and

4.17.2.5.11.5 Any other relevant care information.

4.17.2.5.12 Listing of a Member's known clinical history, health problems and allergies;

4.17.2.5.13 Complete record of all immunizations;

4.17.2.5.14 Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the claims or "visits" module of the VHR;

4.17.2.5.15 Record of notification within two (2) Business Days of the provision of Emergency Services to a FCAAP Member if the Foster Parent, Adoptive Parent, Caregiver or DFCS Staff did not provide consent; and

4.17.2.5.16 Any utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description. This is applicable to codes pertaining to a service event, health care provider, and Member records.

4.17.2.6 The Contractor shall access the GaHIN to display Member health information within their system for the purpose of Care Coordination and management of the Members.

4.17.2.7 The Contractor shall provide DCH with a list of Authorized Users who may access patient health data from the Contractor's Systems. DCH shall review and approve the list, including revisions thereto, of the Contractor's Authorized Users who may access patient health data from the Contractor's systems. The Contractor shall be permitted to access the GaHIN for purposes associated with this Contract only.

4.17.2.8 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.

4.17.3 Global System Architecture and Design Requirements

4.17.3.1 The Contractor shall comply with federal and State policies, standards and regulations in the design, development and/or modification of the Systems it will employ to meet the aforementioned requirements and in the management of Information contained in those Systems. Additionally, the Contractor shall adhere to DCH and State-specific system and data architecture preferences as indicated in this Contract.

- 4.17.3.2 The Contractor's Systems shall:
- 4.17.3.2.1 Employ a relational data model in the architecture of its databases and relational database management system (RDBMS) to operate and maintain them;
 - 4.17.3.2.2 Be SQL and ODBC compliant;
 - 4.17.3.2.3 Adhere to Internet Engineering Task Force/Internet Engineering Standards Group standards for data communications, including TCP and IP for data transport;
 - 4.17.3.2.4 Conform to standard code sets detailed in **Attachment K**;
 - 4.17.3.2.5 Contain industry standard controls to maintain information integrity applicable to privacy and security, especially PHI. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly and mutually agreed upon by the Contractor and DCH; and
 - 4.17.3.2.6 Partner with the State in the development of future standard code sets, not specific to HIPAA or other federal efforts and will conform to such standards as stipulated by DCH.
- 4.17.3.3 Where Web services are used in the engineering of applications, the Contractor's Systems shall conform to World Wide Web Consortium (W3C) standards such as XML, UDDI, WSDL and SOAP so as to facilitate integration of these Systems with DCH and other State systems that adhere to a service-oriented architecture.
- 4.17.3.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the Information is finally recorded. The audit trails shall:
- 4.17.3.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;
 - 4.17.3.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;
 - 4.17.3.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

- 4.17.3.4.4 Be supported by listings, transaction Reports, update Reports, transaction logs, or error logs;
- 4.17.3.4.5 Facilitate auditing of individual Claim records as well as batch audits; and
- 4.17.3.4.6 Be maintained for seven (7) years in either live and/or archival Systems, as applicable. The duration of the retention period may be extended at the discretion of and as indicated to the Contractor by the State as needed for ongoing audits or other purposes.
- 4.17.3.5 The Contractor shall house indexed images of documents used by Members and Providers to transact with the Contractor in the appropriate database(s) and document management systems to maintain the logical relationships between certain documents and certain data.
- 4.17.3.6 The Contractor shall institute processes to ensure the validity and completeness of the data it submits to DCH. At its discretion, DCH will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Member ID, date of service, Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of Claim processing, and date of Claim payment.
- 4.17.3.7 Where Systems are herein required to, or otherwise support, the applicable batch or on-line transaction type, the Systems shall comply with HIPAA-standard transaction code sets as specified in **Attachment K**, and as updated thereafter.
- 4.17.3.8 The Contractor Systems shall conform to HIPAA standards for information exchange, and as updated thereafter.
- 4.17.3.9 The layout and other applicable characteristics of the pages of Contractor Web sites shall be compliant with Federal “section 508 standards” and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.
- 4.17.3.10 Contractor Systems shall conform to any applicable Application, Information and Data, Middleware and Integration, Computing Environment and Platform, Network and Transport, and Security and Privacy policy and standard issued by GTA as stipulated in the appropriate policy/standard, and as updated thereafter. These policies and standards can be accessed at: http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.html

4.17.4 Data and Document Management Requirements By Major Information Type

4.17.4.1 In order to meet programmatic, reporting and management requirements, the Contractor's Systems shall serve as either the Authoritative Host of key data and documents or the host of valid, replicated data and documents from other systems. **Attachment K** lays out the requirements for managing (capturing, storing and maintaining) data and documents for the major information types and subtypes associated with the aforementioned programmatic, reporting and management requirements.

4.17.5 System and Data Integration Requirements

4.17.5.1 All of the Contractor's applications, operating software, middleware, and networking hardware and software shall be able to interface with the State's systems DCH vendors systems and will conform to standards and specifications set by the Georgia Technology Authority and the agency that owns the system. These standards and specifications are detailed in **Attachment K**.

4.17.5.2 The Contractor's Systems shall be able to transmit and receive transaction data to and from the MMIS as required for the appropriate processing of Claims and any other transaction that may be performed by either system.

4.17.5.3 The Contractor shall generate Encounter data files no less than weekly (or at a frequency defined by DCH) from its Claims management system(s) and/or other sources. The files will contain settled Claims and Claim adjustments and encounters from Providers with whom the Contractor has a capitation arrangement for the most recent month for which all such transactions were completed. The Contractor will provide these files electronically to DCH and/or its designated agent in adherence to the procedure and format indicated in **Attachment K**, and as updated thereafter.

4.17.5.4 The Contractor's Systems shall be capable of generating all required files in the prescribed formats (as referenced in **Attachment K**, including any updates thereto) for upload into state systems used specifically for program integrity and compliance purposes.

4.17.5.5 The Contractor's Systems shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

4.17.6 Systems Access Management and Information Accessibility Requirements

4.17.6.1 The Contractor's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and Information. The access management function shall:

4.17.6.1.1 Restrict access to Information on a "need to know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;

4.17.6.1.2 Restrict access to specific Systems' functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by DCH and the Contractor;

4.17.6.1.3 Restrict attempts to access Systems' functions (both internal and external) to three (3), with a system function that automatically prevents further access attempts and records these occurrences; and

4.17.6.1.4 At a minimum, follow the GTA Security Standard and Access Management protocols, and updates thereto.

4.17.6.2 The Contractor shall make Systems Information available to duly Authorized Representatives of DCH and other State and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

4.17.6.3 The Contractor shall have procedures to provide for prompt electronic transfer of Systems Information upon request to In-Network or Out-of-Network Providers for the medical management of the Member in adherence to HIPAA and other applicable requirements.

4.17.7 Systems Availability and Performance Requirements

4.17.7.1 The Contractor will ensure that Member and Provider portal and/or phone-based functions and information, such as confirmation of CMO Enrollment (CCE) and electronic claims management (ECM), Member services and Provider services, are available to the applicable Systems' users twenty-four (24) hours a day, seven (7) Days a week, except during periods of scheduled Systems Unavailability agreed upon by DCH and the Contractor. Unavailability caused by events outside of a Contractor's Span of Control is outside of the scope of this requirement.

4.17.7.2 The Contractor shall ensure that at a minimum, all other Systems' functions and Information are available to the applicable Systems'

users between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday with the exception of State holidays.

4.17.7.3 The Contractor shall ensure that the average response time that is controllable by the Contractor is no greater than the requirements set forth below, between 7:00 am and 7:00 pm EST, Monday through Friday for all applicable Systems' functions except a) during periods of scheduled downtime, b) during periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Contractor's Span of Control or c) for Member and Provider portal and phone-based functions such as CCE and ECM that are expected to be available twenty-four (24) hours a day, seven (7) days a week:

4.17.7.3.1 Record Search Time – The response time shall be within three (3) seconds for ninety-eight percent (98%) of the record searches as measured from a representative sample of DCH System Access Devices, as monitored by the Contractor;

4.17.7.3.2 Record Retrieval Time – The response time will be within three (3) seconds for ninety-eight percent (98%) of the records retrieved as measured from a representative sample of DCH System Access Devices; and

4.17.7.3.3 On-line Adjudication Response Time – The response time will be within five (5) seconds ninety-nine percent (99%) of the time as measured from a representative sample of user System Access Devices;

4.17.7.3.4 Screen Display Time – the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor. The Screen Display Time must be within 2 seconds for 95% of the time.

4.17.7.3.5 New Screen Page Time- the time elapsed from the time a new screen is requested until the data from the screen appears or loads to completion on the monitor. The New Screen Page Time must be within 2 seconds for 95% of the time.

4.17.7.3.6 Print Initiation Time- The time elapsed from the command to print a screen or report until it appears in the appropriate queue. The Print Initiation Time must be within 2 seconds for 95% of the time.

- 4.17.7.4 The Contractor shall develop an automated method of monitoring the CCE and ECM functions on at least a thirty (30) minute basis twenty-four (24) hours a day, seven (7) Days per week. The monitoring method shall separately monitor for availability and performance/response time each component of the CCE and ECM systems, such as the voice response system, the PC software response, direct line use, the swipe box method and ECM on-line pharmacy system.
- 4.17.7.5 Upon discovery of any problem within its Span of Control that may jeopardize Systems availability and performance as defined in this Section of the Contract, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, in person, via phone and electronic mail followed by surface mail notification.
- 4.17.7.6 The Contractor shall deliver notification as soon as possible but no later than 7:00 pm EST if the problem occurs during the Business Day and no later than 9:00 am EST the following Business Day if the problem occurs after 7:00 pm.
- 4.17.7.7 Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on Systems Unavailability protocols.
- 4.17.7.8 The Contractor shall provide to the DCH Director, Contract Compliance and Resolution, information on Systems Unavailability events, as well as status updates on problem resolution. These up-dates shall be provided on an hourly basis and made available via electronic mail, telephone and the Contractor's Web Site/DCH Portal.
- 4.17.7.9 Unscheduled Systems Unavailability of CCE and ECM functions, caused by the failure of systems and telecommunications technologies within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the Contractor's discovery of Systems Unavailability. Unscheduled Systems Unavailability to all other Contractor Systems' functions caused by systems and telecommunications technologies within the Contractor's Span of Control shall be resolved, and the restoration of services implemented, within four (4) hours of the Contractor's discovery of Systems Unavailability.

- 4.17.7.10 Cumulative Systems Unavailability caused by systems and telecommunications technologies within the Contractor's Span of Control shall not exceed one (1) hour during any continuous five (5) Calendar Day period.
- 4.17.7.11 The Contractor shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Contractor's Span of Control. Contractor is obligated to work with identified vendors to resolve and report system availability and performance issues.
- 4.17.7.12 Full written documentation that includes a Corrective Action or Remedial Action response that describes what caused the problem, how the problem will be prevented from occurring again, and within a set time frame for resolution must be submitted to DCH within the DCH required timeframe of the problem's occurrence.
- 4.17.7.13 Regardless of the architecture of its Systems, the Contractor shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that at a minimum addresses the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) Systems interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) Systems interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) Systems interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the Systems, i.e. causes unscheduled Systems Unavailability.
- 4.17.7.14 The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore Systems functions per the standards outlined elsewhere in this Contract. The Contractor will prepare a report of the results of these tests and present to DCH staff within five (5) Business Days of test completion. DCH or its designee, federal auditors, or the State Auditor, reserves the right to conduct a site visit of the Contractor's disaster recovery location with one (1) day prior notice.
- 4.17.7.15 In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore Systems functions per the standards outlined in this Contract, the Contractor shall be required

to submit to the State a CAPA response that describes how the failure will be resolved. The CAPA will be delivered within five (5) Business Days of the conclusion of the test.

- 4.17.7.16 The Contractor shall submit monthly Systems Availability and Performance Reports to DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.17.8 Systems User and Technical Support Requirements

- 4.17.8.1 The Contractor shall provide Systems Help Desk (SHD) services to all DCH staff and the other agencies that may have direct access to Contractor Systems.

- 4.17.8.2 The SHD shall be available via local and toll free telephone service and via e-mail from 7:00 a.m. to 7:00 p.m. EST Monday through Friday, with the exception of State holidays. Upon State request, the Contractor shall staff the SHD on a State holiday, Saturday, or Sunday at the Contractor's expense.

- 4.17.8.3 SHD staff shall answer user questions regarding Contractor Systems' functions and capabilities; report recurring programmatic and operational problems to appropriate Contractor or DCH staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate State login account administrator.

- 4.17.8.4 The Contractor shall submit to DCH for review and approval its SHD Standards. At a minimum, these standards shall require that between the hours of 7:00 a.m. and 7:00 p.m. EST ninety percent (90%) of calls are answered by the fourth (4th) ring, the call abandonment rate is five percent (5%) or less, the average hold time is two (2) minutes or less, and the blocked call rate does not exceed one percent (1%).

- 4.17.8.5 Individuals who place calls to the SHD between the hours of 7:00 p.m. and 7:00 a.m. EST shall be able to leave a message. The Contractor's SHD shall respond to messages by noon EST the following Business Day.

- 4.17.8.6 Recurring problems not specific to System Unavailability identified by the SHD shall be documented and reported to Contractor management within one (1) Business Day of recognition so that deficiencies are promptly corrected in accordance with this Contract.

4.17.8.7 Additionally, the Contractor shall have an IT service management system that provides an automated method to record, track, and report on all questions and/or problems reported to the SHD. The service management system shall:

4.17.8.7.1 Assign a unique number to each recorded incident;

4.17.8.7.2 Create State defined extract files that contain summary information on all problems/issues received during a specified time frame;

4.17.8.7.3 Escalate problems based on their priority and the length of time they have been outstanding;

4.17.8.7.4 Perform key word searches that are not limited to certain fields and allow for searches on all fields in the database;

4.17.8.7.5 Notify support personnel when a problem is assigned to them and re-notify support personnel when an assigned problem has escalated to a higher priority;

4.17.8.7.6 Generate a list of all problems assigned to a support person or group;

4.17.8.7.7 Perform searches for duplicate problems when a new problem is entered;

4.17.8.7.8 Allow for entry of at least five hundred (500) characters of free form text to describe problems and resolutions; and

4.17.8.7.9 Generate Reports that identify categories of problems encountered, length of time for resolution, and any other State-defined criteria.

4.17.8.8 The Contractor's call center systems shall have the capability to track call management metrics identified in **Attachment K**, and updates thereto.

4.17.9 Systems Change Management Requirements

4.17.9.1 The Contractor shall absorb the cost of routine maintenance, inclusive of defect correction, Systems changes required to effect changes in State and federal statute and regulations, and production control activities, of all Systems within its Span of Control.

4.17.9.2 The Contractor shall provide DCH prior written notice of non-routine Systems changes excluding changes prompted by events

described in the Systems Access management and Information Accessibility Requirements section above and including proposed corrections to known system defects, within ten (10) Calendar Days of the projected date of the change. As directed by the state, the Contractor shall discuss the proposed change in the Systems Work Group.

4.17.9.3 The Contractor shall respond to State reports of Systems problems not resulting in Systems Unavailability and shall perform the needed changes according to the following timeframes:

4.17.9.3.1 Within five (5) Calendar Days of receipt, the Contractor shall respond via phone and in writing via email to notices of system problems.

4.17.9.3.2 Within fifteen (15) Calendar Days, the correction will be made and confirmed to the State or a Requirements Analysis and Specifications document will be due.

4.17.9.4 The Contractor will correct the deficiency by an effective date to be determined by DCH.

4.17.9.5 Contractor Systems will have a system-inherent mechanism for recording any change to a software module or subsystem.

4.17.9.6 The Contractor shall put in place procedures and measures for safeguarding the State from unauthorized modifications to Contractor Systems.

4.17.9.7 Unless otherwise agreed to in advance by DCH as part of the activities described in the Systems User and Technical Support Requirements section above, scheduled Systems Unavailability to perform Systems maintenance, repair and/or upgrade activities shall take place between 11:00 p.m. EST on a Saturday and 6:00 a.m. EST on the following Sunday.

4.17.10 Systems Security and Information Confidentiality and Privacy Requirements

4.17.10.1 The Contractor shall provide for the physical safeguarding of its data processing facilities and the Systems and Information housed therein. The Contractor shall provide DCH with access to data facilities upon DCH request. The physical security provisions shall be in effect for the life of this Contract and thereafter.

4.17.10.2 The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other

comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

4.17.10.3 The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

4.17.10.4 The Contractor shall ensure that the operation of all of its Systems is performed in accordance with State and federal regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations.

4.17.10.5 The Contractor will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a Contractor's Span of Control.

4.17.10.6 The Contractor shall ensure compliance with:

4.17.10.6.1 42 CFR Part 431 Subpart F (confidentiality of information concerning applicants and Members of public medical assistance programs);

4.17.10.6.2 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and

4.17.10.6.3 Special confidentiality provisions related to people with HIV/AIDS and mental illness.

4.17.10.7 The Contractor shall provide its Members with a privacy notice as required by HIPAA. The Contractor shall provide the State with a copy of its Privacy Notice for its filing.

4.17.11 Information Management Process and Information Systems Documentation Requirements

4.17.11.1 The Contractor shall ensure that written Systems Process and Procedure Manuals, and updates thereto, document and describe all manual and automated system procedures for its information management processes and information systems in accordance to CMS seven conditions and standards, and amendments thereto. Available at: http://www.acs-inc.com/wp_state_self_assessment.aspx

4.17.11.2 The Contractor shall develop, prepare, print, maintain, produce, and distribute distinct Systems Design and Management Manuals, User Manuals and Quick/Reference Guides, and any updates

thereafter, for DCH and other agency staff that use the DCH Portal.

4.17.11.3 The Systems User Manuals shall contain information about, and instructions for, using applicable Systems' functions and accessing applicable system's data.

4.17.11.4 When Systems change are subject to State approval, the Contractor shall draft revisions to all appropriate manuals impacted by the system change, i.e. user manuals, technical specifications etc. prior to State approval of the change.

4.17.11.5 All of the aforementioned manuals and reference guides shall be available in printed form and on-line via the DCH Portal. The manuals will be published in accordance to the applicable DCH and/or Georgia Technology Authority (GTA) standard.

4.17.11.6 Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) Business Days of the update taking effect.

4.17.12 Reporting Requirements

4.17.12.1 The Contractor shall submit to DCH a monthly Systems Availability and Performance Report as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.18 MONITORING AND REPORTING

4.18.1 General Procedures

4.18.1.1 The Contractor shall support DCH in its program monitoring and reporting efforts for program performance and trending analyses through submission of ongoing, dashboard and ad hoc reports to DCH for all activities described in the Contract. The Contractor shall provide ad hoc reports to DCH upon request and within timeframes agreed to by DCH and the Contractor.

4.18.1.2 The Contractor shall meet with DCH Business Owners during implementation to discuss all data requirements and the Contractor's recommended reports. The Contractor shall accommodate DCH's requests for data and reporting based on implementation decisions as well as for ongoing requests during operations.

4.18.2 Ongoing Reporting

4.18.2.1 The Contractor shall collect, validate and report required program data to DCH in an accurate and timely manner. The Contractor's Chief Executive or Financial Officer, or a designee vested with their authority, shall attest to the accuracy and completeness of all submitted reports, in accordance with 42 CFR §438.604. In addition, the Contractor shall comply with all state and federal requirements set forth in this Section and throughout this Contract.

4.18.2.2 The Contractor shall comply with all the reporting requirements established by this Contract and shall submit all Reports included in this Contract. The Contractor shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. **DCH may modify reports, specifications, templates, or timetables as necessary during the Contract year.** Contractor changes to the format must be approved by DCH prior to implementation. The Contractor shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 23.2. The Contractor's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 25.0.

4.18.2.2.1 The Contractor shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, **unless otherwise indicated.**

4.18.2.2.1.1 Weekly Reports shall be submitted on the same day of each week as determined by DCH;

4.18.2.2.1.2 Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month;

4.18.2.2.1.3 Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;

4.18.2.2.1.4 Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12th) month of the contract year ending June 30th;

4.18.2.2.1.5 Ad-Hoc, as determined by DCH; and

4.18.2.2.1.6 Other Reports (bi-annual, according to the due date of the respective report).

4.18.2.2.2 For reports required by DOI and DCH, the Contractor shall submit such reports according to the DOI schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in this Contract, should the DOI schedule of due dates be amended at a future date, the due dates in this Contract shall automatically change to the new DOI due dates.

4.18.2.2.3 The Contractor shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Contractor's responsibility shall be limited to data in its possession.

4.18.3 Public Reporting

4.18.3.1 DCH will periodically publish information or receive requests from audiences such as legislators that may require data from the Contractor. DCH will provide the Contractor with information about the data DCH would like to publish or must produce, and the Contractor shall produce all reports or summary data for DCH to incorporate into a larger report. The Contractor shall develop these reports considering the audience to be targeted.

4.18.3.2 The Contractor shall not publish reports on its website or any other forum without prior consent from DCH.

4.18.4 Ongoing Reporting and Monitoring Meetings

4.18.4.1 The Contractor must be prepared to participate in regularly scheduled meetings with DCH staff to review decisions, resolve issues and define operational enhancements. These meeting schedules will be determined by DCH.

4.18.4.2 The Contractor and its various levels of staff as determined by DCH must also attend an onsite meeting at DCH to report on all activities, trends, opportunities for improvement and recommendations for programmatic and policy changes at the frequency determined by DCH. Contractors must provide best practices and lessons learned to reach GF 360° program goals. The Contractor will prepare the agenda, reports and presentations for these monthly meetings for DCH review and approval.

4.18.5 Georgia Families 360° Reporting Requirements

4.18.5.1 The Contractor must provide all reports included in this Section and as otherwise indicated in this Contract.4. If the Contractor is a vendor on other projects, such as Georgia Families, these reports must be submitted separately for Georgia Families 360° Members.

4.18.5.2 The Contractor must submit data reports relating to the GF 360° population as indicated above based on the specifications provided by DCH. The Contractor shall provide sample reports for DCH approval within thirty (30) Calendar Days of the Operational Start Date. Contractor must also submit ad hoc reports as indicated by DCH.

5.0 DELIVERABLES

5.1 CONFIDENTIALITY

The Contractor shall ensure that any Deliverables that contain information about individuals that is protected by confidentiality and privacy laws shall be prominently marked as “CONFIDENTIAL” and submitted to DCH in a manner that ensures that unauthorized individuals do not have access to the information. The Contractor shall not make public such reports. Failure to ensure confidentiality may result in sanctions and liquidated damages as described in Section 25.

5.2 NOTICE OF APPROVAL/DISAPPROVAL

5.2.1 All Deliverables are subject to approval from DCH.

5.2.2 DCH will provide written notice of disapproval of a Deliverable to the Contractor within fourteen (14) Calendar Days of submission if it is disapproved. DCH may, at its sole discretion, elect to review a deliverable longer than fourteen (14) Calendar Days.

5.2.3 The notice of disapproval shall state the reasons for disapproval as specifically as is reasonably necessary and the nature and extent of the corrections required for meeting the Contract requirements.

5.3 RESUBMISSION WITH CORRECTIONS

Within fourteen (14) Calendar Days of receipt of a notice of disapproval, the Contractor shall make the corrections and resubmit the Deliverable.

5.4 NOTICE OF APPROVAL/DISAPPROVAL OF RESUBMISSION

Within thirty (30) Calendar Days following resubmission of any disapproved Deliverable, DCH will give written notice to the Contractor of approval, Conditional approval or disapproval.

5.5 DCH FAILS TO RESPOND

In the event that DCH fails to respond to a Contractor’s submission or resubmission within the applicable time period, the Contractor should notify DCH

of the outstanding request. DCH's failure to respond within the applicable time period does not constitute approval of the submission.

5.6 REPRESENTATIONS

5.6.1 By submitting a Deliverable or report, the Contractor represents that to the best of its knowledge, it has performed the associated tasks in a manner that will, in concert with other tasks, meet the objectives stated or referred to in the Contract.

5.6.2 By approving a Deliverable or report, DCH represents only that it has reviewed the Deliverable or report and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the Withholding or denial of payment for the work completed. DCH's acceptance of a Deliverable or report does not discharge any of the Contractor's contractual obligations with respect to that Deliverable or report.

5.7 CONTRACTOR DELIVERABLES

Contractor must consider the timeframes for receiving such DCH approval in meeting the specific deadlines for each deliverable. Any dates that fall on a weekend or State holiday shall have a deliverable date of the next Business Day. All deliverables must be complete and comprehensive.

5.7.1 Reports

Contractor shall deliver the following reports to DCH in the format(s) required by DCH or as set forth in this Contract:

Report	Frequency
Pharmacy Rebate File	Weekly
Claims Processing Report	Monthly
Cost Avoidance Report	Monthly
Dental Participation Denial Report	Monthly
Disenrollment Activity Notification Report	Monthly
Eligibility and Enrollment Reconciliation Report	Monthly
FQHC and RHC Report	Monthly
Medical Loss Ratio Report	Monthly
Member Data Conflict Report	Monthly
Provider Complaints Report	Monthly
System Availability and Performance Report	Monthly
Telephone and Internet Activity	Monthly

Report	
Third Party Liability and Coordination of Benefits Report	Monthly
Case Management Report	Quarterly
CMS 416 Report	Quarterly
Clinical Practice Guidelines (CPGs)	Quarterly
Contractor Notification	Quarterly
Dental Utilization Report	Quarterly
Disease Management Report	Quarterly
EPSDT Informing Activity Report	Quarterly
EPSDT Initial Screening Report	Quarterly
EPSDT Medical Health Check Record Review Report	Quarterly
EPSDT Referrals Report	Quarterly
Fraud and Abuse Report	Quarterly
Grievance System Report	Quarterly
Hospital Statistical and Reimbursement Report	Quarterly
Neonatal Intensive Care Supplement Payment Report	Quarterly
Performance Improvement Projects (PIPs) Reports	Quarterly
Pharmacy Audit Reports	Quarterly
Pharmacy Cost Reports	
Prior Authorization and Pre-Certification Report	Quarterly
Provider Network Adequacy and Capacity Report	Quarterly
Timely Access Report	Quarterly
Utilization Management Report	Quarterly
Disclosure of Information on Annual Business Transactions	Annually
EPSDT Reports	Annually
Independent Audit and Income Statement	Annually
Patient Safety Reports and Analysis	Annually
Performance Improvement Projects Reports	Annually
Performance Measures	Annually
Quality Assessment Performance Improvement (QAPI)	Annually
Systems Refresh Plan	Annually
SSAE 16” Reports	Annually
Unclaimed Payments Report	Annually
Unclaimed Property Report	Annually
72 Hour Eligibility Rule Report	Ad Hoc
Focused Studies Report	Ad Hoc

Provider Rep Field Visit Report	Ad Hoc
Quality Oversight Committee Report	Ad Hoc
State Quality Monitoring Reports	Ad Hoc
Subcontractor Agreement and Monitoring Information Report	B-Annually

5.7.2 Other Miscellaneous Deliverables

Contractor shall deliver the following deliverables to DCH in the format(s) required by DCH or as set forth in this Contract:

Deliverable	Contract Section
PCP Auto assignment Policies	2.3.3
Member Handbook	4.3.3
Provider Directory	4.3.5
Sample Member ID card	4.3.6
Telephone Hotline Policies and Procedures (Member and Provider)	4.3.7 4.9.5
Call Center Quality Criteria and Protocols	4.3.7.9 4.9.5.8
Web site Screenshots	4.3.8 4.9.6
Cultural Competency Plan	4.3.9.3
Marketing Plan and Materials	4.4
Provider Marketing Materials	4.4.4
MH/SA Policies and Procedures	4.6.11
EPSDT Policies and Procedures	4.7
Provider Selection and Retention Policies and Procedures	4.8.1.6
Provider Network Listing spreadsheet for all requested Provider types and Provider Letters of Intent or executed Signature Pages of Provider Contracts not previously submitted as part of the RFP response	4.8
Final Provider Network	4.8.1.8

Listing spreadsheet for all requested Provider types, Signature Pages for all Providers, and written acknowledgements from all Providers part of a PPO, IPO, or other network stating they know they are in the Contractor's network, know they are accepting Medicaid patients, and are accepting the terms and conditions of the Provider Contract	
PCP Selection Policies and Procedures	4.8.2.2
Provider Handbook	4.9.2
Provider Training Manuals	4.9.3.2
Provider Complaint System Policies and Procedures	4.9.7
Utilization Management Policies and Procedures	4.11
Care Coordination and Case Management Policies and Procedures	4.11
Quality Assessment and Performance Improvement Program	4.12.7 4.12.8
Focused Studies	4.12.10
Patient Safety Plan	4.12.11
Program Integrity Policies and Procedures	4.13
Grievance System Policies and Procedures	4.14
Staff Training Plan	4.15.3
Claims Management	4.16
Business Continuity Plan	4.17.7.13
System Users Manuals and Guides	4.17.11
Information Management Policies and Procedures	4.17
Subcontractor Agreements	18.0

6.0 **TERM OF CONTRACT**

- 6.1 This Contract shall begin on the Contract Effective Date and shall continue until June 30, 2017 unless terminated earlier pursuant to **Section 24, Termination of Contract**. The Parties agree that DCH has five (5) options to renew this Contract

for additional terms of up to one (1) State fiscal year each, which shall begin on July 1, and end at midnight on June 30 of the following year as follows:

Initial Term:	July 1, 2016 - June 30, 2017
Renewal Option 1:	July 1, 2017 - June 30, 2018
Renewal Option 2:	July 1, 2018 - June 30, 2019
Renewal Option 3:	July 1, 2019 - June 30, 2020
Renewal Option 4:	July 1, 2020 - June 30, 2021
Renewal Option 5:	July 1, 2021 - June 30, 2022

- 6.2 Pursuant to O.C.G.A. § 50-5-64(a)(2), each renewal option shall be exercisable solely and exclusively by DCH. The terms, conditions and pricing in effect at the time of renewal shall apply for each renewal option term. DCH will send Contractor written notice of its intent to exercise a renewal option under this Contract. As to each term, the Contract shall be terminated absolutely at the close of the then current state fiscal year without further obligation by DCH. Notwithstanding any language to the contrary, DCH reserves the right to terminate this Contract prior to the close of the fiscal year pursuant to Section 24 of this Contract.

7.0 PAYMENT FOR SERVICES

7.1 GENERAL PROVISIONS

7.1.1

- 7.1.1.1 DCH will compensate the Contractor on a Per Member Per Month basis for each FC Member, AA Member and DJJ Member enrolled in the Contractor's plan as detailed in **Attachment G** ("FC Member, AA Member and DJJ Capitation Payments") which is incorporated by this reference as if fully written herein. For the first partial month of an FC Member's, AA Member's or DJJ Member's enrollment in the Contractor's plan, DCH will prorate the FC Member, AA Member and DJJ Capitation Payment on a per Calendar Day basis for the remainder of the calendar month. The FC Member, AA Member and DJJ Capitation Payment will be prorated on a per Calendar Day basis for any partial month of Member enrollment in the CMO. The number of enrolled FCAAP and DJJ Members will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's Fiscal Agent Contractor. The FC Member, AA Member and DJJ Capitation Payment will be multiplied by the number of enrolled FC Members, AA Members and DJJ Members. The Contractor must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, and notwithstanding any other

withheld amounts allowed under this Contract, such amount shall be withheld from the prepaid, monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

- 7.1.2 DCH will compensate the Contractor on a Per Member Per Month basis for each P4HB Participant enrolled in the Contractor's plan (See **Attachment O**). The number of enrolled P4HB Participants in each rate cell category will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's Fiscal Agent Contractor. The monthly compensation will be the final negotiated rate for each rate cell multiplied by the number of enrolled P4HB Participants in each rate cell category. The Contractor must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, and notwithstanding any other withheld amounts allowed by this Contract, such amount shall be withheld from the monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

The relevant Deliverables concerning payment under this Contract shall be mailed to the Project Leader named in the Notice provision of this Contract.

- 7.1.3 The total of all payments made by DCH to Contractor under this Contract shall not exceed the Per Member Per Month Capitation payments agreed to under **Attachment G**, which has been provided for through the use of State or federal grants or other funds. With the exception of payments provided to the Contractor in accordance with Section 7.2 on Performance Incentives, DCH will have no responsibility for payment beyond that amount. Also, the total of all payments to the Contractor will not exceed one hundred and five percent (105%) of the Capitation payment pursuant to 42 CFR 438.6 (hereinafter the "Maximum Funds"). It is expressly understood that the total amount of payment to the Contractor will not exceed the maximum funds provided above, unless Contractor has obtained prior written approval, in the form of a Contract amendment, authorizing an increase in the total payment. Additionally, the Contractor agrees that DCH will not pay or otherwise compensate the Contractor for any work that it performs in excess of the Maximum Funds.

7.2 PERFORMANCE INCENTIVES

- 7.2.1 Beginning in Calendar Year (CY) 2017, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold") from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving

performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.

7.2.2 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the eighteen (18) performance measures outlined in **Attachment U**. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold.

7.2.2.1 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to a methodology for quantifying the Contractor's success in achieving targets and payments for each measure.

7.2.3 The Contractor shall develop a plan for distributing to Providers fifty percent (50%) of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize providers on a more frequent schedule than DCH's schedule for payment to the Contractor). The Contractor shall submit the plan to DCH for prior approval. The Contractor shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date.

8.0 FINANCIAL MANAGEMENT

8.1 GENERAL PROVISIONS

8.1.1 The Contractor shall be responsible for the sound financial management of the CMO.

8.2 SOLVENCY AND RESERVES STANDARDS

8.2.1 The Contractor shall establish and maintain such net worth, working capital and financial reserves as required pursuant to O.C.G.A. § 33-21-1 *et seq.*

8.2.2 The Contractor shall provide assurances to the State that its provision against the risk of insolvency is adequate such that its Members shall never be liable for its debts in the event of insolvency.

- 8.2.3 As part of its accounting and budgeting function, the Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. As part of its reserving process, the Contractor shall conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

8.3 REINSURANCE

- 8.3.1 DCH will not administer a Reinsurance program funded from capitation payment withholding.
- 8.3.2 In addition to basic financial measures required by State law and discussed in section 8.2.1 and Section 28, the Contractor shall meet financial viability standards. The Contractor shall maintain net equity (assets minus liability) equal to at least one (1) month's capitation payments under this Contract. In addition, the Contractor shall maintain a current ratio (current assets/current liabilities) of greater than or equal to 1.0.
- 8.3.3 In the event the Contractor does not meet the minimum financial viability standards outlined in 8.3.2, the Contractor shall obtain Reinsurance that meets all DOI requirements. While commercial Reinsurance is not required, DCH recommends that Contractors obtain commercial Reinsurance rather than self-insuring. The Contractor may not obtain a reinsurance policy from an offshore company; the insurance carrier, the insurance carrier's agents and the insurance carrier's subsidiaries must be domestic.

8.4 THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

- 8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.
- 8.4.1.1 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Contractor as its Agent to identify and cost avoid Claims for all CMO Members, including PeachCare for Kids® Members.
- 8.4.1.2 The Contractor shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO Members. To the extent permitted by State and federal law, the Contractor shall use Cost Avoidance processes to ensure that primary payments from the liable third party are identified, as specified below in Section 8.4.2.

8.4.1.3 If the Contractor is unsuccessful in obtaining necessary cooperation from a Member to identify potential Third Party Resources after sixty (60) Calendar Days of such efforts, the Contractor may inform DCH, in a format to be determined by DCH, that efforts have been unsuccessful.

8.4.1.4 For situations other than Medicare payments where payment is already made to the Provider by the CMO, the CMO shall coordinate with the other responsible payer and shall not recoup funds directly from the Provider and cause the Provider to have to resubmit claims to the other responsible payer.

8.4.2 Cost Avoidance

8.4.2.1 The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier, and may deny a service to a Member if the Contractor is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below in Section 8.4.2.2. However, if a third party health insurance carrier requires the Member to pay any cost-sharing amounts (e.g., Co-payment, coinsurance, deductible), the Contractor shall pay the cost sharing amounts. The Contractor's liability for such cost sharing amounts shall not exceed the amount the Contractor would have paid under the Contractor's payment schedule for the service.

8.4.2.2 Further, the Contractor shall not withhold payment for services provided to a Member if third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) Calendar Days.

8.4.2.3 The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services, the Contractor shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Contractor shall then coordinate with DCH or its Agent to enable DCH to recover payment from the potentially liable third party.

8.4.2.4 If the Contractor determines that third party liability exists for part or all of the services rendered, the Contractor may:

8.4.2.4.1 Pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider; and

8.4.2.4.2 Pay the Provider only the amount, if any, by which the Provider's allowable Claim exceeds the amount of third party liability.

8.4.2.5 If the provider determines that a person other than the Contractor to which it has submitted a Claim is responsible for coverage of the Member at the time the service was rendered, the provider may submit the Claim to the person that is responsible and that person shall reimburse all Medically Necessary Services without application of any penalty for failure to file claims in a time manner, for failure to obtain Prior Authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by the DCH for the same type of claim that it pays directly if the provider is not under contract with that person.

8.4.3 Compliance

8.4.3.1 DCH may determine whether the Contractor complies with this Section by inspecting source documents for timeliness of billing and accounting for third party payments.

8.5 PHYSICIAN INCENTIVE PLAN

8.5.1 The Contractor may establish physician incentive plans pursuant to federal and State regulations, including 42 CFR 422.208 and 422.210, and 42 CFR 438.6.

8.5.2 The Contractor shall disclose any and all such arrangements to DCH, and upon request, to Members. Such disclosure shall include:

8.5.2.1 Whether services not furnished by the physician or group are covered by the incentive plan;

8.5.2.2 The type of Incentive Arrangement;

8.5.2.3 The percent of withhold or bonus; and

8.5.2.4 The panel size and if patients are pooled, the method used.

8.5.3 Upon request, the Contractor shall report adequate information specified by the regulations to DCH in order that DCH will adequately monitor the CMO.

- 8.5.4 If the Contractor's physician incentive plan includes services not furnished by the physician/group, the Contractor shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to DCH proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual Member surveys, with results disclosed to DCH, and to Members, upon request.
- 8.5.5 Such physician incentive plans may not provide for payment, directly or indirectly, to either a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.

8.6 REPORTING REQUIREMENTS

- 8.6.1 The Contractor shall submit to DCH the Cost Avoidance Reports within twenty (20) Calendar Days of a written request from DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein
- 8.6.2 The Contractor shall submit to DCH monthly Medical Loss Ratio Reports that detail direct medical expenditures for Members and premiums paid by the Contractor, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.
- 8.6.3 The Contractor shall submit to DCH Third Party Liability and Coordination of Benefits Reports within ten (10) Business Days of verification of available Third Party Resources to a Member, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. The Contractor shall report any known changes to such resources in the same manner.
- 8.6.4 The Contractor, at its sole expense, shall submit by May 15 (or a later date if approved by DCH) of each year a "Reporting on Controls at a Service Organization", meeting all standards and requirements of the American Institute of Certified Public Accountants' (AICPA) SSAE 16 "type 2" report, for the Contractor's operations performed for DCH under this Contract. Such initial report shall cover a period of no less than nine (9) months, ending March 31 of that year. Subsequent reports shall cover 12 months ending on March 31 of that year.
- 8.6.4.1 Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization, is an attestation standard developed by the AICPA which is required for such auditors' reports for periods ending on or after June 15th of each year.

8.6.4.2 For more information on the AICPA's "Statement on Standards for Attestation Engagements No. 16, Reporting on Controls at a Service Organization," Contractor may refer to this AICPA website:
<http://www.aicpa.org/News/FeaturedNews/Pages/SASNo70Transfirmed%E2%80%93ChangesAheadforStandardonServiceOrganizations.aspx>

8.6.4.3 The audit shall be conducted by an independent auditing firm, which has SSAE No. 16 audit experience. The auditor must meet all AICPA standards for independence. The selection of, and contract with the independent auditor shall be subject to the approval of DCH and the State Auditor. Since such audits are not intended to fully satisfy all auditing requirements of DCH, the State Auditor reserves the right to fully and completely audit at their discretion the Contractor's operations, including all aspects, which will have effect upon the DCH account, either on an interim audit basis or at the end of the State's fiscal year. DCH also reserves the right to designate other auditors or reviewers to examine the Contractor's operations and records for monitoring and/or stewardship purposes.

8.6.4.4 The independent auditing firm shall simultaneously deliver identical reports of its findings and recommendations to the Contractor and DCH within forty-five (45) Calendar Days after the close of each review period. The audit shall be conducted and the report shall be prepared in accordance with generally accepted auditing standards for such audits as defined in the publications of the AICPA, entitled Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization.

8.6.4.5 The Contractor shall respond to the audit findings and recommendations within thirty (30) Calendar Days of receipt of the audit and shall submit an acceptable proposed corrective action to DCH. The Contractor shall implement the Corrective Action Plan within forty (40) Calendar Days of its approval by DCH. Such response shall address, at minimum, any opinion other than a clean opinion; any testing exception; and any other exception, deficiency, weakness, opportunity for improvement, or recommendation reported by the independent auditor.

8.6.5 The Contractor shall submit to DCH and the US Department of Health and Human Services a "Disclosure of Ownership and Control Interest Statement".

8.6.5.1 The Contractor shall disclose to DCH full and complete information regarding ownership, financial transactions and

persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including 42 CFR §455.104.

8.6.5.2 The Contractor (including its Subcontractors) shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The Contractor shall screen their employees and contractors initially and on an ongoing quarterly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to the DCH on a monthly basis. The word “contractors” in this Section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.

8.6.5.3 Definition of A Party in Interest – As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

8.6.5.3.1 Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or Member of such corporation under applicable State corporation law;

8.6.5.3.2 Any organization in which a person as described in the above Section is a director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;

8.6.5.3.3 Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or

8.6.5.3.4 Any spouse, child, or parent of an individual as described in section 8.6.5.1.

8.6.5.4 The Contractor shall disclose the name and address of each person with an ownership or control interest in the disclosing entity or in any Provider, Subcontractor or Contractor's fiscal agent of the Contractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. In the case of an individual, it shall include date of birth and Social Security Number.

8.6.5.5 The Contractor shall disclose the identity including the name, address, date of birth, and Social Security Number of any Provider or Subcontractor with whom the Contractor has had significant business transactions, defined as those totaling more than twenty-five thousand dollars (\$25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the Contractor, any wholly owned supplier, or between the Contractor and any Provider or Subcontractor, during the five (5) year period ending on the date of the disclosure.

8.6.5.6 The Contractor shall disclose the identity of any person who has an ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs.

8.6.5.7 Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

8.6.5.7.1 Any sale, exchange or lease of any property between the Contractor and a party in interest;

8.6.5.7.2 Any lending of money or other extension of credit between the Contractor and a party in interest; and

8.6.5.7.3 Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

8.6.5.8 The information which must be disclosed in the transactions listed in Section 8.6.5.7 between the Contractor and a party of interest includes:

8.6.5.8.1 The name of the party in interest for each transaction;

8.6.5.8.2 A description of each transaction and the quantity or units involved;

8.6.5.8.3 The accrued dollar value of each transaction during the fiscal year; and

8.6.5.8.4 Justification of the reasonableness of each transaction.

8.6.5.9 All information regarding ownership and financial transactions which must be disclosed by the Contractor pursuant to Section 8.6.5 is due at any of the following times:

8.6.5.9.1 Upon the Contractor submitting the Contractor Proposal in accordance with the State's procurement process;

8.6.5.9.2 Upon the Contractor executing this Contract with the State;

8.6.5.9.3 Upon renewal or extension of this Contract;

8.6.5.9.4 Within thirty (35) Calendar Days after any change in ownership; and

8.6.5.9.5 At least once every quarter, if so requested by DCH.

8.6.6 The Contractor shall submit all necessary reports, documentation, to DOI as required by State law, which may include, but is not limited to the following:

8.6.6.1 Pursuant to State law and regulations, an annual report on the form prescribed by the National Association of Insurance Commissioners (NAIC) for HMOs, on or before March 1 of each calendar year.

8.6.6.2 An annual income statement detailing the Contractor's fourth quarter and year to date earned revenue and incurred expenses as a result of this Contract on or before March 1 of each year. This annual income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and a reconciliation of the Medical Loss Ratio report to the annual NAIC filing on an accrual basis.

- 8.6.6.3 Pursuant to state law and regulations, a quarterly report on the form prescribed by the NAIC for HMOs filed on or before May 15 for the first quarter of the year, August 15 for the second quarter of the year, and November 15, for the third quarter of the year.
- 8.6.6.4 A quarterly income statement detailing the Contractor's quarterly and year to date earned revenue and incurred expenses because of this Contract filed on or before May 15, for the first quarter of the year, August 15, for the second quarter of the year, and November 15, for the third quarter of the year. Each quarterly income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and reconciliation of the Medical Loss Ratio report to the quarterly NAIC filing on an accrual basis.
- 8.6.6.5 An annual independent audit of its business transactions to be performed by a licensed and certified public accountant, in accordance with NAIC Annual Statement Instructions regarding the Annual Audited Financial Report, including but not limited to the financial transactions made under this Contract.
- 8.6.7 The Contractor shall submit all necessary reports, documentation, to the Department of Revenue as required by State law, which may include, but is not limited to the following for Unclaimed Property Reports:
- 8.6.7.1 Pursuant to State law and regulations, an annual report on the form prescribed by the Georgia Department of Revenue for Unclaimed Property Reports for all Insurance Companies is due on or before May 1 of each calendar year.

9.0 FUNDING

Notwithstanding any other provision of this Contract, the Parties acknowledge that institutions of the State of Georgia are prohibited from pledging the credit of the State. At the sole discretion of DCH, this Contract shall immediately terminate without further obligation of the State if the source of payment for DCH's obligation, including but not limited to state appropriations and/or federal grant funding, no longer exists or is insufficient. The certification by DCH of the events stated above shall be conclusive and not subject to appeal.

10.0 PAYMENT OF TAXES

- 10.1 Contractor will forthwith pay all taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. DCH makes no representation whatsoever as to the liability or exemption from liability of Contractor to any tax imposed by any governmental entity.
- 10.2 Furthermore, Contractor shall be responsible for payment of all expenses related to, based on, or arising from salaries, benefits, employment taxes (whether State

or Federal) and insurance (whether health, disability, personal, or retirement) for its employees, designees, or assignees.

11.0 RELATIONSHIP OF PARTIES

Neither Party is an agent, employee, assignee or servant of the other. It is expressly agreed that Contractor and any Subcontractors and agents, officers, and employees of Contractor or Subcontractor or agent in the performance of this Contract shall act as independent contractors and not as officers or employees of DCH. DCH shall not be responsible for withholding taxes with respect to the Contractor's compensation hereunder. The Parties acknowledge, and agree, that the Contractor, its agents, Subcontractors, employees, and servants shall in no way hold themselves out as agents, employees, or servants of DCH. The parties also agree that the Contractor, its agents, Subcontractors, employees, and servants shall have no claim against DCH hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and DCH.

12.0 INSPECTION OF WORK

12.1 DCH, the State Department of Audits and Accounts, the U.S. Department of Health and Human Services, the General Accounting Office and the Comptroller General of the United States, if applicable, or their authorized representatives, shall have the right to enter into the premises of Contractor and/or all Subcontractors, or such other places where duties under this Contract are being performed for DCH in order to inspect, monitor or otherwise evaluate the services or any work performed pursuant to this Contract. Contractor shall bear all costs associated with inspections and evaluations of work. All inspections and evaluations of work being performed shall be conducted with prior notice and during normal business hours and performed in such a manner as will not unduly delay work.

12.2 Contractor agrees to sign and comply with **Attachment C, *Non-Profit Organization Disclosure Form***.

13.0 STATE PROPERTY

13.1 Contractor agrees that any materials, reports, analyses, compilations of data or other Deliverables that are furnished to DCH in accordance with the terms of this Contract, shall be the property of DCH upon submission of such materials to DCH, for whatever use that DCH deems appropriate. Contractor further agrees to execute any and all documents, or to take any additional actions that may be necessary in the future to effectuate this provision fully. In particular, if the work product or services include the taking of photographs or videotapes of individuals, Contractor must obtain the written consent from such individuals authorizing the

use by DCH of such photographs, videotapes, and names in conjunction with such use. Contractor shall also obtain necessary written releases from such individuals, releasing DCH from any and all damages, claims or demands arising from such use.

- 13.2 All information received by DCH and prepared or maintained on behalf of DCH, including but not limited to all handwritten and electronic documents, papers, letters, emails, maps, books, tapes, photographs, policies, procedures, notes, computer based or generated information, or similar material, is subject to the Open Records Act of Georgia (O.C.G.A. § 50-18-70 et seq.) (hereinafter “ORA”) and open to public inspection. If Contractor claims that any portion of its material submitted to DCH at any time and for any purpose is a proprietary trade secret, Contractor must clearly identify at the time of submission those portions of the material. In addition, Contractor is required to submit an affidavit which meets the requirements of O.C.G.A. § 50-18-72(a)(34) setting forth any and all trade secret claims. Material submitted to DCH that is not designated as a trade secret is subject to disclosure under the ORA. Information that is designated as a trade secret will not be disclosed under the ORA without (1) a determination by DCH’s Office of General Counsel that the information is not a trade secret; and (2) prior notification of Contractor that DCH intends to disclose the information, which notification will enable Contractor to seek legal protection of the information. If DCH determines that information submitted by Contractor is a trade secret and must not be disclosed by DCH as required herein, DCH shall use commercially reasonable efforts to hold such information in confidence.
- 13.3 The Contractor shall be responsible for the proper custody and care of any State-owned property furnished for the Contractor’s use in connection with the performance of this Contract. The Contractor will also reimburse DCH for its loss or damage, normal wear and tear excepted, while such property is in the Contractor’s custody or use.

14.0 OWNERSHIP AND USE OF DATA; RELATED MATTERS

14.1 OWNERSHIP AND USE OF DATA

- 14.1.1 All data created from information, documents, messages (verbal or electronic), reports, or meetings involving or arising out of this Contract is owned by DCH (hereafter referred to as “DCH Data”). The Contractor is expressly prohibited from sharing or publishing DCH Data or any information relating to Medicaid, PeachCare for Kids, or P4HB data without the prior written consent of DCH. In the event of a dispute regarding what is or is not DCH Data, DCH’s decision on this matter shall be final and not subject to Appeal.
- 14.1.2 If DCH consents to the publication of its Data by Contractor, Contractor shall display the following statement within the publication in a clear and conspicuous manner:

"This publication is made possible by the Georgia Department of Community Health (DCH) through a contract managed by (Contractor's name). Neither DCH or (Contractor's name) is responsible for any misuse or copyright infringement with respect to the publication."

- 14.1.3 The statement shall not be considered clear and conspicuous if it is difficult to read or hear, or if the placement is easily overlooked.

14.2 SOFTWARE AND OTHER UPGRADES

- 14.2.1 The Parties also understand and agree that any upgrades or enhancements to software programs, hardware, or other equipment, whether electronic or physical, shall be made at the Contractor's expense only, unless the upgrade or enhancement is made at the Department's request and solely for the Department's use exclusive of the deliverables contemplated by this Contract. Any upgrades or enhancements requested by and made for the Department's sole use shall become the Department's property without exception or limitation. The Contractor agrees that it will facilitate the Department's use of such upgrade or enhancement and cooperate in the transfer of ownership, installation, and operation by the Department.

14.3 INFRINGEMENT AND MISAPPROPRIATION

- 14.3.1 The Contractor warrants that all Deliverables provided by the Contractor do not and will not infringe or misappropriate any right of any third party based on copyright, patent, trade secret, or other intellectual property rights. In case the Deliverables or any one or part thereof is held or alleged to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to the Contractor to be likely to be brought, the Contractor will, at its own expense, either:

14.3.1.1 Procure for the Department the right to continue using the Deliverables; or

14.3.1.2 Modify or replace the Deliverables to comply with the Specifications so that no violation of any intellectual property right occurs.

- 14.3.2 If Contractor fails to comply with the terms and conditions set forth in this Section, DCH shall have the option to terminate the Contract.

14.4 CUSTOMIZATION

- 14.4.1 If the Department requests specific customization of software programs, hardware, or other equipment, whether electronic or physical after the

initial term of this Contract begins, the Contractor shall promptly make the requested change or modification at no cost to the Department.

14.5 SYSTEM CHANGES

- 14.5.1 All system changes required to comply, enable, and operate data transfers pursuant to this Contract shall be enabled, completed, and operated at no cost to DCH.
- 14.5.2 The Parties agree that the required system changes are not complete until they are fully implemented, tested and approved by DCH prior to the live date. In any event, DCH's determination on whether the system changes are complete and satisfactory shall be conclusive and final, subject to Section 30.

14.6 BUSINESS CONTINUITY AND DISASTER RECOVERY

- 14.6.1 Contractor shall provide and maintain for the life of the Contract a detailed Business Continuity and Disaster Recovery (BC-DR) Plan that will be implemented in the event that Contractor's facility experiences a disaster (for example, power outages, computer virus infections, natural disaster, etc.) that impacts fulfilling the requirements of this Contract. The BC-DR Plan shall include the following:
 - 14.6.1.1 Notification process;
 - 14.6.1.2 Identification of the Contractor's disaster recovery location and equipment;
 - 14.6.1.3 Testing frequency of the plan; and
 - 14.6.1.4 Step-by-step explanation of the backup and recovery procedures of services, which must include the number of hours to complete each step within a twelve (12) hour period.
- 14.6.2 Contractor shall submit an updated BC-DR Plan within thirty (30) Calendar Days of notification of Contract renewal.
- 14.6.3 DCH, federal auditors, or the State Auditor, reserves the right to conduct a site visit of the Contractor's disaster recovery location with one (1) day prior notice.
- 14.6.4 Contractor shall conduct an annual Disaster Recovery Plan Review and exercise/drill at the Contractor's own expense. The review must test all components of the Contractor's operation, including services provided by any third parties. A written report of the findings must be delivered to DCH within fifteen (15) Calendar Days of the date that the test is conducted. The Contractor must develop a written CAP for any

deficiencies noted in the test and must thoroughly re-test until satisfactory results are achieved and maintained.

14.6.5 This Section shall survive termination of this Contract for any reason.

14.7 DISCHARGE OF LIENS

14.7.1 The Contractor shall immediately discharge or cause to be discharged any lien or right in lien of any kind, other than in favor of DCH, which at any time exists or arises in connection with work done or equipment or other instrumentality furnished under this Contract. If any such lien or right in lien is not immediately discharged, DCH may discharge or cause to be discharged such lien or right at the expense of the Contractor.

15.0 OWNERSHIP AND USE OF INTELLECTUAL PROPERTY

15.1 OWNERSHIP OF INVENTIONS AND WORKS OF AUTHORSHIP

15.1.1 DCH shall own any Inventions or Works of Authorship that may be (i) made by Contractor personnel in the course of performance of this Contract and relate to Contractor's Technology or (ii) made by DCH personnel.

15.2 SOFTWARE AND OWNERSHIP RIGHTS

15.2.1 The Parties specifically agree that the rights to any Proprietary Software licensed or developed by Contractor pursuant to this Contract shall rest and remain with Contractor, subject to the License. During the term of this Contract, Contractor hereby grants DCH a nonexclusive, term license to use any Proprietary Software owned or sublicensed to DCH by Contractor. In the event of termination of this Contract, a nonexclusive and irrevocable license to use any Proprietary Software necessary and appropriate to DCH business continuity shall be issued to DCH by Contractor at a cost equivalent to the cost paid by DCH during the term of the Contract for the License.

16.0 CONTRACTOR STAFFING

The Contractor shall demonstrate to DCH's satisfaction that it has the necessary staffing, by function and qualifications, to fulfill its obligations as described in this Scope of Work. In addition, the Contractor shall have adequate infrastructure, organization, management and systems in place to carry out the requirements of the GF 360° Program. The Contractor shall provide a detailed listing of contact information for all of its Material Subcontractors, including a description of the Subcontractor's organization and the responsibilities that are delegated to the Subcontractor. The Contractor will not contract with or permit the

performance of any work or services by Material Subcontractors without prior written consent of DCH.

16.1 STAFFING ASSIGNMENTS AND CREDENTIALS

- 16.1.1 The Contractor warrants and represents that all persons, including Subcontractors, independent contractors and consultants assigned by it to perform this Contract, shall be employees or formal agents of the Contractor and shall have the credentials necessary (i.e., licensed, and bonded, as required) to perform the work required herein; failure to notify DCH of replacement of Subcontractors will be considered breach of contract. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work hereunder. The Contractor also agrees that DCH may approve or disapprove the Contractor's Subcontractors or its staff assigned to this Contract prior to the proposed staff assignment. DCH's decision on this matter shall not be subject to Appeal.
- 16.1.2 The Contractor shall ensure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice. On at least an annual basis, the CMO and its Subcontractors will verify that staff has a current license that is in good standing and will provide a list to DCH of licensed staff and current licensure status.
- 16.1.3 In addition, the Contractor warrants that all persons assigned by it to perform work under this Contract shall be employees or authorized Subcontractors of the Contractor and shall be fully qualified, as required in the RFP and specified in the Contractor's Proposal and in this Contract, to perform the services required herein. Personnel commitments made in the Contractor's Proposal shall not be changed unless approved by DCH in writing. Staffing will include the named individuals at the levels of effort proposed.
- 16.1.4 The Contractor shall provide and maintain sufficient qualified personnel and staffing to enable the Deliverables to be provided in accordance with the RFP, the Contractor's Proposal and this Contract. The Contractor shall submit to DCH a detailed staffing plan within thirty (30) Calendar Days of the Contract Effective Date which includes plans to fill any staffing needs to have a sufficient level of support during the Implementation Phase and after the Operational Start Date. Such staffing plan must include a timetable for filling all staffing position(s) after the Contract Effective Date. The Contractor must provide DCH with resumes of Key Staff, reporting responsibilities, Contractor staff to Member ratios and an organizational chart during the Implementation Phase with updates provided to DCH within two (2) Business Days of any changes or vacancies. The staffing must include the employees and management for all CMO functions.

- 16.1.5 At a minimum, the Contractor shall provide the following Key Staff:
- 16.1.5.1 A dedicated project manager to lead program implementation and facilitate ongoing operations. The CMO Project Manager must be stationed at the CMO's metropolitan Atlanta headquarters. The Project Manager must also be onsite at the DCH offices in Atlanta, Georgia at times specified by DCH during the planning, implementation and deployment phases of the Contract.
 - 16.1.5.2 An Executive Administrator who is a full-time administrator with clear authority over the general administration and implementation of the requirements detailed in this Contract.
 - 16.1.5.3 A Medical Director who is a licensed physician in the State of Georgia. The Medical Director shall be actively involved in all major clinical program components of the CMO, shall be responsible for the sufficiency and supervision of the Provider network, and shall ensure compliance with federal, State and local reporting laws on communicable diseases, child abuse, neglect, etc. The Medical Director must approve all clinical and quality reports submitted by the Contractor to DCH.
 - 16.1.5.4 A Quality Improvement Director with appropriate education, training and licensure, if applicable. The Quality Improvement Director shall possess or obtain within six (6) months of hire, training in one or more of the following areas:
 - 16.1.5.4.1 Strategic planning
 - 16.1.5.4.2 Six Sigma Certification
 - 16.1.5.4.3 Lean Six Sigma Certification
 - 16.1.5.4.4 Plan-Do-Study-Act Cycle
 - 16.1.5.4.5 Rapid Cycle Improvement
 - 16.1.5.5 A Chief Financial Officer who oversees all budget and accounting systems.
 - 16.1.5.6 A Strategic Planner to support clinical quality improvement.
 - 16.1.5.7 Utilization Management Director
 - 16.1.5.8 An Information Management and Systems Director and a complement of technical analysts and business analysts as needed

to maintain the operations of Contractor Systems and to address System issues in accordance with the terms of this Contract.

- 16.1.5.9 Pharmacist who is licensed in the State of Georgia.
- 16.1.5.10 A Dental Consultant who is a licensed dentist in the State of Georgia.
- 16.1.5.11 Mental Health Coordinator who is a licensed mental health professional in the State of Georgia.
- 16.1.5.12 A Member Services Director.
- 16.1.5.13 A Provider Services Director.
- 16.1.5.14 A Provider Relations Liaison.
- 16.1.5.15 A Grievance/Complaint Coordinator.
- 16.1.5.16 Compliance Officer.
- 16.1.5.17 A Prior Authorization/Pre-Certification Coordinator who is a physician, registered nurse, or physician's assistant licensed in the State of Georgia.
- 16.1.5.18 Sufficient staff in all departments, including but not limited to, Member services, Provider services, and prior authorization and concurrent review services to ensure appropriate functioning in all areas.
- 16.1.5.19 Hospital-based care managers whose responsibilities include visiting with patients and interacting with hospital staff to ensure proper utilization and Discharge Planning.
- 16.1.5.20 Staff trained in the System of Care approach to service delivery.
- 16.1.5.21 Ombudsman Staff including an Ombudsman Liaison and Ombudsman Coordinator. The Contractor must consider and monitor current Enrollment levels when evaluating the number of Ombudsman staff necessary to meet Member needs. The Ombudsmen staff is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to health care services, and communication and education of Members and Providers.

- 16.1.6 The Contractor shall comply with all staffing/personnel obligations set out in the RFP and this Contract, including but not limited to those pertaining to security, health, and safety issues.
- 16.1.7 The Contractor shall provide the DCH Project Leader with a staff roster every ninety (90) days during the Term of the Contract. This roster shall set forth the names, titles, and physical location of all members of Contractor's staff (including Subcontractor and Contractor affiliates), their areas of assignment and the number of hours they are required to work.

16.2 STAFFING CHANGES

- 16.2.1 DCH may reject any proposed changes in Key staff and may require the removal or reassignment of any Contractor employee or subcontractor employee that the Department deems to be unacceptable in the exercise of its reasonable judgment. The Department's decision on this matter shall be final.
- 16.2.2 Notwithstanding the above provisions, the Parties acknowledge and agree that the Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law. In the event of Contractor termination of any Key staff, Contractor will provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee with a person of equivalent training, experience, and talent within ten (10) Calendar Days of the termination.
- 16.2.3 The Contractor shall notify DCH within five (5) Business Days, via written communication, prior to any changes to Key staff, including the Executive Administrator, Medical Director, Quality Improvement Director, Utilization Management Director, Management Information Systems Director, and Chief Financial Officer. The Contractor shall replace any of the Key staff with a person of equivalent experience, knowledge and talent. Within ten (10) Calendar Days of the termination, Contractor shall provide the DCH Project Leader with the resume of the proposed replacement and offer the DCH Project Leader, and/or his authorized representatives, the opportunity to interview that person. If the DCH Project Leader is not reasonably satisfied with the apparent skill and qualifications of the proposed replacement, he or she shall notify Contractor within ten (10) Calendar Days after receiving the resume or conducting the interview (whichever occurs last). Once that has occurred, the Contractor shall propose another replacement and the DCH Project Leader shall have the same right of approval. Such process shall be repeated until a proposed replacement is approved by the DCH Project Leader. If, after sixty (60) Calendar Days from the notice of termination, a qualified replacement is not approved, liquidated damages may be assessed against and imposed on Contractor.

- 16.2.4 DCH also may require the removal or reassignment of any Contractor employee or Subcontractor employee that DCH deems to be unacceptable. DCH's decision on this matter shall not be subject to Appeal. Notwithstanding the above provisions, the Parties acknowledge and agree that the Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law. In the event of Contractor termination of any key staff, the Contractor shall provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee.
- 16.2.5 The Contractor must submit to DCH quarterly the Contractor Information Report that includes but is not limited to the changes to Contractor's local staff information as well as local and corporate organizational charts.

16.3 CONTRACTOR'S FAILURE TO COMPLY

- 16.3.1 If DCH, in its sole discretion, determines that the Contractor's services and/or performance under the terms, conditions, and requirements of this Contract are insufficient, unacceptable, or unsatisfactory, the Contractor, after notice from DCH, agrees that it will make every attempt to remedy the deficiency within two (2) Business Days.
- 16.3.2 Should the Contractor at any time: 1) refuse or neglect to supply adequate and competent supervision; 2) refuse or fail to provide sufficient and properly skilled personnel, equipment, or materials of the proper quality or quantity; 3) fail to provide the services in accordance with the timeframes, schedule or dates set forth in this Contract; 4) fail in the performance of any term or condition contained in this Contract, 5) knowingly or unknowingly accept payment from DCH of an amount in excess of what it is owed at the time of the payment under the terms of this Contract, DCH may (in addition to any other contractual, legal or equitable remedies) proceed to take any one or more of the following actions after five (5) Calendar Days written notice to the Contractor:
- 16.3.2.1 Withhold any monies then or next due to the Contractor;
 - 16.3.2.2 Obtain the services or their equivalent from a third party, pay the third party for same, and withhold the amount so paid to third party from any money then or thereafter due to the Contractor;
 - 16.3.2.3 Withhold monies in the amount of any damage caused by any deficiency or delay in the services; or
 - 16.3.2.4 Any combination of the above.
- 16.3.3 In addition to the consequences indicated above, if it is determined that Contractor knowingly submitted any false statement, invoice or other

document to DCH, Contractor shall also be subject to the sanctions imposed by O.C.G.A. §16-10-20.

16.4 GEORGIA FAMILIES 360° STAFFING

- 16.4.1 The Contractor must comply with all requirements included in the RFP and this Contract. In addition, the following requirements apply to the GF 360° program.
- 16.4.2 Staff Training
- 16.4.2.1 The Contractor shall conduct ongoing staff training of staff to address the unique needs of the Members. Trainings shall include but are not limited to the following issues: the roles and responsibilities of the DCH, DFCS, DBHDD, DOE, DCH, DECAL and DJJ with regard to the Georgia Families 360° program and how DCH and partner agencies will coordinate with the Contractor; the Kenny A. Consent Decree; needs of the Members.
- 16.4.3 Care Coordination Teams
- 16.4.3.1 The Contractor shall develop a Care Coordination Team staffing plan and submit to DCH within thirty (30) Calendar Days of the Contract Effective Date. This staffing plan shall indicate how the Contractor will maintain adequate Contractor staff to Member ratios and number of Care Coordination personnel and management staff having expertise in physical health, Behavioral Health, and the Members to build Care Coordination Teams. Care Coordinators must be located Statewide in the areas in which they serve.
- 16.4.3.2 The Contractor must continue to assess the staff's ability to complete these functions in a timely nature, and will take corrective action as necessary and provide to DCH results of these assessments upon request.
- 16.4.3.3 The Contractor shall require Care Coordination Teams and any other staff positions that may have direct contact with Members or Member information to pass a background check as a condition of hire, and every two (2) years thereafter.
- 16.4.3.4 The Contractor's staff will not be placed in contact with Members, nor be permitted to co-locate in DFCS or DJJ offices or access Member information, until the Contractor has completed the initial background check and staff has passed the background check. The Contractor shall ensure that all Contractor staff, who have not passed a background check or who are alleged to have committed a criminal offense that would prohibit him or her from having

contact with Members or accessing their information, are not permitted to work with Members or have access to their information.

16.4.3.5 The Contractor will build individual Care Coordination Teams for Members based on their specific needs and will assign the Care Coordination Team within one (1) Business Day of enrollment. The Care Coordination Team will be updated as necessary as determined by the Member's Health Care Service Plan. The Contractor staff available to participate in Care Coordination Teams shall include at a minimum:

- 16.4.3.5.1 Masters level licensed social worker or counselor;
- 16.4.3.5.2 Nurse Care Manager (NCM) to assist Members identified through the health assessments;
- 16.4.3.5.3 Members with Special Health Care Needs;
- 16.4.3.5.4 Behavioral Health Specialist with at least five (5) years of Behavioral Health experience;
- 16.4.3.5.5 Family Peer Support Specialist;
- 16.4.3.5.6 Youth Peer Support Specialist; and
- 16.4.3.5.7 Care Coordinator.

16.4.3.6 The Care Coordination Team shall involve and include the preferences of the Member and the family (Adoptive Parent(s), Foster Care Parent(s), Caregiver and/or biological family members as indicated by DFCS or DJJ) in Care Coordination processes, care planning, and care plan implementation in adherence to System of Care youth- and family-driven principles.

16.4.3.7 The Contractor shall develop transition policies and procedures, including the guidelines it will use to identify Members with Special Health Care Needs requiring priority coordination and care, within ninety (90) Calendar Days of the Operations Start Date.

16.4.4 Ombudsman Staff

16.4.4.1 The Contractor must offer Members an Ombudsmen Liaison and Ombudsmen Coordinator during the entire Contract term.

16.4.4.2 The Contractor must have at a minimum one (1) Ombudsman Liaison and one (1) Ombudsman Coordinator. The Contractor

must consider and monitor current enrollment levels when evaluating the number of Ombudsman staff necessary to meet Member needs. The Contractor must also at least annually evaluate the Ombudsman positions, work plan(s) and job duties, and allocate an additional FTE Ombudsmen position or positions to meet Ombudsmen duties based on increases in the number of Members.

16.4.4.3 The Ombudsmen Liaison is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to health care services, and communication and education for the Members, Providers, Caregivers, Foster and Adoptive Parents, State agencies and Residential Placement Providers. The Contractor shall provide monthly detailed reports on activities associated with the CMO's responsibilities.

16.4.4.4 To meet the requirements for the Ombudsman Liaison position statewide, DCH encourages the Contractor to contract or have a formal memorandum of understanding for advocacy and/or translation services with associations or organizations that have culturally diverse populations within the Contractor service area. However, the Contractor has primary responsibility for the Ombudsman Liaison positions. The Contractor must monitor the effectiveness of the associations and agencies under contract and may alter the contract(s) with written notification to the Department.

16.4.4.5 The Ombudsman Liaison must be knowledgeable and have experience working with the GF 360° population, and shall have adequate time to advocate for Members. Responsibilities of the CMO Ombudsman staff shall include:

16.4.4.5.1 Investigate and resolve access and cultural sensitivity issues identified by Contractor staff, State agency staff, providers, advocating organizations, Members, Foster Parents, Adoptive Parents, Caregivers and Residential Placement Providers;

16.4.4.5.2 Monitor complaints to identify trends or specific problem areas of access and care delivery;

16.4.4.5.3 Recommend policy and procedural changes to Contractor needed to improve Member access to care; and

16.4.4.5.4 Provide ongoing input to the Contractor on how changes in the Provider network will affect Members' access to medical care and continuity of care.

17.0 **CRIMINAL BACKGROUND, EXCLUSIONS, AND DEBARMENT**

17.1 The Contractor further agrees that it will not permit any of its employees or its Subcontractor's employees, including temporary or replacement employees, to perform the services under this Contract unless and until they pass any background test or check requested by the Department.

17.2 The Contractor also agrees to abide by 42 USCS § 1320a-7 and all other related provisions or laws. To that end, the Contractor shall not employ or use any company, entity, or individual that is on the Federal Exclusions List or any company, entity, or individual subject to 42 USCS § 1320a-7.

17.3 By signing or executing this Contract, the Contractor states and certifies that it is in compliance with and that it will continue to comply with the Anti-Kickback Act of 1986, 41 USCS § 51-58, and Federal Acquisition Regulation 52.203-7.

17.4 Additionally, by signing or executing this Contract, the Contractor states and certifies that neither it nor any of its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any State or Federal department or agency.

17.5 Contractor agrees to sign and comply with **Attachment B, Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters.**

18.0 **SUBCONTRACTS**

18.1 **USE OF SUBCONTRACTORS**

18.1.1 The Contractor will not subcontract or permit anyone other than Contractor personnel to perform any of the work, services, or other performance required of the Contractor under this Contract, or assign any of its rights or obligations hereunder, without the prior written consent of DCH. Prior to hiring or entering into an agreement with any Subcontractor, any and all Subcontractors and Subcontracts shall be approved by DCH. DCH must also approve any replacement Subcontractors in the same manner. Upon request from DCH, the Contractor shall provide in writing the names of all proposed or actual Subcontractors. DCH reserves the right to reject any or all Subcontractors that, in the judgment of DCH, lack the skill, experience, or record of satisfactory performance to perform the work specified herein.

18.1.2 Contractor is solely responsible for all work contemplated and required by this Contract, whether Contractor performs the work directly or through a Subcontractor. No subcontract will be approved which would relieve Contractor or its sureties of their responsibilities under this Contract. In

addition, DCH reserves the right to terminate this Contract if Contractor fails to notify DCH in accordance with the terms of this paragraph.

- 18.1.3 All contracts between the Contractor and Subcontractors must be in writing and must specify the activities and responsibilities delegated to the Subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. DCH reserves the right to inspect all subcontract agreements at any time during the Contract period.
- 18.1.4 All contracts entered into between Contractor and any Subcontractor related to this Contract must contain provisions which require Contractor to monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to formal review according to a schedule established by DCH and consistent with industry standards or State laws and regulations. Contractor shall identify any deficiencies or areas for improvement related to any Subcontractor's performance related to this Contract, and upon request from DCH, provide evidence that corrective action has been taken to address the deficiency.
- 18.1.5 For any subcontract, there must be a designated project manager who is a member of the Subcontractor's staff that is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The subcontract agreement must contain a provision which requires the Contractor and its Subcontractors to seek binding arbitration to resolve any dispute between those parties and to provide DCH with written notice of the dispute.
- 18.1.6 Contractor shall give DCH immediate notice in writing by registered mail or certified mail of any action or suit filed by any Subcontractor and prompt notice of any Claim made against the Contractor by any Subcontractor or vendor that, in the opinion of Contractor, may result in litigation related in any way to this Contract.
- 18.1.7 All Subcontractors must fulfill the requirements of 42 CFR 438.6 as appropriate.
- 18.1.8 All Provider contracts shall comply with the requirements and provisions as set forth in Section 4.10 of this Contract.
- 18.1.9 The Contractor shall submit a Subcontractor Information and Monitoring Report to include, but is not limited to: Subcontractor name, services provided, effective date of the subcontracted agreement.
- 18.1.10 The Contractor shall submit to DCH a written notification of any subcontractor terminations at least ninety (90) days prior to the effective date of the termination.

18.2 COST OR PRICING BY SUBCONTRACTORS

- 18.2.1 Contractor shall submit, or shall require any Subcontractors hereunder to submit, cost or pricing data for any subcontract to this Contract prior to Contract Award. The Contractor shall also certify that the information submitted by the Subcontractor is, to the best of their knowledge and belief, accurate, complete and current as of the date of agreement, or the date of the negotiated price of the subcontract to the Contract or amendment to the Contract. The Contractor shall insert the substance of this Section in each subcontract hereunder.
- 18.2.2 If DCH determines that any price, including profit or fee negotiated in connection with this Contract, or any cost reimbursable under this Contract was increased by any significant sum because of the inaccurate cost or pricing data, then such price and cost shall be reduced accordingly and this Contract and the subcontract shall be modified in writing to reflect such reduction.

19.0 LICENSE, CERTIFICATE AND PERMIT REQUIREMENT

- 19.1 Contractor shall have, obtain, and maintain in good standing any licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits that may be necessary, upon DCH's request.
- 19.2 The Contractor warrants that it is qualified to do business in the State and is not prohibited by its articles of incorporation, bylaws, or other controlling documents relevant to Contractor's entity type, or any law of the State under which it is incorporated from performing the services under this Contract. The Contractor shall have and maintain a Certificate of Authority pursuant to O.C.G.A. §33-21-1 *et seq.*, and shall obtain and maintain in good standing any Georgia-licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Loss of the licenses, certificates, permits, or Certificate of Authority for health maintenance organizations shall be cause for termination of the Contract pursuant to Section 24 of this Contract. In the event the Certificate of Authority, or any other license or permit is canceled, revoked, suspended or expires during the term of this Contract, the Contractor shall inform the State immediately and cease all activities under this Contract, until further instruction from DCH. The Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits necessary upon request.
- 19.3 The Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) for MCO, URAC (Health Plan accreditation), Accreditation Association for Ambulatory Health Care (AAAHC) for MCO, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for MCO, or shall be actively seeking and working towards such accreditation. The Contractor

shall provide to DCH upon request any and all documents related to achieving such accreditation and DCH shall monitor the Contractor's progress towards accreditation. DCH may require that the Contractor achieve such accreditation by year three of this Contract.

- 19.4 The Contractor shall notify DCH within fifteen (15) Calendar Days of any accrediting organization noted deficiencies as well as any accreditations that have been rescinded by a recognized accrediting organization.
- 19.5 The Contractor warrants that there is no claim, legal action, counterclaim, suit, arbitration, governmental investigation or other legal, administrative, or tax proceeding, or any order, decree or judgment of any court, governmental agency, or arbitration tribunal that is in progress, pending, or threatened against or relating to Contractor or the assets of Contractor that would individually or in the aggregate have a material adverse effect on Contractor's ability to perform the obligations contemplated by this Contract. Without limiting the generality of the representation of the immediately preceding sentence, Contractor is not currently the subject of a voluntary or involuntary petition in bankruptcy, does not presently contemplate filing any such voluntary petition, and is not aware of any intention on the part of any other person, or entity, to file such an involuntary petition against it.

20.0 RISK OF LOSS AND REPRESENTATIONS

- 20.1 DCH takes no title to any of the Contractor's goods used in providing the services and/or Deliverables hereunder and the Contractor shall bear all risk of loss for any goods used in performing work pursuant to this Contract.
- 20.2 The Parties agree that DCH may reasonably rely upon the representations and certifications made by the Contractor, including those made by the Contractor in the Contractor's Proposal in response to the RFP and this Contract, without first making an independent investigation or verification.
- 20.3 The Parties also agree that DCH may reasonably rely upon any audit report, summary, analysis, certification, review, or work product that the Contractor produces in accordance with its duties under this Contract, without first making an independent investigation or verification.
- 20.4 By submitting a Deliverable, the Contractor represents that, to the best of its knowledge, it has performed the associated tasks in a manner, which will, in concert with other tasks, meet the objectives states or referred to in the Contract.
- 20.5 By unconditionally approving a Deliverable, DCH represents only that it has reviewed the Deliverable and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the withholding or denial of payment for the work completed. DCH's approval of a Deliverable does not discharge any of the Contractor's contractual obligations with respect to that Deliverable.

21.0 **PROHIBITION OF GRATUITIES AND LOBBYIST DISCLOSURES**

- 21.1 The Contractor, in the performance of this Contract, shall not offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of this Contract, and shall comply with the disclosure requirements set forth in O.C.G.A. § 45-1-6.
- 21.2 The Contractor also states and warrants that it has complied with all disclosure and registration requirements for vendor lobbyists as set forth in O.C.G.A. § 21-5-1, et seq. and all other applicable law, including but not limited to registering with the Georgia Government Transparency and Campaign Finance Commission. For the purposes of this Contract, vendor lobbyists are those who lobby State officials on behalf of businesses that seek a contract to sell goods or services to the State or oppose such contract.
- 21.3 As required by applicable Federal law, Contractor states and warrants that no federal money has been used for any lobbying of State officials, as required under applicable federal law.
- 21.4 Contractor agrees to sign and comply with **Attachment E, *Vendor Lobbyist Disclosure and Registration Certification Form***.

22.0 **RECORDS REQUIREMENTS**

The Contractor agrees to maintain books, records, documents, invoices, and any other evidence pertaining to the costs and expenses of this Contract and/or any document that is a part of this Contract by reference or inclusion. This includes, but is not limited to, Contractor's balance sheets, income statements and invoices from Subcontractors, Contractor's affiliates or other vendors. The Contractor's accounting procedures and practices shall conform to generally accepted accounting principles, and the costs properly applicable to the Contract shall be readily ascertainable therefrom. This includes, but is not limited to, payment (with respect to salary), overhead and Subcontractors.

22.1 **RECORDS RETENTION REQUIREMENTS**

- 22.1.1 The Contractor shall preserve and make available all of its records pertaining to the performance under this Contract for a period of seven (7) years from the date of final payment under this Contract, and for such period, if any, as is required by applicable statute or by any other section of this Contract. If the Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of seven (7) years from the date of termination or of any resulting final settlement. Records that relate to Appeals, litigation, or the settlements of Claims arising out of the performance of this Contract, or costs and expenses of any such agreements as to which exception has

been taken by the Contractor or any of its duly Authorized Representatives, shall be retained by Contractor until such Appeals, litigation, Claims or exceptions have been disposed of.

22.2 ACCESS TO RECORDS

22.2.1 The State and federal standards for audits of DCH agents, contractors, and programs are applicable to this section and are incorporated by reference into this Contract as though fully set out herein.

22.2.2 Pursuant to the requirements of 42 CFR 434.6(a)(5), the Contractor shall make all of its books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases available for examination and audit by DCH, the State Attorney General, the State Health Care Fraud Control Unit, the State Department of Audits and Accounts, and/or authorized State or federal personnel. Any records requested hereunder shall be produced immediately for review at DCH or sent to the requesting authority by mail within fourteen (14) Calendar Days following a request. All records shall be provided at the sole cost and expense of the Contractor. DCH shall have unlimited rights to access, use, disclose, and duplicate all information and data in any way relating to this Contract in accordance with applicable State and federal laws and regulations. DCH shall not be restricted in the number of times it may audit, visit, inspect, review or otherwise monitor Contractor and any Subcontractors during the term of this Contract. DCH will only conduct audits as determined reasonably necessary by the Department.

22.3 SUBPOENAS FOR RECORDS OR OTHER DOCUMENTS

The Department may issue subpoenas to Contractor, which require the Contractor or its agents (e.g. employees, subcontractors) to: produce and permit inspection and copying of designated books, papers, documents, or other tangible items; and/or attend and give testimony at a deposition or hearing. The Contractor agrees to comply with all subpoenas issued by the Department or parties acting on behalf of the Department. The Contractor understands that it is ultimately responsible for its agents' compliance with the subpoenas described herein.

22.4 FINANCIAL RECORDS

During the entire life of the Contract, the Contractor and all Subcontractors shall provide DCH with copies of its annual report and all disclosure or reporting statements or forms filed with the State of Georgia and/or the Securities and Exchange Commission (SEC) as soon as they are prepared in final form and are otherwise available for distribution or filing. In the event that the Contractor is not required to or does not prepare either an annual report or SEC disclosure or reporting statements or forms by virtue of being a subsidiary of another corporation, it shall fulfill the requirements of this section, with respect to all such documents for any parent corporation, which reflect, report or include any of its

operations on any basis. In addition, upon the written request of the Program Manager, the Contractor and all Subcontractors shall furnish DCH with the most recent un-audited and audited copies of its current balance sheet within fourteen (14) Calendar Days of its receipt of such request.

22.5 INDEPENDENT SERVICE AUDITOR'S REPORT

At its discretion, DCH may request a third party be engaged to prepare an Independent Service Auditor's Report. This report would meet the standards articulated by the American Institute of Certified Public Accountants including, but not limited to, the Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization. Contractor shall bear the cost of obtaining the report. In addition, Contractor shall provide the Auditor with complete access to the records described in this Section.

22.6 MEDICAL RECORD REQUESTS

- 22.6.1 The Contractor shall ensure a copy of the Member's Medical Record is made available, without charge, upon the written request of the Member or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request.
- 22.6.2 The Contractor shall ensure that Medical Records are furnished at no cost to a new PCP, Out-of-Network Provider or other specialist, upon Member's request, no later than fourteen (14) Calendar Days following the written request.

23.0 CONFIDENTIALITY REQUIREMENTS

23.1 GENERAL CONFIDENTIALITY REQUIREMENTS

- 23.1.1 The Contractor shall treat all individually identifiable health information, including PHI and PII, that is obtained or viewed by its employees, agents, or authorized Subcontractors in the performance of this Contract as confidential information and shall not use any information so obtained, in any manner, except as may be necessary for the proper discharge of its obligations. Employees or authorized Subcontractors of the Contractor who have a reasonable need to know such information for purposes of performing their duties under this Contract shall use personal or patient information, provided such employees and/or Subcontractors have first signed an appropriate non-disclosure agreement that has been approved and maintained by DCH. The Contractor shall remove any person from performance of services hereunder upon notice that DCH reasonably believes that such person has failed to comply with the confidentiality obligations of this Contract. In such cases, Contractor shall replace such removed personnel in accordance with the staffing requirements of this Contract. DCH, the State Attorney General, federal officials as authorized by federal law or regulations, or the Authorized Representatives of these

parties shall have access to all confidential information in accordance with the requirements of State and federal laws and regulations.

23.2 HIPAA COMPLIANCE

23.2.1 Contractor warrants to DCH that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the HITECH Act, and all implementing regulations (together, the “HIPAA Privacy and Security Rules”). Upon the execution of this Contract and upon any material change in the HIPAA Privacy and Security Rules, Contractor must provide DCH with a written description of the policies and procedures used by it to achieve and maintain compliance with the HIPAA Privacy and Security Rules. These policies and procedures are subject to DCH approval.

23.2.2 The Contractor also agrees to assist DCH in its efforts to comply with the HIPAA Privacy and Security Rules, as amended from time to time. To that end, the Contractor will abide by any requirements mandated by the HIPAA Privacy and Security Rules or any other applicable laws in the course of this Contract. Contractor warrants that it will cooperate with DCH, including cooperation with DCH privacy officials and other compliance officers required by the HIPAA Privacy and Security Rules and all implementing regulations, in the course of performance of this Contract so that both parties will be in compliance with HIPAA. The Contractor also acknowledges that the HIPAA Privacy and Security Rules may require the Contractor and DCH to sign documents for compliance purposes, including but not limited to a Business Associate Agreement. Contractor further agrees to sign any other documents that may be required for compliance with the HIPAA Privacy and Security Rules and to abide by their terms and conditions. Contractor also agrees to abide by the terms and conditions of current DCH policies and procedures.

23.3 HIPAA PERFORMANCE GUARANTEE

23.3.1 Failure to achieve or maintain compliance with the requirements of the HIPAA Privacy and Security Rules, as amended from time to time, and with the DCH Business Associate Agreement will constitute failure to substantially perform and will result in the assessment of liquidated damages. These liquidated damages will be assessed in the amount of \$2,000.00 for each day the Contractor fails to achieve or maintain compliance. If DCH incurs penalties and/or fines as a result of Contractor’s non-compliance with the HIPAA Privacy and Security Rules, as amended from time to time, and Contractor indemnifies DCH as required by Section 26 of this Contract with respect to such penalties and/or fines, any liquidated damages due and payable at the time will be offset by the amount that the Contractor paid to indemnify the Department.

23.4 **ENHANCED PRIVACY AND SECURITY PROVISIONS OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (“ARRA”)**

23.4.1 The Contractor warrants that it will comply with all requirements of the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”), specifically related to improved privacy and security provisions. Contractor is subject to the provisions in effect as of the signing of the Act, and any provisions made effective during the term of this Contract, including increased penalties for HIPAA violations as contemplated in 42 U.S.C. §1320d et seq.

24.0 **TERMINATION OF CONTRACT**

24.1 **GENERAL PROVISIONS**

24.1.1 This Contract may terminate, or may be terminated in whole or in part by DCH for any or all of the following reasons:

- 24.1.1.1 Default by the Contractor, upon thirty (30) Calendar Days’ notice;
- 24.1.1.2 Convenience of DCH, upon thirty (30) Calendar Days’ notice;
- 24.1.1.3 Immediately, in the event of insolvency, Contract breach, or declaration of bankruptcy by the Contractor;
- 24.1.1.4 Determination by DCH that the instability of the Contractor’s financial condition threatens delivery of services and continued performance of Contractor’s responsibilities, upon five (5) Calendar Days’ notice; or
- 24.1.1.5 Immediately, when sufficient appropriated funds no longer exist for the payment of DCH's obligation under this Contract.

24.2 **TERMINATION BY DEFAULT**

24.2.1 In the event DCH determines that the Contractor has defaulted by failing to carry out the substantive terms of this Contract or failing to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act, DCH may terminate the Contract in addition to or in lieu of any other remedies set out in this Contract or available by law.

24.2.2 Prior to the termination of this Contract, DCH will:

- 24.2.2.1 Provide written notice of the intent to terminate at least thirty (30) Calendar Days prior to the termination date, the reason for the termination, and the time and place of a hearing to give the

Contractor an opportunity to Appeal the determination and/or cure the default;

24.2.2.2 Provide written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of the termination; and

24.2.2.3 For an affirming decision, give Members or the Contractor notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

24.3 TERMINATION FOR CONVENIENCE

DCH may terminate this Contract for convenience and without cause upon thirty (30) Calendar Days written notice. Termination for convenience shall not be a breach of the Contract by DCH. The Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by DCH.

24.4 TERMINATION FOR INSOLVENCY OR BANKRUPTCY

The Contractor's insolvency, or the Contractor's filing of a petition in bankruptcy, shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy, the Contractor shall immediately advise DCH. If DCH reasonably determines that the Contractor's financial condition is not sufficient to allow the Contractor to provide the services as described herein in the manner required by DCH, DCH may terminate this Contract in whole or in part, immediately or in stages. The Contractor's financial condition shall be presumed not sufficient to allow the Contractor to provide the services described herein, in the manner required by DCH if the Contractor cannot demonstrate to DCH's satisfaction that the Contractor has risk reserves and a minimum net worth sufficient to meet the statutory standards for licensed health care plans. The Contractor shall cover continuation of services to Members for the duration of period for which payment has been made, as well as for inpatient admissions up to Discharge.

24.5 TERMINATION FOR INSUFFICIENT FUNDING

In the event that federal and/or State funds to finance this Contract are insufficient or otherwise unavailable, DCH, at its sole discretion, may terminate the Contract immediately. DCH shall provide prompt written notice of such termination. Subject to the availability of funds, the Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the terminate date. The certification by DCH of the events stated above shall be conclusive and not subject to appeal.

24.6

TERMINATION PROCEDURES

- 24.6.1 DCH will issue a written notice of termination to the Contractor by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall cite the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective. Termination shall be effective at 11:59 p.m. EST on the termination date.
- 24.6.2 Upon receipt of notice of termination or on the date specified in the notice of termination and as directed by DCH, the Contractor shall:
- 24.6.2.1 Stop work under the Contract on the date and to the extent specified in the notice of termination;
 - 24.6.2.2 Place no further orders or Subcontract for materials, services, or facilities, except as may be necessary for completion of such portion of the work under the Contract as is not terminated;
 - 24.6.2.3 Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
 - 24.6.2.4 Assign to DCH, in the manner and to the extent directed by the DCH Contract Administrator, all of the right, title, and interest of Contractor under the orders or subcontracts so terminated, in which case DCH will have the right, at its discretion, to settle or pay any or all Claims arising out of the termination of such orders and Subcontracts;
 - 24.6.2.5 With the approval of the DCH Contract Administrator, settle all outstanding liabilities and all Claims arising out of such termination or orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of the Contract;
 - 24.6.2.6 Complete the performance of such part of the work as shall not have been terminated by the notice of termination;
 - 24.6.2.7 Take such action as may be necessary, or as the DCH Contract Administrator may direct, for the protection and preservation of any and all property or information related to the Contract that is in the possession of Contractor and in which DCH has or may acquire an interest;
 - 24.6.2.8 Promptly make available to DCH, or another CMO acting on behalf of DCH, any and all records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this

Contract in the format required by DCH. Such records shall be provided at no expense to DCH;

24.6.2.9 Promptly supply all information necessary to DCH, or another CMO acting on behalf of DCH, for reimbursement of any outstanding Claims at the time of termination; and

24.6.2.10 Submit a termination plan to DCH for review and approval that includes the following terms:

24.6.2.10.1 Maintain Claims processing functions as necessary for ten (10) consecutive months in order to complete adjudication of all Claims;

24.6.2.10.2 Comply with all duties and/or obligations incurred prior to the actual termination date of the Contract, including but not limited to, the Appeal process as described in Section 4.14;

24.6.2.10.3 File all Reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;

24.6.2.10.4 Ensure the efficient and orderly transition of Members from coverage under this Contract to coverage under any new arrangement developed by DCH in accordance with procedures set forth in Section 4.11.8;

24.6.2.10.5 Maintain the financial requirements, and insurance set forth in this Contract until DCH provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled; and

24.6.2.10.6 Submit Reports to DCH every thirty (30) Calendar Days detailing the Contractor's progress in completing its continuing obligations under this Contract until completion.

24.6.3 Upon completion of these continuing obligations, the Contractor shall submit a final report to DCH describing how the Contractor has completed its continuing obligations. DCH will advise, within twenty (20) Calendar Days of receipt of this report, if all of the Contractor's obligations are discharged. If DCH finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, then DCH will require the Contractor to submit a revised final report to DCH for approval.

24.7 TERMINATION CLAIMS

24.7.1 After receipt of a notice of termination, the Contractor shall submit to the DCH Contract Administrator any termination claim in the form, and with

the certification prescribed by, the DCH Contract Administrator. Such claim shall be submitted promptly but in no event later than ten (10) months from the effective date of termination. Upon failure of the Contractor to submit its termination claim within the time allowed, the DCH Contract Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the Contract, determine, on the basis of information available, the amount, if any, due to the Contractor by reason of the termination and shall thereupon cause to be paid to the Contractor the amount so determined.

- 24.7.2 Upon receipt of notice of termination, the Contractor shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this Contract or any other contract. Upon termination, the Contractor shall be paid in accordance with the following:
- 24.7.2.1 At the Contract price(s) for completed Deliverables and/or services delivered to and accepted by DCH; and/or
- 24.7.2.2 At a price mutually agreed upon by the Contractor and DCH for partially completed Deliverables and/or services.
- 24.7.3 In the event the Contractor and DCH fail to agree in whole or in part as to the amounts with respect to costs to be paid to the Contractor in connection with the total or partial termination of work pursuant to this article, the provisions of Section 30 shall control.

25.0 DAMAGES/PERFORMANCE GUARANTEES

25.1 GENERAL PROVISIONS

- 25.1.1 The Contractor shall, at all times, comply with all terms, conditions, and performance requirements and expectations specified in the RFP, Contractor's Proposal, and this Contract. In the event that Contractor fails to meet the terms, conditions, or requirements of this Contract and said failure results in damages that can be measured in actual cost, DCH will assess the actual damages warranted by said failure.
- 25.1.2 Contractor acknowledges that its failure to: complete the tasks, activities, and responsibilities set forth in Sections 25.2, 25.3, 25.4, 25.5 and 25.6; and submit Deliverables specified by the deadlines required therein, will cause the DCH substantial damages of types and in amounts which are difficult or impossible to ascertain exactly. The Parties further acknowledge and agree that the specified liquidated damages in Sections 25.2, 25.3, 25.4, 25.5 and 25.6 are the result of a good faith effort by the Parties to estimate the actual harm caused by the Contractor's failure to meet the Performance Guarantees. Accordingly, Contractor agrees that DCH may assess liquidated damages against the Contractor for its failure

to meet the Performance Guarantees outlined in Sections 25.2, 25.3, 25.4, 25.5 and 25.6.

- 25.1.3 The Parties further acknowledge and agree that the liquidated damages referenced in Sections 25.2, 25.3, 25.4, 25.5 and 25.6 are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of DCH's projected financial loss and damage resulting from: the Contractor's nonperformance, including financial loss as a result of project delays, of the activities and responsibilities described in Sections 25.2, 25.3, 25.4, 25.5 and 25.6; or Contractor's failure to timely submit the deliverables described therein. Accordingly, Contractor agrees that DCH may assess liquidated damages against the Contractor for its failure to meet the Performance Guarantees outlines in Sections 25.2, 25.3, 25.4, 25.5 and 25.6.
- 25.1.4 Contractor acknowledges, affirms, ratifies, and agrees that the damage provisions set forth herein meet the criteria for enforceable damages that are reasonable, appropriate, and necessary. Liquidated damages shall be in addition to any other remedies that DCH may have. Accordingly, DCH reserves the right to seek all other reasonable and appropriate remedies available at law and in equity.
- 25.1.5 If the Contractor commits any of the violations or fails to meet the requirements set forth in Sections 25.2, 25.3, 25.4, 25.5 and 25.6, the Contractor shall submit a written CAP to DCH for review and approval prior to implementing the corrective action. All Corrective Action Plans must be submitted within the timeframe outlined in the Contract.
- 25.1.6 Contractor must agree to or provide evidence acceptable to DCH to challenge the reimbursement to the State for actual damages or the amounts set forth as liquidated damages within thirty (30) Calendar Days as further discussed in Section 25.1.7 below.
- 25.1.7 DCH will notify Contractor in writing of the proposed damage assessment. The amounts due to DCH as actual or liquidated damages may be deducted from any fees or other compensation payable to the Contractor or DCH may require the Contractor to remit the actual or liquidated damages within thirty (30) Calendar Days following the notice of assessment or resolution of any dispute at DCH's sole discretion. At DCH's option, DCH may obtain payment of assessed actual or liquidated damages through one (1) or more claims upon any irrevocable letter of credit furnished by the Contractor.
- 25.1.8 The Parties agree that disputes arising under this Section shall be handled through negotiations with DCH Vendor Management. The Contractor shall be allowed to appeal the decision of DCH Vendor Management to the Commissioner of DCH or his or her designee. Pending final

determination of any dispute, the Contractor shall proceed diligently with performance of the Contract and in accordance with the direction of DCH.

25.1.9 Imposition of liquidated damages will not relieve the Contractor from submitting the CAP and implementing the associated corrective action as determined by DCH.

25.1.10 Notwithstanding any sanction or liquidated damages imposed upon the Contractor other than Contract termination, the Contractor shall continue to administer all the associated corrective action as determined by DCH.

25.1.11 The venue for any formal legal proceedings shall lie in Fulton County, Georgia.

25.2 **CATEGORY 1**

25.2.1 Liquidated damages up to \$100,000.00 per day may be imposed for Category 1 events. For Category 1 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 1 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.2.1.1 Failure to “go live” by the implementation date of July 1, 2016; and

25.2.1.2 Failure to meet the readiness and/or annual review requirements, as specified in Section 2.13.

25.3 **CATEGORY 2**

25.3.1 Liquidated damages up to \$100,000 per violation may be imposed for Category 2 events. For Category 2 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 2 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.3.1.1 Acts that discriminate among Members on the basis of their health status or need for health care services;

25.3.1.2 Misrepresentation of information or false statements furnished to CMS or the State;

25.3.1.3 Failure to implement requirements stated in the Contractor’s Proposal, the RFP, this Contract, or other material failures in the Contractor’s duties;

- 25.3.1.4 Failure to provide an adequate provider network of physicians, pharmacies, hospitals, and other specified health care Providers in order to assure member access to all Covered Services;
- 25.3.1.5 Failure to achieve the Performance Target for each Quality Performance Measure as described in Section 4.12.3;
- 25.3.1.6 Failure to comply with the eighty percent (80%) screening ratio for periodic visits on the Contractor's CMS-416 EPSDT as described Section 4.7.3.9;
- 25.3.1.7 Failure to deliver effective Demonstration services as evidenced by lack of achievement of annual targeted LBW and VLBW reduction targets as identified in **Attachment M**;
- 25.3.1.8 Failure to achieve annual targeted reductions in the Pregnancy Rate as identified in **Attachment M**; and
- 25.3.1.9 Failure to fulfill duties to report Member abuse, neglect, or exploitation as a State Mandated Reported as defined by the Official Code of Georgia Annotated, as may be amended from time to time.

25.4 **CATEGORY 3**

- 25.4.1 Liquidated damages up to \$25,000 per violation may be imposed for Category 3 events. For Category 3 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 3 events are monitored by DCH to determine compliance and include the following:
 - 25.4.1.1 Substantial failure to provide Medically Necessary Services that the Contractor is required to provide under law, or under this Contract, to a Member covered under this Contract;
 - 25.4.1.2 Misrepresentation of information or false statements furnished to a Member, Potential Member, or health care Provider;
 - 25.4.1.3 Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;
 - 25.4.1.4 Distribution directly, or indirectly, through any Agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;

- 25.4.1.5 Violation of any other applicable requirements of Section 1903(m) or 1932 of the Social Security Act and any implementing regulations;
- 25.4.1.6 Failure of the Contractor to assume full operation of its duties under this Contract in accordance with the transition timeframes specified herein;
- 25.4.1.7 Imposition of premiums or charges on Members that are in excess of the premiums or charges permitted under the Medicaid program (the State will deduct the amount of the overcharge and return it to the affected Member);
- 25.4.1.8 Failure to resolve Member Appeals and Grievances within the timeframes specified in this Contract;
- 25.4.1.9 Failure to ensure client confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of noncompliance will be assessed as per member and/or per HIPAA regulatory violation;
- 25.4.1.10 Violation of a subcontracting requirement in the Contract; and
- 25.4.1.11 Failure to provide notice of any known or suspected conflicts of interest, as prescribed in Section 31, **Attachment P**, **Attachment Q** and **Attachment R**.

25.5

CATEGORY 4

- 25.5.1 Liquidated damages up to \$5,000.00 per day may be imposed for Category 4 events. For Category 4 events, a written Corrective Action Plan may be required and corrective action must be taken. In the case of Category 4 events, if corrective action is taken within four (4) Business Days, then liquidated damages may be waived at the discretion of DCH. Category 4 events are monitored by DCH to determine compliance and shall include the following:
 - 25.5.1.1 Failure to submit required Reports and Deliverables in the timeframes prescribed in Section 4.18 and Section 5.7;
 - 25.5.1.2 Submission of incorrect or deficient Deliverables or Reports as determined by DCH, including the submission of Deliverables or Reports in a format unacceptable to DCH;
 - 25.5.1.3 Failure to comply with the Claims processing standards as follows:
 - 25.5.1.3.1 Failure to process and finalize to a paid or denied status ninety-seven percent (97%) of all Clean Claims within fifteen (15) Business Days during a fiscal year; and

- 25.5.1.3.2 Failure to pay Providers interest at an eighteen percent (18%) annual rate, calculated daily for the full period during which a clean, unduplicated Claim is not adjudicated within the claims processing deadlines. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from 15 calendar days after the date the claim was submitted. A Contractor shall pay all interest required to be paid under this provision or O.C.G.A. Section 33-24-59.5 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the Contractor to the Provider. A Contractor shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic claims, a CMS Form 1500 for non-electronic claims, or any claim prescribed by DCH.
- 25.5.1.4 Failure to provide an initial visit within fourteen (14) Calendar Days for all newly enrolled women who are pregnant in accordance with Sections 4.6.9.1;
- 25.5.1.5 Failure to comply with the Notice of Proposed Action and Notice of Adverse Action requirements as described in Sections 4.14.3 and 4.14.5;
- 25.5.1.6 Failure to comply with any Corrective Action Plan as required by DCH;
- 25.5.1.7 Failure to seek, collect and/or report third party information as described in Section 8.4;
- 25.5.1.8 Failure to comply with the Contractor staffing requirements and/or any other conditions described in Sections 16.1 and 16.2;
- 25.5.1.9 Failure of Contractor to issue written notice to Members upon Provider's notice of termination in the Contractor's plan as described in Section 4.3.1.1.8;

- 25.5.1.10 Failure to comply with federal law regarding sterilizations, hysterectomies, and abortions and as described in Section 4.6.5;
- 25.5.1.11 Failure to submit acceptable Member and Provider directed materials or documents in a timely manner, i.e., member, handbooks, policies and procedures;
- 25.5.1.12 Failure to conduct and report in a timely manner the Medical and Trauma Assessments as set forth in Section 4.5.7.2;
- 25.5.1.13 Failure to comply with the required Demonstration Reports and Deliverables as prescribed in **Attachments L and M**;
- 25.5.1.14 Failure to conduct quarterly Validation of Provider demographic data and provide DCH with current and accurate data for all contracted Providers as described in Section 4.8.3.2; and
- 25.5.1.15 Failure to submit attestations for each Provider network report in the established DCH format with all required data elements as described in Section 4.8.3.3.

25.6 **CATEGORY 5**

- 25.6.1 Liquidated damages as specified below may be imposed for Category 5 events. Imposition of liquidated damages will not relieve the Contractor from submitting and implementing the Corrective Action Plan or corrective action as determined by DCH. Category 5 events are monitored by DCH to determine compliance and include the following:
 - 25.6.1.1 Failure to implement the business continuity-disaster recovery (BC-DR) plan as follows:
 - 25.6.1.1.1 Implementation of the (BC-DR) plan exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars (\$5,000) per day up to day 2;
 - 25.6.1.1.2 Implementation of the (BC-DR) plan exceeds the proposed time by more than (2) and up to five (5) Calendar Days: ten thousand dollars (\$10,000) per each day beginning with Day 3 and up to Day 5;
 - 25.6.1.1.3 Implementation of the (BC-DR) plan exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days, twenty-five thousand dollars (\$25,000) per day beginning with Day 6 and up to Day 10; and

- 25.6.1.1.4 Implementation of the (BC-DR) plan exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars (\$50,000) per each day beginning with Day 11.
- 25.6.1.2 Unscheduled System Unavailability (other than CCE and ECM functions described below) occurring during a continuous five (5) Calendar Day period, may be assessed as follows:
 - 25.6.1.2.1 Greater than or equal to two (2) and less than twelve (12) clock hours cumulative: up to one hundred twenty-five dollars (\$125) for each thirty (30) minutes or portions thereof;
 - 25.6.1.2.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to two hundred fifty dollars (\$250) for each thirty (30) minutes or portions thereof; and
 - 25.6.1.2.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to five hundred dollars (\$500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars (\$25,000) per occurrence.
- 25.6.1.3 Confirmation of CMO Enrollment (CCE) or Electronic Claims Management (ECM) system downtime. In any calendar week, penalties may be assessed as follows for downtime outside the State's control of any component of the CCE and ECM systems, such as the voice response system and PC software response system:
 - 25.6.1.3.1 Less than twelve (12) clock hours cumulative: up to two hundred fifty dollars (\$250) for each thirty (30) minutes or portions thereof;
 - 25.6.1.3.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to five hundred (\$500) for each thirty (30) minutes or portions thereof; and
 - 25.6.1.3.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to one thousand dollars (\$1,000) for each thirty (30) minutes or portions thereof up to a maximum of fifty thousand dollars (\$50,000) per occurrence.
- 25.6.1.4 Failure to make available to the State and/or its agent readable, valid extracts of Encounter Information for a specific month within fifteen (15) Calendar Days of the close of the month: five hundred dollars (\$500) per day. After fifteen (15) Calendar Days of the close of the month: two thousand dollars (\$2000) per day.

25.6.1.5 Failure to correct a system problem not resulting in System Unavailability within the allowed timeframe, where failure to complete was not due to the action or inaction on the part of DCH as documented in writing by the Contractor:

25.6.1.5.1 One (1) to fifteen (15) Calendar Days late: two hundred and fifty dollars (\$250) per Calendar Day for Days 1 through 15;

25.6.1.5.2 Sixteen (16) to thirty (30) Calendar Days late: five hundred dollars (\$500) per Calendar Day for Days 16 through 30; and

25.6.1.5.3 More than thirty (30) Calendar Days late: one thousand dollars (\$1,000) per Calendar Day for Days 31 and beyond.

25.6.1.6 Failure to meet the Telephone Hotline performance standards:

25.6.1.6.1 One thousand dollars (\$1,000) for each percentage point that is below the target answer rate of eighty percent (80%) in thirty (30) seconds;

25.6.1.6.2 One thousand (\$1,000) for each percentage point that is above the target of a one percent (1%) Blocked Call rate; and

25.6.1.6.3 One thousand (\$1,000) for each percentage point that is above the target of a five percent (5%) Abandoned Call rate.

25.6.1.7 Failure to make available to the State and/or its agent readable valid neonatal intensive care supplement payment reports for a specific month within fifteen (15) Calendar Days of the close of the month:

25.6.1.7.1 Five hundred dollars (\$500) per Calendar Day; and

25.6.1.7.2 Two thousand dollars (\$2,000) per Calendar Day after fifteen (15) Calendar Days of the close of the month.

25.6.1.9 Failure to have office space procured and operational by the Operational Start Date:

25.6.1.9.1 One thousand dollars (\$1,000) per Calendar Day

25.6.1.10 The Contractor shall ensure Member access to all covered benefits at all times. The Contractor shall be in full compliance with

geographic access standards and submit electronic provider network reporting demonstrating its full compliance with the Provider network requirements within ten (10) Calendar Days after receiving the initial Member file. The initial Member file will be delivered to the Contractor prior to the Operational Start Date.

25.6.1.10.1 .25% of the monthly Capitation Payment for failure to meet the requirements set forth in 25.6.1.10.

25.6.1.11 Failure to test and ensure the Information Systems are fully operational and meet all RFP and Contract requirements prior to the Operational Start Date:

25.6.1.11.1 Ten thousand dollars (\$10,000) per Calendar Day

25.7 OTHER REMEDIES

25.7.1 In addition to other liquidated damages described above for Category 1-4 events, DCH may impose the following other remedies in addition to other remedies available at law or equity::

25.7.1.1 Appointment of temporary management of the Contractor as provided in 42 CFR 438.706, if DCH finds that the Contractor has repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Social Security Act;

25.7.1.2 Granting Members the right to terminate Enrollment without cause and notifying the affected Members of their right to disenroll;

25.7.1.3 Suspension of all new Enrollment, including default Enrollment, after the effective date of remedies;

25.7.1.4 Suspension of payment to the Contractor for Members enrolled after the effective date of the remedies and until CMS or DCH is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur;

25.7.1.5 Termination of the Contract if the Contractor fails to carry out the substantive terms of the Contract or fails to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act;

25.7.1.6 Civil Monetary Fines in accordance with 42 CFR 438.704;

25.7.1.7 Additional remedies allowed under State statute or State regulation that address areas of non-compliance specified in 42 CFR 438.700;

25.7.1.8 Referral to appropriate state licensing agency for investigation; and

25.7.1.9 Referral to the Office of the Attorney General for investigation.

25.8 **NOTICE OF REMEDIES**

- 25.8.1 Prior to the imposition of either liquidated damages or other remedies, DCH will issue a written notice of remedies that will include the following:
- 25.8.1.1 A citation to the law, regulation or Contract provision that has been violated;
 - 25.8.1.2 The remedies to be applied and the date the remedies will be imposed;
 - 25.8.1.3 The basis for DCH's determination that the remedies should be imposed;
 - 25.8.1.4 Request for a Corrective Action Plan, if applicable; and
 - 25.8.1.5 The time frame and procedure for the Contractor to dispute DCH's determination. A Contractor's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damage or remedies.

26.0 **INDEMNIFICATION**

- 26.1 Contractor hereby releases and agrees to indemnify and hold harmless DCH, the State of Georgia, its departments, agencies and instrumentalities (including but not limited to the State Tort Claims Trust Fund, the State Authority Liability Trust Fund, The State Employee Broad Form Liability Funds, the State Insurance and Hazard Reserve Fund, and other self-insured funds, all such funds hereinafter collectively referred to as the "Funds"), and each of its current or former officers, directors, and employees, in individual and official capacities from and against any and all claims, demands, liabilities, losses, costs or expenses, and attorneys' fees, caused by, growing out of, or arising from this Contract, due to any act or omission on the part of Contractor, its agents, employees, customers, invitees, licensees or others working at the direction of Contractor or on its behalf, or due to any breach of this Contract by Contractor, or due to the insolvency or declaration of bankruptcy by Contractor, or due to the application or violation of any pertinent federal, state or local law, rule or regulation. This indemnification extends to the successors and assigns of Contractor, and this indemnification survives the termination of the Contract and the dissolution or, to the extent allowed by law, the bankruptcy of Contractor.
- 26.2 The Parties who shall be entitled to enforce this indemnity of the Contractor shall be DCH, the State of Georgia, its officials, agents, employees, and representatives, including attorneys or the Office of the Attorney General, other

public officials, any successor in office to any of the foregoing individuals, and their respective legal representatives, heirs, and beneficiaries.

27.0 INSURANCE

27.1 Contractor shall, at a minimum, prior to the commencement of work, procure and maintain the insurance policies identified below at Contractor's own cost and expense and shall furnish DCH with an insurance certificate evidencing proof of coverage at least in the amounts indicated, which shall list DCH as certificate holder and as an additional insured. The insurance certificate must document that the Commercial General Liability insurance coverage purchased by Contractor includes contractual liability coverage applicable to this Contract.

27.2 In addition, the insurance certificate must provide the following information: the name and address of the insured; name, address, telephone number and signature of the authorized agent; name of the insurance company (authorized to operate in Georgia); a description of coverage in detailed standard terminology [including policy period, policy number, limits of liability, exclusions, endorsements, and policy notification requirements for claims (to whom, address and time limits)]; and an acknowledgment of notice of cancellation to DCH.

27.3 It shall be the responsibility of Contractor to require any Subcontractor to secure the same insurance coverage as prescribed herein for Contractor, and to obtain a certificate evidencing that such insurance is in effect. Upon request, Contractor shall provide evidence of such insurance to DCH. In addition, Contractor shall indemnify and hold harmless DCH and the State from any liability arising out of Contractor's or Subcontractor's untimely failure in securing adequate insurance coverage as prescribed herein:

27.3.1 Workers' Compensation Insurance

Contractor shall maintain Workers' Compensation Insurance in accordance with the statutory limits established by the General Assembly of the State of Georgia. The Workers' Compensation Policy must include Coverage B – Employer's Liability Limits of:

Bodily Injury by Accident	\$100,000.00 per employee
Bodily Injury by Disease	\$100,000.00 per employee
Policy Limits	\$500,000.00 policy limits

27.3.2 Commercial General Liability

Contractor shall maintain Commercial General Liability Policy(ies), which shall include, but need not be limited to, coverage for bodily injury and property damage arising from premises and operations liability, personal injury liability and contractual liability. The Commercial General Liability Insurance shall provide at least the following limits (per occurrence) for each type of coverage with a \$3,000,000.00 aggregate:

Premises and Operations	\$1,000,000.00
Personal Injury	\$1,000,000.00
Contractual Liability	\$1,000,000.00

27.3.3 Automobile Liability

27.3.3.1 Contractor shall procure and maintain Commercial Automobile Liability Insurance, which shall include coverage for bodily injury and property damage arising from the operation of any owned, non-owned or hired automobile with limits of at least:

Automobile Liability
 Combined Singled Limit
 \$1,000,000.00

27.3.3.2 To achieve the appropriate coverage levels, a combination of a specific policy written with an umbrella policy covering liabilities above stated limits is acceptable.

27.3.4 Professional Liability Insurance \$1,000,000.00

27.4 Each of the insurance policies required pursuant to this section shall be issued by a company licensed to transact the business of insurance in the State of Georgia by the Insurance Commissioner for the applicable line of insurance and, unless waived or modified in writing by DCH, shall be an insurer with a Best Policyholders Rating of "A" or better and with a financial size rating of Class IX or larger. Each such policy shall also contain the following provisions, or the substance thereof, made a part of the insurance policy:

27.4.1 The Contractor agrees that this policy shall not be canceled, changed, allowed to lapse, or allowed to expire until thirty (30) Calendar Days after DCH and the Department of Administrative Services, Risk Management Division, has received written notice thereof as evidenced by return receipt of registered letter or until such time as other valid and effective insurance coverage acceptable in every respect to DCH and providing protection equal to protection called for in the policy shown above shall have been received, accepted, and acknowledged by DCH. It is also agreed that said notice shall be valid only as to such project as shall have been designated by name in said notice.

28.0 IRREVOCABLE LETTER OF CREDIT

28.1 Within five (5) Business Days of the Contract Effective Date, Contractor shall obtain and maintain in force and effect an irrevocable letter of credit. For SFY 2017 and thereafter, on or before July 2 each following year, Contractor shall modify the amount of the irrevocable letter of credit in force and effect as of June 30 to equal 37.5% of the average of the incurred Capitation Payments calculated

by the Department for the Contractor for the months of January, February and March. For each fiscal year, the irrevocable letter of credit shall be for the duration of that fiscal year.

- 28.2 If at any time during the year, the actual GF 360° lives enrolled in Contractor's plan increases or decreases by more than twenty-five percent, DCH, at its sole discretion, may increase or decrease the amount required for the irrevocable letter of credit.
- 28.3 With regard to the irrevocable letter of credit, DCH may recoup payments from the Contractor for liabilities or obligations arising from any act, event, omission or condition which occurred or existed subsequent to the Contract Effective Date and which is identified in a survey, review, or audit conducted or assigned by DCH.
- 28.4 DCH may also, at its discretion, redeem Contractor's irrevocable letter of credit in the amount(s) of actual damages suffered by DCH if DCH determines that the Contractor is (1) unable to perform any of the terms and conditions of the Contract or if (2) the Contract is terminated by default or bankruptcy or material breach that is not cured within the time specified by DCH, or under both conditions described at one (1) and two (2).

29.0 COMPLIANCE WITH ALL LAWS

29.1 NON-DISCRIMINATION

The Contractor agrees to comply with applicable federal and State laws, rules and regulations, and the State's policy relative to nondiscrimination in employment practices because of political affiliation, religion, race, color, sex, physical handicap, age, or national origin including, but not limited to, Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972 as amended; the Age Discrimination Act of 1975, as amended; Equal Employment Opportunity (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375) and the Americans with Disability Act of 1993 (including but not limited to 28 C.F.R. § 35.100 et seq.). Nondiscrimination in employment practices is applicable to employees for employment, promotions, dismissal and other elements affecting employment.

29.2 DELIVERY OF SERVICE AND OTHER FEDERAL LAWS

- 29.2.1 Contractor agrees that all work performed pursuant to this Contract shall comply fully with all applicable laws, statutes, case law, codes, rules, regulations, and procedures (whether administrative or otherwise) whether federal or State. Specifically, the Contractor agrees to comply with laws, regulations, and guidelines, including but not limited to §1902(a)(7) of the Social Security Act, DCH Policies and Procedures, HIPAA and the Health Insurance Title XIII of the American Recovery and Reinvestment Act of 2009 (the Health Information Technology for Economic and Clinical

Health Act, or “HITECH”), and in the implementing regulations of HIPAA and HITECH. Implementing regulations are published as the Standards for Privacy and Security of Individually Identifiable Health Information in 45 C.F.R. Parts 160 and 164. Together, HIPAA, HITECH and their implementing regulations are referred to in this Contract as the “Privacy Rule and Security Rule”. The Contractor assumes responsibility for full compliance with all such applicable laws, regulations, and guidelines, and agrees to fully reimburse DCH for any loss of funds or resources or overpayment resulting from non-compliance by Contractor, its staff, agents or subcontractors, as revealed in audits conducted by or on behalf of DCH.

29.2.2 The provisions of the Fair Labor Standards Act of 1938 (29 U.S.C. § 201 et seq.) and the rules and regulations as promulgated by the United States Department of Labor in Title XXIX of the Code of Federal Regulations are applicable to this Contract. Contractor shall agree to conform with such federal laws as affect the delivery of services under this Contract including but not limited to the Titles VI, VII, XIX, XXI of the Social Security Act, the Federal Rehabilitation Act of 1973, the Davis Bacon Act (40 U.S.C. § 276a et seq.), the Copeland Anti-Kickback Act (40 U.S.C. § 276c), the Americans with Disabilities Act of 1990 (including but not limited to 28 C.F.R. § 35.100 et seq.), the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as Amended (33 U.S.C. 1251 et seq.); the Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); and Debarment and Suspension (45 CFR 74 Appendix A (8) and Executive Order 12549 and 12689). Contractor will agree to conform to such requirements or regulations as the United States Department of Health and Human Services may issue from time to time. Authority to implement federal requirements or regulations will be given to the Contractor by DCH in the form of a Contract amendment.

29.2.3 The Contractor shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

29.2.4 The Contractor shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

29.3 COST OF COMPLIANCE WITH APPLICABLE LAWS

The Contractor agrees that it will bear any and all costs (including but not limited to attorneys’ fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not

limited to federal and State statutes, case law, precedent, regulations, policies, and procedures which exist at the time of the execution of this Contract. The Contractor further agrees that it will bear any and all costs (including but not limited to attorneys' fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not limited to federal and state statutes, case law, precedent, regulations, policies, and procedures which become effective or are amended throughout the life of the Contract. In the event of a disagreement on this matter, DCH's determination on this matter shall be conclusive and not subject to Appeal.

29.4 GENERAL COMPLIANCE

Additionally, the Contractor agrees to comply and abide by all laws, rules, regulations, statutes, policies, or procedures that may govern the Contract, the deliverables in the Contract, or either Party's responsibilities. To the extent that applicable laws, rules, regulations, statutes, policies, or procedures – either those in effect at the time of the execution of this Contract, or those which become effective or are amended during the life of the Contract – require the Contractor to take action or inaction, any costs, expenses, or fees associated with that action or inaction shall be borne and paid by the Contractor solely.

30.0 CONFLICT RESOLUTION

30.1 GOOD FAITH EFFORTS

Except for the right of either Party to apply to a court of competent jurisdiction for a temporary restraining order or other provisional remedy to preserve the status quo or prevent irreparable harm, the Parties agree to attempt in good faith to promptly resolve any dispute, controversy or claim arising out of or relating to this Contract, including but not limited to payment disputes, through negotiations between senior management of the Parties.

30.2 RESOLUTION

If the dispute cannot be resolved within thirty (30) Calendar Days of initiating such negotiations, the dispute shall be decided by the DCH Director of Contracts Administration, who shall reduce his or her decision to writing and mail or otherwise furnish a copy to the Contractor.

30.3 APPEAL

The written decision of the DCH Director of Contracts Administration shall be final and conclusive, unless the Contractor mails or otherwise furnishes a written appeal to the Commissioner of DCH within ten (10) Calendar Days from the date of receipt of such decision. The decision of the Commissioner or his duly authorized representative for the determination of such appeal shall be final and conclusive.

30.4 OTHER REMEDIES

If either Party is dissatisfied, after exhausting the administrative process described above, that Party may pursue its available legal and equitable remedies.

30.5 CONTINUATION OF WORK

Contractor and DCH agree that, the existence of a dispute notwithstanding, they will continue without delay to carry out all their respective responsibilities under this Contract.

31.0 CONFLICT OF INTEREST AND CONTRACTOR INDEPENDENCE

31.1 No official or employee of the State of Georgia or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the GF 360° program shall, prior to the termination of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract.

31.2 The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any material manner or degree with, or have a material adverse effect on the performance of its services hereunder. The Contractor further covenants that in the performance of this Contract, no person having any such interest shall be employed.

31.3 All of the parties hereby certify that the provisions of O.C.G.A. §45-10-20 through §45-10-28, which prohibit and regulate certain transactions between State officials and employees and the State of Georgia, have not been violated and will not be violated in any respect throughout the duration of this Contract.

31.4 In addition, it shall be the responsibility of the Contractor to maintain independence and to establish necessary policies and procedures to assist the Contractor in determining if any Contractors or Subcontractors performing work under this Contract have any impairment to their independence. To that end, the Contractor shall submit a written plan to DCH within five (5) Business Days of Contract Award in which it outlines its Impartiality and Independence Policies and Procedures relating to how it monitors and enforces Contractor and Subcontractor impartiality and independence. The Contractor further agrees to take all necessary actions to eliminate threats to impartiality and independence, including but not limited to reassigning, removing, or terminating Contractors or Subcontractors.

32.0 NOTICE

32.1 All notices under this Contract shall be deemed duly given upon delivery, if delivered by hand, or three (3) Calendar Days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the addresses set

forth below or to such other address as a party may designate by notice pursuant hereto.

For DCH:

Contract Administration:

Project Leader:

For [Care Management Organization]:

32.2 It shall be the responsibility of the Contractor to inform the Contract Administrator of any change in address in writing no later than five (5) Business Days after the change.

32.3 Within two (2) Business Days of receipt of notice, the Contractor shall inform DCH of any legal action, whether the action is formal, informal, administrative, mediation, arbitration, actual litigation, or proposed litigation, which is instituted against the Contractor by a Subcontractor, sub-subcontractor, vendor, supplier, or manufacturer.

32.4 The Contractor shall inform DCH immediately of any legal action, whether the action is formal, informal, administrative, mediation, arbitration, actual litigation, or proposed litigation, that it knows, knew, or should have known would be instituted or brought against the Contractor by a Subcontractor, sub-subcontractor, vendor, supplier, or manufacturer for work based on, arising from, or related to this Contract.

33.0 MISCELLANEOUS

33.1 ASSESSMENT OF FEES

The Contractor and DCH agree that DCH may elect to deduct any assessed fees from payments due or owing to the Contractor or direct the Contractor to make payment directly to DCH for any and all overpayments previously made to Contractor by DCH or any fees or penalties assessed against DCH as a result of

Contractor's negligence, acts or omissions. The method of collection of assessed fees is solely and strictly at DCH's discretion.

33.2 ATTORNEY'S FEES

In the event that either party deems it necessary to take legal action to enforce any provision of this Contract, and in the event DCH prevails, the Contractor agrees to pay all expenses of such action including reasonable attorney's fees and costs at all stages of litigation as awarded by the court, a lawful tribunal, hearing officer or administrative law judge. If the Contractor prevails in any such action, the court or hearing officer, at its discretion, may award costs and reasonable attorney's fees to the Contractor. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

33.3 AUTHORITY

DCH has full power and authority to enter into this Contract, the person acting on behalf of and signing for the Contractor has full authority to enter into this Contract, and the person signing on behalf of the Contractor has been properly authorized and empowered to enter into this Contract on behalf of the Contractor and to bind the Contractor to the terms of this Contract. Each party further acknowledges that it has had the opportunity to consult with and/or retain legal counsel of its choice, read this Contract, understands this Contract, and agrees to be bound by it.

33.4 BINDING

This Contract and all of its terms, conditions, requirements, and amendments shall be binding on DCH, the Contractor, and their respective successors and permitted assigns.

33.5 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT AND OTHER MATTERS

The Contractor certifies that it is not presently debarred, suspended, proposed for debarment or declared ineligible for award of contracts by any federal or State agency or department.

33.6 CHOICE OF LAW OR VENUE

This Contract shall be governed in all respects by the laws of the State of Georgia. Any lawsuit or other action brought against DCH or the State based upon, or arising from this Contract shall be brought in a court or other forum of competent jurisdiction in Fulton County in the State of Georgia.

33.7 CONTRACT DRAFTING

The Parties agree that each Party had an opportunity to have the legal counsel of its choice review, revise, edit, negotiate, and modify this Contract as needed or desired.

33.8 CONTRACT LANGUAGE INTERPRETATION

The Contractor and DCH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DCH's interpretation of the Contract language in dispute shall control and govern. DCH's interpretation of the Contract language in dispute shall not be subject to Appeal under any circumstance.

33.9 COOPERATION WITH AUDITS

33.9.1 The Contractor agrees to assist and cooperate with the Department in any and all matters and activities related to or arising out of any audit or review, whether federal, private, or internal in nature, at no cost to the Department.

33.9.2 The Parties also agree that the Contractor shall be solely responsible for any costs it incurs for any audit related inquiries or matters. Moreover, the Contractor may not charge or collect any fees or compensation from DCH for any matter, activity, or inquiry related to, arising out of, or based on an audit or review.

33.10 COOPERATION WITH OTHER CONTRACTORS

33.10.1 In the event that DCH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, the Contractor agrees to cooperate fully with such other contractors. The Contractor shall not commit any act that will interfere with the performance of work by any other contractor.

33.10.2 Additionally, if DCH eventually awards this Contract to another contractor, the Contractor agrees that it will not engage in any behavior or inaction that prevents or hinders the other Contractor's work related thereto. The Contractor agrees to submit a written turnover plan and/or transition plan to DCH within thirty (30) Calendar Days of receiving the Department's intent to terminate notice. The Parties agree that the Contractor has not successfully met this obligation until the Department accepts its turnover plan and/or transition plan.

33.10.3 The Contractor's failure to cooperate and comply with this provision, shall be sufficient grounds for DCH to halt all payments due or owing to the Contractor until it becomes compliant with this or any other contract

provision. DCH's determination on the matter shall be conclusive and not subject to Appeal.

33.11 DRUG-FREE WORKPLACE

The Contractor must certify to DCH that a drug-free workplace will be provided for the Contractor's employees during the performance of this Contract as required by the "Drug-Free Workplace Act", O.C.G.A. § 50-24-1, et seq. and certify compliance with applicable federal law as set forth in **Attachment A**. Contractor agrees to sign and comply with **Attachment A**. The Contractor will secure from any Subcontractor hired to perform services under this Contract such similar certification. Any false certification by the Contractor or violation of such certification, or failure to carry out the requirements set forth in the State of Georgia or federal statutes, rules, regulations, policies, or guidelines relating to a drug-free workplace may result in the Contractor being suspended, terminated or debarred from the performance of this Contract.

33.12 ENFORCEABILITY

If, for any reason, a court of competent jurisdiction finds any provision of this Contract, or portion thereof, to be unenforceable, that provision shall be enforced to the maximum extent permissible so as to effect the intent of the Parties, and the remainder of this Contract shall continue in full force and effect.

33.13 ETHICS IN PUBLIC CONTRACTING

33.13.1 Contractor understands, states, and certifies that it made its proposal to the RFP without collusion or fraud and that it did not offer or receive any kickbacks or other inducements from any other Contractor, supplier, manufacturer, or Subcontractor in connection with its proposal to the RFP.

33.13.2 Contractor agrees to sign and comply with **Attachment P, Statement of Ethics, Attachment Q, DCH Ethics in Procurement Policy, and Attachment R, Code of Ethics and Conflict of Interest Policy**

33.14 FORCE MAJEURE

Neither party to this Contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party. Such acts shall include, but not be limited to, acts of God, strikes, riots, lockouts, and acts of war, epidemics, fire, earthquakes, or other disasters.

33.15 HOMELAND SECURITY CONSIDERATIONS

33.15.1 The Contractor shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the Contractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by

the U.S. Department of Homeland Security and such individual has not met this requirement.

33.15.2 If the Contractor performs services, or uses services, in violation of the foregoing paragraph, the Contractor shall be in material breach of this Contract and shall be liable to the Department for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Contractor shall be required to hold harmless and indemnify DCH pursuant to the indemnification provisions of this Contract.

33.15.3 The prohibitions in this Section shall also apply to any and all agents and Subcontractors used by the Contractor to perform any services under this Contract.

33.16 LEGAL CONSIDERATIONS

The Contractor agrees to be bound by the laws of the State of Georgia. The solicitation and this Contract shall be construed and interpreted in accordance with Georgia law, regardless of where services are performed, in the event a choice of law situation arises. The Contractor further acknowledges that nothing contained in this Contract, shall be construed as a waiver of the immunity from liability, which would otherwise be available to the State of Georgia under the principles of sovereign immunity. In particular, the Contractor agrees that the sole and exclusive means for the presentation of any claim against the State arising out of this Contract, shall be in accordance with all applicable Georgia statutes and the Contractor further covenants not to initiate legal proceedings in any State or Federal court in addition to, or in lieu of, any proceedings available under Georgia statutes.

33.17 LIMITATIONS OF LIABILITY/EXCEPTIONS

Nothing in this Contract shall limit the Contractor's indemnification liability or civil liability arising from, based on, or related to claims brought by DCH or any third party or any claims brought against DCH or the State by a third party or the Contractor.

33.18 OPEN RECORDS

33.18.1 In the event Contractor receives a public records request pursuant to any independent Freedom of Information legislation (including but not limited to the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552 and/or the Georgia Open Records Act, O.C.G.A. § 50-18-71, *et seq.*) while this Contract is in effect or after the termination of this Contract for any information relating to this Contract, Contractor shall provide a copy of the request to DCH's Open Records Officer at openrecordsrequest@dch.ga.gov and to the DCH HIPAA Privacy and Security Specialist specified in **Attachment D, Business Associate Agreement**, on the same business day.

33.18.2 Upon notifying DCH of the request, Contractor agrees to comply with the response requirements, restrictions, and exceptions in the applicable statute(s) under which the request is made. Contractor will cooperate with DCH to ensure that DCH's interests are represented and that the confidentiality of the information is not compromised by any actions or omissions of Contractor in relation to the public records request or responses thereto. If DCH objects and Contractor is still required by law to disclose the information, Contractor shall do so only to the minimum extent necessary to comply with the operation of the law, and shall provide DCH a copy of the information disclosed.

33.19 ORDER OF PRECEDENCE

33.19.1 This Contract shall include (1) the body of this Contract contained at pages 1-342 and **Attachments A-X**, (2) the Request for Proposals (**Exhibit 1**), and (3) the Contractor's Proposal (**Exhibit 3**).

33.18.2 In the event of any conflict in language between or among the provisions and documents incorporated into, referenced, or contained in the Contract, the order of precedence shall be as enumerated above, except that the terms of **Attachment D**, shall govern, for the express and agreed upon purpose of compliance with the more stringent protections of confidentiality, privacy, and security. Any other conflicts shall be clarified or decided by DCH.

33.20 OWNERSHIP AND FINANCIAL DISCLOSURE

33.20.1 The Contractor shall disclose each person or corporation with an ownership or control interest of five percent (5%) or more in the Contractor's entity for the prior twelve (12) month period as required in Section 8.6.5 of this Contract.

33.20.2 In the event Contractor is, or becomes during the course of this Contract, the wholly owned subsidiary of a publicly owned company, in lieu of the requirements set forth above, Contractor shall disclose financial statements of its immediate parent organization and identify each person, corporation, or entity with an ownership or control interest of five percent (5%) or more in the Contractor's entity for the prior twelve (12) consecutive calendar month period.

33.20.3 For the purposes of this Section, a person, corporation, or entity with an ownership or control interest shall mean a person, corporation, or entity that:

33.20.3.1 Owns directly or indirectly five percent (5%) or more of the Contractor's capital or stock or received five percent (5%) or more of its profits;

33.20.3.2 Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, and that interest is equal to or exceeds five percent (5%) of the total property and assets of the Contractor; and

33.20.3.3 Is an officer or director of the Contractor (if it is organized as a corporation), is a member or manager in the Contractor's organization (if it is organized as a limited liability company) or is a partner in the Contractor's organization (if it is organized as a partnership).

33.20.4 All ownership and financial disclosures shall be submitted to DCH when the Contractor's Proposal is submitted and updated or amended at least once every quarter, unless otherwise requested by DCH.

33.21 PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED AND SUSPENDED

33.21.1 The Contractor shall not knowingly have a relationship with an individual, or an affiliate of an individual, who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. For the purposes of this Section, a "relationship" is described as follows:

33.21.1.1 A director, officer or partner of the Contractor;

33.21.1.2 A person with beneficial ownership of five percent (5%) or more of the Contractor entity; and

33.21.1.3 A person with an employment, consulting or other arrangement with the Contractor's obligations under its Contract with the State.

33.21.2 The Contractor shall submit a quarterly Program Integrity Exception List report that identifies Providers, owners, agents, employees, Subcontractors and contractors (as defined in Section 8.6.5.2) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities) (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp) and/or the CMS MED (Medicare Exclusion Database).

33.21.3 All disclosures required under this Section shall be included in the Contractor's quarterly Fraud and Abuse Report (See Sections 4.13.4 and 5.7.1).

33.22 SECTION TITLES NOT CONTROLLING

The Section titles used in this Contract are for reference purposes only and shall not be deemed a part of this Contract.

33.23 SURVIVABILITY

The terms, provisions, representations and warranties contained in this Contract shall survive the delivery or provision of all services or Deliverables hereunder.

33.24 TIME IS OF THE ESSENCE

Time is of the essence in this Contract. Any reference to “Days” shall be deemed Calendar Days unless otherwise specifically stated.

33.25 WAIVER

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written consent of the parties. Forbearance or indulgence in any form or manner by either party, in any regard whatsoever, shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any remedy available under the Contract.

34.0 AMENDMENT IN WRITING

34.1 No amendment, waiver, termination or discharge of this Contract, or any of the terms or provisions hereof, shall be binding upon either party unless confirmed in writing. Nothing may be modified or amended, except by writing executed by both parties.

34.2 If the Contractor desires an amendment or modification to any provision, condition, or obligation contained in this Contract, it must deliver a timely and written change order request to the Department that includes a detailed explanation of the proposed change, justification, and any and all potential cost implications, if any, for the proposed change.

34.3 Additionally, the Contractor understands and agrees that CMS and the Georgia Department of Administrative Services approval may be required before any such amendment or proposed amendment can become effective. DCH shall determine, in its sole discretion, when such approval is required.

34.4 Any agreement of the Parties to amend, modify, eliminate or otherwise change any part of this Contract shall not affect any other part of this Contract, and the

remainder of this Contract shall continue to be of full force and effect as set out herein.

35.0 **CONTRACT ASSIGNMENT**

35.1 Unless otherwise authorized by an act of the legislature, the rights of DCH under this Contract may be assigned to any other agency of the State of Georgia, with ten (10) Calendar Days' prior notice to Contractor.

35.2 Contractor shall not assign this Contract, in whole or in part, without the prior written consent of DCH, and any attempted assignment not in accordance herewith shall be null and void and of no force or effect. Any assignment or transfer of any interest under the Contract, by Contractor, shall be made explicitly subject to all rights, defenses, set-offs, or counterclaims, which would have been available to DCH against the Contractor in the absence of such assignment or transfer of interest. This provision includes reassignment of Contract due to change of ownership of Contractor.

36.0 **PROHIBITION OF CERTAIN CONTRACT PROVISIONS**

Contractor acknowledges that pursuant to Georgia Constitution Article 3, Section 6, Paragraph 6, the Department is prohibited from entering into any contract that grants any donation or gratuity or forgives any debt or obligation owing to the public.

37.0 **SEVERABILITY**

Any section, subsection, paragraph, term, condition, provision, or other part of this Contract that is judged, held, found or declared to be voidable, void, invalid, illegal or otherwise not fully enforceable shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be of full force and effect as set out herein. The Contract shall not be interpreted for or against any party on the basis that such party or its legal representatives caused part of or the entire Contract to be drafted.

38.0 **COMPLIANCE WITH AUDITING AND REPORTING REQUIREMENTS FOR NONPROFIT ORGANIZATIONS (O.C.G.A. § 50-20-1 ET SEQ.)**

The Contractor agrees to comply at all times with the provisions of the Federal Single Audit Act (hereinafter called the Act) as amended from time to time, all applicable implementing regulations, including but not limited to any disclosure requirements imposed upon non-profit organizations by the Georgia Department of Audits as a result of the Act, and to make complete restitution to DCH of any payments found to be improper under the provisions of the Act by the Georgia Department of Audits, the Georgia Attorney General's Office or any of their respective employees, agents, or assigns.

39.0 **COUNTERPARTS/ELECTRONIC SIGNATURE**

This Contract may be signed in any number of counterparts, each of which shall be an original, with the same effect as if the signatures thereto were upon the same instrument. Any signature below that is transmitted by facsimile or other electronic means shall be binding and effective as the original.

40.0 **ENTIRE AGREEMENT**

This Contract constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, representations or contracts. No written or oral agreements, representatives, statements, negotiations, understandings, or discussions that are not set out, referenced, or specifically incorporated in this Contract shall in any way be binding or of effect between the Parties.

(Signatures on following page)

[THIS SPACE LEFT BLANK INTENTIONALLY]

CONTRACT SHEET

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties state and affirm that, they are duly authorized to bind the respected entities designated below as of the day and year indicated.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Clyde L. Reese III, Esq., Commissioner

Date

Chief – Division of Medical Assistance Plans

Date

[CARE MANAGEMENT ORGANIZATION]

BY: _____
Signature

Date

Print/Type Name

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized by Corporate Resolution to Execute on Behalf of and Bind the Corporation to a Contract

EXHIBIT 1

REQUEST FOR PROPOSALS

Request for Proposal Number [XXX]

(to be placed here)

CONTRACT SHELL

EXHIBIT 2

CONTRACTOR'S PROPOSAL

(to be placed here)

CONTRACT SHELL

ATTACHMENT A

DRUG-FREE WORKPLACE CERTIFICATE

This certification is required by regulations implementing the Drug-Free Workplace Act of 1988 and O.C.G.A. § 50-24-1 *et seq.* The certification set out below is a material representation of fact upon which DCH relied when entering into **Contract #2016XXX** with **CONTRACTOR** (hereinafter referred to as the “Contractor”). False certification or violation of the certification shall be grounds for suspension of payments, termination of the contract, or government-wide suspension or debarment.

By signing this Drug-Free Workplace Certificate, Contractor certifies that it will provide a drug-free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession or use of a controlled substance or marijuana is prohibited in Contractor’s workplace and specifying the actions that will be taken against employees for violations of such policy;
2. Establishing a drug-free awareness program to inform employees about:
 - a. The dangers of drug abuse in the workplace;
 - b. Contractor’s policy of maintaining a drug-free workplace;
 - c. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - d. The penalties that may be imposed upon employees for drug abuse violations;
3. Providing each employee with a copy of the statement provided for in paragraph (1) of this certification;
4. Notifying each employee in the statement provided for in paragraph (1) that, as a condition of employment, the employee shall:
 - a. Abide by the terms of the statement; and
 - b. Notify Contractor of any criminal drug statute conviction for a violation occurring in the workplace no later than five calendar days after such conviction;
5. Notifying DCH within ten calendar days after receiving notice under subparagraph 4(b) from an employee or otherwise receiving actual notice of such conviction;
6. Taking one of the following actions, within 30 days of receiving notice under subparagraph 4(b), with respect to any employee who is so convicted:
 - a. Taking appropriate personnel action against such an employee, up to and including termination; or
 - b. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency;

7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1, 2, 3, 4, 5, and 6.

[CONTRACTOR]

Signature

Date

CONTRACT SHELL

ATTACHMENT B

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT, AND OTHER RESPONSIBILITY MATTERS



Federal Acquisition Regulation 52.209-5, Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters (March 1996)

- (A) The Contractor certifies, to the best of its knowledge and belief, that:
- (1) The Contractor and/or any of its Principals:
 - A. Are are not presently debarred, suspended, proposed for debarment, or declared ineligible for award of contracts by any Federal agency; Have have not within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract or subcontract; violation of federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, evasion, or receiving stolen property; and Are are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity with commission of any of the offenses enumerated in subdivision (a)(1)(i)(B) of this provision.
 - (2) The Contractor has has not within a three-year period preceding this offer, had one or more contracts terminated for default by any federal agency.
 - (3) "Principals," for purposes of this certification, means officers, directors, owners, partners, and persons having primary management or supervisory responsibilities within a business entity (e.g., general manager, plant manager, head of a subsidiary, division, or business segment; and similar positions).

This certification concerns a matter within the jurisdiction of an Agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under 18 U.S.C. § 1001.

- (B) The Contractor shall provide immediate written notice to the Contracting Officer if, at any time prior to contract award, the Contractor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
- (C) A certification that if any of the items in paragraph (a) of this provision exist will not necessarily result in withholding of an award under this solicitation. However, the certification will be considered in connection with a determination of the Contractor's responsibility. Failure of the Contractor to furnish a certification or provide such additional information as requested by the Contracting Officer may render the Contractor nonresponsible.
- (D) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of a Contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
- (E) The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available to the Government, the Contracting Officer may terminate the contract resulting from this solicitation for default.

[CONTRACTOR]

Signature

Date

ATTACHMENT C

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
NON-PROFIT ORGANIZATION DISCLOSURE FORM**

Notice to all DCH Contractors: Pursuant to Georgia law, non-profit organizations that receive funds from a state organization must comply with audit requirements as specified in O.C.G.A. § 50-20-1 *et seq.* (hereinafter “the Act”) to ensure appropriate use of public funds. “Non-profit Organization” means any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized primarily for profit; and uses its net proceeds to maintain, improve or expand its operations. The term non-profit organization includes non-profit institutions of higher education and hospitals. For financial reporting purposes, guidelines issued by the American Institute of Certified Public Accountants should be followed in determining non-profit status.

The Department of Community Health (DCH) must report contracts with non-profit organizations to the Department of Audits and must ensure compliance with the other requirements of the Act. Prior to execution of any contract, the potential contractor must complete this form disclosing its corporate status to DCH. This form must be returned, along with proof of corporate status, to: Director, Contract Administration, Georgia Department of Community Health, 40th Floor, 2 Peachtree Street, N.W., Atlanta, Georgia 30303-3159.

Acceptable proof of corporate status includes, but is not limited to, the following documentation:

- Financial statements for the previous year;
- Employee list;
- Employee salaries;
- Employees’ reimbursable expenses; and
- Corrective action plans.

Entities that meet the definition of non-profit organization provided above and are subject to the requirements of the Act will be contacted by DCH for further information.

COMPANY NAME: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

CORPORATE STATUS: (check one) For Profit _____ Non-Profit _____

I, the undersigned duly authorized representative of _____ do hereby attest that the above information is true and correct to the best of my knowledge.

Signature

Date

ATTACHMENT D

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (hereinafter referred to as “Agreement”), effective this _____ day of _____, _____ (hereinafter the “Effective Date”) is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as “DCH”) and **[INSERT CONTRACTOR NAME]** (hereinafter referred to as “Contractor”) as **Attachment D** to **Contract No. XXXX** between DCH and Contractor dated _____ (hereinafter referred to as the “Contract”).

WHEREAS, DCH is a hybrid entity, as defined in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), and is required by HIPAA to enter into a Business Associate Agreement with certain entities that provide functions, activities, or services on behalf of or in support of health care components of DCH, which functions, activities or services involve the use of Protected Health Information as defined by HIPAA (“PHI”);

WHEREAS, Contractor, under the Contract provides functions, activities, or services involving the use of PHI;

NOW, THEREFORE, for and in consideration of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, DCH and Contractor (each individually a “Party” and collectively the “Parties”) hereby agree as follows:

1. Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms have in HIPAA and in Title XIII of the American Recovery and Reinvestment Act of 2009 (the Health Information Technology for Economic and Clinical Health Act, or “HITECH”), and in the implementing regulations of HIPAA and HITECH. Implementing regulations are published as the Standards for Privacy and Security of Individually Identifiable Health Information in 45 C.F.R. Parts 160 and 164. Together, HIPAA, HITECH, and their implementing regulations are referred to in this Agreement as the “Privacy Rule and Security Rule.” If the meaning of any defined term is changed by law or regulation, then this Agreement will be automatically modified to conform to such change. The term “NIST Baseline Controls” means the baseline controls set forth in National Institute of Standards and Technology (NIST) SP 800-53 established for “moderate impact” information.
2. Except as limited in this Agreement, Contractor may use or disclose PHI only to the extent necessary to meet its responsibilities as set forth in the Contract provided that such use or disclosure would not violate the Privacy Rule or the Security Rule, if done by DCH. Furthermore, except as otherwise limited in this Agreement, Contractor may:
 - A. Use PHI for internal quality control and auditing purposes.
 - B. Use or disclose PHI as Required by Law.
 - C. After providing written notification to DCH’s Office of Inspector General, use PHI to make a report to a health oversight agency authorized by law to investigate DCH (or

otherwise oversee the conduct or conditions of the DCH) about any DCH conduct that Contractor in good faith believes to be unlawful as permitted by 45 C.F.R. 164.502(j)(1). Notwithstanding the foregoing, Contractor shall not be required to provide prior written notice to DCH's Office of Inspector General if Contractor is provided written instruction otherwise by the health oversight agency authorized by law to investigate DCH.

- D.** Use and disclose PHI to consult with an attorney for purposes of determining Contractor's legal options with regard to reporting conduct by DCH that Contractor in good faith believes to be unlawful, as permitted by 45 C.F.R. 164.502(j)(1).
- 3.** Contractor represents and warrants that only individuals designated by title or name on Attachments D-1 and D-2 will request PHI from DCH or access DCH PHI in order to perform the services of the Contract, and these individuals will only request the minimum necessary amount of information necessary in order to perform the services.
 - 4.** Contractor represents and warrants that the individuals listed by title on Attachment D-1 require access to PHI in order to perform services under the Contract. Contractor agrees to send updates to Attachment D-1 whenever necessary. Uses or disclosures of PHI by individuals not described on Attachment D-1 are impermissible.
 - 5.** Contractor represents and warrants that the individuals listed by name on Attachment D-2 require access to a DCH information system in order to perform services under the Contract. Contractor agrees to notify the Project Leader and the Access Control Coordinator named on Attachment D-2 immediately, but at least within 24 hours, of any change in the need for DCH information system access by any individual listed on Attachment D-2. Any failure to report a change within the 24 hour time period will be considered a security incident and may be reported to Contractor's Privacy and Security Officer, Information Security Officer and the Georgia Technology Authority for proper handling and sanctions.
 - 6.** Contractor agrees that it is a Business Associate to DCH as a result of the Contract, and represents and warrants to DCH that it complies with the Privacy Rule and Security Rule requirements that apply to Business Associates and will continue to comply with these requirements. Contractor further represents and warrants to DCH that it maintains and follows written policies and procedures to achieve and maintain compliance with the HIPAA Privacy and Security Rules that apply to Business Associates, including, but not limited to policies and procedures addressing HIPAA's requirements that Business Associates use, request and disclose only the minimum amount of PHI necessary to perform their services, and updates such policies and procedures as necessary in order to comply with the HIPAA Privacy and Security Rules that apply to Business Associates and will continue to maintain and update such policies and procedures. These policies and procedures, and evidence of their implementation, shall be provided to DCH upon request.
 - 7.** The Parties agree that a copy of all communications related to compliance with this Agreement will be forwarded to the following Privacy and Security Contacts:
 - A.** At DCH: HIPAA Privacy and Security Specialist
Office of General Counsel
hipaa@dch.ga.gov

Sherman Harris
Agency Information Security Officer
sheharris@dch.ga.gov
404-656-9653

B. At Contractor: _____

8. Contractor further agrees that it will:

- A. Not request, create, receive, use or disclose PHI other than as permitted or required by this Agreement, the Contract, or as required by law.
- B. Establish, maintain and use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or the Contract. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.
- C. Implement and use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DCH. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.
- D. In addition to the safeguards described above, Contractor shall include access controls that restrict access to PHI to the individuals listed on D-1 and D-2, as amended from time to time, shall implement encryption of all electronic PHI during transmission and at rest.
- E. Upon DCH's reasonable request, but no more frequently than annually, obtain an independent assessment of Contractor's implementation of the NIST Baseline Controls and the additional safeguards required by this Agreement with respect to DCH PHI, provide the results of such assessments to DCH, and ensure that corrective actions identified during the independent assessment are implemented.
- F. Mitigate, to the extent practicable, any harmful effect that may be known to Contractor from a use or disclosure of PHI by Contractor in violation of the requirements of this Agreement, the Contract or applicable regulations. Contractor shall bear the costs of mitigation, which shall include the reasonable costs of credit monitoring or credit restoration when the use or disclosure results in exposure of information commonly used in identity theft.
- G. Maintain a business associate agreement with its agents or subcontractors to whom it provides PHI, in accordance with which such agents or subcontractors are contractually

obligated to comply with at least the same obligations that apply to Contractor under this Agreement, and ensure that its agents or subcontractors comply with the conditions, restrictions, prohibitions and other limitations regarding the request for, creation, receipt, use or disclosure of PHI, that are applicable to Contractor under this Agreement and the Contract.

- H.** Report to DCH any use or disclosure of PHI that is not provided for by this Agreement or the Contract of which it becomes aware.
- I.** Make an initial report to the DCH in writing in such form as DCH may require within three (3) business days after Contractor (or any subcontractor) becomes aware of the unauthorized use or disclosure. This report will require Contractor to identify the following:
 - i. The nature of the impermissible use or disclosure (the “incident”), which will include a brief description of what happened, including the date it occurred and the date Contractor discovered the incident;
 - ii. The Protected Health Information involved in the impermissible use or disclosure, such as whether the full name, social security number, date of birth, home address, account number or other information were involved);
 - iii. Who (by title, access permission level and employer) made the impermissible use or disclosure and who received the Protected Health Information as a result;
 - iv. What corrective or investigational action Contractor took or will take to prevent further impermissible uses or disclosures, to mitigate harmful effects, and to prevent against any further incidents;
 - v. What steps individuals who may have been harmed by the incident might take to protect themselves; and
 - vi. Whether Contractor believes that the impermissible use or disclosure constitutes a Breach of Unsecured Protected Health Information.

Upon request by the DCH HIPAA Privacy and Security Officer or the DCH Information Security Officer, Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and a proposed corrective action plan. Upon approval of a corrective action plan by the DCH, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH within five (5) business days of DCH’s request for proof of implementation.

- J.** Report to the DCH HIPAA Privacy and Security Officer and the DCH Agency Information Security Officer any successful unauthorized access, modification, or destruction of PHI or interference with system operations in Contractor’s information systems as soon as practicable but in no event later than three (3) business days of discovery. If such a security incident resulted in a use or disclosure of PHI not permitted

by this Agreement, Contractor shall also make a report of the impermissible use or disclosure as described above. Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and, if appropriate, a proposed corrective action plan designed to protect PHI from similar security incidents in the future. Upon DCH's approval of Contractor's corrective action plan, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH.

- K.** Upon DCH's reasonable request and not more frequently than once per quarter, report to the DCH Agency Information Security Officer any (A) attempted (but unsuccessful) unauthorized access, use, disclosure, modification, or destruction of PHI or (B) attempted (but unsuccessful) interference with system operations in Contractor's information systems. Contractor does not need to report trivial incidents that occur on a daily basis, such as scans, "pings," or other routine attempts that do not penetrate computer networks or servers or result in interference with system operations.
- L.** Cooperate with DCH and provide assistance necessary for DCH to determine whether a Breach of Unsecured Protected Health Information has occurred, and whether notification of the Breach is legally required or otherwise appropriate. Contractor agrees to assist DCH in its efforts to comply with the HIPAA Privacy and Security Rules, as amended from time to time. To that end, the Contractor will abide by any requirements mandated by the HIPAA Privacy and Security Rules or any other applicable laws in the course of this Contract. Contractor warrants that it will cooperate with DCH, including cooperation with DCH privacy officials and other compliance officers required by the HIPAA Privacy and Security Rules and all implementing regulations, in the course of performance of this Contract so that both parties will be in compliance with HIPAA.
- M.** If DCH determines that a Breach of Unsecured Protected Health Information has occurred as a result of Contractor's impermissible use or disclosure of PHI or failure to comply with obligations set forth in this Agreement or in the Privacy or Security Rules, provide all notifications to Individuals, HHS and/or the media, on behalf of DCH, after the notifications are approved by the DCH. Contractor shall provide these notifications in accordance with the security breach notification requirements set forth in 42 U.S.C. §17932 and 45 C.F.R. Parts 160 & 164 subparts A, D & E as of their respective Compliance Dates, and shall pay for the reasonable and actual costs associated with such notifications.

In the event that DCH determines a Breach has occurred, without unreasonable delay, and in any event no later than thirty (30) calendar days after Discovery, Contractor shall provide the DCH HIPAA Privacy and Security Officer a list of Individuals and a copy of the template notification letter to be sent to Individuals. Contractor shall begin the notification process only after obtaining DCH's approval of the notification letter.

- N.** Make any amendment(s) to PHI in a Designated Record Set that DCH directs or agrees to pursuant to 45 CFR 164.526 within five (5) business days after request of DCH. Contractor also agrees to provide DCH with written confirmation of the amendment in such format and within such time as DCH may require.

- O. In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, Contractor shall, within five (5) business days following DCH's request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH, provide DCH access to the PHI in an individual's Designated Record Set. However, if requested by DCH, Contractor shall provide access to the PHI in a Designated Record Set directly to the individual to whom such information relates.
- P. Give the Secretary of the U.S. Department of Health and Human Services (the "Secretary") or the Secretary's designees access to Contractor's books and records and policies, practices or procedures relating to the use and disclosure of PHI for or on behalf of DCH within five (5) business days after the Secretary or the Secretary's designees request such access or otherwise as the Secretary or the Secretary's designees may require. Contractor also agrees to make such information available for review, inspection and copying by the Secretary or the Secretary's designees during normal business hours at the location or locations where such information is maintained or to otherwise provide such information to the Secretary or the Secretary's designees in such form, format or manner as the Secretary or the Secretary's designees may require.
- Q. Document all disclosures of PHI and information related to such disclosures as would be required for DCH to respond to a request by an Individual or by the Secretary for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. By no later than five (5) business days of receipt of a written request from DCH, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH HIPAA Privacy and Security Officer, Contractor shall provide an accounting of disclosures of PHI regarding an Individual to DCH. If requested by DCH, Contractor shall provide an accounting of disclosures directly to the individual. Contractor shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the DCH upon request.
- R. In addition to any indemnification provisions in the Contract, indemnify the DCH from any liability resulting from any violation of the HIPAA Privacy and Security Rules or Breach that arises from the conduct or omission of Contractor or its employee(s), agent(s) or subcontractor(s). Such liability will include, but not be limited to, all actual and direct costs and/or losses, civil penalties and reasonable attorneys' fees imposed on DCH.
- S. For any requirements in this Agreement that include deadlines, pay performance guarantee payments of \$300.00 per calendar day, starting with the day after the deadline and continuing until Contractor complies with the requirement. Contractor shall ensure that its agreements with subcontractors enable Contractor to meet these deadlines.

9. DCH agrees that it will:

- A. Notify Contractor of any new limitation in the applicable Notice of Privacy Practices in accordance with the provisions of the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such limitation will affect Contractor's use or disclosure of PHI.

- B. Notify Contractor of any change in, or revocation of, authorization by an Individual for DCH to use or disclose PHI to the extent that DCH determines in the exercise of its sole discretion that such change or revocation will affect Contractor's use or disclosure of PHI.
- C. Notify Contractor of any restriction regarding its use or disclosure of PHI that DCH has agreed to in accordance with the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such restriction will affect Contractor's use or disclosure of PHI.
- D. Prior to agreeing to any changes in or revocation of permission by an Individual, or any restriction, to use or disclose PHI, DCH agrees to contact Contractor to determine feasibility of compliance. DCH agrees to assume all costs incurred by Contractor in compliance with such special requests.

10. The **Term of this Agreement** shall be effective on the Effective Date and shall terminate when all of the PHI provided by DCH to Contractor, or created or received by Contractor on behalf of DCH, is destroyed or returned to DCH, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this section.

- A. **Termination for Cause.** Upon DCH's knowledge of a material breach of this Agreement by Contractor, DCH shall either:
 - i. Provide an opportunity for Contractor to cure the breach of Agreement within a reasonable period of time, which shall be within thirty (30) calendar days after receiving written notification of the breach by DCH;
 - ii. If Contractor fails to cure the breach of Agreement, terminate the Contract upon thirty (30) calendar days notice; or
 - iii. If neither termination nor cure is feasible, DCH shall report the breach of Agreement to the Secretary of the Department of Health and Human Services.

B. Effect of Termination.

- i. Upon termination of this Agreement, for any reason, DCH and Contractor shall determine whether return of PHI is feasible. If return of the PHI is not feasible, Contractor agrees to continue to extend the protections of this Agreement to the PHI for so long as the Contractor maintains the PHI and shall limit the use and disclosure of the PHI to those purposes that made return or destruction of the PHI infeasible. If at any time it becomes feasible to return or destroy any such PHI maintained pursuant to this paragraph, Contractor must notify DCH and obtain instructions from DCH for either the return or destruction of the PHI.
- ii. Contractor agrees that it will limit its further use or disclosure of PHI only to those purposes DCH may, in the exercise of its sole discretion, deem to be in the public interest or necessary for the protection of such PHI, and will take such

additional actions as DCH may require for the protection of patient privacy and the safeguarding, security and protection of such PHI.

iii. This Effect of Termination section survives the termination of the Agreement.

11. Interpretation. Any ambiguity in this Agreement shall be resolved to permit DCH and Contractor to comply with applicable laws, rules and regulations, the HIPAA Privacy Rule, the HIPAA Security Rule and any rules, regulations, requirements, rulings, interpretations, procedures or other actions related thereto that are promulgated, issued or taken by or on behalf of the Secretary; provided that applicable laws, rules and regulations and the laws of the State of Georgia shall supersede the Privacy Rule if, and to the extent that, they impose additional requirements, have requirements that are more stringent than or have been interpreted to provide greater protection of patient privacy or the security or safeguarding of PHI than those of the HIPAA Privacy Rule.

12. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations or liabilities whatsoever.

13. All other terms and conditions contained in the Contract and any amendment thereto, not amended by this Agreement, shall remain in full force and effect.

(Signatures on following page)

IN WITNESS WHEREOF, Contractor, through its authorized officer and agent, has caused this Agreement to be executed on its behalf as of the date indicated.

[CONTRACTOR]

BY: _____
SIGNATURE

DATE

TITLE*

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

CONTRACT SHELL

ATTACHMENT D-1

List of Individuals Permitted to Receive, Use and Disclose DCH PHI

The following Position Titles, as employees and/or representatives of Contractor, need access to DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

- _____
- _____
- _____
- _____
- _____

Transfers of PHI must comply with DCH Policy and Procedure 419: Appropriate Use of Information Technology Resources.

Approved methods of secure delivery of PHI between Contractor and DCH:

- A.** Secure FTP file transfer (preferred)
- B.** Encrypted email or email sent through “secure tunnel” approved by DCH Information Security Officer
- C.** Email of encrypted document (password must be sent by telephone only)
- D.** Encrypted portable media device and tracked delivery method

Contractor must update this list as needed and provide the updated form to DCH. Use of DCH Protected Health Information by individuals who are not described on this Attachment D-1, as amended from time to time, is impermissible and a violation of the Agreement. Contractor must update this Attachment D-1 as needed and provide the updated form to DCH.

DCH Project Leader Contact Information: [INSERT HERE]

ATTACHMENT D-2

Part 1:

Please initial beside the correct option. Please select only one option.

_____ Contractor DOES NOT need any user accounts to access DCH Information Systems.
Do not complete Part 2 of this form.

_____ Contractor DOES need user accounts to access DCH Information Systems. Please
complete Part 2 of this form.

Part 2:

Please complete the table below if you indicated that Contractor DOES need any user accounts to access DCH Information Systems. Please attach additional pages if needed.

List of Individuals Authorized to Access a DCH Information System Containing PHI

The following individuals, as employees and/or representatives of Contractor, need access to DCH Information Systems containing DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

Full Name	Employer	DCH Information System	Type of Access (Read only? Write?)

The DCH Project Leader must submit a completed DCH Network Access Request Form for each individual listed above. Access will be granted and changed in accordance with DCH Policy and Procedure 435: Managing Authorization, Access and Control of Information Systems.

Contractor must notify the Project Leader identified in the Contract and the DCH Access Control Coordinator (dchois@dch.ga.gov and helpdesk@dch.ga.gov) immediately, but at least within 24 hours, after any individual on this list no longer needs the level of access described. Failure to provide this notification on time is a violation of the Agreement and will be reported as a security incident.

Contractor must update this Attachment D-2 as needed and provide the updated form to DCH.
DCH Project Leader Contact Information: **[INSERT HERE]**

ATTACHMENT E

VENDOR LOBBYIST DISCLOSURE AND REGISTRATION CERTIFICATION FORM



Pursuant to Executive Order Number 10.01.03.01 (the “Order”), which was signed by Governor Sonny Perdue on October 1, 2003, Contractors with the state are required to complete this form. The Order requires “Vendor Lobbyists,” defined as those who lobby state officials on behalf of businesses that seek a contract to sell goods or services to the state or those who oppose such a contract, to certify that they have registered with the State Ethics Commission and filed the disclosures required by Article 4 of Chapter 5 of Title 21 of the Official Code of Georgia Annotated. Consequently, every vendor desiring to enter into a contract with the state must complete this certification form. False, incomplete, or untimely registration, disclosure, or certification shall be grounds for termination of the award and contract and may cause recoupment or refund actions against Contractor.

In order to be in compliance with Executive Order Number 10.01.03.01, please complete this Certification Form by designating only one of the following:

- Contractor *does not have any* lobbyist employed, retained, or affiliated with the Contractor who is seeking or opposing contracts for it or its clients. Consequently, Contractor has not registered anyone with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.

- Contractor *does have* lobbyist(s) employed, retained, or affiliated with the Contractor who are seeking or opposing contracts for it or its clients. The lobbyists are:

Contractor states, represents, warrants, and certifies that it has registered the above named lobbyists with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.

[CONTRACTOR]

Signature

Date

ATTACHMENT F

RESERVED

CONTRACT SHELL

ATTACHMENT G

CAPITATION PAYMENT

(to be placed here)

CONFIDENTIAL – NOT FOR CIRCULATION

CONTRACT SHELL

ATTACHMENT H



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing**. Your request for a hearing, along with a copy of the adverse action letter, must be *received* within **thirty (30) days** of the date of the letter. Please mail your request for a hearing to [Managed Care Organization] at the following address:

[CMO Address Line 1]
[CMO Address Line 2]
[CMO Address Line 3]
[CMO Address Line 4]

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. Georgia Legal Services Program

1-800-498-9469

(Statewide legal services, EXCEPT

for the counties served by Atlanta Legal Aid)

2. Georgia Advocacy Office

1-800-537-2329

(Statewide advocacy for persons with disabilities or mental illness)

3. Atlanta Legal Aid

404-377-0701 (DeKalb/Gwinnett Counties)

770-528-2565 (Cobb County)

404-524-5811 (Fulton County)

404-669-0233 (So. Fulton/Clayton County)

678-376-4545 (Gwinnett County)

ATTACHMENT I

MAP OF SERVICE REGIONS/LIST OF COUNTIES BY SERVICE REGIONS

Atlanta	Central	East	North	SE	SW
Barrow	Baldwin	Burke	Banks	Appling	Atkinson
Bartow	Bibb	Columbia	Catoosa	Bacon	Baker
Butts	Bleckley	Emanuel	Chattooga	Brantley	Ben Hill
Carroll	Chattahoochee	Glascok	Clarke	Bryan	Berrien
Cherokee	Crawford	Greene	Dade	Bulloch	Brooks
Clayton	Crisp	Hancock	Dawson	Camden	Calhoun
Cobb	Dodge	Jefferson	Elbert	Candler	Clay
Coweta	Dooly	Jenkins	Fannin	Charlton	Clinch
DeKalb	Harris	Lincoln	Floyd	Chatham	Coffee
Douglas	Heard	McDuffie	Franklin	Effingham	Colquitt
Fayette	Houston	Putnam	Gilmer	Evans	Cook
Forsyth	Jones	Richmond	Gordon	Glynn	Decatur
Fulton	Lamar	Screven	Habersham	Jeff Davis	Dougherty
Gwinnett	Laurens	Taliaferro	Hall	Liberty	Early
Haralson	Macon	Warren	Hart	Long	Echols
Henry	Marion	Washington	Jackson	McIntosh	Grady
Jasper	Meriwether	Wilkes	Lumpkin	Montgomery	Irwin
Newton	Monroe		Madison	Pierce	Lanier
Paulding	Muscogee		Morgan	Tattnall	Lee
Pickens	Peach		Murray	Toombs	Lowndes
Rockdale	Pike		Oconee	Ware	Miller
Spalding	Pulaski		Oglethorpe	Wayne	Mitchell
Walton	Talbot		Polk		Quitman
	Taylor		Rabun		Randolph
	Telfair		Stephens		Seminole
	Treutlen		Towns		Schley
	Troup		Union		Stewart
	Twiggs		Walker		Sumter
	Upson		White		Terrell
	Wheeler		Whitfield		Thomas
	Wilcox				Tift
	Wilkinson				Turner
	Johnson				Webster
					Worth

ATTACHMENT J

APPLICABLE CO-PAYMENTS

Children under age twenty-one (21), pregnant women, nursing facility residents, members enrolled in breast and cervical cancer programs, and Hospice care Members are exempted from co-payments.

There are no co-payments for family planning services or for emergency services except as defined below.

Services cannot be denied to anyone based on the inability to pay these co-payments.

Service	Additional Exceptions	Co-Pay Amount
Ambulatory Surgical Centers		A \$3 co-payment to be deducted from the surgical procedure code billed. In the case of multiple surgical procedures, only one \$3 amount will be deducted per date of service.
FQHC/RHCs		A \$2 co-payment on all FQHC and RHC.
Outpatient		A \$3 member co-payment is required on all non-emergency outpatient hospital visits
Inpatient	Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility are exempted from the inpatient co-payment.	A co-payment of \$12.50 will be imposed on hospital inpatient services
Emergency Department		A \$3 co-payment will be imposed if the Condition is not an Emergency Medical Condition

ATTACHMENT K

INFORMATION MANAGEMENT AND SYSTEMS

(Requirements to be Defined by DCH and Provider at a Later Date)

CONTRACT SHELL

ATTACHMENT L

DEMONSTRATION COVERED SERVICES

Family Planning Demonstration Services: Services provided to P4HB participants must be provided by a physician or an advanced practice nurse.

Services Include:

- Family planning initial or annual exams
- Follow up, brief and comprehensive visits
- Contraceptive services and supplies
- Patient education and counseling
- Counseling and referrals to:
 - Social services
 - Primary health care providers
- Family planning lab tests:
 - Pregnancy tests
 - Pap Smear and Pelvic exam
 - A colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are coverable as a family planning-related service under this Demonstration. Colposcopies which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital are not covered under this waiver as family planning-related services
- Screening, treatment and follow up for sexually transmitted infections (STIs), except HIV/AIDS and Hepatitis
 - Antibiotic treatment for STIs when the infections are identified during a routine family planning visit.
 - A follow up visit for the treatment/drugs may be covered
 - Subsequent follow-up visits to re-screen for STIs based on the Centers for Disease Control and Prevention guidelines
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/ drugs may be covered.
- Treatment of major complications related to the delivery of Demonstration related services such as:
 - Treatment of a perforated uterus due to an intrauterine device insertion;
 - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
 - Treatment of surgical or anesthesia-related complications during a sterilization procedure.
- Tubal Ligation (Sterilization)
 - Treatment and follow-up of an STI diagnosed at the time of sterilization.

- Family Planning pharmacy visits
- Folic acid and/or a multivitamin with folic acid.
- Select immunizations for aged 19 and 20. The Contractor shall provide all P4HB participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the Advisory Committee on Immunization Practices (ACIP) guidelines as needed
- P4HB participants age 18 receive vaccines at no cost under the Vaccines for Children (VFC) program
- Additionally women who have delivered a very low birth weight baby following implementation of the Demonstration will be eligible for Interpregnancy Care services including the Resource Mother Outreach benefit.
 - Interpregnancy Care (IPC) covered services:

In addition to the family planning and family planning related services listed above, P4HB participants enrolled in the IPC component of the waiver will receive:

- Primary Care services, up to 5 office/outpatient visits
 - Limited Dental Services
 - Management and treatment of chronic diseases
 - Substance abuse treatment including detoxification and intensive outpatient rehabilitation
 - Case Management/Resource Mother Outreach
 - Prescription drugs (non-family planning) for the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery
 - Non-emergency transportation
- Resource Mother Outreach only

Resource Mothers Outreach only services are available to women who are currently enrolled in and are receiving Title XIX services and benefits but who meet all other IPC Demonstration eligibility criteria.

ATTACHMENT M

DEMONSTRATION QUALITY STRATEGY

In order to assess and improve the quality of services delivered under this Demonstration, DCH will implement a rigorous quality strategy and evaluation process formally documented as the Demonstration Evaluation Design. This design or plan will be developed with assistance from Emory University, the independent contractor charged with evaluating the effectiveness of the Demonstration. The evaluation design must incorporate key goals, objectives and a set of performance measures that align well with the logical sequence through which the Demonstration can and will affect Provider's behavior such that the key outcomes - longer inter partum intervals, lower low birth weight rates and cost savings - can be achieved. The evaluation design must receive final approval from CMS. Reporting to CMS will occur on a quarterly and annual basis with a final report due to CMS at the end of the Demonstration period. Contractor reporting will be due on a quarterly and annual basis as identified below and in the CMS Special Terms and Conditions.

The Evaluation Design will include:

- Key Goals, Objectives and Performance Targets
- Program Hypotheses
- Performance Measures
- Analysis pertaining to the achievement of the Performance Targets
- Assessment of the rate at which the Demonstration was implemented
- Assessment of the Demonstration Providers' understanding of program eligibility, service coverage and payment rates across sites of care
- Assessment of the Providers' satisfaction with the Demonstration
- Assessment of the per Demonstration year changes in family planning visits regardless of payer source, per poor and near poor women in Georgia
- Determination of averted births among P4HB participants and tests of budget neutrality
- The relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for "targeted" versus control group women
- The relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among "targeted" and control groups
- The relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

Key Goals:

If participation in the Demonstration penetrates the eligible population to the extent hoped for and P4HB Participants are consistent users of family planning and IPC services and supplies, the DCH anticipates the following major outcomes can be achieved:

- Reduction of Georgia's low birth weight and very low birth weight rates over the course of the Demonstration period
- Reduction in the number of unintended pregnancies in Georgia

- Reduction in Georgia’s Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy related services.

Program Objectives

- Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the three year term of the Demonstration. Achievement of this objective will be measured by:
 - Total family planning visits pre and post the Demonstration;
 - Use of contraceptive services/supplies pre and post the Demonstration;
- Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant. Achievement of this objective will be measured by:
 - Use of inter-pregnancy care services (primary care and Resource Mothers Outreach) by women with a very low birth weight delivery;
- Decrease unintended and high-risk pregnancies among Medicaid eligible women and increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women. Achievement of this objective will be measured by:
 - Average inter-pregnancy intervals for women pre and post the Demonstration;
 - Average inter-pregnancy intervals for women with a very low birth weight delivery pre and post the Demonstration;
- Decrease in late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women. Achievement of this objective will be documented by:
 - The number of repeat teen births assessed annually
- Decrease the number of Medicaid-paid deliveries beginning in the second year of the Demonstration, thereby reducing annual pregnancy-related expenditures. Achievement of this objective will be measured by:
 - The number of Medicaid paid deliveries assessed annually
- Increase consistent use of contraceptive methods by incorporating Care Coordination and patient-directed counseling into family planning visits. Achievement of this objective will be measured by:
 - Utilization statistics for family planning methods
 - Number of Deliveries to P4HB participants
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women who are in need of services but who are not receiving them. Achievement of this objective will be measured by:
 - Enrollment statistics for the Demonstration.
- Increase the overall savings in Medicaid spending attributable to this Demonstration. Achievement of this objective will be measured by:
 - Documentation of achievement of financial savings targets

Program Hypotheses

- That the Demonstration will bring sufficient numbers of women into the program to increase the overall use of family planning services/supplies and will promote the more consistent use of effective contraceptive methods among program users.

That increased use of contraceptives will lead to reduced unintended pregnancies and in turn, unintended births among this population of women (as well as improved inter-pregnancy intervals). That teens are at high risk of unintended pregnancy a related hypothesis is that the rate of unintended births and repeat teen births will also fall post implementation of the waiver. That these changes will be sufficient to lower the number of overall Medicaid paid deliveries/births and hence, costs, such that the state and federal government will realize a net cost savings despite increased spending on family planning services.

Performance Reporting

In order for the program objectives to be achieved there must be sufficient outreach, uptake, and implementation of the Demonstration benefits. The performance measures identified below and in the CMS Special Terms and Conditions must be reported by the Contractor quarterly and annually or as identified in the CMS Special Terms and Conditions.

I. Assessment of the rate at which the Demonstration was implemented using Enrollment, Participation and Use of Services as Performance Measures:

- These reports are to be submitted to DCH within 30 Calendar Days from the close of the previous quarter (e.g., April 30 for the quarter ending March 31).
- Total number of Demonstration Enrollees per CMO stratified by Demonstration component – Family Planning only; IPC; Resource Mothers only
- Total number of Demonstration Enrollees per CMO stratified by age, race and ethnicity, county;
- Average months enrolled per CMO by Age, Race/Ethnicity and County;
- Proportion of LIM population per CMO enrolled in Resource Mothers Outreach
- Total number of P4HB participants per CMO stratified by age, race, ethnicity, county;
- Number of IPC P4HB participants per CMO stratified by age, race and ethnicity, county;
- Number of P4HB participants per CMO in the Resource Mothers only Outreach
- Overview of the Geographic variations in enrollment per CMO;
- Rate of use per CMO of:
 - All Family Planning Services by type;
 - All Contraceptives by type (inclusive of hormonal and non-hormonal contraceptives);
 - Counts of primary care visits for those in the IPC component of the Demonstration.
- Utilization statistics per CMO for all IPC services and IPC services by type

Sufficient “take up” of the Demonstration can only occur if both providers and women understand their new eligibility and coverage. An explanatory design component of the evaluation will help understand if there are barriers in the provider system that could prevent take up and/or visit rates.

II. Assessment of the Demonstration Providers’ s’ understanding of program eligibility, service coverage and payment rates across sites of care

- These semi-annual survey reports are due October 1st and April 1st.

Contractor shall submit a report semi-annually of Provider Surveys conducted by the Contractor with analysis reports highlighting responses to questions regarding knowledge and understanding of the Demonstration, level of participation and training/outreach.

- Contractor shall submit a report semi-annually of P4HB participant Surveys conducted by the Contractor with analysis reports highlighting responses to questions pertaining to satisfaction with eligibility and enrollment processes. The report shall address the following subjects:
 1. Satisfaction with CMO selection process
 2. Satisfaction with educational materials regarding the Demonstration
 3. Satisfaction with service options and services
 4. Satisfaction with contraceptive method
 5. Contraceptive failures/unintended births
 6. Satisfaction with provider selection
 7. Results and analysis of semi-annual member satisfaction surveys

The above data will be gathered through standardized semi-annual Provider and P4HB Participant Surveys administered by each CMO. Survey tools will be developed by the Demonstration's evaluator and made available to the Contractor for review and comment prior to being finalized. A summary of the Contractor's Provider and P4HB Participant survey data and qualitative interviews must be compiled by the Contractor and submitted to DCH by October 1st and April 1st of each Demonstration Year beginning with October 1st of Demonstration year 1.

III. Assessment of the per Demonstration year changes in family planning visits

- These annual reports are due June 30th. Total Demonstration expenses per CMO and stratified by Demonstration component – Family Planning Only, IPC, and Resource Mothers Outreach only
- The average per person expenditures for the IPC component per CMO
- The total expenditures per CMO for the first year infant life costs stratified by birth weight categories
- The average per person expenditures per CMO for the first year of life costs stratified by birth weight categories
- The total expenditures for VLBW deliveries per CMO
- The average per person expenditures for VLBW deliveries per CMO

IV. Determination of the number of averted births among P4HB Participants and tests of budget neutrality

- These annual reports are to be submitted within 45 calendar days of the end of the 4th quarter.
- Total Pregnancies per CMO stratified by age, race/ethnicity, county/region
- Total Pregnancies per Demonstration population paid per CMO stratified by age, race/ethnicity, county/region, FP only and IPC
- Contraceptive failures per CMO stratified by age, race/ethnicity, county/region

- Actual Live Births per CMO stratified by Age, Race/Ethnicity, county/region and weight categories

V. Determination of the relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for “targeted” versus control group women

- To be calculated by the Demonstration evaluator

VI. Assessment of the relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among “targeted” and control groups:

- These annual reports are to be submitted within 45 calendar days of the end of the 4th quarter.
- CMO documentation of events that occurred during the quarter or are anticipated to occur in the near future affecting the CMO’s health care delivery; benefits; enrollment; grievances; quality of care; access; other operational issues
- Total Births – Live Births and Fetal Deaths stratified by age, race/ethnicity, county/region per CMO
- Unintended Births-Percent of Births Reported as Unwanted or Mistimed per CMO

VII. Assessment of the relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

- These annual reports are due June 30th. Average number of months between pregnancies to the same woman (number of months between initial birth/fetal death event and subsequent birth/fetal death event – the gestational age of the subsequent event) per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in low birth weight or very low birth weight per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in a preterm delivery per CMO

Performance Measures

The Contractor’s failure to meet these goals shall result in a Category 2 Liquidated Damage as defined in Section 25.3 of the Contract.

- Reduction of Contractor membership’s LBW and VLBW rates over the course of the Demonstration period as measured by 10% cumulative reduction from CY 2010 baseline in the Contractor’s LBW and VLBW rates by January 31, 2015.
- 4% reduction in the Pregnancy Rate in the Contractor’s membership over the Demonstration period ending January 31, 2015.

Quarterly Report Data per CMO: Reports are to be submitted to DCH within 30 Calendar Days from the close of the previous quarter (e.g., April 30 for the quarter ending March 31).

- Demonstration expenditures including administrative costs;
- Total number of Demonstration enrollees;
- Total number of P4HB participants
- Total number of Demonstration enrollees stratified by age, race and ethnicity;
- Total number of P4HB participants stratified by age, race and ethnicity
- Total number of IPC enrollees stratified by age, race and ethnicity
- Total number of IPC P4HB participants stratified by age, race and ethnicity
- Total number of Family Planning only enrollees stratified by age, race and ethnicity
- Total number of Family Planning only P4HB participants stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only Enrollees stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only P4HB participants stratified by age, race and ethnicity
- Total number of P4HB participants utilizing services
- Utilization statistics for Family Planning only services by type
- IPC Problem and Strength Identification Quarterly Summary
- Total number of Care Plans for IPC Participants
- Utilization statistics for IPC Services by type;
- Contraceptive types utilized;
- Geographic variations in enrollment;
- Total number of P4HB participants (Participants include all individuals who obtain one or more covered family planning services through the Demonstration);
 - Events occurring during the quarter, or anticipated to occur in the near future that affect:
 - health care delivery
 - benefits
 - enrollment
 - grievances
 - quality of care
 - access
 - pertinent legislative activity
 - eligibility verification activities
 - other operational issues;
- Action plans for addressing any policy and administrative issues identified; and
- Evaluation activities and interim findings.

Annual Report Data per CMO – for Demonstration year 1, appropriate baseline calculations should also be reported using Calendar Year 2010 as the baseline year. Baseline calculations to include but not be limited to: total deliveries, pregnancy rate, total births, number of still births, LBW and VLBW rates, etc.

- Top five (5) Chronic Diseases/Conditions affecting P4HB participants in the IPC Demonstration component;
- The total number of deliveries to Contractor’s Medicaid Members;
- The pregnancy rate for Contractor’s Medicaid Members;

- The number of deliveries to the P4HB participants stratified by Demonstration component: FP Only; FP and IPC; Resource Mothers Only.
- The number of total births to the Contractor's Medicaid Members stratified by birth weight categories;
- The number of live births to P4HB participants in the FP only component of the Demonstration stratified by birth weight categories – Normal (2,500 grams or more), LBW (1,500 grams to 2,499 grams), VLBW (less than 1,500 grams);
- The number of live births to P4HB participants in the IPC component of the Demonstration stratified by birth weight category;
- The number of stillbirths to the IPC P4HB participants;
- IPC Problem and Strength Identification Yearly Summary
- The number of estimated averted births (using the baseline fertility rate) in the waiver application;
- The total and average per person Medicaid expenditures for the Demonstration;
- The total and average per person Medicaid expenditures for the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for the first year infant life costs stratified by birth weight categories;
- The number of VLBW deliveries to Contractor's P4HB participants;
- The number of VLBW deliveries that occur to P4HB participants in the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for VLBW deliveries;
- Results of P4HB participant and Provider satisfaction surveys.

CONTRACT SHEET

ATTACHMENT N

RESOURCE MOTHER OUTREACH

Resource Mother:

The Resource Mother provides a broad range of paraprofessional services to P4HB participants in the Interpregnancy Care component of the Planning for Healthy Babies Program and their families. She performs certain aspects of case management including the provision of assistance in dealing with personal and social problems and may provide supportive counseling to P4HB participants and their families and/or serve as a liaison for social services.

The Contractor has the responsibility for training the Resource Mother and must utilize the standardized Resource Mothers Training Manual specified by DCH. DCH will also provide the Resource Mother Job description and technical support for the Resource Mother Outreach program.

The Contractor must ensure the Resource Mother Outreach is effective through monitoring of the Resource Mother's performance including an evaluation of the Resource Mother's P4HB participant contact activities and contact documentation.

The Resource Mother will carry out the following responsibilities:

- Complete P4HB participant intakes based on interviews with P4HB participants, their families, significant others and appropriate community agencies.
- Demonstrate skillful use of observation and assessment tools to evaluate the P4HB participant's needs and monitor the P4HB participant's progress towards treatment goals.
- Meet with P4HB participants via phone or in person to increase participants' adoption of healthy behaviors, including healthy eating choices and smoking cessation; increase participants' adoption of healthy behaviors such as healthy eating choices and smoking cessation.
- Support P4HB participants' compliance with primary care medical appointments including assistance with non-emergency transportation arrangements; serve as the liaison between P4HB participants and family members, significant others, nurses, physicians, and organizational components to facilitate communication, linkage and continuity of service.
- Consult with physicians, nurses, social workers, and case managers about problems identified and assist in the development of an appropriate action plan.
- Document compliance with appointments and enrollment and participation in planned services and benefits in the P4HB participant's case management record and/or required Demonstration forms.
- Prepare and disseminate pertinent reports for/to supervisors, colleagues and other appropriate individuals. Maintain program statistics for purposes of evaluation and research.

- Submit all data, forms and documentation per Demonstration guidelines.
- Provide short-term case management and referral services to P4HB participants with emergency situations.
- Support P4HB participants' compliance with medications to treat chronic health conditions including assisting the P4HB participant with obtaining needed medications and reinforcing the need for medication compliance.
- Assist the P4HB participant with the coordination of social services support for family and life issues; implement and organize the delivery of specific social services within the community and maintain an updated resource file.
- Assist Participants in locating and utilizing community resources including legal, medical, financial assistance, and other referral services; assist with linking mothers to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Provide emotional support following substance abuse treatment;
- Provide mentoring for P4HB Participants;
- Assist mothers of VLBW babies to obtain regular preventive health visits and appropriate immunizations for their child;
- Link the VLBW infant's mother with community resources such as WIC;
- Provide the mother with the peer and emotional support needed to meet the health demands of her VLBW infant;
- Encourage the VLBW infant's mother to implement the parenting and child safety concepts taught during classes the mother will be encouraged to attend.

Technical Competencies of the Resource Mother

- Successfully complete Resource Mother training module and participate in ongoing in-service training as provided
- Knowledge of agency policies and procedures.
- Ability to coordinate and organize the delivery services.
- Ability to monitor client's progress toward meeting established goals.
- Knowledge of client's treatment goals.
- Ability to interview clients and/or families using established techniques.
- Ability to develop client profile.
- Knowledge of agency confidentiality policies.
- Knowledge of state and federal confidentiality laws and regulations.
- Knowledge of available community resources.
- Ability to make appropriate referrals.
- Knowledge of crisis intervention.

- Ability to develop P4HB participant service plan to assist P4HB participant in attaining social, educational and vocational goals.
- Ability to contact health care professionals to obtain additional background information.
- Knowledge of target population.
- Knowledge of agency specific software.
- Knowledge of available databases.
- Ability to prepare reports and case history records.
- Knowledge of eligibility requirements.
- Knowledge of what qualifies as an emergency situation.

Entry Qualifications

- High school diploma or GED and two years of experience in a social services related position or Bachelor's degree in a social services related field
- Valid driver's license
- Reliable vehicle with motor vehicle insurance coverage
- Good communication skills. Comfortable communicating with both professionals (physicians, nurses, social workers, etc.) and with lay persons

CONTRACT SHELL

ATTACHMENT O

TABLE OF CONTRACTED RATES

Attachment O is a table displaying the contracted rates by rate cell for each contracted region. These rates will be the basis for calculating capitation payments in each contracted Region.

Rate Cell	P4HB Capitation Rates
Family Planning - All Regions Interpregnancy Care - All Regions	

For members receiving full Medicaid benefits through a CMO or fee-for-service, the following rate will be paid for Resource Mother services. For members enrolled in a CMO, this rate will be in addition to any capitation paid to provide medical services to the member.

Rate Cell	P4HB Capitation Rates
Resource Mother Services Only- All Regions	

ATTACHMENT P

STATEMENT OF ETHICS

Preamble

The Department of Community Health has embraced a mission to improve the health of all Georgians through health benefits, systems development, and education. In accomplishing this mission, DCH employees must work diligently and conscientiously to support the goals of improving health care delivery and health outcomes of the people we serve, empowering health care consumers to make the best decisions about their health and health care coverage, and ensuring the stability and continued availability of health care programs for the future. Ultimately, the mission and goals of the organization hinge on each employee's commitment to strong business and personal ethics. This Statement of Ethics requires that each employee:

- Promote fairness, equality, and impartiality in providing services to clients
- Safeguard and protect the privacy and confidentiality of clients' health information, in keeping with the public trust and mandates of law
- Treat clients and co-workers with respect, compassion, and dignity
- Demonstrate diligence, competence, and integrity in the performance of assigned duties
- Commit to the fulfillment of the organizational mission, goals, and objectives
- Be responsible for employee conduct and report ethics violations to the DCH Inspector General and to the DCH Ethics Officer
- Engage in carrying out DCH's mission in a professional manner
- Foster an environment that motivates DCH employees and vendors to comply with the Statement of Ethics
- Comply with the Code of Ethics set forth in O.C.G.A. Section 45-10-1 et seq.

Not only should DCH employees comply with this Statement of Ethics, but DCH expects that each vendor, contractor, and subcontractor will abide by the same requirements and guidelines delineated. Moreover, it is important that employees and members of any advisory committee or commission of DCH acknowledge the Statement of Ethics.

Ethical Guidelines

1. Code of Conduct

All employees of DCH are expected to maintain and exercise at all times the highest moral and ethical standards in carrying out their responsibilities and functions. Employees must conduct themselves in a manner that prevents all forms of impropriety, including placement of self-interest above public interest, partiality, prejudice, threats, favoritism and undue influence. There will be no reprisal or retaliation against any employee for questioning or reporting possible ethical issues.

2. Equal Employment

The Department is committed to maintaining a diverse workforce and embraces a personnel management program which affords equal opportunities for employment and advancement based on objective criteria. DCH will provide recruitment, hiring, training, promotion, and other conditions of employment without regard to race, color, age, sex, religion, disability, nationality, origin, pregnancy, or other protected bases. The Department expects employees to support its commitment to equal employment. The failure of any employee to comply with the equal employment requirements provided in DCH Policy #21 may result in disciplinary action, up to and including termination.

3. Harassment

DCH will foster a work environment free of harassment and will not tolerate harassment based on sex (with or without sexual conduct), race, color, religion, national origin, age, disability, protected activity (*i.e.*, opposition to prohibited discrimination or participation in a complaint process) or other protected bases from *anyone* in the workplace: supervisors, co-workers, or vendors. The Department strongly urges employees to report to the Human Resources Section any incident in which he or she is subject to harassment. Additionally, any employee who witnesses another employee being subjected to harassment should report the incident to the Human Resources Section. If DCH determines that an employee has engaged in harassment, the employee shall be subject to disciplinary action, up to and including termination, depending on the severity of the offense.

4. Appropriate Use of DCH Property

Employees should only use DCH property and facilities for DCH business and not for any type of personal gain. The use of DCH property and facilities, other than that prescribed by departmental policy, is not allowed. Furthermore, the use of DCH property and facilities for any purpose which is unlawful under the laws of the United States, or any state thereof, is strictly prohibited. Employees who divert state property or resources for personal gain will be required to reimburse the Department and will be subject to the appropriate disciplinary action, up to and including, termination.

5. Secure Workplace

DCH is committed to maintaining a safe, healthy work environment for its employees. Accordingly, it is DCH's expectation that employees refrain from being under the influence of alcohol or drugs in the workplace because such conduct poses a threat to the employee, as well as others present in the workplace. Additionally, DCH has a zero tolerance policy regarding violence in the workplace. Specifically, DCH will not condone the threat of or actual assault or attack upon, a client, vendor, or other employee. If an employee engages in violent behavior which results in an assault of another person, he or she will be immediately terminated.

6. Political Activities

Although the DCH recognizes that employees may have an interest in participating in political activities and desires to preserve employees' rights in participating in the political process, employees must be aware of certain allowances and prohibitions associated with particular political activities. DCH encourages employees to familiarize themselves with DCH Policy #416 to gain understanding about those instances when a political activity is disallowed and/or approval of such activity is warranted.

7. Confidentiality

DCH has a dual mandate in terms of confidentiality and privacy. Foremost, as a state agency, DCH must comply with the Georgia Open Records Act and Open Meetings Act. The general rule that is captured by those laws is that all business of the agency is open to the public view upon request. The exceptions to the general rule are found in various federal and state laws. In order to protect the individuals' health information that is vital to the delivery of and payment for health care services, DCH sets high standards of staff conduct related to confidentiality and privacy. Those standards are reinforced through continuous workforce training, vendor contract provisions, policies and procedures, and web-based resources.

8. Conflicts of Interest

Employees should always strive to avoid situations which constitute a conflict of interest or lend to the perception that a conflict of interest exists. Specifically, employees must avoid engaging in any business with the DCH which results in personal financial gain. Similarly, employees must encourage family members to avoid similar transactions since they are subject to the same restrictions as employees. DCH encourages its employees to seek guidance from the Office of General Counsel regarding questions on conflicts of interest.

9. Gifts

Employees are strictly prohibited from individually accepting gifts from any person with whom the employee interacts on official state business. Gifts include, but are not limited to, money, services, loans, travel, meals, charitable donations, refreshments, hospitality, promises, discounts or forbearance that are not generally available to members of the public. Any such item received must be returned to the sender with an explanation of DCH's Ethics Policy.

10. Relationships with Vendors and Lobbyists

DCH values vendors who possess high business ethics and a strong commitment to quality and value. Business success can only be achieved when those involved behave honestly and responsibly. Therefore, it is critical that employees ensure that vendors contracting with DCH are fully informed of DCH policies concerning their relationships with DCH employees and that these policies be uniformly applied to all vendors. Among other requirements, DCH expects that each vendor will honor the terms and conditions of its contracts and agreements. If DCH determines that a vendor has violated the terms and conditions of a contract or agreement, the vendor shall be held responsible for its actions.

Employees must ensure that fair and open competition exists in all procurement activities and contracting relationships in order to avoid the appearance of and prevent the opportunity for favoritism. DCH strives to inspire public confidence that contracts are awarded equitably and economically. DCH will apply the state procurement rules, guidelines, and policies. Open and competitive bidding and contracting will be the rule.

DCH recognizes that lobbyists, both regulatory and legislative, may from time to time seek to meet with DCH employees to advance a particular interest. DCH recognizes that employees may have personal opinions, even those that may be contrary to a position that DCH has adopted. DCH employees, however, must recognize that the public, including legislators and lobbyists, may have difficulty differentiating between the official DCH position and a personal opinion. Accordingly, employees should always work directly with the Director of Legislative Affairs in preparing any responses to requests or questions from elected officials and their staff or lobbyists.

11. Mandatory Reporting

If I have knowledge of any ethics violation, I am aware that I am responsible for reporting such violation to the DCH Inspector General and the DCH Ethics Officer. My good faith reports will be free from retaliation. If I am a supervisor, I am aware that I am responsible for reporting such violation and for forwarding any such report from a member of my staff to the DCH Inspector General and the DCH Ethics Officer. As a supervisor, I am additionally responsible for ensuring that the employees who report to me are aware of and comply with the ethical standards and policies that are applicable to their positions.

(Signatures on following page)

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understand the Georgia Department of Community Health's *Statement of Ethics*; and
- B. It agrees to comply with the provisions of the Georgia Department of Community Health's *Statement of Ethics*;

[CONTRACTOR]

Signature

Date

ATTACHMENT Q

DCH ETHICS IN PROCUREMENT POLICY

DCH Ethics In Procurement Policy	Policy No. 402
Effective Date: April 10, 2006 Revised and Restated: April 2, 2012	Page 1 of 12

I. THE COMMITMENT

The Department is committed to a procurement process that fosters fair and open competition, is conducted under the highest ethical standards, is fully compliant with all legal authority, and has the complete confidence and trust of the public it serves. To achieve these important public purposes, it is critical that current vendors and those making proposals to provide goods or services to the Department, as well as employees of the Department, members of the Board of Community Health, and independent contractors, consultants and temporary staffing agency employees currently on an assignment with DCH, have a clear understanding and an appreciation of, the DCH Ethics in Procurement Policy (the "Policy").

II. SCOPE

This Policy is applicable to all Vendors and DCH Workers, as those terms are defined below.

III. ETHICAL PROCUREMENT STANDARDS

In order to maintain an ethical procurement process, DCH Workers and Vendors must act in accordance with the following standards:

A. Fulfilling Legitimate Business Needs

The procurement of goods and services will be limited to those necessary to accomplish the mission, goals, and objectives of the Department.

B. Identifying and Resolving Conflicts of Interest

Conflicts of interest shall be promptly identified and resolved early in the Procurement process. A "conflict of interest" exists when an individual possesses personal, financial or professional interests that compete, conflict or otherwise interfere with the individual's actual or perceived ability to act in the best interests of the Department or carry out that individual's duties in an impartial manner. A conflict of interest situation can arise when an individual takes actions or has interests that may make it difficult to perform his or her work objectively and effectively. Conflicts of interest also arise when an individual, or a family member of that individual, receives personal

benefits as a result of the individual's action, decision, or disclosure of Confidential Information in a Procurement.

C. Avoiding the Appearance of Impropriety

DCH Workers must take care to avoid any appearance of impropriety and must promptly disclose to their supervisors any material transaction or relationship that reasonably could be expected to give rise to a conflict of interest. Similarly, anyone engaged in a business relationship with the Department should avoid any appearances of impropriety.

D. Maintaining Impartiality

DCH Workers must maintain an impartial, arms' length relationship with anyone seeking to influence the outcome of a Procurement.

E. Declining Gifts

DCH Workers are prohibited at all times from soliciting, demanding, accepting, or agreeing to accept Gifts from Vendors, including Gifts from consultants, independent contractors or temporary staffing agency employees currently on assignment with DCH.

F. Avoiding Misrepresentations

DCH Workers and Vendors may not knowingly falsify, conceal or misrepresent material facts concerning a Procurement.

G. Obtaining Sufficient Authorization

DCH Workers may not obligate the Department without having received prior authorization from an approved official. Engaging in such activity is a misrepresentation of authority. DCH Workers who are consultants, independent contractors or temporary staffing agency employees shall not represent themselves as having the authority of a DCH employee.

H. Reporting Possible Conflicts of Interests

DCH Workers and Vendors involved in Procurements must promptly report possible conflicts of interests to DCH in accordance with Section V "General Requirements" of the Policy.

A DCH Worker's failure to act in accordance with these standards, or failure to follow the guidelines set forth herein shall be grounds for disciplinary action, up to and including, termination of the working relationship with DCH. Similarly, a Vendor's failure to comply with this Policy will result in appropriate action as determined by governing state and/or federal law, rules and regulations, and other applicable Department policies and procedures.

IV. DEFINITIONS

For purposes of this policy:

“Affiliate Vendor Team” shall include, but not be limited to, owners, employees, directors, officers, contractors, and consultants of a Vendor that directly or indirectly assist the Vendor in the preparation of response to a Procurement. For individual consultants, independent contractors and temporary staffing agency workers, the “Affiliate Vendor Team” includes the owners, employees, directors, officers, contractors and consultants of the company for whom the individual consultant, independent contractor or temporary staffing agency worker works.

“Confidential Information” shall mean all information not subject to disclosure pursuant to the Open Records Act, O.C.G.A. §50-18-70 et seq. For all Procurements governed by the State Purchasing Act, O.C.G.A. §50-5-50 et seq., “Confidential Information” shall also include records related to the competitive bidding and proposal process which, if disclosed prior to the issuance of the public notice of intent to award would undermine the public purpose of obtaining the best value for the Department. Such records include, but are not limited to, cost estimates, bids, proposals, evaluation criteria, evaluations of Vendors’ bids/proposals, negotiation documents, offers and counter-offers, and records revealing preparation for the Procurement.

“DCH” and “Department” shall mean the Georgia Department of Community Health.

“DCH Worker” shall mean any person who works for the Department as an employee or as an independent contractor, consultant or temporary staffing agency employee on assignment with the Department, as well as members of the Board of Community Health.

“DOAS” shall mean the Georgia Department of Administrative Services.

“Evaluation Team” shall mean a designated group of DCH Workers who review, assess, and score documents submitted to the Department in response to a Procurement Solicitation. An Evaluation Team for a Staffing Recruitment includes the individuals responsible for reviewing resumes submitted in response to the Staffing Recruitment Solicitation, interviewing prospective staffing agency workers, and approving the selection of the individuals.

“Family Member” shall mean a spouse, adult living in the household of the DCH worker, and relatives of the DCH Worker, his or her spouse, or an adult living in the household of the DCH Worker. Relatives include the following: parent/stepparent, grandparent, child, grandchild, brother (full, half, step), sister (full, half, step), uncle, aunt, nephew, niece, and first cousin.

“Financial Interest” shall mean an ownership interest in assets or stocks of the Vendor, current employment with the Vendor, or prospective employment with the Vendor. “Financial Interest” does not include an ownership interest in a Vendor that is part of a widely held investment fund (such as a mutual fund, regulated investment company, common trust fund maintained by a bank or similar financial institution, pension or deferred

compensation plan, or any other investment fund), if the individual has no ability to control the financial interests held by the fund AND (A) The fund is publicly traded or available; or (B) The assets of the fund are widely diversified, meaning it holds no more than 5% of the value of its portfolio in the securities of any one issuer, other than the U.S. Government, and no more than 20% in any particular economic or geographic sector.

“Gifts” shall mean anything of value, including but not limited to the following: goods, money, advances, personal services, entertainment, lodging, parking, real property or the use thereof, commissions, promises of future employment, stocks, bonds, notes or other investment interests in an entity, rights of action, intellectual property, gratuities, loans, extensions of credit, forgiveness of debts, memberships, subscriptions, travel or means of personal transportation, meals, tickets to events, charitable donations, refreshments, hospitality, and promises, discounts or forbearance that are not generally available to members of the public. A Gift need not be intended to influence or reward a DCH Worker.

“Issuing Officer” shall mean the Procurement Professional designated in the Procurement Solicitation to be the Vendor’s only point of contact with the Department following the public advertisement of the Procurement Solicitation until such time as the results of the Procurement Solicitation are publicly announced or the Procurement Solicitation is cancelled. The Issuing Officer is responsible for managing all communication during this time period, including, but not limited to, answering Vendors’ questions, contacting Vendors for clarification requests, negotiations, and contract discussions.

“Kickback” shall mean compensation of any kind directly or indirectly accepted by a DCH Worker from or on behalf of a Vendor seeking/competing for or doing business with the Department, for the purpose of influencing the award of a contract or the manner in which the Department conducts its business. Kickbacks include, but are not limited to, money, fees, gifts, employment opportunities for a DCH Worker or Family Member, commissions or credits. DCH Workers who are employed by a Vendor, such as consultants, independent contractors and temporary staffing agency workers, may receive payment from the Vendor associated with the work performed on a DCH assignment. However, any payment received by the consultant, independent contractor or staffing agency worker as a result of another DCH Worker’s services for the Department may be a prohibited kickback. For example, a consultant who owns a consulting company may receive compensation for his or her work on an assignment with DCH. However, if he or she employs an individual who then becomes a consultant for DCH, any mark-up or payment received as a result of the employee’s services for DCH shall be disclosed for evaluation by DCH and may be considered a kickback.

“Procurement” shall mean buying, purchasing, renting, leasing, or otherwise acquiring any supplies, services, or construction. The term also includes all activities that pertain to obtaining any supply, service, or construction, including description of requirements, selection and solicitation of sources, preparation and award of contract, as well as the disposition of any Protest. A Procurement is not limited to, but specifically includes, procurements which are either exempt or non-exempt either by statute or under DOAS rules, a procurement of professional services, a Staffing Recruitment and procurements under any other approved procurement vehicle.

“Procurement Manual” shall mean the most current version of the Georgia Procurement Manual released by DOAS.

“Procurement Professional” shall mean the Department’s Office of Procurement Services (OPS) staff member assigned to and responsible for managing the Procurement process, including, but not limited to, needs identification and fact-finding, market research, requests for information, development of requirements and specifications, determination of the Procurement strategy and management of the Procurement solicitation, evaluations and awards. The Procurement Professional is charged with adhering to the highest ethical standards and ensuring that Procurements are executed in a fair and impartial manner, consistent with applicable laws, rules and regulations, which may include the Georgia Procurement Manual (GPM), the Georgia State Purchasing Act and Department procurement policies.

“Procurement Solicitation” shall mean the Department’s solicitation of offers from Vendors for the needed supplies, services or construction. Procurement Solicitation shall include, but not be limited to, requests for quotes, requests for qualified contractors, requests for proposals, requests for approvals, requests for pre-qualifications, reverse auctions and any other approved solicitation method.

“Prohibited Contact” applies only to a Procurement subject to DOAS rules and refers to a Vendor’s contact with DCH Workers other than through the Issuing Officer after the public advertisement of a Procurement Solicitation and until such time as the results of the Procurement Solicitation are publicly announced or the Procurement Solicitation is cancelled. During that time period, “Prohibited Contact” shall mean contact with any DCH Worker, other than the Issuing Officer, whereby it could be reasonably inferred that such contact was intended to influence, or could reasonably be expected to influence, the outcome of a Procurement Solicitation. This prohibition includes, without limitation, personal meetings, meals, entertainment functions, telephonic communications, letters, faxes and e-mails, as well as any other activity that exposes the DCH Worker to direct contact with a Vendor. This prohibition does not include contacts with DCH Workers for the purpose of discussing existing on-going Department work which is unrelated to the subject of the Procurement Solicitation or existing consulting assignments. Inquiries regarding the status of a Procurement should always be directed to the Issuing Officer.

“Protest” shall mean a written objection by an interested party to Procurement Solicitation, or to a proposed award or award of a contract, with the intention of receiving a remedial result.

“Protestor” shall mean an actual bidder/offeror who is aggrieved in connection with a Procurement Solicitation or intended or actual contract award and who files a Protest.

“Requirements Team” shall mean a designated group of DCH Workers who develop a Procurement Solicitation. A Requirements Team for the selection of professional services, consultant or temporary staffing agency employee includes the individuals responsible for drafting the request for such professional, consultant or staffer and approving the posting of the request. A DCH Worker is not a member of a Requirements Team simply because he or she identifies potential Vendors or meets with potential Vendors or current Vendors to

discuss Departmental needs and review relevant information. A Requirements Team is formed once it is determined that a Procurement Solicitation or request for services is necessary to meet a Departmental need.

“Staffing Recruitment” shall mean a Procurement for the specific purpose of selecting temporary staffing agency employees in accordance with DOAS statewide contracts.

“Staffing Recruitment Professional” shall mean the Department’s Office of Human Resources staff member assigned to and responsible for managing the Staffing Recruitment process. The Staffing Recruitment Professional is charged with adhering to the highest ethical standards and ensuring that Staffing Recruitments are executed in a fair and impartial manner, consistent with applicable laws, rules and regulations.

“Staffing Recruitment Solicitation” shall mean a Procurement Solicitation for the specific purpose soliciting offers as part of a Staffing Recruitment.

“Vendor” shall mean any individual or entity seeking to do business or doing business with the Department, including, without limitation, contractors, professionals, consultants, suppliers, manufacturers seeking to act as the primary contracting party, officers and employees of the foregoing, any subcontractors, sub consultants and sub suppliers at all lower tiers, as well as any person or entity engaged by the Department to provide a good or service. A professional, consultant or temporary staffing agency and its employee who desires to be placed on an assignment with DCH is a Vendor. Once selected, the professional, consultant or temporary staffing agency employee remains a Vendor, but is also a DCH Worker.

V. General Requirements

A. Responsibilities of Procurement Professionals, Staffing Recruitment Professionals and DCH Workers who are on a Requirements Team or Evaluation Team

1. Procurement Professionals and Staffing Recruitment Professionals must ensure that DCH Workers participating in any Procurement activities have sufficient understanding of the Procurement and evaluation process and the applicable DCH and DOAS rules and regulations and policies associated with the processes.
2. Requirements Team members are tasked with developing standards of work, Procurement Solicitations and related documents in an objective and impartial manner. Typically, a Procurement Professional or Staffing Recruitment Professional facilitates the activities of a Requirements Team and a designated DCH Worker who is a Requirements Team member serves as the Head of the Requirements Team. Often, Requirements Team members are uniquely qualified to develop this material because of their experience with the industry. This experience may have been gained through employment or performance of services with Vendors. These Requirements Team members also maintain professional relationships that enable them to gather valuable information about current products and services. While participating on the Requirements Team, it is essential that Requirements Team members use their experiences and contacts

solely to benefit the Department. They must place aside any personal and/or professional biases or prejudices that may exist when developing standards of work, Procurement Solicitations and related documents. A DCH Worker serving on a Requirements Team must not allow the DCH Worker's or Family Member's personal or professional relationships (e.g., friendships, dating, prior or current employment) with employees, principals, directors, officers, etc. of a Vendor or individuals on the Affiliate Vendor Team to interfere with the ability to prepare these Procurement Solicitations fairly and objectively in the interests of the Department. Such relationships may give rise to the appearance of, and/or create an actual conflict of interest and must be promptly disclosed in writing to the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Requirements Team prior to the DCH Worker's participation on the Requirements Team using the Attestation Form attached as Exhibit A to this Policy (or Exhibit C to this Policy for a Staffing Recruitment), or a similar form provided by the Ethics Officer.

3. The designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer before making a determination as to whether a DCH Worker who has made any written disclosures on the Attestation Form or for whom there is a potential conflict of interest is permitted to participate on the Requirements Team. The Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists, and will notify the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Requirements Team. The Ethics Officer may recommend actions that are necessary to assure the objectivity and fairness of the Procurement Solicitation and to prevent the appearance of a conflict of interest. If an actual conflict or appearance of conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to exclude the individual from the Requirements Team or prepare a written description of the actions that will be taken to "cure" the conflict and assure the objectivity and fairness of the Procurement Solicitation. The designated Procurement Professional or Staffing Recruitment Professional shall maintain this written description of actions and ensure compliance with its terms. In some cases, disclosure of the conflict may be sufficient to "cure" the conflict.

4. Evaluation Team members are tasked with conducting objective, impartial evaluations, and, therefore, must place aside any personal and/or professional biases or prejudices that may exist. A DCH Worker serving on an Evaluation Team must not allow the DCH Worker's or DCH Worker's Family Member's personal or professional relationships (i.e. friendships, dating, prior or current employment) with employees, principals, directors, officers, etc. of a Vendor or individuals on the Affiliate Vendor Team to interfere with the rendering of fair and objective determinations. Such relationships may give rise to the appearance of, and/or create an actual conflict of interest and must be promptly disclosed in writing to the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Evaluation Team prior to the Worker's participation on the Evaluation Team using the Attestation Form attached as

Exhibit B to this Policy (or Exhibit C to this Policy for a Staffing Recruitment), or a similar form provided by the Ethics Officer.

5. The designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer before making a determination as to whether a DCH Worker who has made any written disclosures on the Attestation Form or for whom there is a potential conflict of interest is permitted to participate on the Evaluation Team. The Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists, and will notify the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Evaluation Team. The Ethics Officer may recommend actions that are necessary to assure the objectivity and fairness of the Evaluation and to prevent the appearance of a conflict of interest. If an actual conflict or appearance of conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to exclude the individual from the Evaluation Team or prepare a written description of the actions that will be taken to “cure” the conflict and assure the objectivity and fairness of the Evaluation. The designated Procurement Professional or Staffing Recruitment Professional shall maintain this written description of actions and ensure compliance with its terms. In some cases, disclosure of the conflict may be sufficient to “cure” the conflict.
6. In the event that the Department determines that a conflict of interest does exist and a DCH Worker on a Requirements Team or Evaluation Team failed to make the appropriate disclosure, the Department will evaluate whether the conflict is of sufficient magnitude to disqualify the DCH Worker from further participation on the Requirements Team and/or the Evaluation Team. Furthermore, in the event that the Department determines that the conflict of interest did negatively impact the final Procurement Solicitation or the outcome of a Procurement, such DCH Worker may be subject to disciplinary action, up to and including termination of employment.
7. In the event the Department becomes aware that a DCH Worker maintains a relationship of any sort that may be a conflict of interest or may have the appearance of a conflict of interest with respect to a Procurement, the designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer, after which the Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists. Based on that determination and the impact of the conflict or the appearance of a conflict, the Ethics Officer may recommend actions that are necessary to cure the conflict or the appearance of a conflict. If an actual or appearance of a conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to take appropriate action, up to and including the disallowance of the DCH Worker’s participation in any Procurement activities.
8. Prior to participating on a Requirements Team or an Evaluation Team, each DCH Worker (including the Head of the Requirements Team and Head of the Evaluation Team) and the designated Procurement Professional or Staffing Recruitment

Professional must execute the appropriate Attestation Form in Exhibit A or B to this Policy (or Exhibit C to this Policy for a Staffing Recruitment).

B. Responsibilities of DCH Workers who are not on a Requirements Team or Evaluation Team

All DCH Workers should be mindful of the importance of confidentiality during any Procurement. Even if a DCH Worker is not serving in the capacity of a member on the Evaluation Team or Requirements Team, all DCH Workers must refrain from engaging in conduct with a Vendor that could result in a conflict of interest or be considered a Prohibited Contact.

C. Responsibilities of DCH Workers who are also Vendors

A DCH Worker who is a consultant or temporary staffing agency employee on an assignment with DCH is also a Vendor. Consultants or temporary staffing agency employees shall provide professional, objective and impartial advice and services, and at all times hold the Department's interests paramount, without any consideration for future work for themselves or members of the Vendor Affiliate Team. In addition to the general obligations of a DCH Worker and Vendor, such individuals shall do the following in order for the Department to identify potential or perceived conflicts of interest that may impact procurements:

1. Disclose to the supervising DCH employee and Director of Human Resources every current and former employer
2. Disclose to the supervising DCH employee and Director of Human Resources the name of every current DCH Worker with whom the individual or the individual's Family Member has a current or pre-existing personal or professional relationship
3. Disclose to the supervising DCH employee and Director of Human Resources any project for another client that may give rise to an actual or perceived conflict of interest
4. Appropriately identify him or herself as an employee of the entity that actually pays his or her compensation and state that he or she is on a contract assignment with DCH
5. Ensure that he or she only performs work that is within the scope of the current assignment
6. Coordinate with the supervising DCH employee to ensure that his or her level of access to Confidential Information is limited to the scope of the current assignment

D. DOAS rules applicable

DOAS rules and regulations may apply to a Procurement, which DOAS rules and regulations may also be applicable to conflicts of interest and may be more restrictive than the provisions of this Policy. It is the responsibility of all DCH Workers to comply with DOAS rules and regulations, when applicable.

VI. VENDOR RESPONSIBILITIES

A. Gifts and Kick-Backs

Vendors may neither offer nor give any Gift or Kick-backs, directly or indirectly, to a DCH Worker. Similarly, no Vendor may offer or give any Gift or Kick-backs, directly or indirectly, to any member of a DCH Worker's Family. Such prohibited activity may result in the termination of the contract, in those cases where the Vendor has executed a contract with the Department. In the event that a potential Vendor who has submitted a response to a Procurement Solicitation engages in such activity, the Department shall act in accordance with DOAS protocol.

B. Family Relationships with DCH Workers

If a Vendor has a family or personal relationship with a DCH Worker, a Gift that is unconnected with the DCH Worker's duties at the DCH is not necessarily prohibited. In determining whether the giving of an item was motivated by personal rather than business concerns, the history of the relationship between the Vendor and DCH Worker shall be considered. However, regardless of the family or personal relationship between a Vendor and a DCH Worker, a Gift is strictly forbidden where it is being given under circumstances where it can reasonably be inferred that it was intended to influence the DCH Worker in the performance of his or her official duties.

C. Vendor Submittals

The Department expects all Vendors to be forthcoming, always submitting true and accurate information in response to a Procurement Solicitation or with regard to an existing business relationship. If the Department determines that the Vendor has intentionally omitted or failed to provide pertinent information and/or falsified or misrepresented material information submitted to the Department, the Department shall act in accordance with applicable state law and DOAS procurement policies and procedures.

Vendors must calculate the price(s) contained in any bid in accordance with the Georgia Procurement Manual.

D. Business Relations

A Vendor may not be allowed to conduct business with the Department for the following reasons:

1. Falsifying or misrepresenting any material information to the Department as set forth hereinabove;

2. Conferring or offering to confer upon a DCH Worker participating in a Procurement (which the entity has bid or intends to submit a bid) any Gift, gratuity, favor, or advantage, present or future; and
3. Any other reasons not explicitly set forth herein that are contained in the Georgia Procurement Manual or applicable Department policy.

E. *Prohibited Contact*

The Vendor is precluded from engaging in Prohibited Contact upon the release of a Procurement Solicitation or posting of a request for consulting or temporary staffing services, during the evaluation process, and any time prior to the Department's public announcement of the results of the Procurement Solicitation, filling of the temporary position, or the Department's cancellation of the Procurement Solicitation.

VII. USE OF CONFIDENTIAL INFORMATION

DCH Workers will not use Confidential Information for their own advantage or profit, nor will they disclose Confidential Information to any potential Vendor or to any unauthorized recipient. DCH Workers will comply with all confidentiality requirements set forth in DCH policies and applicable law.

VIII. ADDRESSING VIOLATIONS

A. *The Process*

All DCH Workers are responsible for bringing violations to the attention of the Issuing Officer under Procurement protocols, the Procurement Professional or the Staffing Recruitment Professional or to a supervisor/manager if the affected DCH Worker is not a part of the Procurement. The supervisor/manager and/or the designated Procurement Professional or Staffing Recruitment Professional shall promptly report such violation to the Ethics Officer. If for any reason it is not appropriate to report a violation to the DCH Worker's immediate supervisor or the designated Procurement Professional or Staffing Recruitment Professional, DCH Workers will report such violations or concerns to the Ethics Officer or the Office of Inspector General. Procurement Professionals, Staffing Recruitment Professionals and managers are required to report suspected ethics violations to the Ethics Officer and the Office of Inspector General, who have specific responsibility for investigating all reported violations.

Confirmed violations will result in appropriate disciplinary action, up to and including termination from employment. In some circumstances, criminal and civil penalties may be applicable.

The Ethics Officer or Inspector General will notify the DCH Worker making the report of the suspected violation of receipt of such report. All reports will be promptly

investigated and appropriate corrective action will be taken if warranted by the investigation.

B. Good Faith Filings

Anyone filing a complaint concerning a violation of this Policy must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Good faith reporting of suspected policy violations by others shall not jeopardize a DCH Worker's employment with the Department. However, any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

C. Confidentiality

Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. Additionally, all DCH Workers are expected to cooperate in the investigation of such violations. Failure to cooperate in an investigation may result in disciplinary action, up to and including termination from employment.

(Signatures on following page)

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understand the Georgia Department of Community Health's *Ethics in Procurement Policy*;
- B. It agrees to comply with those provisions of the Georgia Department of Community Health's *Ethics in Procurement Policy* applicable to Contractor; and
- C. It shall cooperate in good faith with the Georgia Department of Community Health so that the Georgia Department of Community Health and its workers will be in compliance with the *Ethics in Procurement Policy*.

[CONTRACTOR]

Signature

Date

ATTACHMENT R

CODE OF ETHICS AND CONFLICT OF INTEREST POLICY

Georgia Department of Community Health

Code of Ethics and Conflict of Interest Policy	Policy No. 401
Effective Date: November 1, 2006 Revision Date: January 26, 2011	Page 1 of 10

- References:**
1. O.C.G.A. §45-10-1 et seq.;
 2. O.C.G.A. § 21-5-1, et seq.;
 3. Governor’s Executive Order Establishing a Code of Ethics for Executive Branch Officers and Employees, January 10, 2011;
 4. DCH Ethics Statement
 5. DCH Ethics in Procurement Policy

I. Purpose

The purposes of this policy are to assist DCH Employees and Board members in maintaining the highest standards of ethics and to provide guidelines that DCH Employees and Board members should follow in order to avoid a conflict of interest or the appearance of conflict.

II. Definitions

For the purposes of this policy, the following terms shall have the following meanings:

- A. “Agency” shall mean any agency, authority, department, board, bureau, commission, corporation, committee, office, or instrumentality of the State of Georgia.
- B. “Board member” shall refer to all members of the Board of Community Health established under O.C.G.A. § 31-2-3.
- C. “Commissioner” shall mean the Commissioner of the Department of Community Health.
- D. “Department” shall refer to the Department of Community Health established under O.C.G.A. § 31-2-4.
- E. “Employee” shall mean any person who is employed by the Department.
- F. “Expenses” shall mean the provision of food, beverages, travel, lodging, and registration fees that are attendant to an Employee’s participation in a public meeting related to official or professional duties. Expenses are limited to those items that are

directly associated with the business or professional duties and are not attributable to personal, social or recreational activities.

- G. "Family Member" means a spouse, parent, grandparent, child, brother, sister, uncle, aunt, nephew, niece, first cousin, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepchild, stepbrother, stepsister, half brother or half sister.
- H. "Gifts" shall mean, for the purposes of this Policy, money, advances, personal services, gratuities, loans, extensions of credit, forgiveness of debts, memberships, subscriptions, travel, meals, charitable donations, refreshments, hospitality, promises, discounts or forbearance that are not generally available to members of the public. A Gift need not be intended to influence or reward an Employee.
- I. "Honorarium" shall mean payment to a professional person for services for which no fee is required. Honorarium excludes such things as a certificate or other token of appreciation, which has nominal value and may be accepted as a ceremonial courtesy.
- J. "Indirectly" is intended to cover, but not be limited to, any scheme, device or plan which circumvents the literal language of this Policy but provides material financial benefits to a Board member or an Employee or such person's Family Member. "Limited powers" shall mean those powers exercised by Public Officials, which affect and influence a specific agency. "Lobbyist" shall have the meaning set forth in O.C.G.A. Section 21-5-70(5).
- K. "Nepotism" shall mean demonstrating favor on the basis of Family Member relationship in employment decisions such as hiring, promotions, transfers, or terminations.
- L. "Part time" shall mean employed for less than thirty (30) hours per week for a continuous period of fewer than twenty-six (26) weeks.
- M. "Public Official" shall mean any person elected or appointed to a state office wherein the person has administrative and discretionary authority to receive and expend public funds and perform certain duties that impact the public.
- N. "State-wide powers" shall mean those powers exercised by Public Officials which affect and influence all of state government.
- O. "State" shall mean the State of Georgia.
- P. "Substantial interest" shall mean the direct or indirect ownership of more than 25 percent of the assets or stock of any business.
- Q. "Transacting business" shall mean to sell or lease any personal or real property, surplus personal or real property, or services on one's behalf or on behalf of any third party as an agent, broker, dealer, or representative.

- R. “Vendor” shall mean the definition set forth in O.C.G.A. Section 45-1-6(a)(5), as well as any person seeking or opposing a certificate of need.
- S. “Value” shall mean actual retail price or cost attributable to a gift minus taxes and/or gratuities or a reasonable estimate based upon customary charges for like goods or services.

III. Code of Ethics

In fulfilling designated duties and responsibilities, Employees and Board members should be mindful of the following principles:

- A. Uphold the Constitution, laws, and legal regulations of the United States and the State.
- B. Give a full day’s labor for a full day’s pay and perform duties with earnest effort and best thought.
- C. Never discriminate unfairly by extending special favors or privileges, whether for remuneration or not, and never accept, for personal gain or for a Family Member, favors or benefits under circumstances which might be construed by reasonable persons as influencing the performance of governmental duties.
- D. Make no private promises of any kind binding upon the duties of office, since a government Employee has no private word, which can be binding on public duty.
- E. Refrain from engaging in business with the government, either direct or indirectly, which is inconsistent with the conscientious performance of governmental duties.
- F. Never use confidential information in the performance of governmental duties as a means of making a profit.
- G. Expose corruption.
- H. Seek to find and employ more efficient and economical ways of getting tasks accomplished.
- I. Uphold these principles, ever conscious that public office is a public trust.

IV. Transacting Business

A. DCH Board members and Employees

- 1. DCH Board members and Employees must refrain from transacting business with the Department for personal gain or on behalf of another party. However, it is allowable for DCH Board members and Employees to conduct business with other Agencies as long as the business transaction does not result in a benefit for the Department.

2. Part-time Employees, however, are allowed to transact business with the Department under the following circumstances:
 - a. the transaction resulted from a sealed competitive bid; or
 - b. the transaction does not exceed \$250.00 in benefit to the Employee, or transactions in a given calendar year do not, in the aggregate, exceed \$9,000.
3. A business in which DCH Board members or Employees maintain a substantial interest may not transact business with the Department.

B. Family Members

If a Family Member of a Public Official or Employee maintains a substantial interest in a business, that business may not engage in a business relationship with the Department. Because Family Members are subject to the same ethical constraints as Public Officials and/or Employees, Family Members may conduct business with other Agencies only as long as the business transaction does not result in a benefit for the Department. This prohibition stems from the presumption that the Public Official or Employee, by virtue of his or her Family Member's relationship, has benefited from the business transaction.

C. Exceptions

The following transactions are permitted:

1. A transaction by a full-time or part-time Public Official or part-time Employee that does not exceed \$250.00, or in the alternative, transactions, which in the aggregate in any given year, do not exceed \$9000 in value.
2. A transaction involving the sale of real property through eminent domain.
3. A transaction involving the purchase of health, life, disability, retirement or pension benefits as a part of compensation.
4. A transaction involving a Public Official or Employee and the sale of property or services, where State funds pay for the transaction, and the property or service remains with a third party who is restricted from selling the property or services to an Agency.
5. A transaction between a DCH Board member or Employee and a public contractor.
6. Any transaction involving an emergency purchase by the Department which must be made to protect the health, safety, or welfare of the citizens or property of Georgia; provided, however, that such emergency shall be attested to in writing by the DCH Division Chief under whose scope of responsibility the purchase is made.

7. A transaction wherein a Public Official or DCH Board member is the only source of supply within the State; provided, however, that the limitation to such exclusive, sole source shall be attested to in writing by the DCH Division Chief under whose scope of responsibility the transaction is made.
8. A transaction occurring before March 1, 1983.
9. A transaction involving the provision of Medicaid or Medicare related services and benefits to an Employee or his Family Member; provided, however, in the case of an Employee, he or she shall have no decision-making authority or influence over the determination of eligibility for or amount of such services or benefits.
10. Any transaction between a DCH board member or Employee and an entity within the University System wherein the transaction has been approved by the unit of the University System.
11. Any transaction occurring prior to a Public Official's qualification to run for office or acceptance of an appointment to a public office if the transaction predates the qualifying or acceptance date.
12. Any transaction, wherein the course of business, a DCH Board member or Employee collects sales tax, license fees, excise taxes, or commission as compensation for the performance of a service or good.

D. Disciplinary Actions and Other Remedial Actions

In the event that a DCH Board member or Employee participates in impermissible transactions and/or fails to comply with the reporting requirements in Paragraph V, the following consequences may result:

1. Removal from the Board by the Governor;
2. Termination from employment;
3. Civil fines not to exceed \$10,000; and
4. Restitution to the State for any financial benefit received as a result of the business transaction.

Similarly, if any business in which the DCH Board member's or Employee's Family Member has a substantial interest participates in an impermissible transaction, the business may be subject to the following consequences:

1. Civil fines not to exceed \$10,000; and

2. Restitution to the State for any financial benefit received a result of the business transaction.

V. Other Conflicts of Interest

A. Procurement

The Department is committed to a procurement process that fosters fair and open competition, is conducted under the highest ethical standards, and enjoys the complete confidence of the public. To achieve these important public purposes, it is critical that Employees and Board members have a clear understanding of, and an appreciation for, the ethics in procurement. See DCH Policy No. 402, "Ethics in Procurement" for further guidance.

B. Gifts

Employees are prohibited from accepting gifts from any person with whom the Employee interacts on official state business. To the extent that gifts of nominal value are offered, (i.e., gifts with value of less than \$25.00), they may be shared with other members of the DCH. Exceptions shall include perishable items, such as a basket of fruit, which may be accepted and promptly placed in a common area of state property for sharing among a group.

Employees are allowed, however, to accept a gift on behalf of any Agency or the Office of the Governor or when ceremonial courtesies require such an acceptance. Upon acceptance, the Employee should transfer the gift to DCH, the Office of the Governor, or in the alternative, to a charitable organization on behalf of DCH or the Office of the Governor.

If a Vendor has a personal relationship with the Employee, a Gift that is unconnected with the Employee's duties at the DCH is not necessarily prohibited. In determining whether the giving of an item was motivated by personal rather than business concerns, the history of the relationship between the Vendor and Employee shall be considered. However, regardless of the personal relationship between a Vendor and an Employee, a Gift is strictly forbidden where it is being given under circumstances where it can reasonably be inferred that it was intended to influence the Employee in the performance of his or her official duties.

C. Honoraria

Honoraria are payments to a professional person for services for which no fee is required. Honorarium excludes such things as a certificate or other token of appreciation, which has nominal value and may be accepted as a ceremonial courtesy. Employees are not allowed to accept honoraria.

D. Service on Boards

In general, Employees are restricted from serving as a corporate officer or director of for-profit or publicly held organizations. Notwithstanding the foregoing, each circumstance may be assessed on a case-by-case basis to determine if an actual conflict of interest exists, which would determine whether the Employee could provide such service.

Employees may provide pro bono services to non-profit organizations as long as such services do not negatively impact the Employee's ability to perform his or her duties effectively and with objectivity.

E. Dual Employment

See DCH Policy No. 411 for guidance regarding secondary employment.

F. Political Activities

See DCH Policy No. 416 for guidance regarding political activities.

G. Nepotism

The manner in which Family Members are employed in any organization may lend to an appearance of conflict of interest. The Governor's Executive Order Establishing a Code of Ethics for Executive Branch Officers and Employees prohibits an Employee from advocating for or causing the advancement, appointment, employment, promotion, or transfer of a Family Member to a position within the Department. Additionally, Georgia law restricts the Commissioner and Board members from engaging in that same activity wherein the salary of the Employee is \$10,000 annually or more.

In that the Department desires to assist supervisors in making equitable decisions regarding work assignments, promotions, performance evaluations, disciplinary actions, and all other actions which have a direct impact on an individual's employment, the Department reserves the right to impose the following restrictions:

1. Family Members of individuals currently employed by the Department may be hired only if they will not be working directly for or supervising a Family Member.
2. If Family Members are currently employed, they cannot be transferred into a direct reporting relationship.
3. If the Family Member relationship is established after employment and there is a direct reporting relationship, the manager shall make the determination as to which Employee shall be subject to transfer, if such transfer does not adversely affect the business needs of the Department.

This policy shall in no means violate state and federal laws regarding discrimination on the basis of marital status.

VI. Lobbyists

Employees must ensure that any vendor who submits bids and/or responses to request for proposals, submits an application for a certificate of need, or seeks confirmation of status, letter of non-reviewability, or opposition has certified on forms prescribed by the Department that any lobbyist employed or retained by the vendor has registered with the Government Transparency and Campaign Finance Commission and made the appropriate disclosures.

VII. Reporting Requirements

A. Annual Filing by All Board Members

Each Board member is required to file an annual affidavit relating to the impact of official actions on the member's private, financial and business interests. This affidavit must be filed with the Government Transparency and Campaign Finance Commission by January 31 of each year.

B. Annual Filing by Board Members and Employees Who Engaged in Certain Business Transactions

DCH Board members and Employees must report, on a form prescribed by the Government Transparency and Campaign Finance Commission, an itemized list of business transactions with the State of Georgia or any state agency. This disclosure statement, containing the previous year's business transactions, must be submitted to the Government Transparency and Campaign Finance Commission no later than January 31 of each year. A copy of this report should be submitted to the General Counsel.

Board members and Employees are not required to submit such disclosure statements if they have not transacted business or if such transactions include only those set forth in Paragraph IV(C)(1).

C. Annual Personal Financial Disclosure Filing by Commissioner

The Commissioner shall be required to file, on an annual basis, a financial disclosure statement, including all information contained in O.C.G.A. Section 21-5-50.

D. Report of Expenses and Fees

As a rule, all expenses for an Employee to participate in conferences, meetings and other activities on behalf of DCH shall be paid by DCH. Expenses include food, beverages, travel and lodging. In limited exceptions, a person or entity, on behalf of an

Employee, may offer to pay or waive registration fees when such fees are attendant to the Employee's participation in a public meeting related to official or professional duties; provided, however, that in no event may such fees be paid or waived by a contractor, vendor, potential bidder or lobbyist. Fees are limited to those items that are directly associated with the business or professional duties and are not attributable to personal, social or recreational activities.

A report of such fees must be filed with DCH's Ethics Officer no later than thirty (30) days after the fees have been paid or waived. The report should include:

1. Name and address of the person paying the registration fees; and
2. The description and value of each registration fee.

E. Report of Gifts

If an Employee receives a gift on behalf of DCH or the Office of the Governor, the Employee must file a report with DCH's Ethics Officer no later than thirty (30) days after the receipt of the gift. The report should include:

1. Name and address of the person giving the gift
2. The date the gift was given
3. The monetary value of the gift
4. An explanation of the disposition of the gift

VIII. Guidance

In the event that a DCH Board member or Employee has reason to believe that a conflict of interest might exist in a particular circumstance, the Board member or Employee should seek guidance from the DCH Inspector General.

In those situations where a DCH Board member has in fact identified a conflict involving a matter before the DCH Board, the Board member should immediately recuse himself or herself from any discussion or voting on the matter. The withdrawal of the Board member from consideration of the matter should be entered in the minutes of the meeting of the Board and made a part of the permanent records of the Department.

IX. Mandatory Reporting

Any and every employee who has knowledge of any ethics violation is responsible for reporting such violation to the DCH Inspector General and the DCH Ethics Officer. Good faith reports will be free from retaliation. Supervisors are responsible for reporting such violation and for forwarding any such report from any member of the supervisor's staff to the DCH Inspector General and the DCH Ethics Officer. Supervisors are additionally

responsible for ensuring that the employees under his or her supervision are aware of and comply with the DCH ethical standards and policies.

Reporting suspected policy violations by others shall not jeopardize an Employee's tenure with the Department. Anyone reporting a possible violation of this policy must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation.

Any Department employee may report information, in good faith, concerning the possible violations of this policy in any Department programs or operations. No DCH employee will take action against, direct others to take action against, recommend personnel action against, approve personnel action against, or threaten another Department employee for questioning or reporting in good faith possible violations of this policy.

X. Acknowledgement of Policy

Each Board member and Employee shall sign an acknowledgement that he or she:

- A. Has received a copy of the policy;
- B. Has read and understands the policy or, at least, is aware of the policy and is accountable for compliance with it;
- C. Agrees to comply with the policy;
- D. Agrees to submit the Financial Disclosure Statement as required by this policy, if required; and
- F. Agrees to the disclosure of business transactions with the State.

(Signatures on the following page)

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understand the Georgia Department of Community Health's *Code of Ethics and Conflict of Interest Policy*;
- B. It agrees to comply with those provisions of the Georgia Department of Community Health's *Code of Ethics and Conflict of Interest Policy* applicable to Contractor;
- C. It shall cooperate in good faith with the Georgia Department of Community Health so that the Georgia Department of Community Health and its workers will be in compliance with the *Code of Ethics and Conflict of Interest Policy*; and
- D. It is a contractor.

[CONTRACTOR]

Signature

Date

ATTACHMENT S

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT

Public Employer:	Georgia Department of Community Health
Contractor's Name:	CONTRACTOR
Contract Title:	
Contract No.:	2016XXX

CONTRACTOR AFFIDAVIT

By executing this affidavit, the undersigned Contractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the Contractor identified above has registered with and is participating in a federal work authorization program*, in accordance with the applicability provisions and deadlines established in O.C.G.A. § 13-10-91.

The undersigned further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of services pursuant to this contract with the Georgia Department of Community Health (hereinafter "DCH"), Contractor will secure from such subcontractor(s) similar verification of compliance with O.C.G.A. § 13-10-91 on the attached Subcontractor Affidavit. Contractor further agrees to maintain records of such compliance and provide a copy of each such verification to DCH at the time the subcontractor(s) is retained to perform such service.

EEV / E-Verify™ Company Identification Number

E-Verify Authorization Date

BY: Signature of Authorized Officer or Agent
of Contractor

Signature Date

Printed Name of Authorized Officer or Agent

Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE

____ DAY OF _____, 20__

[NOTARY SEAL]

Notary Public

My Commission Expires:

*any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-603.

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	CONTRACTOR
Contract Title:	
Contract No.:	2016XXX

ADDITIONAL INSTRUCTIONS TO CONTRACTOR: Please list below all subcontractors and sub-subcontractors (if any) used to perform services under the DCH contract referenced above. In addition, you must attach a signed and notarized affidavit (third page of this form) from each of the subcontractors and sub-subcontractors listed below. The contractor is responsible for providing a signed and notarized affidavit to DCH within five (5) days of the addition of any new subcontractor or sub-subcontractor used to perform under the identified DCH contract.

Contractor's Name:	CONTRACTOR
Subcontractors:	

Sub-Subcontractors (if any)	
Name of Subcontractor:	Name of Sub-subcontractor:

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	CONTRACTOR
Contract Title:	
Contract No.:	2016XXX
Subcontractor's Name:	
Sub-Subcontractor's Name:	

**SUBCONTRACTOR AFFIDAVIT
 OR
 SUB-SUBCONTRACTOR AFFIDAVIT**

By executing this affidavit, the undersigned Subcontractor/Sub-subcontractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the Subcontractor/Sub-subcontractor which is engaged in the performance of services under a contract with the Contractor (or Subcontractor as applicable) on behalf of DCH has registered with and is participating in a federal work authorization program*, in accordance with the applicability provisions and deadlines established in O.C.G.A. § 13-10-91.

Please initial beside only one choice below:

1. I am an authorized representative of the Subcontractor identified above.
2. I am an authorized representative of the Sub-Subcontractor identified above.

 EEV / E-Verify™ Company Identification Number

 E-Verify Authorization Date

 BY: Signature of Authorized Officer or Agent
 of Subcontractor/Sub-Subcontractor (as applicable)

 Signature Date

 Printed Name of Authorized Officer or Agent

 Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN
 BEFORE ME ON THIS THE

____ DAY OF _____, 20__

[NOTARY SEAL]

 Notary Public

My Commission Expires:

**any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-*

ATTACHMENT T

**MEMORANDUM OF UNDERSTANDING FOR
THE PEACHCARE PARTNERSHIP PROGRAM**

(To be placed here)

CONTRACT SHELL

**Attachment U
Georgia Families 360°**

Value Based Purchasing Measures

Figure Y. Value Based Purchasing Performance Measures and Targets – Georgia Families 360°

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2014 Validation Period: SFY 2015 Published: September 2015		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
1	Care Management – The percentage of members who received appropriate and timely contacts by their Care Coordinator according to intensity level (e.g. complex care--one face to face per month).			92% for Complex Care 92% for Intensive Care 95% Care Management		95% for Complex Care 95% for Intensive Care 97% Care Management		97% for Complex Care 97% for Intensive Care 99% Care Management	
2	Operations – percent of members whose Prior Authorizations for PCP, Dental and Behavioral Health are completed within 5 days of receipt.			85% completed in 5 days or less		87% completed in 5 days or less		90% completed in 5 days or less	
3	Behavioral Health – The percent of members readmitted to a behavioral health facility (CSU, PRTF or Inpatient Acute Care Facility) within 30 days of discharge.			Fewer than 8%		Fewer than 6%		Fewer than 5%	
4	Behavioral Health – The percentage of enrolled members who experienced reduced behavioral health acute care stays AND increased functional status as determined according to agreed-upon and validated instrument.			Establish baseline		Eligibility for incentive requires that 1. 75% of members who use BH services have completed functional status determination 2. reduction in acute BH		Eligibility for incentive requires that 1. 100% of members who use BH services have completed functional status determination 2. reduction in acute BH	

**Attachment U
Georgia Families 360°
Value Based Purchasing Measures**

Performance Measures	Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
	Calendar Year: 2014 Validation Period: SFY 2015 Published: September 2015		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
					stays must be a minimum of 50% fewer Average Bed Days		stays must be a minimum of 70% fewer Average Bed Days	

Figure Z: Value Based Purchasing Performance Measures and Targets - Georgia Families 360° Core Measures

Performance Measures	Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
	Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
1 Preventive Care for Children: Well-child visits in the First 15 Months of Life – 6 or more visits – The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.		68.46		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
2 Preventive Care for Children: Childhood Immunization Status – Combo 10 – The percentage of children two years of age who had 4 DTaP; 3 IPV; 1 MMR; 3 HiB; 3 HepB; 1 VZV; 4 PCV; 1 HepA; 2 – 3 RV; and 2 Influenza vaccines by their second birthday.		40.28		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile
3 Developmental Screening: Developmental Screening in the first three years of life – The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third		42.82		70%		Absolute 10% improvement over CY 2017 rate		Absolute 10% improvement over CY 2018 rate

Attachment U
Georgia Families 360°
Value Based Purchasing Measures

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	birthday.								
4	Preventive Care for Adolescents: Adolescents Well-Care Visits – The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.		52.55		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
5	Preventive Dental Services: Total Eligibles Receiving Preventive Dental Services – The percentage of individuals ages 1-20 who are enrolled for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.	52.65		60%		10% relative improvement above CY 2017 rate		10% relative improvement above CY 2018 rate	
6	Obesity Prevention: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile – Total – The percentage of members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, Counseling for nutrition, and Counseling for physical activity.		BMI %tile - 51.16; Nutrition Counseling - 61.11 Physical Activity; Counseling - 54.63		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile
7	Behavioral Health: Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase – The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Initiation Phase – 43.12; Continuation Phase – 59.22			HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile

Attachment U
Georgia Families 360°
Value Based Purchasing Measures

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
8	Pregnancy-related Care: Prenatal and Postpartum Care – Postpartum Care – The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following: <i>Postpartum Care</i> - The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.		63.24		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 90 th percentile		HEDIS 2018 National 90 th percentile
9	Birth Outcomes: Rate of Infants with Low Birth Weight – The percentage of live births that weighed less than 2,500 grams during the reporting period.	8.32		<= National Vital Statistics LBW rate published Dec of 2016		<= National Vital Statistics LBW rate published Dec of 2017		<= National Vital Statistics LBW rate published Dec or 2018	
10	Diabetes: Comprehensive Diabetes Care (18-75 years old) – The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing; HbA1c poor control (>9.0%); HbA1c control (<8.0%); HbA1c control (<7.0%) for a selected population; Eye exam (retinal) performed; Medical attention for nephropathy; and BP control (<140/90 Hg).		HbA1c testing – 80.5; HbA1c >9 – 52.47; HbA1c <8 – 39.64; HbA1c <7 – 30.08; Eye exam – 57.81; Nephropathy – 74.51; BP control – 56.91		HEDIS 2016 National 75 th percentile for HbA1c testing; 50 th percentile for all other rates		HEDIS 2017 National 90 th percentile for HbA1c testing; 50 th percentile for > 9.0 and 75 th percentile for all other rates		HEDIS 2018 National 90 th percentile for HbA1c testing; 25 th percentile for >9.0 and 75 th percentile for all other rates
11	Cardiovascular Conditions: Controlling High Blood Pressure (18-85) – The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.		48.36		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
12	Respiratory Conditions: Medication Management for People with Asthma – The percentage of members 5-64 years of age during the measurement year who	50% compliant - 5 – 11yo – 49.08;		HEDIS 2016 National 75th percentile		HEDIS 2017 National 75th percentile		HEDIS 2018 National 90th percentile	

**Attachment U
Georgia Families 360°
Value Based Purchasing Measures**

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1) The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period; 2) The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	50% compliant- 12 – 18 yo – 46.26 75% compliant - 5 – 11yo – 22.88; 75% compliant - 12 – 18 yo – 22.18							
13	Experience with Care: CAHPS 5.0H Child Version – Shared Decision Making – This measure provides information on parents' experience with their child's Medicaid organization. A composite score is calculated for the Shared Decision Making domain of member experience and responses of "Yes" and "A lot" are considered achievements for the Shared Decision Making composite.	Adult – 53.7% Child – 57.7%		Absolute 10% above baseline		Relative 10% above CY 2017 rate		Relative 10% above CY 2018 rate	
14.	Increase in the number of Patient Centered Medical Homes in the Contractor's Network – The percent increase of Providers enrolled in the Contractor's network that receive NCQA recognition.	Establish Baseline		Absolute 15% above baseline		Relative 15% above CY 2017 total		Relative 15% above CY 2018 total	

Attachment U
Georgia Families 360°
Value Based Purchasing Measures

Figure Z. Methodology for Calculating Value Based Purchasing Performance Measures – Georgia Families 360°

Performance Measures		2017	2018	2019	Methodology
1	Care Management: The percentage of Members who received appropriate and timely contacts by their Care Coordinator according to the below intensity levels.				
	a. Complex Care Coordination: Rigorously coordinated care management/care coordination of medical and social supports for Members with multiply-involved chronic conditions	92%	95%	97%	Denominator: Total number of Members enrolled in GF360° and assigned to Complex Care where Member months are counted only when Member was enrolled and assigned for full months (i.e. all 28, 30, or 31 days of the month in consideration). Numerator: Total number of Members who during each full month enrolled received all of the following: <ol style="list-style-type: none"> 1. Two (2) face-to-face visits 2. One (1) weekly contact 3. A minimum of two (2) hours per week Care Coordination 4. One (1) Child and Family Team Meeting 5. One (1) care plan update
	b. Intensive Care Coordination: Care coordination provided at a greater frequency, duration, and scope than traditional case management to support Members with managing chronic or acute conditions	92%	95%	97%	Denominator: Total number of Members enrolled in GF360° and assigned to Intensive Care where Member months are counted only when Member was enrolled and assigned for full months (i.e. all 28, 30, or 31 days of the month in consideration). Numerator: Total number of Members who during each full month enrolled received all of the following: <ol style="list-style-type: none"> 1. One (1) Face-to-face visit 2. One (1) weekly contact 3. One (1) Child and Family Team Meeting 4. One (1) care plan update
c. Care Management: Traditional case management	95%	97%	99%	Denominator: Total number of Members enrolled in GF360° and assigned to Care Management where Member quarters are counted only when Member was enrolled and assigned for a full quarter (e.g. three contiguous, full months). Numerator: Total number of Members who during each full quarter enrolled received one (1) phone contact.	
2	Operations: Percent of Members whose Prior Authorizations from PCP, Dental and Behavioral Health Providers	85%	87%	90%	Denominator: Total number of Prior Authorizations requested by PCP, Dental Home, and Behavioral Health Providers during time

Attachment U
Georgia Families 360°
Value Based Purchasing Measures

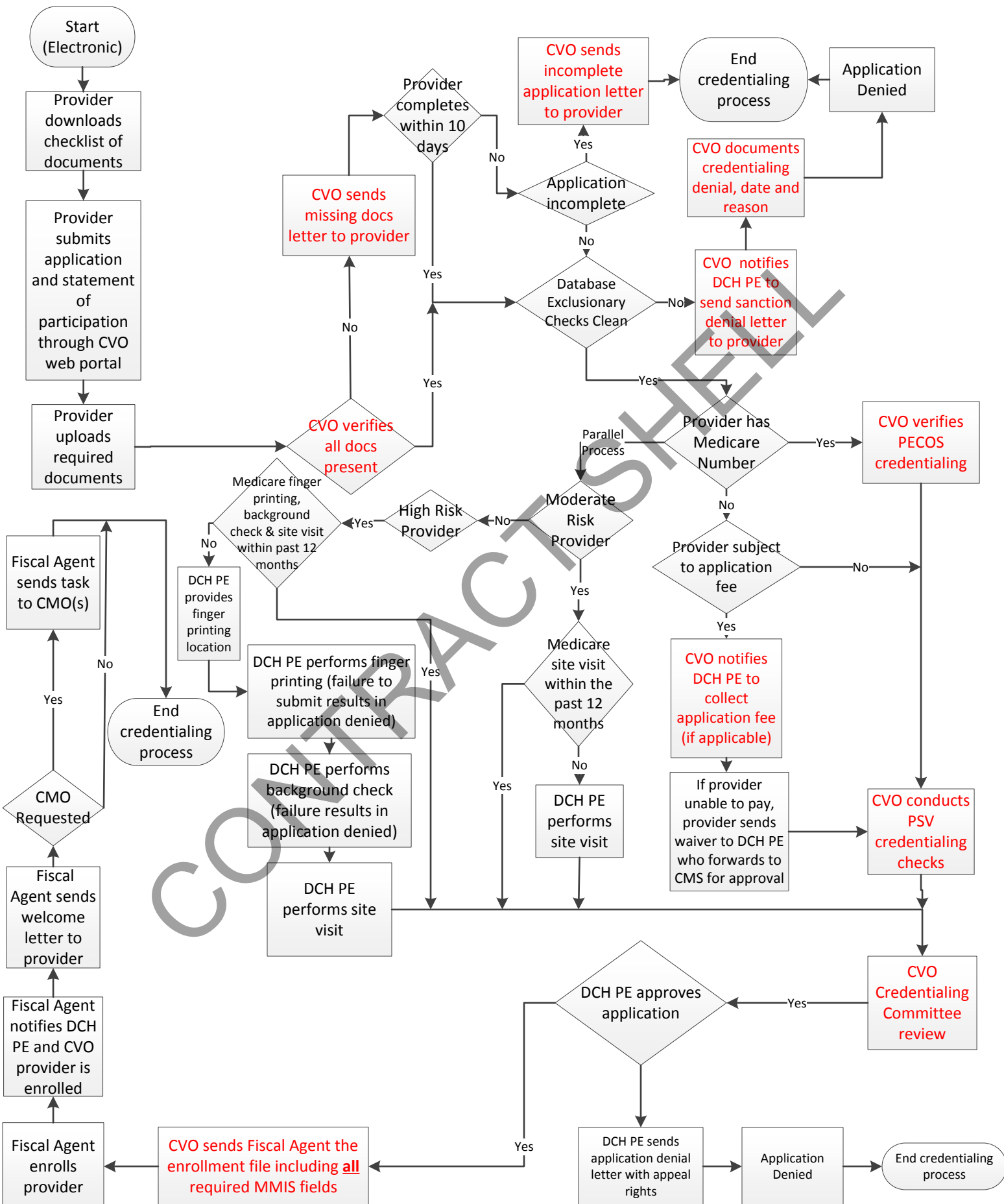
Performance Measures		2017	2018	2019	Methodology
	are completed within five (5) days or less of receipt				period. Numerator: Total number of Prior Authorizations completed (approved or denied status) within five (5) days of received request.
3	Behavioral Health: Percent of Members readmitted to a Behavioral Health facility (CSU, PRTF or Inpatient Acute Care Facility) within thirty (30) days of discharge	Fewer than 8%	Fewer than 6%	Fewer than 5%	Denominator: Total number of Members admitted to an inpatient Behavioral Health facility during period. Numerator: Total number of Members who experienced a second admission to an inpatient facility within thirty (30) days of the day of discharge.
4	Behavioral Health: Percentage of enrolled Members who experienced reduced Behavioral Health acute care stays AND increased functional status as determined according to agreed-upon and validated instrument	Establish baseline	Eligibility for incentive requires: a. 75% of Members who use Behavioral Health services have completed functional status determination b. Reduction in acute Behavioral Health stays must be a minimum of 50% fewer Average Bed Days	Eligibility for incentive requires: a. 100% of Members who use Behavioral Health services have completed functional status determination b. Reduction in acute Behavioral Health stays must be a minimum of 70% fewer Average Bed Days	Step 1: Determine total number of Members at baseline period who had multiple inpatient admission(s) to a Behavioral Health facility and document the number of total bed days for each Member. Step 2: Conduct or collect functional assessment to determine level of functional status/impairment for each Member in population or minimum of 75% (2018) or 100% (2019). Calculate the average of the baseline functional impairment score. Step 3: At the twelve- (12) month look back, determine of those Members who had multiple inpatient admission(s) to a Behavioral Health facility at the baseline period AND for whom baseline functional status is known (must be 75%/100% of total Members), how many had additional admissions and document total bed days during the twelve (12) month period. Step 4: Calculate a weighted average percentage difference in inpatient BH bed days for all Members by subtracting the total bed days in the twelve- (12) month period from the total bed days in baseline period divided by the total bed days in the baseline period. Step 5: Calculate the weighted average percentage difference in functional impairment for all Members by subtracting the total function impairment score in the twelve- (12) month period from the total function impairment score in baseline period divided by the total function impairment score in the baseline period. If the weighted average in Step 4 is 50% less than in the baseline period and the weighted average in Step 5 is less than the average in the baseline period, the incentive is earned.

ATTACHMENT V

Georgia Department of Community Health

Traditional Managed Care Provider Credentialing Process

'Red' font indicates responsibilities of the CVO.



Note: This timeline represents a 30 Calendar Day window for the credentialing process for Traditional providers submitting clean applications and enrolling with a CMO. This timeline does not include steps needed for providers to contract with CMO(s).

**ATTACHMENT W
PROVIDER CREDENTIALING TIMELINES**

Georgia Department of Community Health

Provider Credentialing Timeline - Traditional Managed Care Providers

'Clean' Applications

Step No.	Credentialing Steps	Number of Calendar Days																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1	CVO verifies provider submitted all required docs, including statement of participation	1																													
2	CVO conducts database exclusionary checks (fraud and abuse verification)																														
3	CVO conducts PECOS Credentialing verification																														
4	CVO conducts PSV Credentialing verification																														
5	DCH PE conducts finger printing if needed (High-Risk Providers only)																														
6	DCH PE conducts background check if needed (High-Risk Providers only)																														
7	DCH PE conducts site visit, if needed (High and Moderate Risk Providers)																														
8	CVO Credentialing Committee Review																														
9	DCH PE approves application																														
10	CVO sends enrollment file to Fiscal Agent																														
11	Fiscal Agent enrolls providers and notifies DCH PE and CVO provider is enrolled																														
12	Fiscal Agent sends welcome letter to Provider and notifies CMO if requested by provider (Managed Care Only)																														

Note: This timeline represents a 30 Calendar Day window for the Credentialing process for Traditional providers submitting clean applications and enrolling with one or more CMO(s). This timeline does not include steps needed for Providers to contract with CMO(s).

CONTRACT SHEET

ATTACHMENT X
KENNY A. CONSENT DECREE

-----X
KENNY A., by his next friend,)
Linda Winn; et al.,)
)
Plaintiffs,)
)
vs.)
)
SONNY PERDUE, in his official)
capacity as Governor of the)
State of Georgia; et al.)
)
Defendants.)
-----X

Civil Action No. 1: 02-CV- 1686-MHS

CONSENT DECREE

CONTRACT SHELL

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1. INTRODUCTION

Plaintiffs brought this class action lawsuit by the filing of a complaint on June 6, 2002, in the Superior Court of Fulton County, seeking declaratory and prospective injunctive relief against Defendants based upon alleged violations of constitutional and statutory rights arising out of the operation of foster care systems in Fulton and DeKalb Counties. Plaintiffs alleged both federal and state law claims. All Defendants joined in removing the case to this Court, invoking the Court's federal question jurisdiction and denying that their operation of the Fulton and DeKalb County foster care systems violated any constitutional or statutory guidelines.

In order to resolve all issues pending between these parties without the expense, risks, delays and uncertainties of a trial and any appeals that might follow such a trial, Plaintiffs and State Defendants agree to the terms of this Consent Decree as stated below. By entering into this Consent Decree, State Defendants do not admit to the truth or validity of any claim made against them by Plaintiffs. State Defendants also do not speak for the Georgia General Assembly, which has the power under Georgia law to determine the appropriations for the State's programs for child welfare. However, State Defendants acting under their existing authority agree that it will be a condition of their conduct of the child welfare program covered by this Consent Decree to comply with the Consent Decree. If Plaintiffs seek a judicial remedy for State Defendants' noncompliance in accordance with Section 17 of this Consent Decree, and at any stage of subsequent enforcement proceedings State Defendants assert insufficient funds as a legal excuse, Plaintiffs may move to rescind their consent to the Consent Decree. State Defendants submit to the enforcement of this Consent Decree to the full extent permitted by law.

All parties acknowledge that the Court has jurisdiction over this case and authority to enter this Consent Decree and to enforce its terms. The Court shall retain jurisdiction of this matter to enforce this Decree in accordance with its terms.

2. DEFINITIONS APPLICABLE TO CONSENT DECREE

For purposes of this Consent Decree, the following terms have the meaning indicated below.

- A. "Adoptive placement" means the interval during which a child is placed with a prospective adoptive family following the signing of the appropriate adoptive placement agreement form, but before the entry of the adoption decree by the court.
- B. "Business days" mean every day except Saturdays, Sundays and legal holidays, pursuant to O.C.G.A. § 1-4-1.
- C. "Calendar days" mean every day including Saturdays, Sundays, and legal holidays.

- D. “Child” or “children” or “class member children” or “class members” shall mean a child or children who have been, are, or will be alleged or adjudicated deprived who (1) are or will be in the custody of any of the State Defendants; and (2) have or will have an open case in Fulton County DFCS or DeKalb County DFCS.
- E. “Commissioner” means the Commissioner of the Georgia Department of Human Resources.
- F. “Corporal punishment” means any physical punishment of a child that inflicts pain.
- G. “Day” or “days” mean calendar days unless otherwise indicated.
- H. “DeKalb DFCS” means the DeKalb County Department of Family and Children Services.
- I. “DFCS” when used alone means State DFCS.
- J. “DHHS” means the United States Department of Health and Human Services.
- K. “DHR” means the Georgia Department of Human Resources.
- L. “Discipline or Other Serious Foster Care Violation” means and includes those acts or situations by the caregiver that pose an immediate or potential risk to the safety or well-being of the child in care. These may include, but are not limited to, inappropriate disciplinary measures (both physical/corporal and emotional), violations of supervision or other safety requirements that pose serious risk factors to the child.
- M. “EPSDT” means the Early and Periodic Screening, Diagnosis and Treatment Program for individuals under 21 years of age contained in Title XIX of the Social Security Act, as amended.
- N. “Fulton DFCS” means the Fulton County Department of Family and Children Services.
- O. “Georgia Health Check Program” means Georgia Medicaid’s well-child or preventive health care program adopted pursuant to EPSDT, and shall contain such components as they exist in the Georgia Health Check Program as of February 1, 2005.
- P. “Governor” means the Governor of the State of Georgia.

- Q. “Legal guardianship” means the appointment of an individual as a legal guardian for a child as authorized by either the probate court under O.C.G.A. Title 29 or the juvenile court under O.C.G.A. Chapter 15-11.
- R. “One episode of foster care” means the period of time that a child is in foster care from the date of removal from the home until the child is discharged from DFCS custody, except that a runaway does not trigger a new episode of foster care.
- S. “Permanent legal custody” means custody granted in accordance with an order of the superior court or the juvenile court which places a child in the custody of an individual or individuals until the child reaches 18 years of age.
- T. “Permanent placement with relatives” means placement of a child with a relative who is willing to assume long-term responsibility for the child but has reasons for not adopting the child or obtaining guardianship or permanent legal custody, and it is in the child’s best interests to remain in the home of the relative rather than be considered for adoption, permanent legal custody, or guardianship by another person. In such circumstances, there shall be in place an agreement for long-term care signed by DFCS and the relative committing to the permanency and stability of this placement unless it is necessary to disrupt the long-term placement.
- U. “State DFCS” means the Division of Family and Children Services of the Georgia Department of Human Resources.
- V. “State Defendants” means Defendants Sonny Perdue (in his official capacity as Governor of Georgia), the Georgia Department of Human Resources, B.J. Walker (in her official capacity as Commissioner of the Georgia Department of Human Resources), Fulton County Department of Family and Children Services, Debra Keyes (in her official capacity as Administrator of Fulton DFCS), DeKalb County Division of Family and Children Services, and Walker Solomon (in his official capacity as Director of DeKalb DFCS).
- W. “Suspected abuse or neglect” means being based on reasonable cause to believe that a child may have been abused or neglected.
- X. “Suspected corporal punishment” means being based on reasonable cause to believe that corporal punishment may have been used on a child.

3. PRINCIPLES

The parties to this Consent Decree agree that the following are desired principles that serve as the goals of Georgia’s child welfare system and are not separately enforceable standards

or provisions under which State Defendants' conduct under the terms of this Consent Decree shall be measured.

1. Georgia's child welfare system must actively promote and support the opportunity for children to grow up within a safe, nurturing family, either their biological family or, if that is not possible, within an adoptive family.
2. When children are in foster care, all non-destructive family ties should be maintained and nurtured. If appropriate, children should be placed with relatives who are able to provide a safe, nurturing home for them. Reasonable efforts should be made to place siblings together, and relationships with relatives and siblings should be facilitated and maintained by the child welfare agency, if it is in the child's best interest to do so.
3. Foster care should be as temporary an arrangement as possible, with its goal being to provide a permanent home for the child as quickly as possible. In making the determination about what plans and services will best meet this goal, the child's interests must be paramount.
4. The state has primary responsibility for the care and protection of children who enter the foster care system. Insofar as it relies on private contractors to assist in meeting this responsibility, it should only do so according to standards set by and rigorously monitored by the state.
5. All children in need of child welfare services should receive full and equal access to the best available services, regardless of race, religion, ethnicity, or disabilities.
6. Children in foster care placement should be in the least restrictive, most family-like setting possible, and the state should make reasonable efforts to avoid the use of non-family settings for children, particularly young children.
7. Children in foster care placement should have stable placements that meet their needs and the services necessary to address both the trauma of foster care placement and the problems surrounding their removal from their family. Children in foster care placement should have placements that meet their needs and the services necessary to promote the stability of their placements.
8. The Department of Human Resources, acting through its Commissioner, has the authority and responsibility to deliver foster care services by the means it deems appropriate consistent with the requirements of law.

4. **PLANNING**

A. For children entering placement after the entry of the Consent Decree

1. Within 24 hours after a child's 72-hour hearing, DFCS will make a referral to a Comprehensive Child and Family Assessment ("CCFA") provider to initiate an assessment for the child.
2. An initial Family Team Meeting will be held within 3-9 days after a child comes into foster care.
 - a. Barring exigent circumstances, the Family Team Meeting participants shall include the DFCS case manager and supervisor and, if applicable, the case manager from the private contract agency which has the child in placement. DFCS will make reasonable efforts to ensure the attendance of the parents and the child (if 12 or older), and other persons significant to the family if appropriate, at the Family Team Meeting. The Family Team Meeting may also include the CCFA provider, relatives, and other persons significant to the family. A Family Team Meeting shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance. Efforts to ensure the attendance of participants shall be documented in the child's case file.
 - b. Participants at the Family Team Meeting will identify:
 - i. The needs of the children and parents.
 - ii. Goals for meeting those needs.
 - iii. Steps for meeting the goals.
 - iv. Strengths of the family members with regard to meeting the needs of the child, the child's parents, and possible placements for the child.
 - c. At the Family Team Meeting, DFCS will make the following determinations and shall identify and ensure the provision of necessary services to achieve such determinations:
 - i. Whether the child can be safely returned home.

- ii. Whether any evaluations are necessary of the child and/or parents to ensure the development of an appropriate case plan.
 - iii. If the child cannot safely be returned home, whether there is an appropriate relative with whom the child can be placed.
 - iv. If the child has siblings in placement and the siblings are not placed together, the identity of necessary steps to place the siblings together in accordance with Section 5.C.4.d, and necessary steps to ensure sibling visitation.
 - v. If the child is of school age, the identity of steps that can be taken to ensure that the child remains enrolled in school, does not miss school days extensively, and does not have to change schools if at all possible.
 - vi. The frequency with which visiting will take place between the child and the child's parents and significant family members.
- d. If DFCS is unable to secure the parents' attendance at a meeting after the child is placed, the meeting shall nevertheless be held with the other participants, and DFCS shall make reasonable efforts to notify and review with the parents the goals outlined at the meeting, as soon thereafter as possible.
 - e. The outcomes of the Family Team Meeting will be reported to the Multidisciplinary Team ("MDT") for use at its meeting.

- 3. Within 25 days of a child's placement in foster care, an MDT Meeting will be held. Barring exigent circumstances, the MDT Meeting participants shall include the DFCS case manager and supervisor and, if applicable, the case manager from the private contract agency which has the child in placement. DFCS will make reasonable efforts to ensure the attendance of the parents and the child, if appropriate, at the MDT Meeting. The MDT Meeting may also include relatives, foster parents/placement providers, DFCS representatives, school representatives, therapists, mental health professionals, the CCFA provider, medical professionals, representatives from Public Health, and judicial representatives. An MDT Meeting shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance. Efforts to ensure attendance of participants in the MDT shall be documented in the child's case file.

- a. The MDT will review the CCFA and make recommendations concerning the case plan and the services to be provided to the child and the family, including but not limited to the issues addressed at Family Team Meetings as described in section A.2. above, as well as (i) appropriateness of education (including special education); (ii) the creation and appropriateness of independent living plans and services for children 14 and older; and (iii) an appropriate permanency goal for the child and the services necessary to implement that goal. The case plan will be an outgrowth of the CCFA assessment and shall be developed at the MDT meeting.
 - b. DFCS shall identify and ensure the provision of necessary services to achieve the determinations made at the MDT meeting, and contained in the child's case plan, unless and until altered by the Juvenile Court.
 4. Within 30 days from the date of placement, a case plan with all required elements will be submitted to the Juvenile Court for approval. Case plans with all required elements and service needs shall be reviewed, updated and revised (with submission to the Juvenile Court for approval) whenever necessary, including after the MDT meeting, and at every six-month review and 12-month permanency review.
 5. DFCS will include training on facilitating family team meetings as part of its pre-service training. DFCS shall have family team specialists who will attend and facilitate all family team meetings. The Fulton County Administrator and the DeKalb County Director will designate staff to follow up on the results of all family team meetings.
- B. For children who have reached their sixth month in care after the entry of the Consent Decree, and for the remaining period of time while in DFCS custody**
1. Plaintiffs and State Defendants intend that within six months of the child's placement in foster care, and every six months thereafter, the child's case plan shall be reviewed by the Judicial Citizen Review Panel (JCRP) and/or the Juvenile Court, as long as the child remains in the custody of Fulton or DeKalb DFCS.
 2. Plaintiffs and State Defendants desire that the persons who participate at each JCRP or Juvenile Court review shall include the parents, the child, pre-adoptive parents or relatives providing care for the child, foster parents/placement providers, the DFCS case manager, the private provider case manager (if applicable), the case supervisor, other DFCS representatives, the CCFA providers, medical and mental health professionals, representatives from Public Health and the child's school,

and other professionals having specific knowledge or information relative to the child's case. The parties further desire that a JCRP or Juvenile Court review shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance.

3. Plaintiffs and State Defendants intend that, at each six month case plan review, the JCRP and/or the Juvenile Court shall evaluate the following:
 - a. The necessity and appropriateness of the child's placement;
 - b. Whether reasonable efforts have been made to obtain permanency for the child;
 - c. The degree of compliance with the specific goals and action steps set out in the case plan;
 - d. Whether any progress has been made in improving the conditions that caused the child's removal from the home; and
 - e. Whether changes need to be made to the case plan, including a change in the permanency goal and the projected date when permanency for the child is likely to be achieved, or changes or the addition of any services needed by the child.
4. Plaintiffs and State Defendants intend that, if the JCRP conducts the case plan review, the panel will submit a report to the Juvenile Court, which shall include the panel's findings and recommendations, as well as the findings and recommendations of Fulton or DeKalb DFCS, along with Fulton or DeKalb DFCS' proposed revised plan for reunification or other permanency plan.
5. If the Juvenile Court conducts a review of the case plan, Fulton or DeKalb DFCS shall submit its recommendations to the court regarding a proposed revised plan for reunification or other permanency plan.
6. Following a JCRP or a Juvenile Court review, the Juvenile Court may adopt a revised case plan, taking into consideration recommendations made by Fulton or DeKalb DFCS, the JCRP, and/or the parents and enter a supplemental order in accordance with Chapter 11 of Title 15 of the Official Code of Georgia Annotated.

7. DFCS shall identify and ensure the provision of necessary services to achieve the determinations made following the actions of the Juvenile Court.
8. If deemed necessary by the case manager or case supervisor, additional meetings involving family members and professionals to discuss the implementation of the case plan may be conducted at any time.
9. If the Juvenile Court does not convene a six-month JCRP or Juvenile Court review within 45 days from the date that is six months after the last review, DHR/DFCS shall cause to be filed with the Juvenile Court a request for an immediate JCRP or Juvenile Court six-month review.
10. If the Juvenile Court does not convene a 12-month JCRP or Juvenile Court permanency review within 45 days from the date that is 12 months after the last permanency review, DHR/DFCS shall cause to be filed with the Juvenile Court a request for an immediate JCRP or Juvenile Court 12-month permanency review.

C. For children who reach their thirteenth month in care after the entry of the Consent Decree and for the remaining period in time while in DFCS custody

1. By the end of the 13th month after a child has been in placement, Fulton and DeKalb DFCS will forward a Permanency Report to the State Social Services Director. Prior to the forwarding of the Permanency Report, another Family Team Meeting will be convened in accordance with Paragraph A.2. of this Planning Section. This Family Team Meeting will consider the issues listed in Paragraph A.3.a. of this Section. The results of such Family Team Meeting shall be forwarded to the Social Services Director with the Permanency Report. The Permanency Report will include a profile description of the child, the case plan, a list of impediments for achieving permanency, the CCFA, and a list of steps to be taken by the county to achieve permanency. The State Social Services Director or his designee shall review the Permanency Report within five business days of its receipt, and shall either concur with the report or refer the case for a county/state staffing.
2. A county/state staffing shall be held no later than ten days after the State Social Service Director's decision.
3. Barring exigent circumstances, the county/state staffing shall include the Fulton or DeKalb County case manager and supervisor, regional adoption coordinator, regional field specialist, county program administrator, and State Social Services Director or his designee. A county/state staffing

shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance.

4. The county/state staffing shall establish a plan to move the child toward permanency, and the State Social Services Director shall monitor the plan. DHR/DFCS shall identify and ensure the provision of necessary services to achieve the determinations made following the county/state staffing.
5. Additional meetings shall be held at any time when deemed necessary by the State Social Services Director or by the county case manager and supervisor, and may include those participants from the initial county/state staffing, provided that at least one additional county/state staffing meeting shall be conducted by the end of the 25th month after a child remains in placement. DHR/DFCS shall identify and ensure the provision of necessary services to achieve the determinations made following any subsequent county/state staffing.
6. If the Juvenile Court orders aftercare supervision, the child's case manager shall make monthly visits with the child following discharge from foster care for the period of time specified by the Juvenile Court. DFCS will determine whether additional services are necessary to ensure the continued success of the discharge.

D. For children who have already reached their 13th month in care at the time of the entry of the Consent Decree

Within 120 days from the entry of the Consent Decree, Fulton and DeKalb DFCS will submit a Permanency Report for all children who have reached their 13th month in care at the time of the entry of the Consent Decree to the State Social Service Director for a permanency review as provided in Paragraphs 1-4 of Section C, above.

E. For all children for whom adoption has been identified as the goal

1. DHR shall determine whether the foster parent(s) are appropriate potential adoptive parents and if so, determine whether they are interested in adoption, and shall make known to the foster parents the availability of adoption assistance. Foster children who meet the eligibility criteria for the program, and who are special needs children, as defined in 42 U.S.C. § 673 and DFCS policy, shall be eligible to receive an adoption assistance subsidy. If the child is eligible, DHR/DFCS will determine the child's adoption assistance subsidy based on the needs of the child. Under no circumstance shall the subsidy amount exceed the family foster care

maintenance payment that the child would be eligible to receive at the time of the adoptive placement. The amount and term of the adoption assistance subsidy shall be determined prior to the signing of the adoptive placement agreement.

2. For children for whom the foster parent(s) are either inappropriate or uninterested in becoming adoptive parents, and for whom adoptive parents are not otherwise available, DFCS shall undertake child-specific adoption recruitment. DFCS will not use as a documented compelling reason for not filing a petition for termination of parental rights the fact that there is an absence of an adoptive resource for the child.
3. Where appropriate, DFCS shall make available post-adoption services to support and stabilize adoptions for a period of at least 18 months following adoption finalization.

F. For children who reach their 18th month in care after the entry of the Consent Decree, and those who have already been in care for 18 months or more upon the entry of the Consent Decree, and for the remaining period in time while they are in DFCS custody

1. DHR/DFCS will establish a Specialized Case Manager position to focus on and to remove barriers to permanence for children in DFCS custody for 18 months or longer. The maximum caseload for any person serving in the Specialized Case Manager position will be 12.
2. Within 60 days of the entry of this Consent Decree, all children who have already reached their 18th month in care upon the date of entry of this Consent Decree shall be assigned a Specialized Case Manager as described in this Section F. Beginning 60 days after the entry of this Consent Decree and continuing thereafter, all children that reach their 18th month in care shall be assigned a Specialized Case Manager as described in this Section F. The Specialized Case Manager, once assigned to a child, shall be the sole responsible DFCS case manager for the child. To the extent possible, the child's DFCS assignment to a particular Specialized Case Manager, once made, shall continue for the remaining period of time while the child is in DFCS custody.
3. The Specialized Case Manager provided for in this paragraph shall do the following as appropriate for the children in this Section F:
 - a. Convene meetings, access funding, and make independent decisions in order:

- i. To determine the continuing appropriateness and effectiveness of the child's permanency goal and to seek court approved change of the goal if appropriate;
 - ii. To determine the continuing appropriateness and effectiveness of the services being provided to the child; whether new or different services are necessary for the child; and, if so, by whom and when they will be provided;
- b. Partner with the county Independent Living Coordinator to determine whether adequate independent living services and plans are being provided for all children age 14 and older;
 - c. Evaluate the continuing appropriateness and effectiveness of services to biological parents and relatives, and determine whether new or different services are necessary to assist the biological parents and relatives in achieving the child's permanency goal;
 - d. Consult with public and private professionals and take all steps necessary to ensure the provision of services leading to the child achieving permanency;
 - e. No sooner than 30 days prior to discharge, regardless of the discharge destination, convene a special discharge planning meeting that shall be held to ensure that appropriate services and plans are in place to ensure a successful discharge.

5. PLACEMENT

A. Identification of Needs and Placement Options

1. DFCS agrees to obtain, by means of a Request for Proposal, a qualified external expert to conduct a needs assessment in Fulton County and DeKalb County. The needs assessment shall be based on the standards for the placement of children identified in Section 5.C. below, as applied to factual data about individual children's needs obtained in Comprehensive Child and Family Assessments and case plans pursuant to Section 4 of this Consent Decree, and as applied to other factual data relevant to determining the needs of children in the Plaintiff Class. The needs assessment shall identify what new and/or different placements and related services, if any, are needed to provide substantially for the care of the Plaintiff Class.

2. Counsel for Plaintiffs and DFCS will jointly review the responses to the Request for Proposal, which shall be drafted to accomplish the purposes of this section of the Consent Decree, and shall jointly agree to the expert. The expert shall be selected within 90 days from the entry of this Consent Decree, and shall be selected in accordance with the procurement laws of the State of Georgia.
3. The needs assessment shall be completed no later than 120 days after the expert has been retained.
4. DFCS shall provide all of the placements and related services identified in the needs assessment, except that the expert will recommend the priority for implementing the findings of the needs assessment, based on the severity of the needs of the children whose needs are currently unmet or inadequately met. DFCS will phase in the implementation of the findings of the needs assessment, with the findings substantially implemented no later than 12 months after the completion of the needs assessment.

B. Reimbursement Rates for Placements

1. Basic foster care maintenance payments:
 - a. With regard to the provision of basic foster family services, including kinship care (limited to kin who are approved foster parents), effective July 1, 2005, DHR/DFCS shall set and pay the following basic foster care maintenance payments: for each child ages 0-6, \$13.78; for each child ages 7-12, \$15.50; and for each child age 13 and older, \$17.75. DHR/DFCS shall ensure that this rate is paid to all foster parents providing basic foster family services, regardless of whether they are directly supervised by DFCS or directly supervised by private providers. These rates shall be uniform.
 - b. The Commissioner shall propose a periodic increase in the basic foster care maintenance payments referenced in subparagraph a., above, effective in succeeding fiscal years, based upon discussions with affected foster parent groups and consideration of whether an increase in any amount for any age group is needed to adequately compensate for basic foster care for the relevant age groups. Class counsel shall be notified of the amount of any such increase in the basic foster care maintenance payments within 30 days of the effective date of such change in payment.
 - c. Beginning July 1, 2007, and continuing until the termination of this Consent Decree as provided in Section 19, if Class Counsel forms a

good faith opinion that the amounts paid by DHR for basic foster care maintenance payments are insufficient to adequately compensate for foster family care, then Class Counsel may seek judicial remedies under the provisions set forth in Section 17 of this Consent Decree, and shall have the burden to show that the payment structure set by the Commissioner fails to adequately compensate for basic foster care for a particular age group or groups.

2. Within 60 days after the parties sign the Consent Decree, DHR/DFCS shall establish a Reimbursement Rate Task Force. The Reimbursement Rate Task Force shall accept and shall not revise the base-level rate for the provision of family foster care services (including kinship care) as defined in subsection 1 above. The Reimbursement Rate Task Force shall create a rate structure based on measurable outcomes for all children in foster care (excluding basic, non-therapeutic foster family care) based on the reasonable cost for achieving these outcomes. The Reimbursement Rate Task Force shall examine the Level of Care system and make recommendations for either revising or replacing it, and shall also consider the results of various pilot programs being carried out across the state. The rate structure established by the Reimbursement Rate Task Force must comply with Title IV-E and Medicaid funding guidelines so that DHR/DFCS can draw down such funds.
3. The rate structure established by the Reimbursement Rate Task Force shall serve as the basis for performance-based contracting, and shall be phased in beginning 90 days after the Reimbursement Rate Task Force issues its findings, provided that the rates fixed by the Commissioner must be fully implemented in the contracting cycle beginning July 1, 2007.
4. Beginning in the July 1, 2006 contracting cycle and continuing thereafter, DHR/DFCS shall ensure that all approved foster parents (regardless of whether they are supervised directly by DFCS or by private providers) receive the same reimbursement rate for a given level of service.
5. If DHR/DFCS directly supervises any approved foster homes that provide therapeutic services or operates any specialized group facilities, those approved foster parents or group facilities shall be paid at the same rate. All specialized group facilities shall be paid at the same rate for the same level of services.
6. The Reimbursement Rate Task Force shall be composed of the following members: James L. Kunz, Howard A. Peters III, and Becky Butler. The Task Force may meet when necessary in order to accomplish its duties, and shall work to finalize its recommendations in the most efficient and

economical manner possible. The Reimbursement Rate Task Force shall have access to data, documents and information needed, and shall otherwise have the support needed to carry out its duties. DHR shall reimburse the members of the Task Force for approved expenses and fees incurred in performing its duties, in accordance with state regulations.

7. The Task Force shall make every effort to present its findings no later than 120 days after the entry of the Consent Decree, unless the Task Force requests and the parties consent to an extension for the presentation of findings. The Task Force shall include recommendations on the priority for implementing its findings.

C. Ensuring that the placement process secures the most appropriate placement for all children.

1. Children for whom placement has determined to be necessary shall receive an assessment of their placement needs by a qualified professional no later than 30 business days after the child enters placement. The assessment shall include the initial physical health, dental health, and mental health screenings referred to in Section 6, Paragraph A. of this Consent Decree and all other required elements.
2. As soon as the placement assessment is completed, the child's current placement shall be reevaluated to ensure that it meets the child's needs and if not a new placement shall be obtained as quickly as practicable.
3. DHR shall ensure that each county has a placement process in place, including placement specialists with knowledge of both the resources available to enable the child to remain at home safely to avoid the need for placement if possible and of the placement resources, including the specific placement (foster home or group setting) available in a contract agency and its suitability for the particular child needing placement to reasonably ensure that each child receives the most appropriate placement for his/her individual needs.
4. Children shall be placed according to the following standards:
 - a. Children shall be placed in accordance with their individual needs, as determined by the needs assessment in paragraph C.1 of this section, taking into account the child's needs to be placed as close to home and community as possible, the need to place siblings together, the DHR/DFCS preference for placement with relative resources, and the need to place children in the least restrictive, most home-like setting.

- b. Children shall be placed within their own county or within 50 miles of the home from which they were removed. This provision shall not apply if (i) the child's needs are so exceptional that they cannot be met by a family or facility within their own county or within 50 miles of the home from which they were removed, (ii) the child is placed through the ICPC consistent with its terms, (iii) the child is appropriately placed with relatives, or (iv) the child is in an adoptive placement.
- c. No child shall be placed in an emergency or temporary facility or any other foster home or group facility beds used on a temporary basis, for more than 30 days. Children shall not be placed in more than one emergency or temporary facility within one episode of foster care. No child shall spend more than 23 hours in a county DFCS office, or any facility providing intake functions, including but not limited to the current Children's Center in DeKalb County and the Fulton Family Resource Center in Fulton County.
- d. Siblings who enter placement at or near the same time shall be placed together, unless doing so is harmful to one or more of the siblings, one of the siblings has such exceptional needs that can only be met in a specialized program or facility, or the size of the sibling group makes such placement impractical notwithstanding diligent efforts to place the group together. If a sibling group is separated at the initial placement, the case manager shall make immediate efforts to locate or recruit a family in whose home the siblings can be reunited.
- e. No child shall be placed in a foster home if that placement will result in more than three (3) foster children in that foster home, or a total of six (6) children in the home, including the foster family's biological and/or adopted children, without the written approval of the Social Services Director based on a reasonable determination that the home is appropriate for and can meet the needs of the additional number of children. No placement will result in more than 3 children under the age of 3 residing in a foster home. The only exception to these limits shall be circumstances in which the placement of a sibling group in a foster home with no other children in the home would exceed one or more of these limits.
- f. Group Care Restrictions

The capacity of a group care setting shall include all beds on the entire grounds of the setting, and includes the total number of beds in multiple cottages.

- i. No child under six years of age shall be placed in a group care setting without the express written approval of the Social Services Director based upon his or her certification that the individual child has exceptional needs which cannot be met in any foster home placement or other facility. The certification shall describe the services which are available in the group care setting to address the child's exceptional needs. No child under six years of age who shall be certified for a group care setting under the terms in this subparagraph shall be placed in any group care setting which has a total capacity in excess of 12 children. This paragraph shall not apply to a child who is under six years of age and who is also the son or daughter of another child placed in a group care setting either prior to or after the entry of this Consent Decree. This paragraph shall not apply to a child who is under six years of age who is also the sibling of another child who has been placed in a group care setting prior to the entry of this Consent Decree, except that any such sibling under the age of six shall be moved to a foster home placement within 12 months of the entry of this Consent Decree unless doing so would not be in the best interest of the children in question.
- ii. No child between the ages of six and 12 years of age shall be placed in a group care setting without the express written approval of the Social Services Director based upon his or her certification and specific findings that the individual child has needs which can be met in the particular group care setting and that the particular group setting is the least restrictive placement that can meet such needs. The certification shall describe the services which are available in the group care setting to address the child's needs. No child between the ages of six and 12 years of age who shall be certified for a group care setting under the terms in this subparagraph shall be placed in any group care setting which has a total capacity in excess of 12 children. This paragraph shall not apply to a child between the ages of six and 12 years who is also the sibling of another child who has been placed in a group care setting prior to the entry of this Consent Decree, except that any such sibling between the ages of six and 12 years shall be moved to a foster home placement within 12 months of the entry of this Consent Decree unless doing so would not be in the best interest of the children in question. For any other children between the ages of six and 12 who were placed in a group care setting prior to the entry of this Consent Decree, DHR/DFCS shall have 12 months from the entry of this Consent Decree to move such children to a

non-group care setting unless doing so would not be in the best interest of the child or children in question.

- iii. Children who are at least 12 years of age and older may be placed in a group care setting without any of the restrictions contained in paragraphs i. or ii., above.
 - g. Children for whom the permanency goal is adoption should, whenever possible, be placed with a family in which adoption is a possibility.
 - h. Race and/or ethnicity and/or religion shall not be the basis for a delay or denial in the placement of a child, either with regard to matching the child with a foster or adoptive family or with regard to placing a child in a group facility. Race and/or ethnicity shall otherwise be appropriate considerations in evaluating the best interest of an individual child to be matched with a particular family. DHR shall not contract with any program or private agency that gives preference in its placement practices by race, ethnicity, or religion, but may utilize its authority to contract with private providers to ensure that the pool of available foster and adoptive families reflects and meets the needs of children for whom foster and adoptive placements are needed, including placements for children for whom placement resources are scarce or unavailable.
 - i. DHR shall only contract for placements or services with licensed contractors or subcontractors. No child shall be placed in an unlicensed facility.
 - j. DFCS will ensure the basic physical needs of food, clothing and shelter for children in foster care. At the time of placement or at any placement move, DFCS will review the child's clothing needs to assess appropriateness and take necessary steps to ensure that the child has appropriate clothing.
5. DFCS shall take steps to minimize any trauma which may be experienced by a child which is associated with either a change in placement or in case managers.
6. DHR/DFCS shall take appropriate steps to ensure that foster children placed in foster family homes, whether directly supervised by DHR/DFCS or private providers, receive adequate supports, including the following:

- a. DHR/DFCS shall ensure that before a child is placed in any approved foster family home, the foster parents have received uniform and appropriate pre-service training;
- b. DHR/DFCS shall ensure that all approved foster parents with whom foster children are placed shall receive uniform and appropriate ongoing training, and that they are reasonably informed of any changes in laws or DHR/DFCS policies that affect foster parents;
- c. DHR/DFCS shall ensure that all foster parents (including kinship providers) with whom foster children are placed can contact DHR/DFCS and receive information 24 hours a day, 7 days a week, so that questions or concerns can be timely and appropriately addressed;
- d. DHR/DFCS shall ensure that available information concerning a specific foster child, including family history, medical, dental, mental health and educational information, and any other information that is relevant to the child's safety and well-being, is provided to approved foster parents, before the child is placed in the home, and that complete and accurate updated information is provided to the approved foster parents after the child is placed as such information becomes available.

D. Visitation

The frequency and intensity of in-placement visits and other visits with a child shall be determined by the individual needs of the child. An in-placement visit refers to a private face-to-face visit with the child *in the child's home/placement*, in order to monitor and document the child's adjustment to the placement, the appropriateness of the placement to meet the child's needs, the receipt of appropriate treatment and services by the child, the child's safety, and service goals. A visit refers to a face-to-face visit with the child, in order to monitor and document the child's adjustment to the placement, the appropriateness of the placement to meet the child's needs, the receipt of appropriate treatment and services by the child, the child's safety, and service goals. The following minimum in-placement visits and other visits shall apply:

1. For all children in placements other than adoptive placements:
 - a. For the first eight weeks after an initial placement or upon any change in placement, there shall be at least: (a) one in-placement visit during the first week of the placement; (b) one in-placement visit between the third and the eighth week of the placement; and (c) six additional visits during the eight week period.

- b. Thereafter, there shall be at least one in-placement visit per month and one additional private visit per month.
 2. For all children in adoptive placements, there shall be (a) one in-placement visit the day after the child is placed; and (b) at least one in-placement visit per month after the placement but before the adoption petition is filed; and (c) at least one in-placement visit per quarter after the adoption petition is filed.

6. HEALTH SERVICES TO CHILDREN

A. Initial Screenings and Follow-Up Treatment

1. **Physical Health Screening:** All children shall receive a medical screening within ten days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing physician.
2. **Dental Health Screening:** All children shall receive a dental screening within ten days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing dentist.
3. **Mental Health:** All children four years of age and older shall receive a mental health screening conducted by a licensed mental health professional and completed within 30 days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing professional. The mental health screening shall be commenced prior to the MDT meeting provided in Section 4.A.3. of this Consent Decree. All children under four years of age shall receive a developmental assessment conducted by a licensed professional and completed within 30 days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing professional. The developmental assessment shall be commenced prior to the MDT meeting provided in Section 4.A.3. of this Consent Decree.

B. Periodic Health Screenings and Treatment

1. Ages zero through six months: All children between the ages of zero to six months shall receive no less than three periodic EPSDT/Georgia Health Check Program health screenings.
2. Ages six months through 18 months: All children between the ages of six months through 18 months shall receive no less than four periodic EPSDT/Georgia Health Check Program health screenings performed at approximate three month intervals.
3. Ages 18 months through five years: All children between the ages of 18 months through five years shall receive no less than one periodic EPSDT/Georgia Health Check Program health screening performed every six months.
4. Ages six years and over: All children of six years of age and older shall receive no less than one periodic EPSDT/Georgia Health Check Program health screening performed every year.
5. All children shall receive any follow-up treatment or care as directed by the physician who administered the periodic EPSDT/Georgia Health Check Program health screening.
6. Every child shall receive an EPSDT/Georgia Health Check Program health screening within ten days of receiving a final discharge from placement.
7. Children's health needs, including dental and mental health needs, between periodic screenings shall be met as provided by EPSDT.
8. All children age 3 and over shall receive at least one annual dental screening in compliance with EPSDT standards, including at a minimum, the components identified in the EPSDT/Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing dentist.

- C. All medication prescribed for a child will be administered as ordered in such prescription(s). Only designated, authorized, and appropriately trained personnel shall administer the taking of any prescribed medication for children in any non-foster family care placement.

7. **SINGLE STATEWIDE AUTOMATED CHILD WELFARE INFORMATION SYSTEM**

- A. State Defendants shall have a fully implemented, single statewide automated child welfare information system (“SACWIS”) containing at a minimum:
1. The system shall have the functionalities as identified and described in Appendix “A” hereto;
 2. The system shall have the data integrity and quality assurance processes as identified and described in Appendix “B” hereto; and
 3. The system shall have the security and data recording and recovery elements as identified and described in 45 CFR Part 95, Subpart F, §95.621.
- B. The date certain for full implementation shall be set forth in a contract with a selected vendor, with the vendor selected and the contract effective on or before December 31, 2005. The date for full implementation shall be added to this Consent Decree after the contract is executed.
- C. Both leading up to and subsequent to the full implementation of a single statewide automated child welfare information system, State Defendants shall at all times satisfy all federal reporting requirements and shall maintain data integrity and accuracy on a continuous basis.

8. **CASELOADS**

- A. DFCS will phase in a reduction in its caseload in Fulton and DeKalb Counties for its CPS investigators, ongoing case managers, placement case managers, and adoption case managers over a two year period as provided below. In the event that a worker has a mixed caseload, the caseload shall be weighted to reflect the standards in this section.
1. By the end of the second reporting period, the following caseloads will exist in Fulton and DeKalb County DFCS:
 - a. No CPS case manager shall have more than 20 cases.
 - b. No ongoing case manager shall have more than 20 cases.
 - c. No placement case manager shall have more than 25 cases.
 - d. No adoption case manager shall have more than 22 cases.

2. By the end of the fourth reporting period and continuing thereafter, the following caseloads will exist in Fulton and DeKalb County DFCS:
 - a. No CPS case manager shall have more than 12 cases.
 - b. No ongoing case manager shall have more than 17 cases.
 - c. No placement case manager shall have more than 15 cases.
 - d. No adoption case manager shall have more than 16 cases.
- B. DFCS will phase in a reduction in the ratio of supervisors to case managers in Fulton and DeKalb County over a two-year period as provided below.
 1. By the end of the second reporting period, no supervisor shall supervise more than six case managers at any one time in Fulton and DeKalb County DFCS.
 2. By the end of the fourth reporting period and continuing thereafter, no supervisor shall supervise more than five case managers at any one time in Fulton and DeKalb County DFCS.
- C. DFCS will phase in elimination in the employment or utilization of temporary personnel (“PRNs”) as case managers in Fulton and DeKalb County over a one-year period as provided below.
 1. From the period beginning six months from the entry of the Consent Decree up through the period ending one year from the entry of the Consent Decree, PRNs shall comprise no more than 11% of the total allocation of social services case managers for Fulton and DeKalb County DFCS, respectively.
 2. From the period beginning one year from the entry of the Consent Decree and continuing thereafter, no PRNs shall be employed or utilized as case managers in Fulton and DeKalb County DFCS.
- D. The caseloads for Specialized Case Managers shall be governed by Section 4.F. of this Consent Decree.

9. SUPERVISION OF CONTRACT AGENCIES

- A. DHR shall require, and shall take appropriate steps to ensure, that all child-caring institutions or child-placing agencies that provide placements and services to class members meet all applicable terms of this Consent Decree.

- B. This Section 9 applies to any contract for the provision of placements and services to class members into which DHR enters during the contract cycle beginning July 1, 2005, or as soon as practicable following the entry of the Consent Decree. Into any such contract, which shall be annual performance-based contracts, DHR will incorporate all applicable requirements of this Consent Decree, but will do so without reference to the Consent Decree itself. DHR will also specify in any such contract that the suspected abuse or neglect of any class member while receiving such placements or services shall be reported to DHR for investigation, that all placement providers for foster children in DFCS custody are prohibited from using or authorizing the use of corporal punishment, and that any suspected corporal punishment while in that provider's care shall be reported to DHR for screening, assessment or investigation as necessary. The findings of investigations of suspected abuse or neglect, or of the assessment or investigation of suspected corporal punishment, shall be included in the criteria that DHR uses in determining whether to renew the license of a contract agency. With respect to contract agencies' contractual violations, DHR may use such contractual remedies as provided by the contract and by applicable Georgia statutes and Rules and Regulations. The failure of a contract agency to report suspected abuse or neglect of a child to DHR/DFCS shall result in appropriate process being issued in accordance with applicable statutes, rules and regulations for immediate termination of the contract or placement of the provider on probation, and a repeated failure within one year shall result in termination of the contract.
- C. DHR shall ensure that all child-caring institutions or child-placing agencies that provide placements and services to class members report to DHR accurate data on at least a bi-annual (6 months) basis so that their compliance with the terms of this Consent Decree can be measured.
- D. DHR, through its Office of Regulatory Services ("ORS"), shall conduct licensing evaluations of all child-caring institutions and child-placing agencies providing placements and services to class members, to ensure, among other things, the safety and well being of class members and to ensure that the contract agency is complying with the applicable terms of this Consent Decree. As part of such evaluations, ORS shall ensure that each child-caring institution and child-placing agency shall receive at least one unannounced inspection a year to review all relevant aspects of the agency/institution's operations, and that, in addition, 5% of family foster homes or a total of 10 homes (whichever is greater, or all homes for agencies providing less than 10 homes in total) provided by each child-placing agency shall receive such an unannounced annual inspection to review all relevant aspects of the agency/institution's operations. ORS shall prepare a written report after each visit detailing its findings, and shall provide follow-up visits or monitoring if deemed necessary. With respect to license-holders' deficiencies, ORS may use such remedies as are provided by applicable Georgia statutes and Rules and Regulations.

10. TRAINING

- A. No case manager shall assume responsibility for a CPS, ongoing, foster care or adoption case, until after completing pre-service training as specified below and after passing an appropriate skills-based competency test, as determined by DHR/DFCS. No case manager supervisor shall assume supervisory responsibility until after completing pre-service training as specified below and after passing an appropriate skills-based competency test, as determined by DHR/DFCS.
- B. DFCS shall have a full time Education and Training Services Section headed by a manager of Education and Training with appropriate qualifications, as determined by DHR/DFCS.
1. The training unit shall provide comprehensive and appropriate child welfare pre-service training to ensure that all case managers and supervisors responsible for children will have training to permit them to comply with the terms of this Consent Decree, law, DFCS policy and reasonable professional standards, as determined by DHR/DFCS.
 2. DHR/DFCS management shall determine, on an annual basis, those DFCS workers in need of re-training, as indicated by workers' failure to ensure that the cases for which they are responsible comply with the terms of this Consent Decree, law, DFCS policy and reasonable professional standards, as determined by DHR/DFCS, and shall ensure that additional training is provided to them.
 3. All new case managers shall have a minimum of 160 hours of pre-service training, including instructional training and supervised field training, unless waived by the Director of Education and Training Services in accordance with the Office of Child Protective Services New Case Manager Training Waiver Guidelines issued April 1, 2005, or comparable guidelines. All case manager supervisors shall receive a minimum of 40 hours of in-service training that is directed specifically at the supervision of child welfare workers, prior to receiving any supervisory duties. All case managers shall receive a minimum of 20 hours of ongoing training each year. All case managers with supervisory responsibility shall receive a minimum of 20 hours of in-service training each year.
 4. Private provider agencies with whom DFCS contracts for the provision of placements for children in DFCS custody shall be required, through contract provisions, to certify that employees providing case management or supervisory services for DFCS have met the following criteria:

- a. Have an undergraduate degree from an accredited college or university;
 - b. Have completed a training curriculum consisting of at least 160 hours of classroom, internet and/or supervised field instruction, unless waived by the Director of Education and Training Section in accordance with the Office of Child Protective Services New Case Manager Training Waiver Guidelines issued April 1, 2005, or comparable guidelines. The curriculum shall be approved by DHR/DFCS to ensure that the general content areas are appropriate to the work being performed. Where case work activities mirror those of DFCS case managers or supervisors, the curriculum shall be comparable to DHR/DFCS' pre-service and in-service training;
 - c. Have a passing score on the case manager and/or supervisor online assessment required for new worker certification as of July 1, 2005; and
 - d. Have 20 hours of job related ongoing professional development annually.
- C. All case manager supervisors employed after the entry of this Consent Decree shall have a minimum of a bachelor's degree in social work, and at least two years of experience as a case manager in social services.

11. FOSTER PARENT SCREENING, LICENSING AND TRAINING

- A. All paragraphs in this section shall apply to all class members, whether they are in placements supervised directly by DHR/DFCS, or in placements supervised directly or provided by private contract agencies.
- B. DHR/DFCS shall develop and maintain uniform standards for the approval, and re-approval, of all foster and pre-adoptive families with whom class members may be placed. These standards shall comply with federal law.
- C. The actual processes for approval and re-approval of all foster and pre-adoptive families/parents with whom class members may be placed, shall be developed and carried out by DFCS in conjunction with ORS.
- D. DHR/DFCS shall require uniform training of all foster and pre-adoptive families/parents with whom class members may be placed. Uniform training for all foster parents shall be required prior to the placement of any children with a

foster or pre-adoptive family. All foster parents shall also be required to complete annual training, as part of an annual re-approval process.

- E. Within 90 days of the entry of this Consent Decree, DHR/DFCS shall have an automated information system that can provide the following:
1. For every foster and pre-adoptive family/parents with whom class members may be placed, the name, address, phone number, and, if supervised directly by a private provider, the name and address of the private provider.
 2. For every foster and pre-adoptive family/parents with whom class members may be placed, a list of all foster children in the home, the number and age of any other children in the home, any other adults who are providing direct care or supervision for class members in the home, and the county DFCS office with custody of each foster child.
 3. For every foster or pre-adoptive family/parents with whom class members may be placed, the approval or re-approval status of the home.
 4. For every foster or pre-adoptive family/parents with whom class members may be placed, a complete history beginning in January 1, 2002 and going forward, of any reports of abuse or neglect and any substantiated reports of abuse or neglect.
 5. DHR/DFCS shall consider the information above before a child is placed with any foster or pre-adoptive family/parents, and before any approval, or re-approval is granted.
- F. DHR/DFCS shall not allow any foster or pre-adoptive family/parents to be given approval or re-approval, and shall not allow any class members to be placed or to continue to be placed with such foster or pre-adoptive family/parents, if that same foster or pre-adoptive family/parents has been found to be the perpetrator of substantiated abuse or neglect, or has had their home closed as the result of a policy violation that threatened the safety of a child, has had their home closed as a result of two violations of the corporal punishment policy, or has had their home closed as a result of a single violation of the corporal punishment policy where the family was not amenable to change, correction, or DFCS intervention. DHR/DFCS shall be able to identify if (a) foster or pre-adoptive family/parents were the perpetrators of substantiated abuse or neglect, or had their homes closed, while being supervised by a private contract agency, and they subsequently seek to become approved or re-approved with a different private contract agency or directly as a DFCS supervised foster or pre-adoptive family/parents; or (b) foster or pre-adoptive family/parents were the perpetrators of substantiated abuse or

neglect, or had their homes closed, while being supervised directly by DFCS, and they subsequently seek to become approved or re-approved with a private contract agency.

- G. DHR/DFCS shall also maintain the following information in accessible paper file form:
1. For every foster or pre-adoptive family/parents with whom class members may be placed, the approval or re-approval status of the home, and for any foster or pre-adoptive family/parents not in full approval or re-approval status, the reasons for lack of full approval or re-approval status.
 2. For every foster or pre-adoptive family/parents with whom class members may be placed, a complete history for the prior 5 years of any reports of possible abuse or neglect and any substantiated reports of abuse or neglect (and the nature of the report and the nature of the substantiation), home closings (and the reasons therefore) or refusals to place further children in the home (and reasons therefore), or other corrective actions or disciplinary actions ever taken against the foster or pre-adoptive family/parents (and reasons therefore).
 3. DHR/DFCS shall consider the information above before a child is placed with any foster or pre-adoptive family/parents, and before any approval, or re-approval is granted.

12. ABUSE IN CARE INVESTIGATIONS

- A. All referrals of reports of suspected abuse or neglect of children in foster care shall be investigated by DFCS child protective services staff in the manner and within the time frame provided by law and DFCS policy.
- B. All referrals of suspected abuse or neglect of foster children in institutional, group, residential or foster family homes provided or directly supervised by private providers shall also be referred to and reviewed by the Office of Regulatory Services and the Social Services Treatment Services Unit. The purpose of this review is to determine whether a pattern of abuse or neglect exists within the institutional, group, residential, foster family homes or private provider agency that contributed to the abuse or neglect; whether the contract should be terminated; whether particular homes or facilities should be closed; and what other steps are necessary to safeguard the safety and well-being of children.

C. Corporal Punishment.

1. DHR/DFCS shall continue to require that foster parents and other placement resources for children in the custody of DHR shall not use corporal punishment of children in their care, nor shall they authorize or permit any other individual or agency to administer corporal punishment.
2. When a report of suspected corporal punishment of a foster child in DHR/DFCS custody is received, the allegations must be immediately screened by the Child Protective Services intake unit or the Regional Field Program Specialist. Such personnel shall have appropriate training in child protective services including the screening of reports of potential corporal punishment and abuse/neglect and in discerning the difference between them. No such personnel shall also have any responsibility for the selection, recruitment, approval or re-approval, retention or matching of foster, adoptive or other placement options for foster children. If there is reasonable cause to believe that abuse or neglect occurred, the report of corporal punishment must be treated as an abuse referral and forwarded immediately to the Child Protective Services Supervisor who will follow policy requirements for abuse or neglect reports. All reports of suspected corporal punishment in child caring institutions shall be treated as an abuse referral and forwarded immediately to the Child Protective Services Supervisor who will follow policy requirements for abuse or neglect reports.
3. If suspected corporal punishment in DHR/DFCS custody does not result in an abuse referral, the following provisions shall apply to assessments of foster homes:
 - a. Assessment:
 - i. The assessment of suspected corporal punishment shall be conducted in the manner and within the time frames required by law and DFCS policy.
 - ii. No additional placements may be made in the foster home until the investigation is complete.
 - b. Assessment and Conclusions:
 - i. If the allegation of suspected corporal punishment is supported by the assessment findings, the home must be closed if:

- a. the violation had direct impact on the safety and well being of the child or posed a serious risk factor for the child in the home;
 - b. the violation is the second Discipline or Other Serious Foster Care Violation; or
 - c. the family is not amenable to change, correction or DFCS intervention.
- ii. If the allegation that the discipline policy has been violated is supported and none of the conditions listed in i. above is present, then the home may remain open and a corrective action plan must be developed, agreed upon, and signed by all participants. DHR/DFCS shall ensure that the corrective action plan is appropriately monitored and enforced. The county director may close the foster home in his or her discretion. In deciding whether to close the foster home, the county director should consider: the severity of the incident, the pattern of behavior and history of the foster parents, the identified needs of the child, the willingness of the foster parents to look at alternative approaches to discipline, and the quality of the relationship between the child and foster parent.
- 4. Office of Regulatory Service Regulation 290-2-5.18 prohibits the use of corporal punishment in child caring institutions. Violation of this regulation shall be enforced by the Office of Regulatory Services and shall be punishable by fine, probation, suspension or revocation of license and other sanctions under the Rules and Regulation of the Department of Human Resources.

13. CORRECTIVE ACTIONS

- A. Within 60 days of the final entry of this Consent Decree, DHR/DFCS shall identify all class member children in custody for 12 months or more who have not had a medical examination within the prior 12 months, and all foster children in custody for more than 30 days and less than 12 months who have not have a medical examination since their most recent entry into custody. The identified children shall be provided with a medical examination and treatment as set forth in Section 6 of this Consent Decree concerning Health Services to Children by the end of the first reporting period.

- B. Within 60 days of the final entry of this Consent Decree, DHR/DFCS shall identify all foster care placements (foster family homes or non-foster family homes, DFCS-supervised, or private provider-supervised) in which one or more class member children have been placed in the past 6 months, for which placements there have been 2 or more substantiated reports of abuse or neglect in the past 18 months. For each placement identified, by the end of the first reporting period, DHR/DFCS shall conduct an unannounced inspection of the home to determine if there are any risks to the health, safety and well-being of children living in such placements, and shall take all appropriate actions.

14. MAXIMIZATION OF FEDERAL FUNDING

DHR/DFCS shall maximize funds available to it through Title IV-B and IV-E of the Social Security Act. DHR/DFCS shall establish baselines for present levels of state and federal funding in order to identify increases in federal funding. The parties intend that any increases achieved in federal funding shall not supplant state funds for foster care services. DHR/DFCS shall demonstrate to the reasonable satisfaction of the Accountability Agents that DHR/DFCS has an appropriate mechanism in place for reporting the budgeting of both federal and state dollars. Plaintiffs' agreement herein is premised upon the good faith representation by DHR and the Governor that that their policy will be to urge the General Assembly that state dollars committed to DHR/DFCS for the provision of services and resources to benefit children in the class shall not be decreased from current levels if efforts to maximize federal dollars result in additional federal funding.

15. OUTCOME MEASURES

State Defendants shall meet the following Outcome Measures in the Reporting Periods specified. Performance percentages required "by the end of" a Reporting Period will be measured during the immediately subsequent Reporting Period. Each Reporting Period shall be six months. State Defendants will comply with each Outcome Measure according to its terms for the duration provided for Outcome Measures in Section 19 of this Consent Decree.

1. Commencement of CPS investigations concerning foster children: By the end of the first reporting period, at least 95% of all investigations of reports of abuse or neglect of foster children shall be commenced, in accordance with Section 2106 of the Social Services Manual, within 24 hours of receipt of the report.
2. Completion of CPS investigations concerning foster children: By the end of the first reporting period, at least 95% of all investigations of reported abuse or neglect of foster children shall be completed, in accordance with

Section 2106 of the Social Services Manual, within 30 days of receipt of the report.

3. Contact with the alleged victim: By the end of the first reporting period, at least 99% of all investigations of reported abuse or neglect of foster children during the reporting period shall include timely face-to-face, private contact with the alleged victim, including face-to-face, private contact with a child who is non-verbal due to age or for any other reason.
4. Re-entry into care: By the end of the second reporting period, no more than 8.6% of all foster children entering custody shall have re-entered care within 12 months of the prior placement episode.
5. Maltreatment in care: By the end of the first reporting period, no more than 1.27% of all children in foster care shall be the victim of substantiated maltreatment while in foster care. By the end of the second reporting period, no more than .94% of all children in foster care shall be the victim of substantiated maltreatment while in foster care. By the end of the fourth reporting period, no more than .57% of all children in foster care shall be the victim of substantiated maltreatment while in foster care.
6. By the end of the second reporting period, 90% of all foster homes will not have an incident of corporal punishment within the previous six months. By the end of the third reporting period, 98% of all foster homes will not have an incident of corporal punishment within the previous 12 months.
7. Search for relatives: By the end of the second reporting period, at least 70% of all foster children entering care shall have had a diligent search for parents and relatives undertaken and documented within 90 days of entering foster care. By the end of the fourth reporting period, at least 95% of all foster children entering care shall have had a diligent search for parents and relatives undertaken and documented within 60 days of entering foster care.
8. (a) Of all children entering custody following the entry of the Consent Decree, at least 40% shall have had one of the following permanency outcomes within 12 months or less after entering custody: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. Performance on this measure shall be taken on the first day after the end of the second reporting period, and shall be taken at the end of subsequent reporting periods, as necessary. For example, to sustain compliance at the end of the third reporting period, of all children who entered custody after the entry of the Consent Decree, at least 40% shall

have had one of the following permanency outcomes within 12 months or less after entering custody: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. Performance on this measure shall be taken on the first day after the end of the third reporting period.

(b) Of all children entering custody following the entry of the Consent Decree, at least 74%: (1) shall have had one of the following permanency outcomes within 12 months or less after entering custody: reunification or permanent placement with relatives; or (2) shall have had one of the following permanency outcomes within 24 months or less after entering custody: adoption, permanent legal custody or guardianship. Performance on this measure shall be taken on the first day after the end of the fourth reporting period, and shall be taken at the end of subsequent reporting periods, as necessary. For example, to sustain compliance at the end of the fifth reporting period, of all children who entered custody after the entry of the Consent Decree, at least 74% shall have had one of the permanency outcomes within the types of permanent placement and time frames as listed in (1) or (2) above. Performance on this measure shall be taken on the first day after the end of the fifth reporting period.

9. Children in custody for up to 24 months and still in custody upon entry of the Consent Decree (children in the “24 month backlog pool”): For all children in the 24 month backlog pool, by the end of the second reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For children in the 24-month backlog pool who remain in custody at the end of the second reporting period, by the end of the third reporting period at least 40% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For children in the 24-month backlog pool who remain in custody at the end of the third reporting period, by the end of the fourth reporting period at least 40% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship.
10. Children in custody for more than 24 months and still in custody upon entry of Consent Decree (children in the “over 24 month backlog pool”): For all children in the over 24 month backlog pool, by the end of the second reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For all children in the over 24 month backlog pool who remain in custody by the end of the

second reporting period, by the end of the third reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For all children in the over 24 month backlog pool who remain in custody by the end of the third reporting period, by the end of the fourth reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship.

11. By the end of the second reporting period, for all children whose parental rights have been terminated or released during the reporting period, 80% will have their adoptions or legal guardianships finalized within 12 months of final termination or release of parental rights.
12. For children whose parental rights have been terminated or released and the child has an identified adoptive or legal guardian resource at the time of the entry of the Consent Decree, 90% shall have had their adoptions or legal guardianships finalized within six months after the entry of the Consent Decree.
13. For all children for whom parental rights have been terminated or released at the time of entry of the Consent Decree, and the child does not have an identified adoptive resource, 95% shall have been registered on national, regional, and local adoption exchanges, and have an individualized adoption recruitment plan or plan for legal guardianship within 60 days of the entry of the Consent Decree.
14. Adoption disruptions: No more than 5% of adoptions finalized during the reporting period shall disrupt within the 12 months subsequent to the reporting period.
15. Permanency efforts (15/22): By the end of the second reporting period, at least 80% of all foster children who reached the point of being in state custody for 15 of the prior 22 months, shall have had either (1) a petition for the termination of parental rights filed as to both parents or legal caregivers as applicable OR (2) documented compelling reasons in the child's case record why termination of parental rights should not be filed.

By the end of the fourth reporting period, at least 95% of all foster children who reached the point of being in state custody for 15 of the prior 22 months, shall have had either (1) a petition for the termination of parental rights filed as to both parents or legal caregivers as applicable OR (2) documented compelling reasons in the child's case record why termination of parental rights should not be filed.

16. Sibling Placement: By the end of the second reporting period, at least 70% of all foster children who entered foster care during the reporting period along with one or more siblings shall be placed with all of their siblings. By the end of the fourth reporting period, at least 80% of all foster children who entered foster care during the reporting period along with one or more siblings shall be placed with all of their siblings.
17. Multiple Placement Moves: By the end of the second reporting period, at least 86.7% of all children in care shall have had 2 or fewer moves during the prior 12 months in custody. By the end of the fourth reporting period, at least 95% of all children in care shall have had 2 or fewer moves during the prior 12 months in custody.
18. Caseworker continuity: By the end of the second reporting period, at least 90% of all children in care at a point in time during the reporting period shall have had 2 or fewer DFCS placement case managers during the prior 12 months in custody. This measure shall not apply to cases that are transferred to an adoption worker or to a Specialized Case Manager as referenced in Section 4.F.; case managers who have died, been terminated, or transferred to another county; or case managers who have covered a case during another case manager's sick or maternity leave.
19. Placement within county: By the end of the second reporting period, at least 70% of all children in care shall be placed in their own county (the county from which they were removed) or within a 50 mile radius of the home from which they were removed, subject to the exceptions in Paragraph 5.C.4.b(ii) and (iii) above. By the end of the third reporting period, at least 80% of all children at a point in time during the reporting period shall be placed in their own county (the county from which they were removed) or within a 50 mile radius of the home from which they were removed, subject to the exceptions in Paragraph 5.C.4.b(ii) and (iii) above. By the end of the fourth reporting period, at least 90% of all children at a point in time during the reporting period shall be placed in their own county (the county from which they were removed) or within a 50 mile radius of the home from which they were removed, subject to the exceptions in Paragraph 5.C.4.b(ii) and (iii) above.
20. Visitation (worker-child): By the end of the second reporting period, at least 95% of children in care at a point in time during the reporting period shall have had at least one in-placement visit and one other visit, as defined in Section 5.D, each month by their case manager during the prior 12 months in custody.

21. Visitation (parent-child when goal is reunification): By the end of the third reporting period, 75% of the children with a goal of reunification shall have had appropriate visitation with their parents to progress toward reunification. By the end of the fourth reporting period, 85% of the children with a goal of reunification shall have had appropriate visitation with their parents to progress toward reunification.
22. Visitation (worker-caregiver): By the end of the second reporting period, at least 90% of all children in care at a point in time during the reporting period shall have had visits between their DFCS placement case manager and their foster parent, group care, institutional or other caretaker at least one time each month during the prior 12 months in custody.
23. Visitation (between siblings): By the end of the second reporting period, at least 80% of children in the Class at a point in time during the reporting period who have one or more siblings in custody with whom they are not placed shall have had visits with their siblings at least one time each month during the prior 12 months in custody, unless the visit is harmful to one or more of the siblings, the sibling is placed out of state in compliance with ICPC, or the distance between the children's placements is more than 50 miles and the child is placed with a relative.
24. Achievement Measures on Discharge: A baseline measure shall be developed that shows the percentage of children discharged from foster care at age 18 or older during the 12 months prior to the entry of the consent decree who have graduated from high school or earned a GED. By the end of the second reporting period, that percentage shall increase by 10 percentage points. By the end of the fourth reporting period, that percentage shall increase by an additional 10 percentage points.
25. Placements not in full approval status: By the end of the first reporting period, at least 85% of all foster children in custody at a point in time during the reporting period shall be in placements that are in full approval and/or licensure status. By the end of the second reporting period, at least 95% of all foster children in custody at a point in time during the reporting period shall be in placements that are in full approval and/or licensure status. By the end of the fourth reporting period, at least 98% of all foster children in custody at a point in time during the reporting period shall be in placements that are in full approval and/or licensure status.
26. Case files not containing required court ordered language: By the end of the second reporting period, at least 85% of foster children in custody at a point in time during the reporting period shall have all applicable language in court orders necessary to assess qualification for federal funding under

Title IV-E of the Social Security Act. By the end of the fourth reporting period, at least 95% of foster children in custody at a point in time during the reporting period shall have all applicable language in court orders necessary to assess qualification for federal funding under Title IV-E of the Social Security Act. This outcome shall be measured for court orders entered after the entry of the Consent Decree.

27. By the end of the second reporting period, at least 80% of foster children in custody for six months or more shall have either had their six-month case plan review completed by the Juvenile Court within six months of their prior case plan review, or DFCS shall have submitted the child's six-month case plan to the Juvenile Court and filed a motion requesting a six-month case plan review within 45 days of the expiration of the six-month period following the last review. By the end of the third reporting period, at least 85% of foster children in custody for six months or more shall have either had their six-month case plan review completed by the Juvenile Court within six months of their prior case plan review, or DFCS shall have submitted the child's six-month case plan to the Juvenile Court and filed a motion requesting a six-month case plan review within 45 days of the expiration of the six-month period following the last review. By the end of the fourth reporting period, at least 95% of foster children in custody for six months or more shall have either had their six-month case plan review completed by the Juvenile Court within six months of their prior case plan review, or DFCS shall have submitted the child's six-month case plan to the Juvenile Court and filed a motion requesting a six-month case plan review within 45 days of the expiration of the six-month period following the last review.
28. By the end of the second reporting period, at least 95% of foster children in custody for twelve or more months shall have either had a permanency hearing held by the Juvenile Court within 12 months of the time the child entered foster care or had his or her last permanency hearing, or DFCS shall have submitted the documents required by the Juvenile Court for and requested a permanency hearing within 45 days of the expiration of the 12-month period following the time the child entered foster care or had his or her last permanency hearing.
29. By the end of the third reporting period, no more than 5% of all children in the physical custody of DHR/DFCS for 12 months or more shall have had a lapse in their legal custody within the prior 13 months. For the purposes of this outcome measure, a lapse in legal custody is defined as any period of expired legal custody. This Outcome Measure shall not apply to children who have been placed in the custody of another person and returned to the custody of DFCS during the 13-month period.

30. Meeting children's service needs: By the end of the second reporting period, at least 80% of children in care at a point in time at the end of the reporting period shall not have any unmet medical, dental, mental health, education or other service needs, according to the service needs documented in the child's most recent case plan. By the end of the fourth reporting period, at least 85% of children in care at a point in time at the end of the reporting period shall not have any unmet medical, dental, mental health, education or other service needs, according to the service needs documented in the child's most recent case plan.
31. By the end of the second reporting period and continuing thereafter, no more than 10% of all children in foster homes shall be placed in foster care homes that exceed the capacity limits referenced in Section 5.C.4.e. of this Consent Decree, concerning the requirement that no child shall be placed in a foster home if that placement will result in more than three (3) foster children in that foster home, or a total of six (6) children in the home, including the foster family's biological and/or adopted children.

16. ACCOUNTABILITY

- A. The Court shall appoint James T. Dimas and Sarah Morrison as the Court's independent Accountability Agents. In the event that either Mr. Dimas or Ms. Morrison is unable to fulfill his or her duties under this agreement, the parties will select a replacement with the advice and consent of the remaining Accountability Agent. The parties agree that data support will be provided to the Accountability Agents by Chapin Hall Center for Children at the University of Chicago and Georgia State University. The Accountability Agents shall conduct the factual investigation and verification of data and state documentation necessary to compile and to issue public record reports on State Defendants' performance relative to the terms of the Consent Decree directly to the Court and to the parties. These reports shall be issued for each six month reporting period, commencing approximately 90 days after the close of the first reporting period.
- B. DHR, through its employees or agents, will collect data with regard to each element of performance under this Consent Decree, and make it available on a timely basis to the Accountability Agents. DHR shall cooperate with the Accountability Agents in providing access to personnel, documents and other information necessary to perform their duties, as determined by the Accountability Agents, including without limitation interviews with agency staff, contract agency personnel, and interviews with DHR clients. The Accountability Agents shall conduct case record and other reviews as they deem necessary,

including recommending or requiring DHR to conduct regular case reviews according to a systematic process.

- C. DHR shall provide the Accountability Agents and/or the organizations through which they are employed with the necessary resources to perform their duties, including payment of their approved fees and expenses in accordance with state regulations. The Accountability Agents will prepare an initial budget proposal to the parties and the Court within 30 days of the signing of the consent decree. This budget will be updated and revised annually on or about the anniversary date of entry of the consent decree.
- D. All actions required for Plaintiff class members shall be documented within the individual case file of each member of the class on a timely and accurate basis. DFCS shall ensure that all required information concerning all foster parents, whether supervised by DFCS or by private providers, is timely and accurately entered into a foster parent file for each foster parent. DFCS shall ensure that a copy of all required information concerning contract agency providers is timely and accurately entered into a file for each contract agency provider and housed centrally at DFCS.

17. **ENFORCEMENT**

- A. Except for the Principles set forth in Section 3 (“the Principles”), all provisions of this Consent Decree are separately and independently enforceable.
- B. All provisions of this Consent Decree shall apply to all class members, regardless of whether they are in custody under the direct supervision of DCFS or of a contract provider.
- C. If Class Counsel notify State Defendants that, to the best of Class Counsel’s knowledge, information, and belief (formed after an inquiry reasonable under the circumstances), State Defendants are in violation of this Consent Decree, Plaintiffs may give notice to State Defendants in writing, and if so shall state with specificity the alleged noncompliance.
- D. Except when Class Counsel allege, in conformity with subsection E below, the existence of imminent danger of substantial harm to class members, the provisions of this paragraph shall apply.
 - 1. When notice of an alleged violation is given pursuant to subsection C, above, State Defendants shall respond to Class Counsel in writing within 25 days by asserting that Class Counsel has alleged only a violation of the Principles, by denying that any substantial noncompliance has occurred, or

by accepting (without necessarily admitting) the allegation of noncompliance and proposing steps that State Defendants shall take, and by when, to cure the alleged noncompliance.

2. If State Defendants (a) fail to respond within 25 days; (b) assert that Class Counsel has alleged only a violation of the Principles; or (c) deny that any substantial noncompliance has occurred, Class Counsel may thereafter seek an appropriate judicial remedy.
3. If State Defendants timely respond by accepting noncompliance and proposing curative action by a specified deadline, Class Counsel may accept State Defendants' proposal or may offer a counterproposal for a different curative action or deadline and negotiate over the appropriate action and deadline, but in no event shall Class Counsel seek an appropriate judicial remedy for the accepted noncompliance until at least 45 days after State Defendants have responded under subsection D.1 above and until both sides have conferred in good faith to resolve any differences. The parties may, by mutual agreement, extend the time period specified in this subsection.
4. If no agreement on the issue of appropriate curative action or deadline is reached within the timeframe set in subsection D.3 above, Class Counsel may seek an appropriate judicial remedy.
5. If the parties reach agreement on a plan and timetable for curative action, but State Defendants thereafter fail to implement the curative action within the time specified in the agreement, Class Counsel may seek an appropriate judicial remedy upon ten (10) days written notice to State Defendants.
6. If the parties reach agreement on a plan of curative action and State Defendants implement the plan, but the plan fails to correct substantially the alleged violation within the time specified in the agreement, Class Counsel may seek an appropriate judicial remedy upon ten (10) days written notice to State Defendants, unless State Defendants issue a written revised proposal for curative action accepting that the violation alleged in Class Counsel's initial noncompliance notice is continuing, and specifying: (i) why, in their view, the initial plan of curative action failed to produce compliance by the deadline and (ii) a revised proposal for curative action specifying a deadline for compliance.
7. If State Defendants issue a timely revised proposal for curative action and deadline in conformance with subsection D.6. above, the parties shall engage in good faith negotiations to attempt to reach agreement on a

revised plan for curative action and deadline. If the parties fail to reach agreement on a revised plan within 25 days of State Defendants' issuance of a revised proposal, Class Counsel may seek an appropriate judicial remedy.

8. If the parties reach agreement on a revised plan for curative action but that revised plan fails to correct substantially the noncompliance within the time specified in the agreement, Class Counsel may seek an appropriate judicial remedy within ten (10) days written notice to State Defendants; provided, however, that the parties may, at their option, continue to attempt to reach agreement on further curative action, further extension of the compliance deadline specified in the Consent Decree, or modification of the Consent Decree.

E. The provisions of this paragraph shall apply when Class Counsel allege the existence of imminent danger of substantial harm to class members.

1. If Class Counsel acting in conformity with subsection C above notify State Defendants that, to the best of Class Counsel's knowledge, information, and belief (formed after an inquiry reasonable under the circumstances), a violation of this Consent Decree has caused or threatens to cause an imminent danger of substantial harm to class members, Class Counsel may give emergency notice of their allegations to State Defendants by electronic mail or facsimile transmission, and if so, shall state with specificity the alleged violation and the alleged imminent danger of substantial harm.
2. Within four business hours of the receipt by the State Defendants of Class Counsel's emergency notice, State Defendants shall respond with their position by electronic mail or facsimile transmission.
3. If State Defendants fail to respond within 4 business hours, or if State Defendants respond by denying the danger is imminent, the threatened harm is substantial, or there is substantial noncompliance with the Consent Decree, Class Counsel may thereafter seek an appropriate judicial remedy.
4. If State Defendants timely respond to an emergency notice with a proposal for specific investigative or curative steps, the parties shall immediately thereupon engage in good faith efforts to reach agreement on appropriate investigative or curative action, including a time period for implementation.

5. If the parties are unable after conferring in good faith to agree on appropriate investigative and curative action and a timetable for implementation, Class Counsel may seek an appropriate judicial remedy.
- F. Class Counsel and their clients shall not issue a noncompliance notice or seek a judicial remedy for the first six months after entry of this Consent Decree except with respect to an alleged case of imminent danger of substantial harm to class members, as described in subsection E above. Nothing in this Consent Decree shall authorize or enable the Class or its Counsel to initiate discovery without order of the Court following the filing of a motion by Class Counsel as authorized by the Federal Rules of Civil Procedure and the local rules of Court.

18. QUALITY ASSURANCE

DFCS shall maintain an appropriate quality assurance system that will meet the requirements of federal law, and will monitor, through case reviews, Fulton and Dekalb County DFCS' compliance with DFCS policy and the terms of this Consent Decree.

19. DURATION OF DECREE

- A. With respect to the State Defendants, this Consent Decree shall remain in effect until (1) State Defendants are in substantial compliance with the final measures on all Outcome Measures in Section 15 of this Consent Decree simultaneously for three consecutive reporting periods; and (2) a motion to terminate jurisdiction over this Consent Decree is approved by the Court. Plaintiffs shall not contest a timely and appropriate motion to terminate unless: (i) Plaintiffs dispute State Defendants' assertion that they have achieved and sustained substantial compliance on all Outcome Measures for the requisite time period; (ii) an unresolved motion relating to non-compliance with any other provision of this Consent Decree pursuant to Section 17 remains pending; or (iii) any Court Order or Stipulation providing a remedy for a prior allegation of such non-compliance with any other provision of this Decree is in effect or has not been complied with at the time of the motion to terminate.
- B. The parties intend and agree that this Consent Decree shall remain in effect and shall be enforceable by a court of competent jurisdiction for the entire duration of this Consent Decree as provided in Section 19.A. above. The parties intend and agree that State Defendants may only request termination of jurisdiction under the terms of Section 19.A.(1) above.
- C. The parties acknowledge that this Consent Decree is a final resolution of all claims of any type on behalf of Plaintiff class members, whether known or

unknown, that have been brought or could have been brought by or on behalf of the Plaintiffs against the State Defendants up through the date on which the Consent Decree is entered. This paragraph explicitly does not bar claims on behalf of any children in Fulton or DeKalb Counties concerning any programs or services for children prior to a child's placement into State custody, including, but not limited to, any diversion, differential response, or other programs or services providing an alternative to the investigation and/or substantiation of a report of abuse or neglect and/or the removal of a child from their home and placement into State custody, and any programs or services for investigations of reported abuse or neglect for children not in State custody.

- D. In the interest of permitting the parties to focus upon and achieve the objectives of this Consent Decree, Plaintiffs agree that they shall not commence any new action for systemic declaratory, injunctive or other form of equitable relief based on facts, events, actions or omissions by the State Defendants that relate in any way to any claim that was raised or could have been raised in the present case and that occur after the entry of this Consent Decree and prior to the entry of a termination order pursuant to this Section. This paragraph explicitly does not bar claims on behalf of any children in Fulton or DeKalb Counties concerning any programs or services for children prior to a child's placement into State custody, including, but not limited to, any diversion, differential response, or other programs or services providing an alternative to the investigation and/or substantiation of a report of abuse or neglect and/or the removal of a child from their home and placement into State custody, and any programs or services for investigations of reported abuse or neglect for children not in State custody.
- E. This paragraph shall not prevent an action, at any time, by an individual plaintiff for damages or equitable relief tailored solely to the specific circumstances of that individual plaintiff. Further, nothing in this paragraph shall prevent Plaintiffs in any action for systemic declaratory, injunctive or other form of equitable relief brought after the entry of a termination order pursuant to this Section and based on claims arising after the entry of such order, from offering into evidence facts arising prior to such order.

20. MISCELLANEOUS PROVISIONS

- A. Each party agrees that it will perform its obligations under this Consent Decree in accordance with all applicable laws.
- B. Unless otherwise provided in this Consent Decree, all notices under this Consent Decree shall be deemed duly given upon delivery by hand, or three days after posting, if sent by registered mail, return receipt requested. All notices under this Decree shall be provided to the party at the address set forth as follows:

As to Plaintiffs:

Marcia Robinson Lowry, Esq.
Ira Lustbader, Esq.
Children's Rights, Inc.
404 Park Avenue South, 11th Floor
New York, NY 10016
Phone: (212) 683-2210
Facsimile: (212) 683-4015
E-mail: mlowry@childrensrights.org; ilustbader@childrensrights.org

Jeffrey O. Bramlett, Esq.
Bondurant, Mixson & Elmore, L.L.P.
3900 One Atlantic Center
1201 West Peachtree Street
Atlanta, Georgia 30309
Phone: (404) 881-4100
Facsimile: (404) 881-4111
E-mail: Bramlett@bmelaw.com

As to State Defendants:

Brenda K. Woodard, Esq.
Chief Legal Officer
Georgia Department of Human Resources
2 Peachtree Street, N.W.
Atlanta, GA 30303
Phone: (404) 656-4421
Facsimile: (404) 657-1123
E-mail: bkwoodard@dhr.state.ga.us

Steven E. Love (or his successor)
Acting Director, Division of Family and Childrens Services
Georgia Department of Human Resources
2 Peachtree Street, N.W.
Atlanta, GA 30303
Phone: (404) 657-5202
Facsimile: (404) 657-5105
E-mail: selove@dhr.state.ga.us

Shalen S. Nelson, Esq. (or her designee)
Senior Assistant Attorney General

State Law Department
132 State Judicial Building
40 Capitol Square, S.W.
Atlanta, GA 30334
Phone: (404) 656-3377
Facsimile: (404) 463-1062
E-mail: shalen.nelson@law.state.ga.us

- C. This Consent Decree constitutes the entire agreement between the parties with regard to the subject matters contained therein, and hereby supersedes all prior agreements, representations, statements, negotiations, and undertakings.
- D. All parties to the Consent Decree have participated in its drafting and, consequently, any ambiguity shall not be construed either for or against any party.
- E. If, for any reason, the Court fails or refuses to enter this proposed Consent Decree as signed by the authorized signatories, or as altered in accordance with their consent freely given prior to entry, then the proposed Consent Decree itself, and any agreement or statement contained in the proposed Consent Decree, is null and void and may not be enforced.
- F. The Department of Human Resources shall bear all costs of notice prescribed by the Court pursuant to Fed. R. Civ. P. 23 in connection with the process for final Court approval of this Consent Decree.
- G. DHR agrees to provide data and information concerning children in Fulton and DeKalb Counties to the Accountability Agents sufficient to enable the Accountability Agents to issue reports at the intervals specified in Section 16.A., verifying the items below. For purposes of the following items, “children” is meant to include only those children who were not in foster care custody at the time that the substantiated maltreatment took place, and “cases” is meant to include only those cases involving families with children who were not in foster care custody at the time there was a referral into DHR's diversion program.
1. (a) The number of children in each county who, during the reporting period, experienced substantiated maltreatment, and (b) the number and percentage of children in (a) of this item who also experienced substantiated maltreatment during the preceding 12 month period. For purposes of this item, for the term "percentage," the numerator would be the number of children in (a) who had substantiated maltreatment during the preceding 12 months, and the denominator would be all children who had substantiated maltreatment during the reporting period.

2. (a) The number of cases in each county during the reporting period in which there was a referral into DHR's diversion program, and (b) the number and percentage of the cases in (a) of this item in which there was substantiated maltreatment within 11 – 365 days after the referral. For purposes of this item, for the term "percentage," the numerator would be the number of cases in (a) in which there was substantiated maltreatment within 11-365 days after referral to DHR's diversion program, and the denominator would be all cases referred to DHR's diversion program during the reporting period. In addition, for purposes of this item, "DHR's diversion program" refers to action taken by the Department which provides for an alternative to the opening of a CPS case and/or the removal of children from their home and placement into state custody by providing additional instruction, services, or support to the child's legal custodian either by DFCS or other family and child services agencies and programs.

21. RELIEF FOR NAMED PLAINTIFFS

- A. The State Social Services Director shall monitor the individual cases of the named plaintiffs in this action for as long as they are in DHR/DFCS custody, or if they are discharged from and return to DHR/DFCS custody, to ensure that all necessary and appropriate plans are developed and implemented and that all necessary placements and services are provided. As of the date of the signing of this Consent Decree, two named plaintiffs are in DHR/DFCS custody.
- B. The parties shall meet and attempt to agree on necessary services and plans for the named plaintiffs that remain in DHR/DFCS custody within 60 days after the parties sign this Consent Decree.
- C. The DHR Commissioner, through the State Social Services Director, shall ensure that Plaintiffs' Counsel receive documents and reports every 90 days concerning the status of the named plaintiffs in this action, services that have been provided, and implementation of plans, for as long as they are in DHR/DFCS custody. Plaintiffs' Counsel shall receive notification within one calendar day of any significant events or developments concerning the named plaintiffs in this action for as long as they are in DHR/DFCS custody, including but not limited to: any change in placement, services, permanency goal or permanency plans; any reports of any incident of alleged abuse or neglect or violations of disciplinary policy involving any of the named plaintiffs or occurring at the placements where any of the named plaintiffs are placed; any other serious incidents involving any of the named plaintiffs or occurring at the placements where any of the named plaintiffs are placed.

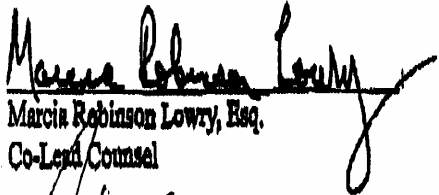
- D. A staffing shall be held in-person or by conference call every 90 days upon Plaintiffs' request, within 10 days after Plaintiffs receive updated documents and reports referenced in Paragraph C above, for the purpose of discussing, with Plaintiffs' Counsel, the status of the named plaintiffs in this action for as long as they are in DHR/DFCS custody, services that have been provided, and implementation of plans. The staffing shall include plaintiffs' counsel, the State Social Services Director or his designee, the child's DFCS case manager, the private agency case manager, if any, the child, and such others that may be needed for the discussion. The parties may on consent modify the schedule of any particular staffing under this paragraph.

22. ATTORNEYS' FEES AND EXPENSES OF LITIGATION

- A. For purposes of the Consent Decree, the parties acknowledge that Plaintiff Class is entitled to recover its expenses of litigation, including reasonable attorneys' fees and nontaxable costs, pursuant to 42 U.S.C. § 1988 and Fed. R. Civ. P. 23(h).
- B. The parties shall attempt without court intervention to resolve the proper amount of Class Counsel's fees and expenses of litigation. If any agreement is reached by the parties regarding recovery of fees and expenses of litigation, the Court shall determine whether the agreed amount and mode of payment are appropriate in accordance with applicable law and procedure.
- C. If the parties cannot reach agreement on the proper amount of attorneys' fees and expenses of litigation, Class Counsel shall file an application for fees and expenses in accordance with the requirements of applicable law and procedure within twenty-five (25) days following entry of this Consent Decree. Any objection to Class Counsel's motion seeking a fee award shall be filed within twenty-five (25) days following the docketing of Class Counsel's motion. The amount of any award shall be determined by the Court in accordance with the requirements of applicable law and procedure.
- D. All parties reserve whatever rights each may have to appeal the amount of attorneys' fees and expenses awarded by the Court.

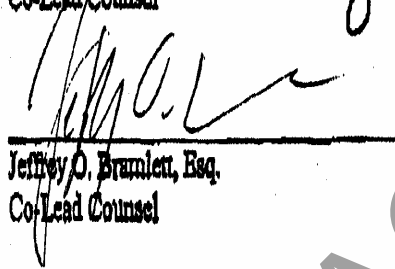
CONSENTED TO:

For the Plaintiffs:



Marcia Robinson Lowry, Esq.
Co-Lead Counsel

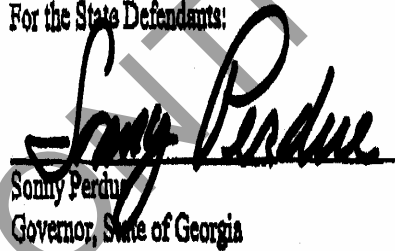
6/15/05
Date



Jeffrey O. Bramlett, Esq.
Co-Lead Counsel

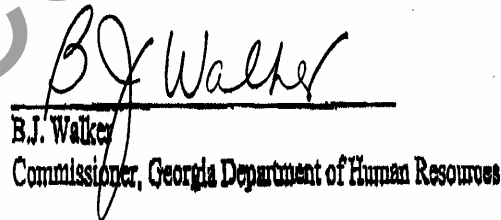
6.15.05
Date

For the State Defendants:



Sonny Perdue
Governor, State of Georgia

6/27/05
Date



B.J. Walker
Commissioner, Georgia Department of Human Resources

6/29/05
Date

Georgia Families 360° Contract (Attachment J): Liquidated Damages

25.2 CATEGORY 1

25.2.1 Liquidated damages up to \$100,000.00 per day may be imposed for Category 1 events. For Category 1 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 1 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.2.1.1 Failure to “go live” by the implementation date of July 1, 2016; and

25.2.1.2 Failure to meet the readiness and/or annual review requirements, as specified in Section 2.13.

25.3 CATEGORY 2

25.3.1 Liquidated damages up to \$100,000 per violation may be imposed for Category 2 events. For Category 2 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 2 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.3.1.1 Acts that discriminate among Members on the basis of their health status or need for health care services;

25.3.1.2 Misrepresentation of information or false statements furnished to CMS or the State;

25.3.1.3 Failure to implement requirements stated in the Contractor’s Proposal, the RFP, this Contract, or other material failures in the Contractor’s duties;

25.3.1.4 Failure to provide an adequate provider network of physicians, pharmacies, hospitals, and other specified health care Providers in order to assure member access to all Covered Services;

25.3.1.5 Failure to achieve the Performance Target for each Quality Performance Measure as described in Section 4.12.3;

25.3.1.6 Failure to comply with the eighty percent (80%) screening ratio for periodic visits on the Contractor’s CMS-416 EPSDT as described Section 4.7.3.9;

- 25.3.1.7 Failure to deliver effective Demonstration services as evidenced by lack of achievement of annual targeted LBW and VLBW reduction targets as identified in **Attachment M**;
- 25.3.1.8 Failure to achieve annual targeted reductions in the Pregnancy Rate as identified in **Attachment M**; and
- 25.3.1.9 Failure to fulfill duties to report Member abuse, neglect, or exploitation as a State Mandated Reported as defined by the Official Code of Georgia Annotated, as may be amended from time to time.

25.4 **CATEGORY 3**

- 25.4.1 Liquidated damages up to \$25,000 per violation may be imposed for Category 3 events. For Category 3 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 3 events are monitored by DCH to determine compliance and include the following:
 - 25.4.1.1 Substantial failure to provide Medically Necessary Services that the Contractor is required to provide under law, or under this Contract, to a Member covered under this Contract;
 - 25.4.1.2 Misrepresentation of information or false statements furnished to a Member, Potential Member, or health care Provider;
 - 25.4.1.3 Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;
 - 25.4.1.4 Distribution directly, or indirectly, through any Agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;
 - 25.4.1.5 Violation of any other applicable requirements of Section 1903(m) or 1932 of the Social Security Act and any implementing regulations;
 - 25.4.1.6 Failure of the Contractor to assume full operation of its duties under this Contract in accordance with the transition timeframes specified herein;
 - 25.4.1.7 Imposition of premiums or charges on Members that are in excess of the premiums or charges permitted under the Medicaid program

(the State will deduct the amount of the overcharge and return it to the affected Member);

- 25.4.1.8 Failure to resolve Member Appeals and Grievances within the timeframes specified in this Contract;
- 25.4.1.9 Failure to ensure client confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of noncompliance will be assessed as per member and/or per HIPAA regulatory violation;
- 25.4.1.10 Violation of a subcontracting requirement in the Contract; and
- 25.4.1.11 Failure to provide notice of any known or suspected conflicts of interest, as prescribed in Section 31, **Attachment P**, **Attachment Q** and **Attachment R**.

25.5 **CATEGORY 4**

- 25.5.1 Liquidated damages up to \$5,000.00 per day may be imposed for Category 4 events. For Category 4 events, a written Corrective Action Plan may be required and corrective action must be taken. In the case of Category 4 events, if corrective action is taken within four (4) Business Days, then liquidated damages may be waived at the discretion of DCH. Category 4 events are monitored by DCH to determine compliance and shall include the following:
 - 25.5.1.1 Failure to submit required Reports and Deliverables in the timeframes prescribed in Section 4.18 and Section 5.7;
 - 25.5.1.2 Submission of incorrect or deficient Deliverables or Reports as determined by DCH, including the submission of Deliverables or Reports in a format unacceptable to DCH;
 - 25.5.1.3 Failure to comply with the Claims processing standards as follows:
 - 25.5.1.3.1 Failure to process and finalize to a paid or denied status ninety-seven percent (97%) of all Clean Claims within fifteen (15) Business Days during a fiscal year; and
 - 25.5.1.3.2 Failure to pay Providers interest at an eighteen percent (18%) annual rate, calculated daily for the full period during which a clean, unduplicated Claim is not adjudicated within the claims processing deadlines. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care

services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from 15 calendar days after the date the claim was submitted. A Contractor shall pay all interest required to be paid under this provision or O.C.G.A. Section 33-24-59.5 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the Contractor to the Provider. A Contractor shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic claims, a CMS Form 1500 for non-electronic claims, or any claim prescribed by DCH.

- 25.5.1.4 Failure to provide an initial visit within fourteen (14) Calendar Days for all newly enrolled women who are pregnant in accordance with Sections 4.6.9.1;
- 25.5.1.5 Failure to comply with the Notice of Proposed Action and Notice of Adverse Action requirements as described in Sections 4.14.3 and 4.14.5;
- 25.5.1.6 Failure to comply with any Corrective Action Plan as required by DCH;
- 25.5.1.7 Failure to seek, collect and/or report third party information as described in Section 8.4;
- 25.5.1.8 Failure to comply with the Contractor staffing requirements and/or any other conditions described in Sections 16.1 and 16.2;
- 25.5.1.9 Failure of Contractor to issue written notice to Members upon Provider's notice of termination in the Contractor's plan as described in Section 4.3.1.1.8;
- 25.5.1.10 Failure to comply with federal law regarding sterilizations, hysterectomies, and abortions and as described in Section 4.6.5;
- 25.5.1.11 Failure to submit acceptable Member and Provider directed materials or documents in a timely manner, i.e., member, handbooks, policies and procedures;

- 25.5.1.12 Failure to conduct and report in a timely manner the Medical and Trauma Assessments as set forth in Section 4.5.7.2;
- 25.5.1.13 Failure to comply with the required Demonstration Reports and Deliverables as prescribed in **Attachments L and M**;
- 25.5.1.14 Failure to conduct quarterly Validation of Provider demographic data and provide DCH with current and accurate data for all contracted Providers as described in Section 4.8.3.2; and
- 25.5.1.15 Failure to submit attestations for each Provider network report in the established DCH format with all required data elements as described in Section 4.8.3.3.

25.6 **CATEGORY 5**

25.6.1 Liquidated damages as specified below may be imposed for Category 5 events. Imposition of liquidated damages will not relieve the Contractor from submitting and implementing the Corrective Action Plan or corrective action as determined by DCH. Category 5 events are monitored by DCH to determine compliance and include the following:

25.6.1.1 Failure to implement the business continuity-disaster recovery (BC-DR) plan as follows:

25.6.1.1.1 Implementation of the (BC-DR) plan exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars (\$5,000) per day up to day 2;

25.6.1.1.2 Implementation of the (BC-DR) plan exceeds the proposed time by more than (2) and up to five (5) Calendar Days: ten thousand dollars (\$10,000) per each day beginning with Day 3 and up to Day 5;

25.6.1.1.3 Implementation of the (BC-DR) plan exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days, twenty-five thousand dollars (\$25,000) per day beginning with Day 6 and up to Day 10; and

25.6.1.1.4 Implementation of the (BC-DR) plan exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars (\$50,000) per each day beginning with Day 11.

- 25.6.1.2 Unscheduled System Unavailability (other than CCE and ECM functions described below) occurring during a continuous five (5) Calendar Day period, may be assessed as follows:
 - 25.6.1.2.1 Greater than or equal to two (2) and less than twelve (12) clock hours cumulative: up to one hundred twenty-five dollars (\$125) for each thirty (30) minutes or portions thereof;
 - 25.6.1.2.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to two hundred fifty dollars (\$250) for each thirty (30) minutes or portions thereof; and
 - 25.6.1.2.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to five hundred dollars (\$500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars (\$25,000) per occurrence.
- 25.6.1.3 Confirmation of CMO Enrollment (CCE) or Electronic Claims Management (ECM) system downtime. In any calendar week, penalties may be assessed as follows for downtime outside the State's control of any component of the CCE and ECM systems, such as the voice response system and PC software response system:
 - 25.6.1.3.1 Less than twelve (12) clock hours cumulative: up to two hundred fifty dollars (\$250) for each thirty (30) minutes or portions thereof;
 - 25.6.1.3.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to five hundred (\$500) for each thirty (30) minutes or portions thereof; and
 - 25.6.1.3.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to one thousand dollars (\$1,000) for each thirty (30) minutes or portions thereof up to a maximum of fifty thousand dollars (\$50,000) per occurrence.
- 25.6.1.4 Failure to make available to the State and/or its agent readable, valid extracts of Encounter Information for a specific month within fifteen (15) Calendar Days of the close of the month: five hundred dollars (\$500) per day. After fifteen (15) Calendar Days of the close of the month: two thousand dollars (\$2000) per day.

- 25.6.1.5 Failure to correct a system problem not resulting in System Unavailability within the allowed timeframe, where failure to complete was not due to the action or inaction on the part of DCH as documented in writing by the Contractor:
 - 25.6.1.5.1 One (1) to fifteen (15) Calendar Days late: two hundred and fifty dollars (\$250) per Calendar Day for Days 1 through 15;
 - 25.6.1.5.2 Sixteen (16) to thirty (30) Calendar Days late: five hundred dollars (\$500) per Calendar Day for Days 16 through 30; and
 - 25.6.1.5.3 More than thirty (30) Calendar Days late: one thousand dollars (\$1,000) per Calendar Day for Days 31 and beyond.
- 25.6.1.6 Failure to meet the Telephone Hotline performance standards:
 - 25.6.1.6.1 One thousand dollars (\$1,000) for each percentage point that is below the target answer rate of eighty percent (80%) in thirty (30) seconds;
 - 25.6.1.6.2 One thousand (\$1,000) for each percentage point that is above the target of a one percent (1%) Blocked Call rate; and
 - 25.6.1.6.3 One thousand (\$1,000) for each percentage point that is above the target of a five percent (5%) Abandoned Call rate.
- 25.6.1.7 Failure to make available to the State and/or its agent readable valid neonatal intensive care supplement payment reports for a specific month within fifteen (15) Calendar Days of the close of the month:
 - 25.6.1.7.1 Five hundred dollars (\$500) per Calendar Day; and
 - 25.6.1.7.2 Two thousand dollars (\$2,000) per Calendar Day after fifteen (15) Calendar Days of the close of the month.
- 25.6.1.9 Failure to have office space procured and operational by the Operational Start Date:
 - 25.6.1.9.1 One thousand dollars (\$1,000) per Calendar Day

25.6.1.10 The Contractor shall ensure Member access to all covered benefits at all times. The Contractor shall be in full compliance with geographic access standards and submit electronic provider network reporting demonstrating its full compliance with the Provider network requirements within ten (10) Calendar Days after receiving the initial Member file. The initial Member file will be delivered to the Contractor prior to the Operational Start Date.

25.6.1.10.1 .25% of the monthly Capitation Payment for failure to meet the requirements set forth in 25.6.1.10.

25.6.1.11 Failure to test and ensure the Information Systems are fully operational and meet all RFP and Contract requirements prior to the Operational Start Date:

25.6.1.11.1 Ten thousand dollars (\$10,000) per Calendar Day

ATTACHMENT L



The Immigration and Security Affidavit, formerly known as SPD-SP054, is no longer available for use by state entities on the State Purchasing web site.

You must now go to the Department of Audits and Accounts web site at http://www.audits.ga.gov/NALGAD/section_3_affidavits.html to locate the proper affidavit for use with this requirement.

**Attachment M
Georgia Families Supplier Client Reference Form**

Material Supplier Name:	
Name and Title of Individual Completing Form:	
Supplier Contact Telephone Number:	
Supplier Contact Email Address:	

The Supplier must complete all sections of the table below as required in Attachment G of the RFP¹.

State	Name of Supplier's Medicaid Managed Care Health Plan ²	Term of Contract (Start to end date)	Brief Description of Services	Average Number of Medicaid Members per Month	Name and Title of Contact for Client Reference ³	Client Reference Business Address	Client Reference Contact Information
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:

¹ Supplier may only submit client references where Supplier is the Prime Contractor and continues to have current and active client contracts. References where Supplier is providing services under grants, demonstrations or pilot programs or initiatives or where Supplier's contract to provide services is terminated or no longer active will not be considered. The Supplier may consider the experience of subsidiaries of the Supplier's Parent Company when submitting references. References from proposed Subcontractors may not be submitted to meet this requirement. The Georgia Department of Community Health cannot be submitted as a reference.

² The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Supplier, both entities must be under the control of the same Parent Company.

³ The reference must be knowledgeable about the contract and its terms, and be accessible to DCH.

Attachment N
Georgia Families Material Subcontractor Client Reference Form

Material Subcontractor Name:	
Name and Title of Individual Completing Form:	
Material Subcontractor Contact Telephone Number:	
Material Subcontractor Contact Email Address:	

The Material Subcontractor must complete all sections of the table below as required in Attachment G of the RFP¹.

State	Name of Material Subcontractor's Medicaid Contract	Term of Contract (Start to end date)	Brief Description of Services	Name and Title of Contact for Client Reference ²	Client Reference Business Address	Client Reference Contact Information
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:

¹ References where the Material Subcontractor is providing services under grants, demonstrations or pilot programs or initiatives or where the Material Subcontractor's contract to provide services is terminated or no longer active will not be considered. The Georgia Department of Community Health cannot be submitted as a reference.

² The reference must be knowledgeable about the contract and its terms, and be accessible to DCH.

**Attachment O
Georgia Families 360° Supplier Client Reference Form**

Supplier Name:	
Name and Title of Individual Completing Form:	
Supplier Contact Telephone Number:	
Supplier Contact Email Address:	

The Supplier must complete all sections of the table below as required in Attachment H of the RFP¹.

State	Name of Supplier's Medicaid Managed Care Health Plan²	Term of Contract (Start to end date)	Brief Description of Services	Average Number of Medicaid Members per Month	Name and Title of Contact for Client Reference³	Client Reference Business Address	Client Reference Contact Information
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:
							Telephone: Email Address: Fax Number:

¹ Supplier may only submit client references where Supplier is the Prime Contractor and continues to have current and active client contracts. References where Supplier is providing services under grants, demonstrations or pilot programs or initiatives or where Supplier's contract to provide services is terminated or no longer active will not be considered. The Supplier may consider the experience of subsidiaries of the Supplier's Parent Company when submitting references. References from proposed Subcontractors may not be submitted to meet this requirement. The Georgia Department of Community Health cannot be submitted as a reference.

² The name of the health plan as it appears on the contract with the state agency. If this is a different name than that being used by the Supplier, both entities must be under the control of the same Parent Company.

³ The reference must be knowledgeable about the contract and its terms, and be accessible to DCH.

**Attachment P
Georgia Families 360° Material Subcontractor Client Reference Form**

Material Subcontractor Name:	
Name and Title of Individual Completing Form:	
Material Subcontractor Contact Telephone Number:	
Material Subcontractor Contact Email Address:	

The Material Subcontractor must complete all sections of the table below as required in Attachment H of the RFP¹.

State	Name of Material Subcontractor's Medicaid Contract	Term of Contract (Start to end date)	Brief Description of Services	Name and Title of Contact for Client Reference²	Client Reference Business Address	Client Reference Contact Information
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:
						Telephone: Email Address: Fax Number:

¹ References where the Material Subcontractor is providing services under grants, demonstrations or pilot programs or initiatives or where the Material Subcontractor's contract to provide services is terminated or no longer active will not be considered. The Georgia Department of Community Health cannot be submitted as a reference.

² The reference must be knowledgeable about the contract and its terms, and be accessible to DCH.



RFX Addendum Form

RFX Number: 41900 DCH0000100	RFX Title: GA Families and GA Families 360° Care Management Organization
Requesting State Entity: Georgia Department of Community Health	
Issuing Officer: Dana Harris	RFX Initially Posted to Internet: February 9, 2015
eMail Address: Dana.Harris@doas.ga.gov	Telephone: 404-657-4322
Addendum Number: 1	Date: March 18 th , 2015

The attached information, provided by the issuing State Entity, is made a part of this RFX. The purpose of this addendum is to revise the RFX as follows:

1. Revised Schedule of Events

Description	Date	Time
Release of eRFP	As Published on the Georgia Procurement Registry ("GPR")	N/A
Deadline for Round 1 written questions sent via email to the Issuing Officer referenced in Section 1.5.	02/25/2015	4:00 p.m. ET
Responses to Round 1 Written Questions	03/18/2015	5:00 p.m. ET
Deadline for Round 2 written questions sent via email to the Issuing Officer referenced in Section 1.5.	04/09/2015	4:00 p.m. ET
Responses to Round 2 Written Questions	04/20/2015	5:00 p.m. ET
Proposals Due/Close Date and Time	As Published on the GPR	See GPR
Proposal Evaluation Completed (on or about)	3 to 4 Weeks after Closing	N/A
Negotiations Invitation Issued (emailed) (on or about); discretionary process	4 to 5 Weeks after Closing	TBD
Negotiations with Identified suppliers (on or about); discretionary process	5 to 7 Weeks after Closing	TBD
Final Evaluation (on or about)	7 to 8 Weeks after Closing	N/A
Finalize Contract Terms	8 to 9 Weeks after closing or Nine calendar days	N/A
Notice of Intent to Award [NOIA] and Certificate of Authority [COA] (on or about)	9 to 10 Weeks after Closing	N/A
Notice of Award [NOA] (on or about)	10 calendar days after NOIA	N/A



2. Georgia Department of Community Health Open Records Policy

Documents received by DCH are normally subject to the Georgia Open Records Act (O.C.G.A. § 50-18-70 et seq.) and open for public inspection. DCH will comply with the requirements of the Georgia Open Records Act, including with regard to the availability of records described in O.C.G.A. § 50-18-72(a)(10).

If a responsive Offeror claims that any portion of its proposal submitted to DCH is a proprietary trade secret or otherwise excepted from disclosure from the Georgia Open Records Act, the Offeror must clearly identify at the time of submission those portions of the proposal that it asserts are excepted from disclosure. DCH requires Offerors to submit redacted versions of their proposals or other submissions in addition to unredacted versions. Offerors are required to submit with their proposals an affidavit meeting the requirements of O.C.G.A. § 50-18-72 (a) (34), as amended, setting forth any and all assertions of trade secret protections. Any material submitted to DCH by a responsive Offeror which has not been clearly designated as a trade secret(s) and expressly referenced as such in the affidavit is subject to disclosure under the Georgia Open Records Act.

PLEASE NOTE: Even though information submitted may be marked as "confidential", "proprietary", or "trade secret," and may be expressly referenced as such in an affidavit, pursuant to the Georgia Open Records Act DCH will make its own determination as to whether the information is a trade secret that may be withheld in response to an open records request. Accordingly, DCH will comply with the requirements described in O.C.G.A. § 50-18-72(a)(34).

Note: In the event of a conflict between previously released information and the information contained herein, the latter shall control.

A signed acknowledgment of this addendum (this page) should be attached to your RFX response.

Supplier's Name

Signature

Printed Name and Title



RFX Addendum Form

RFX Number: 41900 DCH0000100	RFX Title: GA Families and GA Families 360° Care Management Organization
Requesting State Entity: Georgia Department of Community Health	
Issuing Officer: Dana Harris	RFX Initially Posted to Internet: See GPR
eMail Address: Dana.Harris@doas.ga.gov	Telephone: 404-657-4322
Addendum Number: 2	Date: April 6 th , 2015

1. **The language below replaces the current language in Section 17, Criminal Background, Exclusions, and Debarment referenced in Attachments I and J.**

CRIMINAL BACKGROUND, EXCLUSIONS, AND DEBARMENT

17.1 The Contractor agrees that it will not permit any of its employees or its Subcontractor's employees (which in this section includes temporary and contract employees) to perform the services under this Contract unless and until they pass a background check as outlined below.

17.2 Minimum background check requirements

17.2.1 Contractor shall conduct criminal background checks on all employees assigned to or proposed to be assigned to any aspect of the performance of this Contract, who have direct contact with members or who have access to PHI as defined by HIPAA and those individuals designated as Key Staff.

17.2.2 Contractor shall verify that the individual has a satisfactory criminal record. Satisfactory criminal record means that, at minimum, the individual has no history of convictions for the following crimes in his/her record:

17.2.2.1 Aggravated Assault

17.2.2.2 Aggravated Battery

17.2.2.3 Armed Robbery

17.2.2.4 Arson

17.2.2.5 Attempted Murder

17.2.2.6 Financial-related crimes, including but not limited to fraud and identity theft

17.2.2.7 Forgery

17.2.2.8 Kidnapping

17.2.2.9 Murder or Felony Murder

17.2.2.10 Rape

17.2.2.11 Sexual Offenses

17.2.2.12 Theft by taking, by deception or by conversion a conviction shall not include treatment under the Georgia First Offender Act.

17.2.3 The background checks must be conducted prior to the performance of any services under this Contract and on an annual basis.



17.2.4 Contractor shall develop and implement policies and procedures to ensure that employees, at all times during their employment while this Contract is in effect, maintain a satisfactory criminal record as defined in Section 17.2.2.

17.2.5 Contractor shall, on an annual basis, submit to DCH a report which demonstrates compliance with the minimum background check requirements. The report shall include, but need not be limited to, the results of a random sampling of at least 25% of those employees subject to background checks.

17.2.6 Contractor shall have defined oversight procedures to ensure that its subcontractors meet or exceed all minimum background check requirements.

17.2.7 Notwithstanding any language to the contrary, the Parties understand that the requirements set forth in Section 17 are minimum requirements and Contractor may establish additional criteria, as appropriate.

17.3 The Contractor shall not employ or use any company, entity, or individual that is on the Federal Exclusions List or any company, entity, or individual subject to 42 USCS § 1320a-7.

17.4 By signing or executing this Contract, the Contractor states and certifies that it is in compliance with and that it will continue to comply with the Anti-Kickback Act of 1986, 41 USCS § 51-58, and Federal Acquisition Regulation 52.203-7. 17.5 Contractor agrees to sign and comply with **Attachment B, Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters.**



2. The language below replaces the current Business Associate Agreement referenced in Attachments I and J.

**ATTACHMENT D
BUSINESS ASSOCIATE AGREEMENT**

This Business Associate Agreement (hereinafter referred to as “Agreement”), effective this _____ day of _____, _____ (hereinafter the “Effective Date”) is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as “DCH”) and [INSERT CONTRACTOR NAME] (hereinafter referred to as “Contractor”) as Attachment D to Contract No. XXXX between DCH and Contractor dated _____ (hereinafter referred to as the “Contract”).

WHEREAS, DCH is a hybrid entity, as defined in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), and is required by HIPAA to enter into a Business Associate Agreement with certain entities that provide functions, activities, or services on behalf of or in support of health care components of DCH, which functions, activities or services involve the use of Protected Health Information as defined by HIPAA (“PHI”);

WHEREAS, Contractor, under the Contract provides functions, activities, or services involving the use of PHI;

NOW, THEREFORE, for and in consideration of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, DCH and Contractor (each individually a “Party” and collectively the “Parties”) hereby agree as follows:

1. Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms have in HIPAA and in Title XIII of the American Recovery and Reinvestment Act of 2009 (the Health Information Technology for Economic and Clinical Health Act, or “HITECH”), and in the implementing regulations of HIPAA and HITECH. Implementing regulations are published as the Standards for Privacy and Security of Individually Identifiable Health Information in 45 C.F.R. Parts 160 and 164. Together, HIPAA, HITECH, and their implementing regulations are referred to in this Agreement as the “Privacy Rule and Security Rule.” If the meaning of any defined term is changed by law or regulation, then this Agreement will be automatically modified to conform to such change. The term “NIST Baseline Controls” means the baseline controls set forth in National Institute of Standards and Technology (NIST) SP 800-53 established for “moderate impact” information.

2. Except as limited in this Agreement, Contractor may use or disclose PHI only to the extent necessary to meet its responsibilities as set forth in the Contract provided that such use or disclosure would not violate the Privacy Rule or the Security Rule, if done by DCH. Furthermore, except as otherwise limited in this Agreement, Contractor may:

A. Use PHI for internal quality control and auditing purposes.

B. Use or disclose PHI as Required by Law.

C. After providing written notification to DCH’s Office of Inspector General, use PHI to make a report to a health oversight agency authorized by law to investigate DCH (or otherwise oversee



the conduct or conditions of the DCH) about any DCH conduct that Contractor in good faith believes to be unlawful as permitted by 45 C.F.R. 164.502(j)(1). Notwithstanding the foregoing, Contractor shall not be required to provide prior written notice to DCH's Office of Inspector General if Contractor is provided written instruction otherwise by the health oversight agency authorized by law to investigate DCH.

D. Use and disclose PHI to consult with an attorney for purposes of determining Contractor's legal options with regard to reporting conduct by DCH that Contractor in good faith believes to be unlawful, as permitted by 45 C.F.R. 164.502(j)(1).

3. Contractor represents and warrants that only individuals designated by title or name on Attachments D-1 and D-2 will request PHI from DCH or access DCH PHI in order to perform the services of the Contract, and these individuals will only request the minimum necessary amount of information necessary in order to perform the services.

4. Contractor represents and warrants that the individuals listed by title on Attachment D-1 require access to PHI in order to perform services under the Contract. Contractor agrees to send updates to Attachment D-1 whenever necessary. Uses or disclosures of PHI by individuals not described on Attachment D-1 are impermissible.

5. Contractor represents and warrants that the individuals listed by name on Attachment D-2 require access to a DCH information system in order to perform services under the Contract. Contractor agrees to notify the Project Leader and the Access Control Coordinator named on Attachment D-2 immediately, but at least within 24 hours, of any change in the need for DCH information system access by any individual listed on Attachment D-2. Any failure to report a change within the 24 hour time period will be considered a security incident and may be reported to Contractor's Privacy and Security Officer, Information Security Officer and the Georgia Technology Authority for proper handling and sanctions.

6. Contractor agrees that it is a Business Associate to DCH as a result of the Contract, and represents and warrants to DCH that it complies with the Privacy Rule and Security Rule requirements that apply to Business Associates and will continue to comply with these requirements. Contractor further represents and warrants to DCH that it maintains and follows written policies and procedures to achieve and maintain compliance with the HIPAA Privacy and Security Rules that apply to Business Associates, including, but not limited to policies and procedures addressing HIPAA's requirements that Business Associates use, request and disclose only the minimum amount of PHI necessary to perform their services, and updates such policies and procedures as necessary in order to comply with the HIPAA Privacy and Security Rules that apply to Business Associates and will continue to maintain and update such policies and procedures. These policies and procedures, and evidence of their implementation, shall be provided to DCH upon request.



7. The Parties agree that a copy of all communications related to compliance with this Agreement will be forwarded to the following Privacy and Security Contacts:

A. At DCH: HIPAA Privacy and Security Specialist
 Office of General Counsel
 hipaa@dch.ga.gov

 Sherman Harris
 Agency Information Security Officer
 sheharris@dch.ga.gov
 404-656-9653

B. At Contractor: _____

8. Contractor further agrees that it will:

A. Not request, create, receive, use or disclose PHI other than as permitted or required by this Agreement, the Contract, or as required by law.

B. Establish, maintain and use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or the Contract. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.

C. Implement and use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DCH. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.

D. In addition to the safeguards described above, Contractor shall include access controls that restrict access to PHI to the individuals listed on D-2 and D-2, as amended from time to time, shall implement encryption of all electronic PHI during transmission and at rest.

E. Upon DCH's reasonable request, but no more frequently than annually, obtain an independent assessment of Contractor's implementation of applicable HIPAA Privacy and Security Controls and the additional safeguards required by this Agreement with respect to encryption of stored and transmitted DCH PHI, provide the results of such assessments to DCH, and ensure that corrective actions identified during the independent assessment are implemented. Contractor shall bear the costs associated with the independent assessment and for the implementation of corrective actions identified as the result of the assessment.

F. Mitigate, to the extent practicable, any harmful effect that may be known to Contractor from a use or disclosure of PHI by Contractor in violation of the requirements of this Agreement, the Contract or applicable regulations. Contractor shall bear the costs of mitigation, which shall include the reasonable costs of credit monitoring or credit restoration when the use or disclosure results in exposure of information commonly used in identity theft.



G. Maintain a business associate agreement with its agents or subcontractors to whom it provides PHI, in accordance with which such agents or subcontractors are contractually obligated to comply with at least the same obligations that apply to Contractor under this Agreement, and ensure that its agents or subcontractors comply with the conditions, restrictions, prohibitions and other limitations regarding the request for, creation, receipt, use or disclosure of PHI, that are applicable to Contractor under this Agreement and the Contract.

H. Report to DCH any use or disclosure of PHI that is not provided for by this Agreement or the Contract of which it becomes aware.

I. Make an initial report to the DCH in writing in such form as DCH may require within three (3) business days after Contractor (or any subcontractor) becomes aware of the unauthorized use or disclosure. This report will require Contractor to identify the following:

- i. The nature of the impermissible use or disclosure (the "incident"), which will include a brief description of what happened, including the date it occurred and the date Contractor discovered the incident;
- ii. The Protected Health Information involved in the impermissible use or disclosure, such as whether the full name, social security number, date of birth, home address, account number or other information were involved);
- iii. Who (by title, access permission level and employer) made the impermissible use or disclosure and who received the Protected Health Information as a result;
- iv. What corrective or investigational action Contractor took or will take to prevent further impermissible uses or disclosures, to mitigate harmful effects, and to prevent against any further incidents;
- v. What steps individuals who may have been harmed by the incident might take to protect themselves; and
- vi. Whether Contractor believes that the impermissible use or disclosure constitutes a Breach of Unsecured Protected Health Information.

Upon request by the DCH HIPAA Privacy and Security Officer or the DCH Information Security Officer, Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and a proposed corrective action plan. Upon approval of a corrective action plan by the DCH, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH within five (5) business days of DCH's request for proof of implementation.

J. Report to the DCH HIPAA Privacy and Security Officer and the DCH Agency Information Security Officer any successful unauthorized access, modification, or destruction of PHI or interference with system operations in Contractor's information systems as soon as practicable but in no event later than three (3) business days of discovery. If such a security incident resulted in a use or disclosure of PHI not permitted by this Agreement, Contractor shall also make a report



of the impermissible use or disclosure as described above. Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and, if appropriate, a proposed corrective action plan designed to protect PHI from similar security incidents in the future. Upon DCH's approval of Contractor's corrective action plan, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH.

K. Upon DCH's reasonable request and not more frequently than once per quarter, report to the DCH Agency Information Security Officer any (A) attempted (but unsuccessful) unauthorized access, use, disclosure, modification, or destruction of PHI or (B) attempted (but unsuccessful) interference with system operations in Contractor's information systems. Contractor does not need to report trivial incidents that occur on a daily basis, such as scans, "pings," or other routine attempts that do not penetrate computer networks or servers or result in interference with system operations.

L. Cooperate with DCH and provide assistance necessary for DCH to determine whether a Breach of Unsecured Protected Health Information has occurred, and whether notification of the Breach is legally required or otherwise appropriate. Contractor agrees to assist DCH in its efforts to comply with the HIPAA Privacy and Security Rules, as amended from time to time. To that end, the Contractor will abide by any requirements mandated by the HIPAA Privacy and Security Rules or any other applicable laws in the course of this Contract. Contractor warrants that it will cooperate with DCH, including cooperation with DCH privacy officials and other compliance officers required by the HIPAA Privacy and Security Rules and all implementing regulations, in the course of performance of this Contract so that both parties will be in compliance with HIPAA.

M. If DCH determines that a Breach of Unsecured Protected Health Information has occurred as a result of Contractor's impermissible use or disclosure of PHI or failure to comply with obligations set forth in this Agreement or in the Privacy or Security Rules, provide all notifications to Individuals, HHS and/or the media, on behalf of DCH, after the notifications are approved by the DCH. Contractor shall provide these notifications in accordance with the security breach notification requirements set forth in 42 U.S.C. §17932 and 45 C.F.R. Parts 160 & 164 subparts A, D & E as of their respective Compliance Dates, and shall pay for the reasonable and actual costs associated with such notifications.

In the event that DCH determines a Breach has occurred, without unreasonable delay, and in any event no later than thirty (30) calendar days after Discovery, Contractor shall provide the DCH HIPAA Privacy and Security Officer a list of Individuals and a copy of the template notification letter to be sent to Individuals. Contractor shall begin the notification process only after obtaining DCH's approval of the notification letter.

N. Make any amendment(s) to PHI in a Designated Record Set that DCH directs or agrees to pursuant to 45 CFR 164.526 within five (5) business days after request of DCH. Contractor also agrees to provide DCH with written confirmation of the amendment in such format and within such time as DCH may require.

O. In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, Contractor shall, within five (5) business days following DCH's request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH, provide DCH access to the PHI in an individual's Designated Record Set. However,



if requested by DCH, Contractor shall provide access to the PHI in a Designated Record Set directly to the individual to whom such information relates.

P. Give the Secretary of the U.S. Department of Health and Human Services (the "Secretary") or the Secretary's designees access to Contractor's books and records and policies, practices or procedures relating to the use and disclosure of PHI for or on behalf of DCH within five (5) business days after the Secretary or the Secretary's designees request such access or otherwise as the Secretary or the Secretary's designees may require. Contractor also agrees to make such information available for review, inspection and copying by the Secretary or the Secretary's designees during normal business hours at the location or locations where such information is maintained or to otherwise provide such information to the Secretary or the Secretary's designees in such form, format or manner as the Secretary or the Secretary's designees may require.

Q. Document all disclosures of PHI and information related to such disclosures as would be required for DCH to respond to a request by an Individual or by the Secretary for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. By no later than five (5) business days of receipt of a written request from DCH, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH HIPAA Privacy and Security Officer, Contractor shall provide an accounting of disclosures of PHI regarding an Individual to DCH. If requested by DCH, Contractor shall provide an accounting of disclosures directly to the individual. Contractor shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the DCH upon request.

R. In addition to any indemnification provisions in the Contract, indemnify the DCH from any liability resulting from any violation of the HIPAA Privacy and Security Rules or Breach that arises from the conduct or omission of Contractor or its employee(s), agent(s) or subcontractor(s). Such liability will include, but not be limited to, all actual and direct costs and/or losses, civil penalties and reasonable attorneys' fees imposed on DCH.

S. For any requirements in this Agreement that include deadlines, pay performance guarantee payments of \$300.00 per calendar day, starting with the day after the deadline and continuing until Contractor complies with the requirement. Contractor shall ensure that its agreements with subcontractors enable Contractor to meet these deadlines.

9. DCH agrees that it will:

- A. Notify Contractor of any new limitation in the applicable Notice of Privacy Practices in accordance with the provisions of the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such limitation will affect Contractor's use or disclosure of PHI.
- B. Notify Contractor of any change in, or revocation of, authorization by an Individual for DCH to use or disclose PHI to the extent that DCH determines in the exercise of its sole discretion that such change or revocation will affect Contractor's use or disclosure of PHI.
- C. Notify Contractor of any restriction regarding its use or disclosure of PHI that DCH has agreed to in accordance with the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such restriction will affect Contractor's use or disclosure of PHI.



- D. Prior to agreeing to any changes in or revocation of permission by an Individual, or any restriction, to use or disclose PHI, DCH agrees to contact Contractor to determine feasibility of compliance. DCH agrees to assume all costs incurred by Contractor in compliance with such special requests.

10. The Term of this Agreement shall be effective on the Effective Date and shall terminate when all of the PHI provided by DCH to Contractor, or created or received by Contractor on behalf of DCH, is destroyed or returned to DCH, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this section.

- A. Termination for Cause. Upon DCH's knowledge of a material breach of this Agreement by Contractor, DCH shall either:
 - i. Provide an opportunity for Contractor to cure the breach of Agreement within a reasonable period of time, which shall be within thirty (30) calendar days after receiving written notification of the breach by DCH;
 - ii. If Contractor fails to cure the breach of Agreement, terminate the Contract upon thirty (30) calendar days notice; or
 - iii. If neither termination nor cure is feasible, DCH shall report the breach of Agreement to the Secretary of the Department of Health and Human Services.

B. Effect of Termination.

- i. Upon termination of this Agreement, for any reason, DCH and Contractor shall determine whether return of PHI is feasible. If return of the PHI is not feasible, Contractor agrees to continue to extend the protections of this Agreement to the PHI for so long as the Contractor maintains the PHI and shall limit the use and disclosure of the PHI to those purposes that made return or destruction of the PHI infeasible. If at any time it becomes feasible to return or destroy any such PHI maintained pursuant to this paragraph, Contractor must notify DCH and obtain instructions from DCH for either the return or destruction of the PHI.
- ii. Contractor agrees that it will limit its further use or disclosure of PHI only to those purposes DCH may, in the exercise of its sole discretion, deem to be in the public interest or necessary for the protection of such PHI, and will take such additional actions as DCH may require for the protection of patient privacy and the safeguarding, security and protection of such PHI.
- iii. This Effect of Termination section survives the termination of the Agreement.

11. Interpretation. Any ambiguity in this Agreement shall be resolved to permit DCH and Contractor to comply with applicable laws, rules and regulations, the HIPAA Privacy Rule, the HIPAA Security Rule and any rules, regulations, requirements, rulings, interpretations, procedures or other actions related thereto that are promulgated, issued or taken by or on behalf of the Secretary; provided that applicable laws, rules and regulations and the laws of the State of Georgia shall supersede the Privacy Rule if, and to the extent that, they impose additional requirements, have requirements that are more stringent than or have been interpreted to provide



greater protection of patient privacy or the security or safeguarding of PHI than those of the HIPAA Privacy Rule.

12. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations or liabilities whatsoever.

13. All other terms and conditions contained in the Contract and any amendment thereto, not amended by this Agreement, shall remain in full force and effect.

(Signatures on following page)

IN WITNESS WHEREOF, Contractor, through its authorized officer and agent, has caused this Agreement to be executed on its behalf as of the date indicated.

CONTRACTOR

BY: _____

SIGNATURE DATE

TITLE*

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT D-1

List of Individuals Permitted to Receive, Use and Disclose DCH PHI

The following Position Titles, as employees and/or representatives of Contractor, need access to DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

Transfers of PHI must comply with DCH Policy and Procedure 419: Appropriate Use of Information Technology Resources.

Approved methods of secure delivery of PHI between Contractor and DCH:

- Secure FTP file transfer (preferred)
- Encrypted email or email sent through "secure tunnel" approved by DCH Information Security Officer
- Email of encrypted document (password must be sent by telephone only)
- Encrypted portable media device and tracked delivery method

Contractor must update this list as needed and provide the updated form to DCH. Use of DCH Protected Health Information by individuals who are not described on this Attachment D-1, as amended from time to time, is impermissible and a violation of the Agreement. Contractor must update this Attachment D-1 as needed and provide the updated form to DCH. DCH Project Leader Contact Information: [INSERT HERE]



ATTACHMENT D-2

Part 1:

Please initial beside the correct option. Please select only one option.

_____ Contractor DOES NOT need any user accounts to access DCH Information Systems. Do not complete Part 2 of this form.

_____ Contractor DOES need user accounts to access DCH Information Systems. Please complete Part 2 of this form.

Part 2:

Please complete the table below if you indicated that Contractor DOES need any user accounts to access DCH Information Systems. Please attach additional pages if needed.

List of Individuals Authorized to Access a DCH Information System Containing PHI

The following individuals, as employees and/or representatives of Contractor, need access to DCH Information Systems containing DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

Full Name	Employer	DCH Information System	Type of Access (Read only? Write?)

The DCH Project Leader must submit a completed DCH Network Access Request Form for each individual listed above. Access will be granted and changed in accordance with DCH Policy and Procedure 435: Managing Authorization, Access and Control of Information Systems.

Contractor must notify the Project Leader identified in the Contract and the DCH Access Control Coordinator (dchois@dch.ga.gov and helpdesk@dch.ga.gov) immediately, but at least within 24 hours, after any individual on this list no longer needs the level of access described. Failure to provide this notification on time is a violation of the Agreement and will be reported as a security incident.

Contractor must update this Attachment D-2 as needed and provide the updated form to DCH. DCH Project Leader Contact Information: [INSERT HERE]



3. The following language reflects revisions to address additional DSS requirements listed in the following references:

a. Requirements and Scope of Work (Attachment D, Section N. ADMINISTRATIVE SERVICES, 1. Claims Management, c. Encounter Claims Submission Requirements)

The Georgia Families and Georgia Families 360° programs utilize Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Supplier to provide timely, complete and accurate information. Encounter data from the Supplier also allows DCH to budget available resources, set Supplier Capitation Rates, monitor Utilization, follow public health trends and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes.

The Supplier shall work with all contracted Providers to implement standardized billing requirements to enhance the Quality and accuracy of the billing data submitted to the health plan. The Supplier shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, until such time otherwise determined by DCH. The Supplier will emphasize to Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.

The Supplier shall submit to DCH's Fiscal Agent Supplier and Data Warehouse vendor weekly cycles of data files. All identified errors shall be submitted to the Supplier from the Fiscal Agent Supplier each Week. The Supplier shall address identified issues and resubmit the corrected file to the Fiscal Agent Supplier within seven (7) Business Days of receipt. Data files to the DCH Data Warehouse vendor may lag a week based on corrected file re-submissions identified by DCH's Fiscal Agent Supplier.

The Supplier is required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, Member Name, and DOB. These items must match the State's eligibility and Provider file.

The Supplier submitted Claims must consistently include valid values for the below list of fields:

1. Patient name
2. Date of birth
3. Place of service
4. Date of service
5. Type of service
6. Units of service
7. Diagnostic related groupings (DRGs)
8. Treating Provider
9. NPI number of rendering Provider



10. NPI number of OPR Provider
11. Tax Identification Number
12. Facility code
13. A unique Transaction Control Number (TCN)
14. All additionally required CMS 1500 or UB 04 codes
15. CMO Paid Amount
16. DRG version
17. Specify units (by adding allowed units; billed units and paid units of service)

For each submission of Claims per as described in this section, the Supplier must provide via DCH's required electronic format the following Cash Disbursements data elements:

1. Provider/Payee Number
2. Name
3. Address
4. City
5. State
6. Zip
7. Check date
8. Check number
9. Check amount
10. Check code (i.e., EFT, paper check, etc.)

The Supplier will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.

The Supplier shall submit ninety-nine (99%) percent of Encounter Claims within thirty (30) Calendar Days of Claims payment both for the original Claim and any adjustment. DCH will validate Encounter Claims submission according to the cash disbursement journal of the Supplier and any of its applicable Subcontractors.

The Supplier shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the Fiscal Agent Supplier and DCH. The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim counts as an error for that Encounter (this is regardless of how many other errors are detected in the TCN.)



The Supplier's failure to comply with the defined standard(s) will be subject to a Corrective Action Plan and the Supplier may be liable for Liquidated Damages.

Within thirty Calendar Days of Contract Award, the Supplier must submit to DCH a data model of the Supplier's reporting repository, the proposed data layout for weekly data file submissions and a corresponding data dictionary. As these documents are part of DCH's advancement in MITA maturity, such information will not be considered final without DCH approval. Please note that DCH uses the ERwin Data Modeling tool. A sample data dictionary is included in the Suppliers' Library. The sample data dictionary is a guide to provide Suppliers with an understanding of DCH's expectations as it relates to the elements to be included in a dictionary and the format which will be most useful to the DCH. Alternate dictionaries may be accepted if they, at the least, provide the listed elements in a format with similar functionality.

b. Attachment I, Georgia Families, Section 4.16.3 Encounter Claims Submission Requirements

- 4.16.3.1** The GF program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor to provide timely, complete and accurate information. Encounter data from the Contractor also allows DCH to budget available resources, set Contractor Capitation Rates, monitor Utilization, follow public health trends and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes.
- 4.16.3.2** The Contractor shall work with all contracted Providers to implement standardized billing requirements to enhance the Quality and accuracy of the billing data submitted to the health plan.
The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, until such time otherwise determined by DCH. The Contractor will emphasize to Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.
- 4.16.3.3** The Contractor shall submit to DCH's Fiscal Agent Contractor and Data Warehouse vendor weekly cycles of data files. All identified errors shall be submitted to the Contractor from the Fiscal Agent Contractor each Week. The Contractor shall address identified issues and resubmit the corrected file to the Fiscal Agent Contractor within seven (7) Business Days of receipt. Data files to the DCH Data Warehouse vendor may lag a week based on corrected file re-submissions identified by DCH's Fiscal Agent Supplier.
- 4.16.3.4** The Contractors required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, Member Name, and DOB. These items must match the State's eligibility and Provider file.
- 4.16.3.5** The Contractor submitted Claims must consistently include valid values for the below list of fields:
1. Patient name
 2. Date of birth



3. Place of service
4. Date of service
5. Type of service
6. Units of service
7. Diagnostic related groupings (DRGs)
8. Treating Provider
9. NPI number of rendering Provider
10. NPI number of OPR Provider
11. Tax Identification Number
12. Facility code
13. A unique Transaction Control Number (TCN)
14. All additionally required CMS 1500 or UB 04 codes
15. CMO Paid Amount
16. DRG version
17. Specify units (by adding allowed units; billed units and paid units of service)

4.16.3.6

For each submission of Claims per as described in this section, the Contractor must provide via DCH's required electronic format the following Cash Disbursements data elements:

- 4.16.3.6.1. Provider/Payee Number
- 4.16.3.6.2. Name
- 4.16.3.6.3. Address
- 4.16.3.6.4. City
- 4.16.3.6.5. State
- 4.16.3.6.6. Zip
- 4.16.3.6.7. Check date
- 4.16.3.6.8. Check number
- 4.16.3.6.9. Check amount



4.16.3.6.10. Check code (i.e., EFT, paper check, etc.)

- 4.16.3.7** The Contractor will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.
- 4.16.3.8** The Contractor shall submit ninety-nine (99%) percent of Encounter Claims within thirty (30) Calendar Days of Claims payment both for the original Claim and any adjustment. DCH will validate Encounter Claims submission according to the cash disbursement journal of the Contractor and any of its applicable Subcontractors.
- 4.16.3.9** The Contractor shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the Fiscal Agent Contractor and DCH. The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim counts as an error for that Encounter (this is regardless of how many other errors are detected in the TCN.)
- 4.16.3.10** The Contractor's failure to comply with the defined standard(s) will be subject to a Corrective Action Plan and the Contractor may be liable for Liquidated Damages.
- 4.16.3.11** Within thirty Calendar Days of Contract Award, the Contractor must submit to DCH a data model of the Supplier's reporting repository, the proposed data layout for weekly data file submissions and a corresponding data dictionary. As these documents are part of DCH's advancement in MITA maturity, such information will not be considered final without DCH approval. Please note that DCH uses the ERwin Data Modeling tool. A sample data dictionary is included in the Suppliers' Library. The sample data dictionary is a guide to provide Suppliers with an understanding of DCH's expectations as it relates to the elements to be included in a dictionary and the format which will be most useful to the DCH. Alternate dictionaries may be accepted if they, at the least, provide the listed elements in a format with similar functionality.

c. Attachment J, Georgia Families 360°, Section 4.16.3 Encounter Claims Submission Requirements

- 4.16.3.1** The GF 360° program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor to provide timely, complete and accurate information. Encounter data from the Contractor also allows DCH to budget available resources, set Contractor Capitation Rates, monitor Utilization, follow public health trends and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes.
- 4.16.3.2** The Contractor shall work with all contracted Providers to implement standardized billing requirements to enhance the Quality and accuracy of the billing data submitted to the health plan.
The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, until such time otherwise determined by DCH. The Contractor will emphasize to Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.



4.16.3.3 The Contractor shall submit to DCH's Fiscal Agent Contractor and Data Warehouse vendor weekly cycles of data files. All identified errors shall be submitted to the Contractor from the Fiscal Agent Contractor each Week. The Contractor shall address identified issues and resubmit the corrected file to the Fiscal Agent Contractor within seven (7) Business Days of receipt. Data files to the DCH Data Warehouse vendor may lag a week based on corrected file re-submissions identified by DCH's Fiscal Agent Supplier.

4.16.3.4 The Contractors required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, Member Name, and DOB. These items must match the State's eligibility and Provider file.

4.16.3.5 The Contractor submitted Claims must consistently include valid values for the below list of fields:

1. Patient name
2. Date of birth
3. Place of service
4. Date of service
5. Type of service
6. Units of service
7. Diagnostic related groupings (DRGs)
8. Treating Provider
9. NPI number of rendering Provider
10. NPI number of OPR Provider
11. Tax Identification Number
12. Facility code
13. A unique Transaction Control Number (TCN)
14. All additionally required CMS 1500 or UB 04 codes
15. CMO Paid Amount
16. DRG version
17. Specify units (by adding allowed units; billed units and paid units of service)

4.16.3.6 For each submission of Claims per as described in this section, the Contractor must provide via DCH's required electronic format the following Cash Disbursements data elements:



- 4.16.3.6.1. Provider/Payee Number
- 4.16.3.6.2. Name
- 4.16.3.6.3. Address
- 4.16.3.6.4. City
- 4.16.3.6.5. State
- 4.16.3.6.6. Zip
- 4.16.3.6.7. Check date
- 4.16.3.6.8. Check number
- 4.16.3.6.9. Check amount
- 4.16.3.6.10. Check code (i.e., EFT, paper check, etc.)

- 4.16.3.7** The Contractor will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.
- 4.16.3.8** The Contractor shall submit ninety-nine (99%) percent of Encounter Claims within thirty (30) Calendar Days of Claims payment both for the original Claim and any adjustment. DCH will validate Encounter Claims submission according to the cash disbursement journal of the Contractor and any of its applicable Subcontractors.
- 4.16.3.9** The Contractor shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the Fiscal Agent Contractor and DCH. The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim counts as an error for that Encounter (this is regardless of how many other errors are detected in the TCN.)
- 4.16.3.10** The Contractor's failure to comply with the defined standard(s) will be subject to a Corrective Action Plan and the Contractor may be liable for Liquidated Damages.
- 4.16.3.11** Within thirty Calendar Days of Contract Award, the Contractor must submit to DCH a data model of the Supplier's reporting repository, the proposed data layout for weekly data file submissions and a corresponding data dictionary. As these documents are part of DCH's advancement in MITA maturity, such information will not be considered final without DCH approval. Please note that DCH uses the ERwin Data Modeling tool. A sample data dictionary is included in the Suppliers' Library. The sample data dictionary is a guide to provide Suppliers with an understanding of DCH's expectations as it relates to the elements to be included in a dictionary and the format which will be most useful to the DCH. Alternate dictionaries may be accepted if they, at the least, provide the listed elements in a format with similar functionality.



Note: In the event of a conflict between previously released information and the information contained herein, the latter shall control.

A signed acknowledgment of this addendum (this page) should be attached to your RFX response.

Supplier's Name

Signature

Printed Name and Title



RFX Addendum Form

RFX Number: 41900 DCH0000100	RFX Title: GA Families and GA Families 360° Care Management Organization
Requesting State Entity: Georgia Department of Community Health	
Issuing Officer: Dana Harris	RFX Initially Posted to Internet: February 9, 2015
eMail Address: Dana.Harris@doas.ga.gov	Telephone: 404-657-4322
Addendum Number: 3	Date: April 20 th , 2015

The attached information, provided by the issuing State Entity, is made a part of this RFX. The purpose of this addendum is to revise the RFX as follows:

1. Team Georgia Marketplace supports file attachments up to 50 megabytes each.

It is important to follow the naming convention provided without adding dashes or special characters considering that each files name cannot exceed 50 characters and that special characters will not be recognized.

Compressed file formats that include several attachments, may be uploaded, preferably using WinZip, as long as the compressed file meets the 50 megabyte limitation.

Suppliers are strongly advised to upload documents well in advance of the closing date and to validate that documents are uploaded as intended.

Any technical issues with uploading attachments should be reported to the DOAS helpdesk at 404-657-6000.

2. "Revised – Version 2, Attachment G" and "Revised – Version 2, Attachment H" replace "Revised Attachment G" and "Revised Attachment H".
3. The "Revised Provider Listing Report Template" replaces the "Provider Listing Report Template" as posted in the CMO Suppliers' Library on DCH's website.
4. FY15 GA Families and GA Families 360° data has been added to the CMO Suppliers' Library located on DCH's website. This set of data is to be the sole data reference in responses to question 115 of Attachment H.

PLEASE NOTE: Even though information submitted may be marked as "confidential", "proprietary", or "trade secret," and may be expressly referenced as such in an affidavit, pursuant to the Georgia Open Records Act DCH will make its own determination as to whether the information is a trade secret that may be withheld in response to an open records request. Accordingly, DCH will comply with the requirements described in O.C.G.A. § 50-18-72(a)(34).



Note: In the event of a conflict between previously released information and the information contained herein, the latter shall control.

A signed acknowledgment of this addendum (this page) should be attached to your RFX response.

Supplier's Name

Signature

Printed Name and Title

REVISED - VERSION 2, ATTACHMENT G

Mandatory Scored Questions

Offerors must answer all the questions in this spreadsheet in the cell provided.

Failure to answer these questions will result in disqualification of the proposal.

Offerors must indicate whether their proposal meets the individual requirement and provide a supporting narrative in the space provided. The narrative description, along with any required supporting materials, will be evaluated and awarded points in accordance with Section 6, Proposal Evaluation and Award. ONLY upload documents if there is a Yes in the "Upload Attchts with Additional Information?" column, to provide additional information about specific questions. Documents not requested in this column will not be evaluated.

DO NOT INCLUDE ANY COST INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET.

Question #	Questions per Proposal Factors/Categories	Response by Offeror	Upload Attchts with Additional Information?	Attachment File Name
Understanding Scope of Work				
7	<p>Provide an Executive Summary that summarizes the proposed technical approach, staffing structure and task schedule for Georgia Families. The Executive Summary must include a statement of understanding and fully document the Supplier's ability, understanding and capability to provide the requested services. The summary must:</p> <p>a. Demonstrate an expert understanding of the needs of Members in the State of Georgia, including a high-level overview of the Supplier's strategy and approach that highlights the Supplier's key strengths that are relevant to Georgia Families. Additionally, experience and recommendations from the Supplier's experience and results in other Medicaid markets in serving similar populations should be included.</p> <p>b. Provide an overview of the Supplier's proposed organization for this Project. Include an overview of Key Staff, Material Subcontractors and the Supplier's overall staffing plan.</p> <p>c. Identify distinguishing features and innovations the Supplier will implement that will result in improved health outcomes, access to care, and a positive financial impact. Include a discussion of barriers to access and coordinating care for Members and how the Supplier intends to address those barriers. Include Supplier's experience with addressing these barriers for similar contracts.</p> <p>Refer to Attachment D: Requirements and Scope of Work</p>		Yes	Q7 Understanding Scope of Work
Supplier Organization				
8	<p>For the Supplier and each Material Subcontractor included in the proposal, provide the organization's role in this project, corporate background, size, resources and details addressing the following:</p> <p>a. Date Supplier (company) was formed, established, or created</p> <p>b. Ownership structure (whether public, partnership, subsidiary, or specified other)</p> <p>c. Organization chart</p> <p>d. Total number of employees</p> <p>Refer to Attachment D: Requirements and Scope of Work</p>		Yes	Q8 Supplier Organization
9	<p>Provide client references as follows:</p> <p>a. Provide a minimum of three (3) different client references for Supplier, using the reference form provided as Attachment M to the RFP, for which Supplier has successfully provided services under capitated risk-based contracts with Medicaid agencies to support a program or initiative that has an aggregate average membership per year of at least four hundred thousand (400,000) Members per month within the last five (5) consecutive calendar years. Supplier may only submit client references where Supplier is the Prime Contractor and continues to have current and active client contracts. References where Supplier is providing services under grants, demonstrations or pilot programs or initiatives or where Supplier's contract to provide services is terminated or no longer active will not be considered. The Supplier may consider the experience of subsidiaries of the Supplier's Parent Company when submitting references. References from proposed Subcontractors may not be submitted to meet this requirement.</p> <p>b. If applicable, a minimum of three (3) different client references for each Material Subcontractor, using the reference form provided as Attachment N to the RFP, for which the Material Subcontractor has successfully provided services under capitated risk-based contracts with Medicaid agencies within the last five (5) consecutive calendar years. References where the Material Subcontractor is providing services under grants, demonstrations or pilot programs or initiatives or where the Material Subcontractor's contract to provide services is terminated or no longer active will not be considered. The Georgia Department of Community Health cannot be submitted as a reference in any instance described above. Include in the client reference list the following information:</p> <p>a. Contact name and title.</p> <p>b. Contact phone number.</p> <p>c. Contact email address.</p> <p>d. Contact business address.</p> <p>e. Contact fax number.</p> <p>f. Begin date of contract(s) under which services are being rendered.</p> <p>g. Membership for each reference</p> <p>Refer to Attachment D: Requirements and Scope of Work</p>		Yes	Q9 Supplier Organization

10	Provide a description of and an organization chart for this project displaying the overall business structure, including how and where the proposed project fits into the Supplier's organizational structure and displaying how the Parent Company and Material Subcontractor(s) will be incorporated into the business structure. Describe the Supplier's approach to oversight of Material Subcontractors and their performance. Refer to Attachment D: Requirements and Scope of Work		Yes	Q10 Supplier Organization
11	For the Supplier and each Material Subcontractor included in the proposal, demonstrate financial viability, as evidenced by sustained bottom line profitability and no current areas of significant financial risk for the past three (3) calendar years. For the Supplier and each Material Subcontractor included in the proposal, provide copies of financial statements from the most recently completed and audited year. Refer to Attachment D: Requirements and Scope of Work		Yes	Q11 Supplier Organization
12	For the Supplier and each Material Subcontractor included in the proposal, provide a comprehensive listing and description of prior work performed, including evidence of successful outcomes (e.g., improved Quality and health outcomes, reduction of inappropriate high-end service Utilization and decreased costs). Experience included should be from work completed under contracts that are current or have been successfully completed within the last five (5) consecutive calendar years and are of similar population size, type and scope of work outlined in this RFP specific to the Supplier's and, if applicable, Material Subcontractor's experience. Refer to Attachment D: Requirements and Scope of Work		Yes	Q12 Supplier Organization
13	Provide a statement of whether there is any pending litigation related to fraud and abuse against the Supplier, Parent Company or Material Subcontractors. If such exists, list each separately; explain the relevant details and areas of the Contract that could be impacted and the Supplier's strategy to mitigate such risk. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Supplier must be properly licensed to render such opinions. The State may require the Supplier to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions. Refer to Attachment D: Requirements and Scope of Work		Yes	Q13 Supplier Organization
14	Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Supplier or Material Subcontractor(s). If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Supplier's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Supplier must be properly licensed to render such opinions. The State may require the Supplier to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions. Refer to Attachment D: Requirements and Scope of Work		Yes	Q14 Supplier Organization
15	Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the Supplier or Material Subcontractor(s) within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any Corrective Actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or Children's Health Insurance Program (CHIP) contracts. The Supplier shall include the Supplier's Parent Company, and subsidiaries. Refer to Attachment D: Requirements and Scope of Work		Yes	Q15 Supplier Organization
16	For the Supplier and each Material Subcontractor included in this proposal, provide a listing of any contracts terminated with and without cause. Please describe the reason(s) for the termination, the parties involved, and provide the address and telephone number of the client. If the contract was terminated based on the Supplier's performance, please describe any Corrective Action taken to prevent any future occurrence of the problem leading to the termination. The Supplier shall include the Supplier's Parent Company and subsidiaries involved, and provide the address and telephone number of the client. If the contract was terminated based on the Supplier's performance, please describe any Corrective Action taken to prevent any future occurrence of the problem leading to the termination. Refer to Attachment D: Requirements and Scope of Work		Yes	Q16 Supplier Organization
17	For the Supplier, Supplier's Parent Company, subsidiaries and each Material Subcontractor included in this proposal, provide a listing of any Protected Health Information (PHI) breach. Please describe each breach and the Supplier's response. Do not include items excluded per 42 CFR 164.402. Refer to Attachment D: Requirements and Scope of Work		Yes	Q17 Supplier Organization
18	Has the Supplier ever had its accreditation status (e.g., National Committee on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), or Accreditation Association for Ambulatory Health Care (AAAHC)) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Supplier shall include the Supplier's Parent Company, and subsidiaries. Refer to Attachment D: Requirements and Scope of Work		Yes	Q18 Supplier Organization

Project Implementation				
19	<p>Describe the Supplier's approach to project management, including a summary of responsibilities for project governance and how the Supplier will track action items, risks and issues, as well as contingency and mitigation plans. Provide a proposed Program implementation Project Plan in Microsoft Excel, Microsoft Project or similar software based on the Contract implementation date of July 1, 2016 and that includes all required activities, timeframes and due dates in the Implementation Phase and Year 1 of the Contract. At a minimum, the Project Plan must include elements outlined in the Requirements and Scope of Work, for example:</p> <ul style="list-style-type: none"> a. Establishing an office location(s), call centers, and infrastructure b. Provider recruitment activities c. Staff hiring and a training plan d. Establishing interfaces to other information systems operated by DCH or its Agents e. Network contracting f. Tasks the Supplier will undertake to interface with Providers and Members through a web site, and how that interaction will support program participation and program goals g. Policy and procedure development h. Outreach to DCH's sister agencies where applicable <p>Refer to section I.A: Project Implementation – Implementation Planning of Attachment D</p>		Yes	Q19 Project Implementation
20	<p>Submit a sample Transition Plan specifying how the Supplier will coordinate with DCH to assume responsibility for Members transitioning into the Care Management Organization (CMO) from another CMO, the Fee-for-Service system or private insurance. Provide an impact statement outlining the potential impact of the transition of Members, the existing infrastructure, operations and support staff and a detailed description of the Contractor's processes and proposed approach.</p>		Yes	Q20 Project Implementation
Staffing				
21	<p>Describe the Supplier's approaches to acquiring staff, including sources of recruitment. Provide a summary of alternative actions or contingency plans if the Supplier is unable to recruit sufficient numbers of adequately trained staff on a timely basis or if the Supplier's original staffing estimates are too low and for avoiding and minimizing the impact of personnel changes. Explain how the Supplier will assure the State that sufficiently experienced and trained personnel are available to support implementation and ongoing administration of the Georgia Families program.</p> <p>Refer to Attachment D: Requirements and Scope of Work</p>		Yes	Q21 Staffing
22	<p>Describe the Supplier's Key Staff including:</p> <ul style="list-style-type: none"> a. A listing of Key Staff members identified in the RFP, including names, titles, job descriptions, degrees and qualifications and full-time equivalents (FTEs). If the Supplier's proposed approach includes other Key Staff, the Supplier must identify these positions and provide a complete description of how these positions support those required by this RFP. b. Resumes and three (3) references for each proposed Key Staff member. <p>Refer to section I.B: Contractor Staffing of Attachment D</p>		Yes	Q22 Staffing
23	<p>Describe the Supplier's overall staffing for Georgia Families including:</p> <ul style="list-style-type: none"> a. Provision of organizational charts that provide a complete and detailed description of the proposed staffing organization to be used during all phases of the Contract. b. Identification of staff based (1) in the office(s), (2) in the field, and (3) at a corporate office. c. The number of full-time equivalents (FTE) Supplier/Material Subcontractor staff who will be dedicated to this Contract as well as number of FTEs per Member by position type. <p>Refer to section I.B: Contractor Staffing of Attachment D</p>		Yes	Q23 Staffing
24	<p>Provide details about the staff training plan the Supplier intends to implement to ensure all staff, in all departments, are aware of programmatic changes. Provide the frequency with which new and existing employees are trained, how new program updates are disseminated, how the Supplier's organization tracks training completion and how comprehension is measured.</p> <p>Refer to section I.B: Contractor Staffing - Training of Attachment D</p>		Yes	Q24 Staffing
Covered Services and Benefits				

25	Describe any innovative and enhanced services that the Supplier will provide to enhance the general health and well-being of Members and to improve outcomes. Provide examples of initiatives the Supplier proposes to achieve a holistic approach to Member care. Include examples of success with similar Medicaid populations that the Supplier's organization has demonstrated. Refer to section I.C: Georgia Families Covered Services of Attachment D		Yes	Q25 Covered Services and Benefits
26	Describe the Supplier's process of determining medical necessity and how the Supplier will ensure there is no other more conservative or substantially less costly treatment, service or setting available to achieve the desired health outcome. Describe how the Supplier's organization will manage under-Utilization and over-Utilization of services and will work to ensure a high Quality, clinically appropriate yet highly efficient and cost-effective delivery system. Refer to section I.C: Georgia Families Covered Services – Medical Necessity of Attachment D		Yes	Q26 Covered Services and Benefits
27	Describe in detail the Supplier's understanding of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit and the Supplier's plan and operational procedures for EPSDT outreach. Include in the description how the Supplier will: a. Educate Members about the EPSDT Benefit and the importance of following the periodicity and immunization schedule. b. Educate Providers about the EPSDT Benefit and their roles in ensuring Members follow the periodicity and immunization schedule as well as receive the appropriate care. c. Educate relevant Material Subcontractors evaluating medical necessity. d. Use data to enhance outreach efforts. e. Use data to communicate outcomes and identify trends and areas for improvement where additional outreach and education is needed. Refer to section I.C: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit – General Provisions of Attachment D.		Yes	Q27 Covered Services and Benefits
28	Describe the Supplier's proposed approach to ensure children receive timely EPSDT screens in accordance with the DCH's adopted EPSDT periodicity schedule, including the following: a. The Supplier's process for reminder, follow-ups, and outreach to Member. Include proactive activities as well as activities to conduct follow up with Members who do not remain current with the periodicity schedule. How will the Supplier use this information to determine reasons for lack of follow up and to provide support when needed (e.g., coordination with NET broker for transportation)? b. Developing and maintaining an electronic system to track Members' EPSDT screening and immunization status to confirm Members have received all required EPSDT screens. c. Assisting Members by coordinating Referrals and medically necessary follow-up treatment resulting from an EPSDT screen. d. Monitoring Primary Care Providers (PCP)/Providers compliance with appointment standards and EPSDT screening requirements, including a description of what the Supplier will do if it identifies PCPs/Providers who do not meet the performance standards. e. How the Supplier anticipates the approach will improve health outcomes. Include in the response a detailed summary of how the Supplier will assure that Members receive the necessary Diagnostic Services and treatment services resulting from screening results. Refer to section I.C: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit – Outreach and Informing of Attachment D.		Yes	Q28 Covered Services and Benefits
Special Coverage and Provisions				
29	Provide innovative solutions for ensuring Members have adequate access to required Family Planning Services and are accessing those services. Refer to section I.D: Special Coverage Provisions - Family Planning Services of Attachment D		Yes	Q29 Special Coverage and Provisions
30	Describe the Supplier's pharmacy Prior Authorization process. As part of the response, include: a. Transparency in communicating the Conditions for coverage to Providers. b. Service level agreement for Prior Authorization turnaround time. c. Required credentials of those staff reviewing Prior Authorization requests and any distinction between the credentials of who is permitted to approve versus deny a request. d. The use of existing electronic Claims history to adjudicate a Prior Authorization request in an automated fashion. e. How Supplier's organization will review and use trends in Prior Authorization requests to identify possible changes to Prior Authorization guidelines (e.g., to determine if Prior Authorization should continue for a medication that results in a high percentage of approvals). Refer to section I.D: Special Coverage Provisions – Pharmacy of Attachment D		Yes	Q30 Special Coverage and Provisions

31	Describe the Supplier's proposed approach to ensuring Members less than twenty-one (21) years of age receive all vaccines and immunization in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. Include in the response the Supplier's experience in coordinating with other state programs designed to improve immunization levels. Refer to section I.D: Special Coverage Provisions – Immunizations of Attachment D		Yes	Q31 Special Coverage and Provisions
32	Describe the Supplier's proposed approach to coordinating with the Department of Public Health (DPH) to ensure that Providers use vaccines for PeachCare for Kids® Members age eighteen (18) years of age and younger that are available free of cost to Providers through the State Purchasing Vaccine Program? Additionally, describe innovative approaches the Supplier will implement to ensure Providers are aware of the program and use it. Refer to section I.D: Special Coverage Provisions – Immunizations of Attachment D		Yes	Q32 Special Coverage and Provisions
33	Describe the Supplier's proposed approach to assisting Members with accessing Non-Emergency Transportation (NET). Refer to section I.D: Special Coverage Provisions – Transportation of Attachment D		Yes	Q33 Special Coverage and Provisions
34	Describe how the Supplier will coordinate with public health departments to utilize their perinatal risk assessments and plans of care for newly identified pregnant women. Refer to section I.D: Special Coverage Provisions – Perinatal Services of Attachment D		Yes	Q34 Special Coverage and Provisions
35	Describe the Supplier's proposed approach to providing prenatal and postpartum services, including: a. How the Supplier will coordinate with Providers through which women are already receiving prenatal or postpartum care at the time of Enrollment. b. Innovative strategies the Supplier intends to implement to encourage pregnant women to seek prenatal and postpartum care services. Describe how the Supplier will optimize the likelihood that Members will comply with scheduled prenatal visits and return for postpartum checkups. Identify potential challenges the Supplier anticipates when facilitating prenatal care for Members and explain how the Supplier will mitigate those challenges. c. How the Supplier will encourage follow-up and treatment of postpartum depression and related Conditions such as drug and alcohol dependence and other mental illnesses. Include in the description how the Supplier will encourage Provider identification of postpartum depression and related Conditions, and optimize follow-up surveillance, Referral and/or treatment. Refer to section I.D: Special Coverage Provisions – Parenting Education of Attachment D		Yes	Q35 Special Coverage and Provisions
36	Describe the Supplier's proposed approach to the timely delivery of covered Mental Health and Substance Abuse services including any distinction between adult, adolescent, and pediatric populations. The description shall include: a. Approach to the delivery of Behavioral Health Services and Physical Health in the most integrated and person-centered setting available including for those with dual diagnoses (i.e., Mental Health and Substance Abuse diagnoses). b. Approach to identifying Substance Abuse. c. Approach to the provision of recovery-based services. d. Use of innovative Emergency Services diversion techniques and interventions. e. Innovative strategies the Supplier intends to implement for increasing access to all tiers of community Behavioral Health Providers. f. Potential challenges the Supplier anticipates in ensuring Members receive appropriate Mental Health and Substance Abuse care and how the Supplier will mitigate those challenges. Provide examples of successful strategies the Supplier has used to provide these services. Refer to section I.D: Special Coverage Provisions – Mental Health and Substance Abuse of Attachment D		Yes	Q36 Special Coverage and Provisions
37	Describe the Supplier's approach to identifying and initiating Care Coordination for at-risk Members diagnosed with Behavioral Health Conditions. Provide examples of successful strategies the Supplier has used to identify and coordinate care for at-risk Members. Refer to section I.D: Special Coverage Provisions – Mental Health and Substance Abuse of Attachment D		Yes	Q37 Special Coverage and Provisions
Member Enrollment				

38	Describe the Supplier's proposed approach to helping Members to identify PCPs who may best meet their needs, ensure continuity of care and to encourage Members to make voluntary PCP selections. Additionally, include a discussion of the Supplier's approach to inform Members about their PCP assignment and encourage scheduling and keeping appointments. Include how the Supplier will identify and resolve Member barriers to keeping appointments. Refer to section I.E: Member Enrollment – Selection of a Primary Care Provider (PCP) of Attachment D		Yes	Q38 Member Enrollment
39	Describe the Supplier's proposed approach to ensuring Member's with a Behavioral Health diagnosis requesting a Behavioral Health Home are assigned a Behavioral Health Home that best meets their needs. Describe how the Behavioral Health Home will coordinate all physical and Behavioral Health Care for the Member to allow better access to Health Care and improve health outcomes.		Yes	Q39 Member Enrollment
40	Describe the Supplier's proposed process to connect/assign Members to a Dental Home, including the proposed Auto-Assignment algorithm. Include how Member choice, continuity of care, and any methodology for Auto-Assignment to a Dental Home will be incorporated into the Supplier's solution. Additionally, include a discussion of the Supplier's approach to inform Members about their Dental Home assignment and encourage scheduling an initial appointment. Refer to section I.E: Member Enrollment – Dental Home of Attachment D		Yes	Q40 Member Enrollment
Member Services				
41	Provide the Supplier's proposed plan for distributing Member materials, including a description of topics to be addressed. Describe the Supplier's proposed use of technology to reach the most Members and engender the most response. Please describe successful uses of the proposed technologies and other innovations in other markets, if applicable, to reach the most Members. Describe the Supplier's commitment to reassess the effectiveness of the Supplier's planned approach to locate Members should the initial approach produce suboptimal results. Refer to section I.G: Georgia Families Member Services of Attachment D		Yes	Q41 Member Services
42	Describe the Supplier's proposed education and outreach program for Members, including: a. Creative solutions the Supplier will employ to achieve Member interest participation in outreach and education activities. b. An overview of the program and proposed activities. c. Rationale for the selected areas of focus. d. Methodology to provide targeted health education. e. How the Supplier will collect and use feedback from Members to enhance the program. Refer to section I.G: Georgia Families Member Services of Attachment D		Yes	Q42 Member Services
43	Describe the Supplier's proposed approaches for obtaining correct Member contact information including Member phone numbers and email addresses. Refer to section I.G: Georgia Families Member Services – Member Handbook and Member Material Requirements of Attachment D		Yes	Q43 Member Services
44	Describe the Supplier's Member services call center operations, including: a. How the Supplier's organization will provide a fully staffed line between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday, excluding State holidays, and an automated system between the hours of 7:00 p.m. and 7:00 a.m. EST Monday through Friday and on weekends and State holidays. b. Location of operations (If out of State, describe how it will accommodate services for Georgia). c. How call center standards (e.g., average answer speed, average length of call, Blocked Calls, etc.) will be monitored and met. d. Accommodations for non-English speaking and hearing impaired callers. Refer to section I.G: Georgia Families Member Services – Member Call Center of Attachment D		Yes	Q44 Member Services

45	<p>Describe the Supplier's proposed approach to:</p> <p>a. Ensure that Member calls pertaining to immediate medical needs are properly handled.</p> <p>b. Train call center employees on issues such as Member rights, Cultural Competency, identification of emergency needs and the different populations included in the program, how the service offerings differ for each of those.</p> <p>c. Provide staff timely access to current and consistent information needed when responding to Member inquiries.</p> <p>Refer to section I.G: Georgia Families Member Services – Member Call Center of Attachment D</p>		Yes	Q45 Member Services
46	<p>Provide an overview of the Supplier's proposed Member web site and Member portal. Include examples of proposed resources, tools and materials that will be of meaningful use to Members.</p> <p>Refer to section I.G: Georgia Families Member Services – Georgia Families Member Web Site of Attachment D</p>		Yes	Q46 Member Services
47	<p>Describe how Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each.</p> <p>Refer to section I.G: Georgia Families Member Services – Cultural Competency of Attachment D</p>		Yes	Q47 Member Services
Provider Network				
48	<p>Describe the Supplier's proposed ongoing Provider Network development outreach approach and recruitment strategy. Include in the response the Supplier's approach to the following:</p> <p>a. Developing recruitment work plans and carrying out recruitment efforts.</p> <p>b. Obtaining Letters of Intent with existing Medicaid Providers.</p> <p>c. Incenting Providers to participate in the Georgia Families program.</p> <p>If Subcontractors will be used for certain service areas (e.g., dental, transportation, Behavioral Health), describe how their network development efforts will be coordinated with the overall recruitment strategy and how the Supplier will provide oversight and monitoring of network development activities.</p> <p>Refer to section I.I: Georgia Families Provider Network – General Provisions of Attachment D</p>		Yes	Q48 Provider Network
49	<p>Demonstrate progress toward developing network capabilities for statewide access by providing signed Letters of Intent with physicians, specialists, Mental Health providers, dentists, hospitals, pharmacies, therapists, etc. for Georgia Families program networks that shall include the information, at a minimum:</p> <p>a. An Excel worksheet listing every provider with a signed Letter of Intent. The worksheet must include the name of the provider, the provider's address(es), county/counties, Service Region, provider's Medicaid Identification Number(s) and provider type.</p> <p>b. Using the Geo Access tool, Statewide Geographic Access report of all providers with LOIs color coded by provider type by Service Region.</p> <p>Refer to section I.I: Georgia Families Provider Network – Provider Network Composition of Attachment D</p>		Yes	Q49 Provider Network
50	<p>Explain the Supplier's plan to develop a comprehensive Provider network to ensure it meets DCH access and availability requirements for all covered Benefits. Specifically include:</p> <p>a. How the Supplier's organization will identify and act upon network gaps.</p> <p>b. Proposed method to assess and ensure the network standards are maintained for all Provider types, including using Geo Access reporting to ensure network adequacy.</p> <p>c. Supplier's process for continuous network improvement over and above contract compliance, including the approach for monitoring and evaluating PCP compliance with availability and scheduling appointment requirements and ensuring Members have access to care if the Supplier lacks an agreement with a key Provider type in a given geographic area.</p> <p>d. Proposed Member to Provider ratios.</p> <p>e. How the Supplier will address rural access issues and Health Provider Shortage Areas (HPSAs).</p> <p>Refer to section I.I: Georgia Families Provider Network – Provider Selection and Retention Policies and Procedures of Attachment D</p>		Yes	Q50 Provider Network

51	<p>Provide a description of the system the Supplier intends to use in generating Geo Access reports. Describe the system's capacity to:</p> <p>a. Identify whether the system has the capability to generate Geo Access reports based on physical address, as opposed to ZIP code as well as by Provider type.</p> <p>b. Develop exception reports, and for identifying Members or geographic areas where access standards are not achieved. Provide examples of the Supplier's system's output.</p> <p>Refer to section I.I: Georgia Families Provider Network – Provider Selection and Retention Policies and Procedures of Attachment D</p>		Yes	Q51 Provider Network
52	<p>Describe innovative strategies the Supplier intends to use to identify specialty types for which Member access is limited. Describe initiatives the Supplier will implement for increasing the number of specialists within those specialty types that participate in the Supplier's network.</p> <p>Identify potential challenges the Supplier anticipates in ensuring Members receive appropriate care for specialties where access concerns exist and explain how the Supplier will mitigate those challenges.</p> <p>Refer to section I.I: Georgia Families Provider Network – Provider Network Composition of Attachment D</p>		Yes	Q52 Provider Network
53	<p>Describe innovative approaches the Supplier will implement to encourage Providers to attain National Committee on Quality Assurance (NCQA) patient-centered medical home recognition. If the Supplier proposes to incentivize Providers to attain certification, provide the approach to developing and implementing the incentive. The Supplier must not provide any pricing or cost information in its response.</p> <p>Refer to section I.I: Georgia Families Provider Network – Primary Care Providers and section I.M: Quality Management and Performance Improvement – National Committee for Quality Assurance (NCQA) Accreditation of Attachment D</p>		Yes	Q53 Provider Network
54	<p>Describe responsibilities the Supplier will require of PCPs and how the Supplier will verify that PCPs are performing the required responsibilities.</p> <p>Refer to section I.I: Georgia Families Provider Network – Primary Care Providers of Attachment D</p>		Yes	Q54 Provider Network
55	<p>Provide a description of how the Supplier intends to offer improved access to through Telemedicine. Include the following in the description:</p> <p>a. Criteria for recognized sites for Members to access Telemedicine.</p> <p>b. Willingness to pay the presenting site a facility fee (Note: Do not include any financial information in the response).</p> <p>c. Types of Providers the Supplier intends to contract for the provision of Telemedicine.</p> <p>d. Education efforts to inform Members and Providers.</p> <p>e. Inclusion of public health departments as Telemedicine presentation sites.</p> <p>Provide examples of successful Telemedicine programs the Supplier has implemented.</p> <p>Refer to section I.I: Georgia Families Provider Network – Telemedicine of Attachment D</p>		Yes	Q55 Provider Network
56	<p>Describe innovative strategies the Supplier intends to implement to ensure appropriate access to dental Providers actively participating in the Supplier's Provider Network and any specific initiatives the Supplier would implement related to increasing pediatric Utilization of preventive dental services.</p> <p>Identify potential challenges the Supplier may anticipate in ensuring Members receive appropriate dental care and explain how the Supplier will mitigate those challenges.</p> <p>Refer to section I.I: Georgia Families Provider Network – Dental Practitioners of Attachment D</p>		Yes	Q56 Provider Network
57	<p>Describe how the Supplier will ensure that access standards are met when Members cannot access care within the Supplier's Provider network and must utilize an Out-of-Network Provider?</p> <p>Refer to section I.I: Georgia Families Provider Network – Geographic Access Requirements and Georgia Families Provider Network – Out-of-Network Providers of Attachment D</p>		Yes	Q57 Provider Network
58	<p>Describe the Supplier's approach to auditing Provider Network accessibility. Include a description of how the below will be audited, the frequency of the audits and how deficiencies will be addressed.</p> <p>a. Urgent and non-urgent PCP appointment availability and wait time.</p> <p>b. Urgent and non-urgent OB appointment availability and wait time.</p> <p>c. Urgent and non-urgent Specialty Provider availability and wait time.</p> <p>d. Physician twenty-four (24) hour availability.</p> <p>Please provide sample tools the Supplier will use.</p> <p>Refer to section I.I: Georgia Families Provider Network – Waiting Maximums and Appointment Requirements and Access and Availability Audits of Attachment D</p>		Yes	Q58 Provider Network
59	<p>Describe the processes the Supplier will implement to ensure the access standards are met if actual Enrollment exceeds projected Enrollment.</p> <p>Refer to section I.I: Georgia Families Provider Network Attachment D</p>		Yes	Q59 Provider Network

60	Describe the Supplier's process for working with Providers and the Credentialing Verification Organization (CVO) to educate and assist Providers in completing the credentialing and recredentialing process with the CVO. Refer to section I.I: Georgia Families Provider Network – Provider Credentialing of Attachment D		Yes	Q60 Provider Network
61	Describe the Supplier's approach for timely contracting of Providers upon receipt of information from the CVO that a Provider's credentialing is complete. Separately, identify the time from contracting that the Supplier requires to upload a credentialed and contracted Provider into the Claims payment system such that the Provider Claims could be adjudicated for payment consideration. Finally, discuss the Supplier's willingness to pay Claims with dates of service on and after the date of credentialing irrespective of the date the credentialed Provider is loaded into the Supplier's Claims processing system. Refer to section I.I: Georgia Families Provider Network – Provider Credentialing of Attachment D		Yes	Q61 Provider Network
62	Describe how the Supplier would respond to the network termination or loss of a large-scale Provider group or health system. Please develop the response taking the following areas into consideration: a. Notification to DCH. b. The automated systems and membership supports utilized in assisting affected Members with Provider transitions. c. Systems and policies utilized for continuity of care of Members experiencing Provider transition. d. Impact if the loss is in a geographic area where other Providers of the same Provider type are not available and the Contractor's response to that impact Refer to section I.I: Georgia Families Provider Network – Network Changes of Attachment D		Yes	Q62 Provider Network
Provider Services				
63	Provide a description of the Supplier's Provider services program/department and how the Supplier intends to partner with the Provider community in delivering Covered Services. Include the following: a. Information available in the Provider handbook or other media. b. Description of any formal committees or panels the Supplier will form at which Providers can offer input regarding CMO/Provider relations. c. Sample Provider outreach. Provide examples of best practices related to Provider services in other states that the Supplier will utilize in Georgia. Refer to section I.J: Georgia Families Provider Services of Attachment D		Yes	Q63 Provider Services
64	Describe the Supplier's proposed Provider education and training program, including: a. A description of the training program. b. A summary of the Supplier's plans to evaluate Provider behaviors (e.g., Provider profiling or other techniques), and how the Supplier will use such information to educate Providers about how they can improve patient outcomes. c. A workplan that outlines education and training activities, including frequency of office visits to conduct activities. d. A listing of the types of materials the Supplier will distribute (the actual materials are not to be submitted). e. How the Supplier will evaluate usefulness of educational sessions and synthesize that feedback to influence future training sessions. Refer to section I.J: Georgia Families Provider Services – Education and Training of Attachment D		Yes	Q64 Provider Services
65	Describe the Supplier's Provider Services call center operations, including: a. How the Supplier will provide a fully-staffed line between the hours of 7:00 a.m. and 7:00 p.m. Monday through Friday, excluding State holidays, and an automated system between the hours of 7:00 p.m. and 7:00 a.m. EST Monday through Friday and on weekends and State holidays. b. Location of operations (If out of state, describe how it will accommodate services for Georgia). c. How call center standards (e.g., average answer speed, average length of call, Blocked Calls, etc.) will be monitored and met. Refer to section I.J: Georgia Families Provider Services –Provider Services Call Center of Attachment D		Yes	Q65 Provider Services
66	Provide an overview of the Supplier's proposed Provider web site, including examples of information that will be available on the Program web site and portals for Providers. Include proposed resources and tools that will be of meaningful use to Providers. Please provide a description of technology that will be used to enhance the Provider web site. Refer to section I.J: Georgia Families Provider Services – Georgia Families Provider Web Site of Attachment D. Page Limit: 5 pages excluding sample resources, tools and materials		Yes	Q66 Provider Services
67	Provide a description of the Supplier's proposed approach to handling Provider inquiries and grievances. Include intended interaction and correspondence, as well as timeframes in which the Supplier will acknowledge and resolve inquiries and grievances. Explain how the Supplier will track Provider Complaints and inquiries and how the Supplier will use this type of information to improve Provider relations. Include a description of any type of internal reporting the Supplier will perform and how this may influence the activities of the Supplier's Provider Relations representatives. In addition, describe how the Supplier intends to capture and utilize measurable Provider satisfaction information. Provide an overview of how the Supplier will use information collected internally to improve operations. Refer to section I.J: Georgia Families Provider Services – Provider Complaint System of Attachment D		Yes	Q67 Provider Services

Utilization Management and Care Management				
68	<p>Describe the Supplier's proposed approach to Utilization Management (UM), including:</p> <ul style="list-style-type: none"> a. Innovations and automation the Supplier will implement for the Utilization Management program. b. Accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers. c. Data sources and processes to determine which services require Prior Authorization and how often these requirements will be re-evaluated. d. Processes and resources used to develop and regularly review Utilization Review (UR) criteria. e. Prior Authorization processes for Members requiring services from non-participating providers or expedited Prior Authorization. f. How the Supplier will use its Utilization Management Committee to support Utilization Management activities. <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Utilization Management of Attachment D</p>		Yes	Q68 Utilization Management and Care Management
69	<p>Describe the Supplier's proposed approach for using data collected during Utilization Management to drive appropriate use of service, improved cost efficiencies, Member and Provider education and Fraud and Abuse referrals.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Utilization Management of Attachment D</p>		Yes	Q69 Utilization Management and Care Management
70	<p>Describe the Supplier's approach for interfacing with DCH's Prior Authorization Portal. Include a description of how the Supplier will outreach to and educate all network Providers about use of the Portal and notify Providers of the outcome of a Prior Authorization within the required timeframes.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Prior Authorization and Pre-Certification of Attachment D</p>		Yes	Q70 Utilization Management and Care Management
71	<p>Provide a comprehensive discussion of the Supplier's Coordination and Continuity of Care program and how it will meet program goals for improving Member outcomes. Include a discussion of how the Supplier will determine Member eligibility for each level of care (e.g., disease management, Case Management, etc.) and manage co-morbidities. Describe how the Supplier will tailor the program to incorporate a System of Care approach for Members according to their various Health Care needs. Also address community differences across the state, including information about issues such as geographic differences in Provider supply and cultural differences.</p> <p>Provide case studies and experience from other states illustrating the Supplier's ability to successfully address community differences in its Care Coordination approach.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Coordination and Continuity of Care Responsibilities of Attachment D</p>		Yes	Q71 Utilization Management and Care Management
72	<p>How will the Supplier identify community resources and agencies for inclusion in the Coordination of Care and Continuity of Care program? Describe the Supplier's proposed outreach efforts to such agencies and how the Supplier will involve them in the continuum of care for Members.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Coordination and Continuity of Care Responsibilities of Attachment D</p>		Yes	Q72 Utilization Management and Care Management
73	<p>Describe innovative strategies the Supplier will use to identify Members in need of regular care monitoring. Include a description of how the Supplier will engage Members, families, PCPs, specialist and other Providers as necessary in the treatment plan development.</p> <p>Provide experiences from other states illustrating and best practices that the Supplier would suggest DCH implement. For each example from another state, provide statistics demonstrating the impact of the initiative (such as percent change in Utilization of a particular service, etc.).</p> <p>Submit a sample needs assessment template.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Coordination and Continuity of Care Responsibilities of Attachment D</p>		Yes	Q73 Utilization Management and Care Management
74	<p>Explain the Supplier's hospital Discharge planning policies and procedures that will ensure seamless transition for Members. Describe pre-Discharge activities including collaborating with the Member and his/her family, as well as community resources that will be involved at Discharge and thereafter. Include any follow-up activities after Discharge the Supplier intends to perform.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p>		Yes	Q74 Utilization Management and Care Management

75	<p>Describe the Supplier's intended approach to working with other CMOs in the event a Member changes CMOs, or moves to private insurance or to the Fee-for-Service system. Describe how the Supplier will interact with other CMOs to ensure a seamless Transition Of Care and that all relevant information is transferred.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p>		Yes	Q75 Utilization Management and Care Management
76	<p>Provide an overview of the Supplier's proposed Discharge Planning Pilot Program. What innovations will the Supplier implement to improve Quality of care and outcomes, as well as to reduce Re-admissions? Which Member populations will the Supplier target and why? Which hospital(s) will the Supplier target and why? How will the Supplier collaborate with the hospital(s) to agree upon the proposed Discharge planning activities and on the responsibilities of the onsite nurse?</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p>		Yes	Q76 Utilization Management and Care Management
77	<p>Provide an overview of the Supplier's proposed Emergency Department Diversion pilot program. What innovations will the Supplier implement to improve Quality of care and outcomes, as well as to reduce inappropriate Emergency Department visits? How will the Supplier organization identify Member populations and hospital(s) for participation in the pilot? How will the Supplier collaborate with the hospital(s) to agree upon the proposed pilot activities?</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities of Attachment D</p>		Yes	Q77 Utilization Management and Care Management
78	<p>Describe how the Supplier's coordination and continuity of care efforts will maximize Physical and Behavioral Health integration to improve outcomes including:</p> <ol style="list-style-type: none"> The organization's approach to coordinating Behavioral Health service delivery with Primary Care services delivered by a Member's PCP, and vice versa. How the Supplier will encourage the delivery of outpatient Behavioral Health Services following an inpatient Discharge for Behavioral Health Services. Information the Supplier will collect and maintain for use in Behavioral Health coordination efforts. Reports the Supplier will maintain and use that illustrate patterns of Referral as well as services provided to individuals, include an explanation of how the data and its analysis improve healthcare outcomes for Members. How the Supplier will share information with Providers and other stakeholders to contribute to the success of Behavioral Health coordination. How HIPAA requirements might pose challenges and how the Supplier will overcome or address those challenges. Provide case studies and experience from other states illustrating the Supplier organization's ability to successfully integrate Physical and Behavioral Health. <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Integration of Physical and Behavioral Health Services of Attachment D</p>		Yes	Q78 Utilization Management and Care Management
79	<p>Describe the Supplier's approach to identifying Members in need of Case Management services and the level of intensity of Case Management needed. Include a description of how the Supplier will distinguish eligibility for the various levels of Case Management intensity, including the following:</p> <ol style="list-style-type: none"> Detailed description of the methodology used to analyze Claims data. Approach to predictive modeling and other data analysis for identifying Members and to tier or stratify Members according to their risk, cost and impactability. The detailed narrative must communicate the uniqueness of the Supplier's capabilities in this area. The proposed qualifying criteria for children, adolescents and adults, as well as, the Physical Health and Behavioral Health Conditions and factors that the Supplier will consider in identifying Members eligible for Case Management. A description of Member assessment tools the Supplier will use and an example template. How Case Management services provided to Planning for Healthy Babies 1115 Demonstration Waiver (P4HB) Interpregnancy Care component of the 1115 Demonstration Waiver (IPC) Participants may differ from those provided to other Members. <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D</p> <p>Page Limit: 6 pages, excluding Member assessment template</p>		Yes	Q79 Utilization Management and Care Management

80	<p>Describe the responsibilities of case managers and how they will assist Members based on their level of need. Describe the range of case manager expertise to adequately respond to varying degrees of need among Members. What is the Supplier's proposed case manager to Member ratio?</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D</p>		Yes	Q80 Utilization Management and Care Management
81	<p>Describe the specific levels of Case Management Members will receive based on the intensity of the Member's needs. Recommend additional innovative Case Management strategies DCH may want to consider for the Georgia Families program.</p> <p>Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D</p>		Yes	Q81 Utilization Management and Care Management
Quality Management and Performance Improvement				
82	<p>Describe the Supplier's proposed Quality Management program, including:</p> <ul style="list-style-type: none"> a. The program's infrastructure, including coordination with Subcontractors/corporate entities, if applicable. b. The program's lines of accountability. c. Process for selecting areas of focus and using evidence-based practices. d. How the Supplier will comply with and support the Georgia Families Quality Strategy. e. Use of the Quality Management Oversight Committee. f. Use of data to design, implement and evaluate the effectiveness of the program. g. Assurance of separation of responsibilities between Utilization Management and Quality assurance staff. <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D</p>		Yes	Q82 Quality Management and Performance Improvement
83	<p>Describe data-driven clinical initiatives that the Supplier would propose undertaking for the Georgia Families program. Include an overview of the initiative, populations to be targeted and analyses the Supplier will conduct. Provide examples of data-driven clinical initiatives the Supplier has initiated within the past twenty-four (24) months that have yielded improvement in clinical care for a Medicaid managed care population comparable to the Georgia Families population. For each initiative described, provide statistics and results demonstrating the impact of the initiative.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D</p>		Yes	Q83 Quality Management and Performance Improvement
84	<p>Describe two (2) Acute Care clinical initiatives the Supplier proposes to pursue in the first year of the Contract. Document why each topic warrants a Quality improvement investment, and describe the measurable goals for the initiative. Provide the baseline assumptions that led the Supplier organization to propose these two (2) initiatives.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D</p>		Yes	Q84 Quality Management and Performance Improvement
85	<p>Describe the Supplier's proposed process to monitor Providers' implementation of and compliance with new practice guidelines. Include a description of how the Supplier will increase compliance with the use of clinical practice guidelines.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D</p>		Yes	Q85 Quality Management and Performance Improvement
86	<p>Describe the Supplier's proposed methodology to identify, design, implement, and evaluate Performance Improvement Projects (PIP). Describe the Supplier's proposed methodology for a Performance Improvement Project for a population with a high level of emergency department Utilization.</p> <p>Refer to section I.M: Quality Management and Performance Improvement – Performance Improvement Projects of Attachment D</p>		Yes	Q86 Quality Management and Performance Improvement

87	<p>Discuss how the Supplier will assist DCH in establishing and meeting DCH's Value Based Purchasing (VBP) goals, including the following:</p> <ul style="list-style-type: none"> a. How the Supplier will identify and implement initiatives and interventions to achieve targets for the identified performance measures. b. Data analyses the Supplier will conduct, with the assumptions used to conduct the analyses; past experience; knowledge and understanding of the Georgia Families population, including a discussion of potential barriers to performance improvement and how the Supplier intend to address those barriers; and a review of industry best practices. c. Methods for monitoring performance against targets, including how the Supplier will modify interventions if interventions are not successful in helping to attain targets. d. How the Supplier proposes to conduct as close to real-time measurement as possible, and monitoring and providing feedback to hold Providers accountable for providing appropriate services. As part of this discussion, describe the Supplier's proposed approach to incent Provider behavior, how the Supplier will design the Provider performance incentive program and how and the degree to which these incentives will be aligned with Member incentives (if any), Supplier performance goals and DCH performance goals. Discuss the Supplier's experience with Provider incentive programs, the structure of the programs, measurable outcomes and lessons learned. Do not include financial information in the response. e. Supporting rationale. <p>Refer to section I.M: Quality Management and Performance Improvement – Value Based Purchasing (VBP) Program of Attachment D</p>		Yes	Q87 Quality Management and Performance Improvement
88	<p>Describe the Supplier's proposed methodology to identify, assess, and correct disparities in treatment across races and ethnic groups.</p> <p>Refer to section I.M: Quality Management and Performance Improvement of Attachment D</p>		Yes	Q88 Quality Management and Performance Improvement
89	<p>How will the Supplier use the Member and Provider Advisory Committees to improve the Georgia Families program and direct Quality and operational changes? What representation will the Supplier plan to have on each committee (e.g., stakeholder types, from what geographic areas, etc.) How will the Supplier identify participants of the Member and Provider Advisory Committees?</p> <p>Provide examples from other states where the Supplier has collaborated with Member and Provider Committees for program improvement.</p> <p>Refer to section I.M: Quality Management and Performance Improvement – Member Advisory Committee and Provider Advisory Committee of Attachment D</p>		Yes	Q89 Quality Management and Performance Improvement
Admin Services				
90	<p>How will the Supplier ensure and verify that Subcontractor(s) submit timely, accurate, complete and required Encounter Claim data elements to the Supplier for subsequent transmission to the Department? How often and how will the Supplier verify the data?</p> <p>Refer to section I.N: Administrative Services – Claims Management of Attachment D</p>		Yes	Q90 Admin Services
91	<p>Demonstrate the Supplier's ability to perform quarterly scheduled global Claims analyses to ensure an effective, accurate, and efficient Claims processing function that adjudicates and settles Provider Claims. Include how the Supplier will make the results of such analyses known to DCH.</p> <p>Refer to section I.N: Administrative Services – Claims Management of Attachment D</p>		Yes	Q91 Admin Services
92	<p>Describe how the Supplier intends to work with DCH and its Fiscal Agent Contractor (FAC) to maintain timely, accurate and complete submission of Encounter data and stay within specified Encounter Error Rates.</p> <p>Refer to section I.N: Administrative Services – Claims Management of Attachment D</p>		Yes	Q92 Admin Services
93	<p>Describe the specific policies and procedures that the Supplier will adopt to prevent and detect Fraud and Abuse that may be committed by Provider, Members, employees or Subcontractors. Include in the response:</p> <ul style="list-style-type: none"> a. The Supplier's process for ensuring that suspected Fraud and Abuse is reported timely to the Department. b. A description of the position within the Supplier's organization responsible for Fraud and Abuse reporting. c. Methods and technology the Supplier will use to detect Fraud and Abuse. d. How the Supplier will ensure that Providers are made aware of their responsibilities regarding Fraud and Abuse. e. A copy of the Supplier's compliance plan. <p>Refer to section I.N: Administrative Services – Fraud, Waste, an Abuse of Attachment D</p>		Yes	Q93 Admin Services

94	<p>Describe the Fraud and Abuse program the Supplier will implement including:</p> <p>a. Proactive and reactive Fraud and Abuse detection methods that will be used, including dollar amount thresholds used for initiating a review, if applicable.</p> <p>b. Education and training for employees.</p> <p>c. Process for acting upon suspected cases of Fraud and Abuse.</p> <p>d. Process for complying with federal regulations related to disclosures and exclusion of debarred or suspended Providers.</p> <p>e. Other innovative components of the Supplier's Fraud and Abuse program.</p> <p>Refer to section I.N: Administrative Services – Fraud, Waste, an Abuse of Attachment D</p>		Yes	Q94 Admin Services
95	<p>Describe the Supplier's proposed Member Complaint, Grievance, and Appeals Process specifically addressing:</p> <p>a. Compliance with State and Federal requirements.</p> <p>b. Process for Expedited Review.</p> <p>c. Involvement of Members and their families in the Complaint, Grievance, and Appeals Process.</p> <p>d. How Complaints and Grievances are tracked and trended and how the Supplier uses data to make program improvements.</p> <p>e. Process to review decisions overturned in fair hearings and the Supplier's approach to address any needed changes based on this review.</p> <p>Refer to section I.N: Administrative Services – Internal Grievance/Appeals System of Attachment D</p>		Yes	Q95 Admin Services
Information Management and Systems				
96	<p>Provide a description of how the Supplier will comply with HIPAA standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the Supplier's use of the HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the Supplier's internal membership records, including differences in Member's addresses.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D</p>		Yes	Q96 Information Management and Systems
97	<p>Provide a general system description that describes how each component of the Supplier's management information system (MIS) will support the major functional areas of Georgia Families. Include a systems diagram that includes each component of the MIS and the interfacing or supporting systems used to ensure compliance with Contract requirements. Describe how the Supplier's system will:</p> <p>a. Utilize files sent by DCH and DCH's Fiscal Agent Supplier.</p> <p>b. Share information between DCH's systems and its own system to avoid duplication of effort.</p> <p>c. Be used by the Supplier to ensure Material Subcontractors are meeting Program requirements.</p> <p>Explain whether the Supplier's current information system is ready to operate according to the requirements of the Scope of Work. If it requires modifications and/or updates, describe the necessary modifications and/or updates and the Supplier's plan for completion prior to program operations.</p> <p>Additionally, provide information about who will be trained on how to use the system, and how data captured in the system can be integrated into day-to-day operations of the CMO, particularly areas such as Case Management and financial and Quality functions.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D</p>		Yes	Q97 Information Management and Systems
98	<p>Describe the capability the Supplier's management team will have to access a database of service information to create ad hoc reports for both the CMO management team and DCH. Include a description of the system and software, an overview of the data that will be held, and the resources and the capability the Supplier will have to use large amounts of data to create ad hoc reports.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D</p>		Yes	Q98 Information Management and Systems
99	<p>Demonstrate the ability of the Supplier's applications, operating software, middleware, and networking hardware and software to interface with the State's systems and conform to standards and specifications set by the Georgia Technology Authority (GTA) as amended periodically (See: http://gta.georgia.gov/psg/).</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D</p>		Yes	Q99 Information Management and Systems

100	<p>DCH would like to understand how the Supplier will encourage adoption of electronic health records and information exchange and use of the Georgia Health Information Network (GaHIN). Provide a description of initiatives and incentives to foster adoption of electronic health records and information exchange that result in improvements in the Quality and cost of Health Care services.</p> <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D</p>		Yes	Q100 Information Management and Systems
101	<p>Describe the Supplier’s proposed emergency response continuity of operations and disaster recovery plan. Attach a copy of the Supplier’s plan or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery, including:</p> <ul style="list-style-type: none"> a. Employee training. b. Essential business functions and responsible key employees. c. Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable. d. Communication with staff and suppliers when normal systems are unavailable. e. Plans to ensure continuity of services to Providers and Members. f. Testing plan. <p>Refer to section I.N: Administrative Services – Information Management and Systems of Attachment D</p>		Yes	Q101 Information Management and Systems
102	<p>Describe the Supplier’s strategy to maintain a field presence with Members, Providers and other stakeholders, including any commitment to establishing field office(s).</p> <p>Refer to section I.N: Administrative Services – Administration and Management of Attachment D</p>		Yes	Q102 Information Management and Systems
103	<p>Provide a description of the Supplier’s process to ensure Deliverables and reports are reviewed for quality, accuracy, and completeness prior to submission to DCH. Also, describe the approach to integrate these quality and accuracy findings into the Supplier’s operations to address any deficiencies or to proliferate or maintain successful practices evidenced by the review.</p> <p>Refer to section I.N: Administrative Services – Monitoring and Reporting of Attachment D</p>		Yes	Q103 Information Management and Systems
104	<p>Submit a sample Turnover Plan specifying how the Supplier will provide assistance in turning over all documents in its possession, as it relates to the Contract resulting from this RFP, in the event of Contract expiration or termination for any reason. Provide a detailed description of the Supplier’s processes and proposed approach to providing turnover planning, including:</p> <ul style="list-style-type: none"> a. Providing to DCH the Turnover Plan within the timeframes cited in the RFP and including a schedule for turnover by task and phases for turnover. b. An overview of the support the Supplier will provide for the turnover activities for up to ninety (90) Calendar Days. c. Identifying and submitting all records, files, methodologies, data and any supplemental documentation which DCH would require to continue the program. d. Resources and training that would be required by DCH or another contractor to take over operation of the project. e. Coordinating tasks and activities with the incoming contractor, upon DCH request. f. Providing DCH with a turnover results report documenting completion of all tasks at each step of the turnover plan. <p>Refer to section I.N: Administrative Services – Turnover Planning of Attachment D</p>		Yes	Q104 Information Management and Systems
Scenarios				
105	<p>A Member previously enrolled in private insurance enrolls in the CMO. The Member’s contact information available through the member eligibility files has not been helpful in contacting the Member. Within the first three (3) months of CMO Enrollment, the CMO has identified four (4) Emergency Room Claims; three (3) Primary Care Provider Claims; and six (6) narcotic prescription Claims. Describe how the Supplier’s organization would proceed with locating the individual and initiating Coordination of Care.</p>		Yes	Q105 Scenarios
106	<p>Describe the Supplier’s proposed strategy to ensure dental access and Utilization of an annual dental visit for two (2) through twenty (20) year olds who reside in both urban as well as rural service delivery areas.</p>		Yes	Q106 Scenarios

107	A six (6) year old male has had multiple Emergency Department visits in the last six (6) months. He is diagnosed with asthma. A review of his prescription history shows no Claims for medications to control his asthma. The PCP reports the child has missed three (3) of the five (5) appointments that have been scheduled over the last six (6) months. He lives in a rural area of the State. Describe the Supplier's approach to Coordination of Care for this child.		Yes	Q107 Scenarios
108	A thirty (30) year old female who is receiving Level 2 Case Management for major depressive disorder, fibromyalgia, and diabetes has missed her last three (3) Mental Health appointments. However, she is compliant with her Primary Care appointments for her other Conditions. Provide an action plan the Supplier's organization would propose to best manage this patient.		Yes	Q108 Scenarios
109	Through the CMO's connection to the GaHIN, an admission notice alerts the CMO that an adult female with a diagnosis of congestive heart failure has been admitted to an inpatient hospital setting. Describe the actions the Supplier would take and the timing of those actions to conduct Discharge planning and the follow up care that would be envisioned to reduce the likelihood of Re-admission post Discharge.		Yes	Q109 Scenarios
110	A morbidly obese adult male with schizophrenia, uncontrolled Type II Diabetes, and hyperlipidemia is non-compliant with lifestyle modifications, medication therapy, diabetes testing, and follow up appointments. Describe the Supplier's organization's plan to develop and monitor a treatment plan for this Member.		Yes	Q110 Scenarios
111	An eighteen (18) Week pregnant woman resides in a rural service delivery area. She has had a Very Low Birth Weight (VLBW) Baby with her last pregnancy and there is Claims evidence of two (2) other pregnancies that resulted in miscarriage. The Member has no history of prenatal vitamins or any follow up care after the confirmatory pregnancy test. Describe the Supplier's plan to engage the Member with the appropriate prenatal care and services.		Yes	Q111 Scenarios
112	Describe the procedures for ensuring access to the following: a. Well-child visits in the first fifteen (15) months of life. b. Well-child visits in the third, fourth, fifth and sixth years of life. c. Primary care practitioners for well-care visits for twelve (12) to nineteen (19) year olds.		Yes	Q112 Scenarios
113	A Member's current Behavioral Health Provider is not participating in the Supplier's Network. What would the Supplier do for the Member while awaiting the Provider contracting process to be complete if the Out-of-Network Provider agrees to join the Network? Alternatively, what if the Provider refuses to participate?		Yes	Q113 Scenarios
114	Describe the procedures a Member Services representative should follow to respond to the following situations: a. A Member has received a bill for payment of Covered Services from a Network Provider or Out-of-Network Provider. b. A Member is unable to reach her PCP after normal business hours. c. A Member is having difficulty scheduling an appointment for preventive care with her PCP. d. A Member becomes ill while traveling outside of Georgia. e. A Member has a request for a specific medication that the pharmacy is unable to provide.		Yes	Q114 Scenarios

REVISED - VERSION 2, ATTACHMENT H

Additional Scored Responses

All items labeled "Additional Scored Responses" is information that is requested by the State. Offerors must provide a thorough narrative description in the space provided in this spreadsheet.

Answers along with any required supporting materials, will be evaluated and awarded points in accordance with Section 6, Proposal Evaluation and Award. ONLY upload documents if there is a Yes in the "Upload Attchs with Additional Information?" column, to provide additional information about specific questions. Documents not requested in this column will not be evaluated.

Question #	Questions per Proposal Factors/Categories	Response by Offeror	Upload Attchs with Additional Information?	Attachment File Name
360 Executive Summary				
115	<p>Provide an Executive Summary that summarizes the proposed technical approach, staffing structure and task schedule for Georgia Families 360°. The Executive Summary must include a statement of understanding and fully document the Supplier's ability, understanding and capability to provide the full scope of work. Provide an Executive Summary that summarizes the proposed technical approach. The Executive Summary must include a statement of understanding and fully document the Supplier's ability, understanding and capability to provide the requested services. Information related to top diagnoses, procedures and prescription drug usage for Members in the GA Families 360 program have been posted to the Supplier's Library as FY15 GA Families and GA Families 360 - Final Exhibit. Suppliers should only use the information provided in the RFP and the Suppliers' Library to respond. The Supplier's summary must:</p> <p>a. Demonstrate an expert understanding of the needs of Medicaid Members in the State of Georgia who are in Foster Care, receiving Adoption Assistance or involved in the juvenile justice system residing in a community residential setting.</p> <p>b. Include a high-level overview of the Supplier's strategy and approach for administering the Georgia Families 360° program. Additionally, present findings and recommendations from the Supplier's review of the Claims data provided as part of this Request for Proposal (RFP).</p> <p>c. Provide an overview of the Supplier's proposed organization for Georgia Families 360°</p>		Yes	Q115 360 Executive Summary
360 Supplier Organization				
116	<p>Provide client references as follows:</p> <p>a. Provide a minimum of three (3) different client references, using the reference form provided as Attachment O to the RFP, for which Supplier has successfully provided services in fully implemented and funded services contract(s) for capitated risk-based Medicaid managed care programs for children and youth in Foster Care (state custody), receiving Adoption Assistance and/or involved with a juvenile justice system within the last five (5) consecutive calendar years. Supplier may only submit client references where Supplier is the Prime Contractor and continues to have current and active client contracts. References where Supplier is providing services under grants, demonstrations or pilot programs or initiatives or where Supplier's contract to provide services is terminated or no longer active will not be considered. The Supplier may consider the experience of subsidiaries of the Supplier's Parent Company when submitting references. References from proposed Subcontractors may not be submitted to meet this requirement.</p> <p>b. If applicable, a minimum of three (3) different client references for each Material Subcontractor, using the reference form provided as Attachment P to the RFP, for which the Material Subcontractor has successfully provided services in fully implemented and funded services contract(s) for capitated risk-based Medicaid managed care programs for children and youth in Foster Care (state custody), receiving Adoption Assistance and/or involved with a juvenile justice system within the last five (5) consecutive calendar years</p>		Yes	Q116 360 Supplier Organization
360 Project Implementation				

117	<p>Describe the Supplier's approach to project management, including a summary of responsibilities for project governance and how the Supplier will track action items, risks and issues, as well as contingency and mitigation plans. Provide a proposed Program implementation Project Plan in Microsoft Excel, Microsoft Project or similar software based on a program Operational Start Date of July 1, 2016 and that includes all required activities, timeframes and due dates in Year 1 of the contract. At a minimum, the Project Plan must include elements outlined in the RFP, for example:</p> <ul style="list-style-type: none"> a. Establishing an office location and call centers b. Provider recruitment activities c. Staff hiring and a training plan d. Establishing interfaces to other Information Systems operated by DCH or its Agents e. Tasks the Supplier will undertake to interface with Providers and Georgia Families 360° Members through a web site, and how that interaction will support program participation and program goals <p>Refer to section II: Georgia Families 360° of Attachment D</p>		Yes	Q117 360 Project Implementation
360 Staffing				
118	<p>Provide a detailed summary of the Supplier's proposed staff positions and ratios. Specifically, provide the following:</p> <ul style="list-style-type: none"> a. A listing of Key Staff members identified in the RFP, including names, titles, job descriptions, degrees and qualifications and full-time equivalents (FTEs) who are dedicated one hundred percent (100%) to the Georgia Families 360° program with no other responsibilities outside this resulting Contract, as well as their locations and whether each Key Staff position will be filled by a Supplier's employee or a Subcontractor. b. If the Supplier's proposed approach includes Key Staff not identified in the RFP, a listing of these positions and a complete description of how these positions and ratios support Program requirements. c. The number of FTE Supplier/Material Subcontractor staff who will be one hundred percent (100%) dedicated to this contract as well as number of FTEs per Member by position type. d. Resumes, including credentials, clinical licensure, years of experience, level and type of experience, and three (3) references for each proposed Key Staff member. Resumes for other proposed staff must be provided at the request of the State. e. Where the Supplier has used job titles in its staffing model that differ from those identified in the RFP, a crosswalk of those titles. <p>Refer to section II: Georgia Families 360° Staffing of Attachment D</p>		Yes	Q118 360 Staffing
119	<p>Provide a narrative description of the proposed staffing plan that details policies, plans and staffing strategies. The proposed plan must include the following:</p> <ul style="list-style-type: none"> a. Organizational charts that provide a complete and detailed description of the proposed organizational structure the Supplier will use during all phases of the contract, including reporting hierarchy b. Roles and responsibilities of personnel c. Role of the ombudsman d. Job titles and job descriptions and the requisite qualifications, skills and credentials, including clinical licensures e. Other resources the Supplier will use to meet Program requirements f. Staff communication and retention strategies <p>Refer to section II: Georgia Families 360° Staffing of Attachment D</p>		Yes	Q119 360 Staffing

120	<p>Provide a narrative description of the Supplier's approaches to recruiting staff for this Program, including:</p> <p>a. Sources of recruitment</p> <p>b. Alternative actions or contingency plans if the Supplier is unable to recruit sufficient numbers of adequately trained staff on a timely basis or if the Supplier's original staffing estimates are too low and for avoiding and minimizing the impact of personnel changes</p> <p>c. How the Supplier will assure DCH that sufficiently experienced, licensed and trained personnel are available to support implementation and ongoing administration of the program</p> <p>d. How the Supplier will seamlessly transition staff, if necessary, from implementation to ongoing operations</p> <p>Refer to section II: Georgia Families 360° Staffing of Attachment D</p>		Yes	Q120 360 Staffing
121	<p>Describe the role and responsibilities of the Ombudsman Liaison and Ombudsman Coordinator. Describe how the Supplier will monitor current Enrollment levels to evaluating the number of Ombudsman Liaisons necessary to meet Georgia Families 360° Member needs.</p> <p>Requirements and Scope of Work.</p> <p>Refer to section II: Georgia Families 360° Ombudsman Staff of Attachment D</p> <p>GF 360° Staffing: Question 7.</p>		Yes	Q121360 Staffing
122	<p>What prior experience will the Supplier require staff to have had serving populations similar to Georgia Families 360° Members, including the System of Care approach?</p> <p>Refer to section II: Georgia Families 360° Staffing of Attachment D</p>		Yes	Q122 360 Staffing
123	<p>Describe the roles and responsibilities of Care Coordinators and Care Coordination teams (CCT). How will the Supplier maintain adequate Georgia Families 360° Supplier staff to Member ratios and number of Care Coordination personnel and management staff having expertise in Physical Health, Behavioral Health, and the Georgia Families 360° Members to build CCTs?</p> <p>Provide the Supplier's approach to locating the Care Coordinators areas in which they serve.</p> <p>Refer to section II: Georgia Families 360° Care Coordination Teams of Attachment D</p>		Yes	Q123 360 Staffing
124	<p>Provide the Supplier's proposed training program and curriculum for all staff specific to areas of responsibility. Include information about the topics for which staff will receive training, how trainings will differ for new staff members versus ongoing trainings and related training schedules.</p> <p>Refer to section II: Georgia Families 360° Staffing of Attachment D</p>		Yes	Q124 360 Staffing
360 Special Coverage and Provisions				
125	<p>Describe the Supplier's experience in providing services through a holistic, person-centered approach, utilizing a high-fidelity wrap-around model of care.</p> <p>Refer to section II: Georgia Families 360° Special Coverage and Provisions of Attachment D</p>		Yes	Q125 360 Special Coverage and Provisions
126	<p>Describe in detail how the Supplier will develop and provide interventions that will help develop resiliency in Georgia Families 360° Members who have been exposed to trauma and adverse childhood experiences.</p> <p>Refer to section II: Georgia Families 360° Special Coverage and Provisions of Attachment D</p>		Yes	Q126 360 Special Coverage and Provisions

127	<p>Describe the Supplier's approach for ensuring the successful completion of required assessments and screenings. Please include a description of the following:</p> <ul style="list-style-type: none"> a. How the Supplier will coordinate with Georgia Families 360° Members and families, DCH and partner agencies b. How the Supplier will ensure assessments are initiated Immediately upon Member Enrollment in the Georgia Families 360° program c. Any challenges that the Supplier anticipates in completing required assessments and how it will mitigate these challenges <p>Provide examples of how your organization has succeeded in providing assessments to individuals similar to the Members enrolled in Georgia Families 360°.</p> <p>Refer to section II: Georgia Families 360° Required Assessments and Screenings of Attachment D</p>		Yes	Q127 360 Special Coverage and Provisions
128	<p>Include examples of trauma assessment or screening tools the Supplier would recommend DCH consider for the use in identifying trauma in Georgia Families 360° Members.</p> <p>Refer to section II: Georgia Families 360° Required Assessments and Screenings of Attachment D</p>		Yes	Q128 360 Special Coverage and Provisions
129	<p>Submit the proposed Health Risk Screening tool the Supplier will use to develop the Member's Health Care Service Plan. Include a description of how the Supplier will use the results of assessments that sister agencies have conducted in developing the Health Care Service Plan.</p> <p>Provide examples of prior tools the Supplier's organization has used for other similar programs and detail how these tools have contributed to Supplier achieving program goals.</p> <p>Refer to section II: Georgia Families 360° Health Risk Screening of Attachment D</p>		Yes	Q129 360 Special Coverage and Provisions
130	<p>Describe the Supplier's approach to providing all medical services and adhering to timeliness requirements defined in the Kenny A. Consent decree for Foster Care Members (FC Member) in custody of Fulton and DeKalb counties.</p> <p>Refer to section II: Georgia Families 360° Kenny A. Consent Decree of Attachment D</p>		Yes	Q130 360 Special Coverage and Provisions
360 Member Enrollment				
131	<p>Describe the Supplier's proposed approach for coordinating with DCH sister agencies to ensure Georgia Families 360° Members begin receiving services Immediately upon entering Foster Care or juvenile justice. Please include the Supplier's experience expediting enrollment in other markets.</p> <p>Refer to section II: Georgia Families 360° Member Enrollment of Attachment D</p>		Yes	Q131 360 Member Enrollment
132	<p>The eligibility of Members in the Georgia Families 360° Program often changes due to their status in Foster Care or the juvenile Justice system. Describe the Supplier's proposed process for resolving Enrollment and eligibility discrepancies. Include the Supplier's organization's approach for collaborating with DCH, Division of Family and Children Services (DFCS) and Department of Juvenile Justice (DJJ) for resolving eligibility issues.</p> <p>Refer to section II: Georgia Families 360° Georgia Families 360° Member Enrollment of Attachment D</p>		Yes	Q132 360 Member Enrollment
133	<p>Describe the Supplier's proposed process to assign Georgia Families 360° Members to a Primary Care Provider (PCP) within two (2) Business Days of Enrollment. Include a discussion of the Supplier's approach to:</p> <ul style="list-style-type: none"> a. Assist Georgia Families 360° Members to select a PCP and auto-assign Georgia Families 360° Members who do not make a selection within the required timeframes b. Work with DCH, DFCS, DJJ, Foster Parents, and Adoptive Parents to assign PCPs c. Track data to confirm that every Georgia Families 360° Member is assigned to a PCP d. Inform PCPs of new Georgia Families 360° Members within the required timeframes e. Confirm that PCPs received the list of assigned Georgia Families 360° Members <p>Provide a sample of the report the Supplier will use to notify PCPs of their assigned Georgia Families 360° Members.</p> <p>Refer to section II: Georgia Families 360° Selection of a Primary Care Provider (PCP) of Attachment D</p>		Yes	Q133 360 Member Enrollment

134	<p>Describe the Supplier's proposed process for communicating with Georgia Families 360° Members about their PCP assignments and encouraging Georgia Families 360° Members to schedule regular appointments with their assigned PCPs and keep scheduled appointments. Include how the Supplier will identify and work with Georgia Families 360° Members to resolve barriers to keeping appointments and how the Supplier will work with resources available at DCH, DFCS and DJJ to communicate with Georgia Families 360° Members.</p> <p>Please include a discussion of how this process would differ when communicating about their Dental Home assignment and encouraging Georgia Families 360° Members to schedule and keep regular appointments with the Dental Homes.</p> <p>Refer to section II: Georgia Families 360° Selection of a Primary Care Provider (PCP) of Attachment D</p>		Yes	Q134 360 Member Enrollment
135	<p>Children in Foster Care and involved with the Juvenile Justice Department often experience changes in placement. These placement changes may require assignment of new PCPs and Dental Homes. Describe the Supplier's proposed process to Assess Member access to a PCP and Dental Home timely after a change in FC Member or DJJP Member placement and assigning a new PCP or Dental Home if the prior Provider no longer meets access standards.</p> <p>Refer to section II: Georgia Families 360° Dental Home of Attachment D</p>		Yes	Q135 360 Member Enrollment
136	<p>Describe the Supplier's process for engaging Adoptive Parents who request to opt out of the Georgia Families 360° Program to stay enrolled, including:</p> <ul style="list-style-type: none"> a. Process for outreach and engagement of AA Members b. Conducting surveys with AA Members to determine the reason for opting out c. Attempts for periodic re-engagement after Disenrollment <p>Include how the Supplier will use results from the survey to improve the program.</p> <p>Refer to section II: Georgia Families 360° Selection of a Primary Care Provider (PCP) of Attachment D</p>		Yes	Q136 360 Member Enrollment
360 Member Services				
137	<p>Provide the Supplier's proposed plan for providing Georgia Families 360° Members with ID cards in the required timeframes (be issued initially within five (5) Calendar Days of receipt of the eligibility file from DCH and reissued within five (5) Calendar Days of a request for reissue) in the following instances:</p> <ul style="list-style-type: none"> a. Report of a lost card b. A Member name change c. A new PCP assignment d. FC or DJJ Member moves to a new placement or for any other reason that results in a change to the information disclosed on the Member's ID card <p>Refer to section II: Georgia Families 360° Member Services of Attachment D</p>		Yes	Q137 360 Member Services
138	<p>Describe how the Supplier will address and manage Crisis calls during business hours as well as After-Hours. Describe resources the Supplier will use for emergency and Crisis needs, such as Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Georgia Crisis and Access Line (GCAL). If using such resources, describe how the Supplier will establish relationships with DBHDD and GCAL, use the resources, the Supplier's roles and responsibilities for Crisis calls versus those of the other resources and how the Supplier will manage the overall process.</p> <p>Refer to section II: Georgia Families 360° Member Call Center of Attachment D</p>		Yes	Q138 360 Member Services

139	Describe the processes, protocols and guidelines the Supplier will use to achieve maximum stability and the best outcomes for Georgia Families 360° Members in Crisis as well as avoid inappropriate and unnecessary Emergency Room (ER) Utilization and hospital admissions. In the description, describe how the Supplier will prioritize emergency and Crisis calls over routine calls, protocols that will be in place to support warm transfers, and what technology the Supplier will have to enable direct telephonic/computer connectivity to emergent and Crisis intervention resources. Refer to section II: Georgia Families 360° Member Call Center of Attachment D		Yes	Q139 360 Member Services
140	Describe trainings and resources the Supplier will provide to call center staff related to recognition and management of Crisis calls to ensure the most expedient and risk-reducing outcomes, including a description of the level and type of training. Refer to section II: Georgia Families 360° Toll Free Member Call Center of Attachment D		Yes	Q140 360 Member Services
360 Provider Network				
141	Explain the Supplier's plan to develop a comprehensive Provider Network that meets the unique needs of Georgia Families 360° Members. Specifically include: a. Approach to contract with primary care and specialist providers who are trained or experienced in trauma-informed care and in treating individuals with complex special needs, including the Georgia Families 360° Providers who have knowledge and experience in identifying child abuse and neglect, providers who render Core Services and Intensive Family Intervention (IFI) services, significant traditional Medicaid, DFCS, DJJ and Department of Public Health (DPH) and providers meeting Credentialing requirements b. Recruitment strategy, including processes for identifying network gaps, developing recruitment work plans, and carrying out recruitment efforts c. Strategy for retaining specialists and how the Supplier will provide access to specialists if not in the network d. Process for continuous network improvement, including the approach for monitoring and evaluating Provider compliance with availability and scheduling appointment requirements and ensuring Georgia Families 360° Members have access to care if the Supplier lacks an agreement with a key provider type in a given geographic area e. How the Supplier will ensure appointment access standards are met when Georgia Families 360° Members cannot access care within the Provider Network <i>Refer to section II: Georgia Families 360° Provider Network of Attachment D</i>		Yes	Q141 360 Provider Network
142	Provide an example of how the Supplier has contracted for similar networks for similar populations in other programs. Provide a workplan to contract with Georgia Families 360° Providers, with accountabilities and timelines. Refer to section II: Georgia Families 360° Provider Network of Attachment D		Yes	Q142 360 Provider Network
360 Education and Training				
143	Describe the Supplier's proposed approach for collaborating with experts in the field including DFCS, DBHDD, Department of Education (DOE), DPH, Department of Early Care and Learning (DECAL) and DJJ to identify Provider training needs. Please include examples from other Supplier programs exhibiting collaboration with state agencies to identify training needs. Refer to section II: Georgia Families 360° Education and Training of Attachment D		Yes	Q143 360 Education and Training
144	Describe how the Supplier will educate staff, Providers, and other relevant stakeholders regarding coordinating care utilizing a System of Care approach between: Foster Parents and Caregivers; DFCS Case Managers, Juvenile Probation/Parole Specialist (JPPS) or other involved Case Managers; attorneys ad litem; judges; law enforcement officials; Adoptive Parents; and other involved parties from State agencies. Please provide examples of education materials addressing the System of Care approach. Refer to section II: Georgia Families 360° Education and Training of Attachment D		Yes	Q144 360 Education and Training

145	<p>Provide the Supplier's proposed approach to Provider outreach and education. Include a description of how initial training will differ from ongoing training. Describe proposed training materials including but not limited to:</p> <ul style="list-style-type: none"> a. Coordinating services. b. Training in trauma-informed care (include sample materials) c. The effect of abuse and neglect on the developing brain d. The effect of intrauterine assault, fetal alcohol syndrome and shaken baby syndrome e. Screen for and identify Behavioral Health disorders f. The Supplier's Referral process for Behavioral Health services g. Care Coordination Team <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p>		Yes	Q145 360 Education and Training
146	<p>What trainings will the Supplier offer to its Provider network regarding the System of Care approach to care? Submit samples of the materials that the Supplier will use in training and informing Providers about this concept.</p> <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p>		Yes	Q146 360 Education and Training
147	<p>How will the Supplier ensure that the Supplier's staff and network Providers (including but not limited to hospitals, pharmacies, and specialty Providers) receive in-depth training on this program, including what is and is not allowable exchange of information in a HIPAA-compliant organization, to preserve and support continuity of care. How will the Supplier ensure network Providers are aware of the requirements of this program, and how the needs of this population may differ from those of the Georgia Families population?</p> <p>Refer to section II: Georgia Families 360° Education and Training of Attachment D</p>		Yes	Q147 360 Education and Training
148	<p>Describe how the Supplier will educate Law Enforcement Officials and Judges about the Georgia Families 360° program. Provide an overview of suggested topics that will be included in trainings for Law Enforcement Officials and Judges.</p> <p>Refer to section II: Georgia Families 360° Training for Law Enforcement Officials and Judges of Attachment D</p>		Yes	Q148 360 Education and Training
149	<p>Describe the role of non-medical factors (e.g., Placement changes, involvement with the juvenile justice system, etc.) that may drive inappropriate Utilization of medical resources and how the Supplier will account for those factors in the delivery approach. As part of the response, include how the Supplier will identify and leverage non-Medicaid resources that may be available in a community environment, including how it will assist such community-based resources that may serve an important role in the Members' overall Health Care needs and goals even if they are not traditional Medicaid services. Provide examples of any community organizations that the Supplier anticipates involving to provide services to support Members' needs and goals.</p> <p>Refer to section II: Georgia Families 360° - Utilization Management and Care Management of Attachment D</p>		Yes	Q149 360 Education and Training
150	<p>Describe how the Supplier will ensure that Georgia Families 360° Members receive seventy-two (72) hour emergency supplies of prescribed medicines when a prescription for a medication is not filled due to a Prior Authorization requirement.</p> <p>Refer to Section II: Georgia Families 360° Utilization Management and Care Management of Attachment D</p>		Yes	Q150 360 Education and Training
151	<p>Describe how the Supplier will participate in FC Members and JJ Members Discharge planning. Include a description of support that it will provide to DFCS and DJJ and how the Supplier will communicate with DFCS and DJJ to determine your role in the Member's roundtable meetings.</p> <p>Refer to section II: Georgia Families 360° Transition of Members of Attachment D</p>		Yes	Q151 360 Education and Training

152	Describe the Supplier's proposed plan and policies for ensuring continuity of care for Georgia Families 360° Members who are transitioning from another Care Management Organization (CMO), private insurance, or from Fee-for-Service (FFS). Include a plan for coordinating with DCH, DFCS, DPH, DJJ, DOE, DBHDD and DECAL to ensure the Member maintains continuity of care and services. Refer to section II: Georgia Families 360° Transition of Care of Attachment D		Yes	Q152 360 Education and Training
153	Describe the responsibilities of the Supplier's Care Coordinators and how they will assist Georgia Families 360° Members to navigate the Health Care system. Describe the range of Care Coordinators expertise to adequately respond to varying degrees of need among Georgia Families 360° Members. Refer to section II: Georgia Families 360° Care Coordination Responsibilities of Attachment D		Yes	Q153360 Education and Training
154	Describe the specific types of Care Coordination services Georgia Families 360° Members will receive based on intensity of needs and history. Include details about what services will be provided at each level. Refer to section II: Georgia Families 360° Care Coordination Responsibilities of Attachment D		Yes	Q154 360 Education and Training
155	Describe how the Supplier will work with State agency staff, sister agency partners, community partners, associations, and other stakeholders to ensure that the Member's Care Coordination needs are met. Include examples of how you plan to collaborate with State agency and sister agency staff. Refer to section II: Georgia Families 360° Care Coordination Responsibilities of Attachment D		Yes	Q155 360 Education and Training
156	Describe how the Supplier will monitor health outcomes at the individual Member level. Refer to section II: Georgia Families 360° Health Outcomes of Attachment D		Yes	Q156360 Education and Training
157	Describe the Supplier's proposed medication oversight program to ensure appropriate utilization, including a description of the inclusion criteria that you propose to use to monitor the appropriate use of psychotropic medications. Provide a detailed description of the tools your organization will use to ensure the active engagement of the retail pharmacies/pharmacists in the oversight program? (Reminder: Do not disclose specific financial information in this technical proposal.) Refer to section II: Georgia Families 360° Medication Management of Attachment D		Yes	Q157360 Education and Training
158	Discuss the proposed protocols for facilitating communication and sharing of information between Primary Care and Behavioral Health Providers. Include relevant examples of how these protocols and best approaches have worked for the Supplier in similar programs, as well as relevant examples of how the Supplier has coordinated communication and sharing of information between PCPs and multiple Behavioral Health provider types. Refer to section II: Georgia Families 360° Health Coordination and Integration for Georgia Families 360° Members of Attachment D		Yes	Q158360 Education and Training
360 Admin Services				
159	Describe the proposed approach for assisting DCH with development of public reports about the Georgia Families 360° Program. Include recommendations for and an overview of the types of information and data that the Supplier thinks would be beneficial to report publicly. Refer to section II: Georgia Families 360° Reporting Requirements of Attachment D		Yes	Q159 360 Admin Services

160	<p>Submit a sample Turnover Plan specifying how the Supplier will provide assistance in turning over all documents in its possession, as it relates to the Contract resulting from this RFP, in the event of Contract expiration or termination for any reason. Provide a detailed description of the Supplier's processes and proposed approach to providing turnover services, including:</p> <p>a. Specific goals and objectives that articulate how the Supplier will coordinate with DCH and DCH sister agencies to assume responsibility for Georgia Families 360° Members transitioning from another CMO and other scope of work activities</p> <p>b. An impact statement outlining the potential impact of the transition of Georgia Families 360° Members, the existing infrastructure and operations and support staff</p> <p>c. Communications and outreach, specific timeframes for executing the Transition of Care Plan</p> <p>d. Georgia Families 360° Supplier staff involvement in the Transition of Care Plan, approach and involvement with sister agencies, and ensuring continuity of care and plans for conducting all applicable health and trauma assessments</p> <p>Response must include all components specified in Attachment D: Requirements and Scope of Work: Requirements and Scope of Work, section A.</p> <p>Refer to section II: Georgia Families 360° Project Management of Attachment D</p>		Yes	Q160 360 Admin Services
360 Scenarios				
161	<p>An eight (8) year old female was placed in Foster Care at birth, and has had multiple placement changes. She was diagnosed with a brain anomaly, cortical dysplasia, epilepsy, and developmental delays. She has medications prescribed to control her seizures. Recently, she has been evaluated for her developmental delays, vision problems, and for speech therapy. The PCP has not received the results of these evaluations yet.</p> <p>Medications/Treatments: Midazolam for seizures lasting longer than three (3) minutes, or for more than four (4) tonic-clonic seizures in thirty (30) minutes; Zonisamide, Valproate Sodium Syrup, Lamotrigine Tabs, Omeprazole capsules, Ketogenic diet.</p>		Yes	Q161 360 Scenarios
162	<p>A three (3) year old male entered Foster Care upon Discharge from the hospital after his birth. He was placed by DFCS with his aunt who wants to adopt him. However, she is concerned about his future health and Behavioral Health Care needs and what Long Term supports could be available to her through DFCS and the CMO.</p> <p>The child has been diagnosed with autism and developmental delays. He has been hospitalized three (3) times in the last six (6) months for shortness of breath, vomiting, altered mental status and dehydration. Follow up is needed to determine what is causing these issues.</p>		Yes	Q162 360 Scenarios
163	<p>A fifteen (15) year old female in Foster Care with multiple Behavioral Health problems has run away from her Out of Home Placement for sixty (60) out of the last one hundred eight (180) days. Due to her running episodes, she is not receiving recommended counseling services and medications. Her run episodes and Foster Care placement changes have caused changes in Behavioral Health Providers and coordination with DFCS, but she has not developed a relationship with her Providers that will allow her to disclose trauma information. She not had an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) exam for the past two (2) years, although she should have had and EPSDT exam after each incident of running.</p> <p>She has been prescribed multiple psychotropic medications, with no follow-up and no coordination to ensure they do not conflict. Her diagnoses include: oppositional defiant disorder; depression; anxiety; attachment disorder; Post Traumatic Stress Disorder (PTSD); and self-harm behaviors including cutting/burning herself.</p>		Yes	Q163 360 Scenarios

164	Nine (9) year old female who entered Foster Care four (4) days ago due to substantiated allegations of abuse and neglect. While she appears healthy, the DFCS Case Manager reports there was evidence of methamphetamine use and no food in the home. She has no known medical issues reported by parent. However, the child's parent reports she has not been seen by a doctor in the past two (2) years.		Yes	Q164 360 Scenarios
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RFX Addendum Form

RFX Number: 41900 DCH0000100	RFX Title: GA Families and GA Families 360° Care Management Organization
Requesting State Entity: Georgia Department of Community Health	
Issuing Officer: Dana Harris	RFX Initially Posted to Internet: February 9, 2015
eMail Address: Dana.Harris@doas.ga.gov	Telephone: 404-657-4322
Addendum Number: 4	Date: May 11 th , 2015

The attached information, provided by the issuing State Entity, is made a part of this RFX. The purpose of this addendum is to revise the RFX as follows:

1. The State will accept two (2) attachments, with limits of 50 megabytes each, for Question 49, Attachment G, labeled as follows:

Q49 Provider Network A

Q49 Provider Network B

Note: In the event of a conflict between previously released information and the information contained herein, the latter shall control.

A signed acknowledgment of this addendum (this page) should be attached to your RFX response.

Supplier's Name

Signature

Printed Name and Title



RFX Addendum Form

RFX Number: 41900 DCH0000100	RFX Title: GA Families and GA Families 360° Care Management Organization
Requesting State Entity: Georgia Department of Community Health	
Issuing Officer: Dana Harris	RFX Initially Posted to Internet: February 9, 2015
eMail Address: Dana.Harris@doas.ga.gov	Telephone: 404-657-4322
Addendum Number: 5	Date: May 14 th , 2015

The attached information, provided by the issuing State Entity, is made a part of this RFX. The purpose of this addendum is to revise the RFX as follows:

1. Revised Schedule of Events:

Proposals Due/Close Date and Time	May 20 th , 2015 @ 3:00 p.m.
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2. Unlimited Attachments allowed for Question 49, Attachment G:

Addendum 4 informed Suppliers that State will accept two (2) attachments, with limits of 50 megabytes each, for Question 49, Attachment G.

This addendum retracts the limit of attachments and instructs Suppliers to upload as many attachments as needed to be responsive to the question.

3. Naming Convention for documents uploaded for Question 49, Attachment G:

Please label attachments to Question 49, Attachment G to reflect the total number of attachments uploaded. Please follows the below example:

- Q49 Provider Network 1 of XX
- Q49 Provider Network 2 of XX



PLEASE NOTE: Even though information submitted may be marked as "confidential", "proprietary", or "trade secret," and may be expressly referenced as such in an affidavit, pursuant to the Georgia Open Records Act DCH will make its own determination as to whether the information is a trade secret that may be withheld in response to an open records request. Accordingly, DCH will comply with the requirements described in O.C.G.A. § 50-18-72(a)(34).

Note: In the event of a conflict between previously released information and the information contained herein, the latter shall control.

A signed acknowledgment of this addendum (this page) should be attached to your RFX response.

Supplier's Name

Signature

Printed Name and Title

Supplier Q & A Template

RFX Number: 41900 DCH0000100 RFX Title: GA Families and GA Families 360° Care Management Organization

Requesting State Entity: Georgia Department of Community Health

Date: March 18, 2015

Issuing Officer: Dana Harris

RFX Initially Posted to Internet: February 9, 2015

eMail Address: Dana.Harris@doas.ga.gov

Telephone: 404-657-4322

The purpose of this document is to provide answers to supplier questions. Please see Questions and Answers included herein.

Note: This document is intended for informational purposes only. Any changes to the RFX must occur through a published addendum (or through publication of a new version of the RFX in Team Georgia Marketplace™). If multiple Q & A documents are posted, the most recent Q & A shall govern in the event of a conflict.

	Question	Referenced RFP Section	Response
1	The definition for Key Staff in Attachment B states: "Key Staff must be full-time employees located in Georgia with no other client responsibilities other than the Georgia Families, Georgia Families 360° or P4HB programs." Please confirm that key executives will be allowed to maintain existing responsibilities and continue to provide executive oversight for the plan's other lines of business such as Medicare D-SNP and any other programs that might serve DCH managed populations.	Attachment J, Key Staff (pg. 27)	Key Staff may provide oversight of other lines of business and programs that service DCH populations.

	Question	Referenced RFP Section	Response
2	<p>Attachment D (Requirements and Scope of Work), Section K (1) hh. requires the Supplier to notify the Provider in writing no less than thirty (30) Calendar Days prior to any adjustments to the Provider's contracted reimbursement rates and receive written notification from the Provider of acceptance of the new reimbursement rates. Attachment D (Requirements and Scope of Work), Section K (4) provides that the Supplier shall adjust its negotiated rates with Providers to reflect budgetary changes to the Medical Assistance program, as directed by the Commissioner of DCH; to the extent, such adjustments can be made within funds appropriated to DCH and available for payment to the Supplier. The Supplier's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Supplier's obligation to DCH. Change in the terms of the Provider's reimbursement rate Methodology must be agreed to by the Provider. Suppliers are not permitted to simply send a notice advising as to a reimbursement rate Methodology change. This does not prevent routine and necessary adjustments to Maximum Allowable Charge rates.</p> <p>These provisions appear to conflict in that the first provision requires the CMO to obtain Provider's written notification of acceptance of any change in reimbursement but the second provision provides that CMO can adjust provider's rates to reflect DCH budgetary changes and the associated provision in the provider's contract shall constitute agreement to any State initiated change in reimbursement. If DCH transitions to another DRG Version or DCH revises the Medicaid fee schedule, would the above-mentioned provisions require our health plan to negotiate/obtain provider's agreement with the DCH initiated change or would provider's execution of the contract (containing the associated language regarding budgetary changes) still satisfy the requirement?</p>	<p>Attachment D,(Requirements and Scope of Work), Section K (1) hh & Section K 4 (pg. 84 & 86)</p>	<p>Suppliers are not obligated to utilize the Medicaid fee schedule or the same version of DRG used by DCH. Suppliers are not required to use the same Medicaid reimbursement methodology. For example, the Supplier and a hospital may agree to an alternative DRG version or per diem fee schedule rather than using the same DRG version as Fee-for-Service Medicaid. However, if the State budget includes a Provider rate change, Suppliers must pass through that change to Providers. For example, if the State budget requires an increase in hospital rates, the Supplier would be required to pass through the rate increase regardless of its payment methodology with hospitals.</p> <p>If the rate change is mandated by the State's General Assembly, the Supplier is not required to negotiate or obtain the Provider's agreement with respect to the rate change.</p>
3	<p>Please clarify that the timeframe on decisions for non-urgent services is 3 business days, which does not align with current standards of 14 days.</p>	<p>Attachment D, Section L 2 (pg. 91)</p>	<p>For Standard Service Authorizations, the turnaround time is three (3) Business Days.</p>
4	<p>This section states that "Supplier shall conduct access and availability quarterly audits to validate Provider network access" This section of the Scope of Work also states that "The Supplier conduct a review of twenty-five percent (25%) of the combined network." Please clarify whether the 25% refers to the quarterly sample or the annual percentage of providers that the Supplier must audit.</p>	<p>Attachment D, Section 20, Access and Availability Audits (pg. 64)</p>	<p>The Supplier shall conduct a review of twenty-five percent (25%) of their individual plan's network on a quarterly basis.</p>
5	<p>Question 68 does not currently have a page limit. Please consider allowing 8 pages to respond.</p>	<p>Attachment G, Mandatory Scored Questions, #68</p>	<p>No page limits will be applied to question 68. Requirements regarding page limits will be removed from the submission instructions.</p>

	Question	Referenced RFP Section	Response
6	<p>Per Attachment D, Section L.1: The Supplier shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion.</p> <p>The SOW references several types of utilization review activities - prior authorization, pre-certification, prospective review and ambulatory review. Attachment B only contains definitions for prior authorization and pre-certification. It would seem that both prior-authorization and pre-certification fall within the category of prospective review and it is unclear how ambulatory review differs from prior-authorization. Could the Department provide clarification regarding the terms prospective and ambulatory review?</p>	Attachment D, Section L.1 (pg. 89)	<p>Ambulatory Review means Utilization Review of Health Care services performed or provided in an outpatient setting. Prospective Review is review or authorization for procedures or services prior to such services being rendered.</p> <p>Attachment B will be amended to add definitions for Ambulatory Review and Prospective Review.</p>
7	Assuming the Supplier is using nationally recognized evidence based clinical guidelines that are developed using Comparative Effectiveness Research principles, does this meet the intent of involving CER in the medical review process?	Attachment D, Requirements and Scope of Work, Section L.1 (pg. 89)	Nationally recognized, evidence based clinical practice guidelines will meet the intent of involving comparative effectiveness research in the medical review process.
8	Please provide the distinction between "treatment plan" as used in this provision with the "care plan" a CMO develops for members receiving case management services, and the "treatment plan" a provider develops for his or her patient.	Attachment D, Requirements and Scope of Work, Section L.8 (pg. 96)	The RFP will be amended to replace the term 'treatment plan' with the term 'care plan' or 'plan of care'.
9	<p>Per Attachment D, Section L.8.e: "The Supplier must require that Behavioral Health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the XXX, with the Member's or the Member's legal guardian's consent."</p> <p>It appears a word is missing between "the Member's Behavioral Health Status to the" and the comma. Please provide the missing language.</p>	Attachment D, Requirements and Scope of Work, Section L.8.e (pg. 100)	This should read: The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the PCP, with the Member's or the Member's legal guardian's consent.

	Question	Referenced RFP Section	Response
10	<p>Question 71 of Attachment G asks (in part): "Include a discussion of how the Supplier will determine Member eligibility for each level of care (e.g., disease management, Case Management, etc.)..."</p> <p>Will DCH please clarify what information is being requested? Should bidders provide information about how eligibility is determined for each component of our Care Coordination and Continuity of Care Program (as described on p 96 of the RFP as "Case Management, Disease Management, Transition of Care, and Discharge Planning")? Or is DCH asking for criteria and process for determining member eligibility for each offered disease management and case management program?</p>	Attachment G, #71 and #79	The Supplier must provide information regarding the criteria for stratifying Members into care coordination, disease management or Case Management, and the types of case and disease management programs available.
11	Questions 79 and 80 of Attachment G are duplicates. Please consider removing one of the questions.	Attachment G, Mandatory Scored Questions, #79 and #80	Question 79 was duplicated in error. Question 80 states: Describe the responsibilities of case managers and how they will assist Members based on their level of need. Describe the range of case manager expertise to adequately respond to varying degrees of need among Members. What is the Supplier's proposed case manager to Member ratio? Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D
12	For a number of questions located in Attachment G, DCH asks for examples and experience in other states rather than Georgia examples and experience. Please confirm that the Bidder may provide Georgia specific examples where relevant, in addition to or in place of, examples provided from other states or markets.	Attachment G, Mandatory Scored Questions	Suppliers may provide Georgia-specific information but must provide information from other states, if applicable.
13	<p>The Georgia Families Contract requirement states: DM functions include "Consistently informing the Member on progress in the (sic) confidentiality requirements in 45 CFR 160 and 45 CFR 164."</p> <p>This requirement states the word "the" twice; is there language missing because as written, DCH's expectation is unclear. Please provide the missing language that clarifies this DM requirement.</p>	Attachment I (GA Families Contract), Section 4.11.9.2.5 (pg. 156)	Consistently informing Members on progress in the achievement of goals and about the areas that require further improvement. Attachments I and J will be amended accordingly.
14	In regards to the statement: "The Supplier shall collaborate with the Supplier and Providers to decrease potentially preventable admissions...", Please clarify whether the second instance of the word "Supplier" should be "DCH."	Attachment D, Requirements and Scope of Work, Section I.E.2 (pg. 32)	The sentence should read: " Supplier shall collaborate with the DCH and Providers to decrease potentially preventable admissions and Re-admissions and avoidable use of the emergency department."

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Department of Community Health

	Question	Referenced RFP Section	Response
15	The URL provided, "http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.htmlhtml" is not functional. When we attempt to drop the second "html" in the address and go to: http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.html - we receive the message: "Page not Found". Please provide the correct link.	Attachment D, Requirements and Scope of Work, Section I.N.4 (pg. 134)	Please refer to http://gta.georgia.gov/psg/
16	The Scoring Criteria lists 1000 points for Mandatory Scored and/or Additional Scored Responses. Please provide the total point allocation for responses to both the Georgia Families and Georgia Families 360 contracts.	Attachment A, State of Georgia Electronic Request for Proposals, Section 6.4 (pg. 24)	No other breakdown, other than the details listed in section 6.4 of the RFP will be communicated.
17	Consecutive Enrollment Period definition states, "FC Members and Juvenile Justice (JJ) do not have the option to change CMOs without cause." Please confirm how this would apply since only one CMO will be serving this population.	Attachment B Definitions and Acronyms (pg. 7)	Only AA Members are allowed to Disenrollment without cause; FC and JJ Members do not have this option.
18	The Supplier shall offer its Members freedom of selecting a PCP and a PCP if different from the PCP. Please clarify what is meant to replace the second PCP in this sentence.	Attachment D, Requirements and Scope of Work, Section E.2 (pg. 32)	The sentence should read: " The Supplier shall offer its Members freedom of selecting a PCP. "
19	The Supplier must require that Behavioral Health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the XXX, with the Member's or the Member's legal guardian's consent. This requirement shall be specific in all Provider Handbooks as set forth in section J.2 There appears to be language missing in this statement. Please confirm the required audience(s) for the summary reports.	Attachment D, Requirements and Scope of Work, Section L.8.e (pg. 100)	This should read: The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the PCP, with the Member's or the Member's legal guardian's consent.
20	Please consider expanding this page limit to 2 pages (currently 1 page) given the scope/depth of the information requested and required to answer adequately.	Attachment G, Mandatory Scored Question #72	No page limits will be applied to question 68. Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. Instructions regarding page limits will be removed from the submission instructions.
21	"Provide examples from other states where the Supplier has collaborated with Member and Provider Committees for program improvement. Refer to section I.M: Quality Management and Performance Improvement – Member Advisory Committee and Provider Advisory Committee of Attachment D." Please confirm that bidders may provide Georgia-specific examples if relevant in addition to or in place of, examples from other states.	Attachment G, Mandatory Scored Question #89	Suppliers may provide Georgia-specific information but must provide information from other states, if applicable.
22	Please clarify the reference to "Georgia Families UM Responsibilities: Question 7" as indicated at the end of Question 79. There does not appear to be a Question 7 under UM Responsibilities.	Attachment G, Mandatory Scored Question #79	The reference to "Georgia Families UM Responsibilities: Question 7" in question 79 remained from an earlier outline. The information has been deleted and should be disregarded. Please refer to the Revised Attachment G for updated information.

Requesting State Entity:
Department of Community Health

	Question	Referenced RFP Section	Response
23	Question 88 asks for the Supplier's proposed methodology to identify, assess, and correct disparities in treatment across races and ethnic groups, refers the respondent to section I.M: Quality Management and Performance Improvement of Attachment D. I.M. of Attachment D does not appear to contain any language or information regarding disparities in treatment across races and ethnic groups. Would DCH please provide the correct Scope of Work reference(s).	Attachment G, Mandatory Scored Question #88	Please refer to the first two paragraphs of Section I.M of Attachment D in responding to Question 88 in Attachment G.
24	Question 73 asks (in part) that bidders submit "a sample needs assessment template". Please clarify whether DCH is requesting the initial screening tool identify new members who might need Case Management, or our comprehensive assessment tool we would complete for members who are identified as potentially needing Case Management.	Attachment G, Mandatory Scored Question #73	The Supplier should provide an example of the comprehensive needs assessment tool.
25	Question 73 asks (in part) "how the Supplier will engage Members, families, PCPs, specialist and other Providers as necessary in the treatment plan development." Please confirm that DCH is referring to the "care plan" that the health plan develops vs the "treatment plan" which is developed by the provider.	Attachment G, Mandatory Scored Question #73	The RFP will be amended to replace the term 'treatment plan' with the term 'care plan' or 'plan of care'.
26	At what point does DCH consider the member eligible with the CMO?	Georgia Family 360: RFP Question #31	The Supplier is expected to begin Care Coordination upon receipt of an electronic notification from DCH, DFCS, or DJJ that the member is eligible for Georgia Families 360°. Accordingly, the Member is considered eligible for Georgia Families 360° when the Supplier receives notice from DCH, DFCS, or DJJ.
27	In order to reduce the significant administrative burden on the provider community, will DCH consider executed provider contracts that include a DCH approved Medicaid Amendment to be equivalent to Letters of Intent as referenced in Question 49 of the RFP for the purposes of determining a Supplier's ability to create a GEO-sufficient statewide delivery network?	Georgia Family RFP Question #49	All Suppliers must submit letters of intent (LOIs) as detailed in Attachment D of the RFP.
28	Please confirm that bidders submitting a proposal for the Georgia Families 360 program (Questions 115-164 - Attachment H) need not address foster care in their responses to questions 7-114 (Attachment G).	Georgia Family 360 RFP	Questions in Attachment H (Additional Scored Questions) address Georgia 360° contract requirements.
29	Would DCH please consider allowing Bidders to submit proposal responses outside of the Excel work sheets and tables supplied. We are concerned about the character/cell limitations in Excel . In addition, it will be difficult to accurately calculate page limits if bidders have to insert responses into Excel tables.	Attachment A, State of Georgia Electronic Request for Proposals, Section 2	The Supplier should provide responses to questions by uploading electronic files in response to each question. Please use the naming convention indicated for each question. Responses submitted by any other means than those expressly permitted by the eRFP will not be considered. For technical assistance, please call the DOAS help desk at 404-657-6000.
30	If respondents are allowed to submit their proposals outside of the Excel worksheet provided, does DCH have specific font, font size and margin requirements with which Bidders need to comply.	Attachment A, State of Georgia Electronic Request for Proposals, Section 2	The Supplier should provide responses to questions by uploading electronic files. No font, size, and margin requirements are part of the compliance instructions. Section 2.2.3 and 2.2.4 of Attachment A instructs to use commonly accepted software programs to create electronic files. The State Entity has the capability of viewing documents submitted in the following format: Microsoft Word or WordPad, Microsoft Excel, portable document format file (PDF), and plain text files with the file extension noted in parentheses (.txt). Unless the eRFP specifically requests the use of another type of software or file format than those listed above, please contact the Issuing Officer prior to

Requesting State Entity:
Department of Community Health

	Question	Referenced RFP Section	Response
31	If the respondent is required to submit the proposal in the Excel worksheets provided, can the templates be unlocked to allow special characters such as bullets, and other formatting such as bolding, underlining, and italics that will help with ease of reading?	Attachment A, State of Georgia Electronic Request for Proposals, Section 2	The Supplier should provide responses to questions by uploading electronic files in response to each question. Please use the naming convention indicated for each question. Responses submitted by any other means than those expressly permitted by the eRFP will not be considered. For technical assistance, please call the DOAS help desk at 404-657-6000.
32	As it relates to Hepatitis C, can the state please provide a listing of drugs currently covered, current plan reimbursement methodology, and any expected future changes as it relates to reimbursement and new treatments.	General	The State's current Preferred Drug List (PDL) may be found at http://dch.georgia.gov/preferred-drug-lists . The State's current prior authorization criteria may be found at http://dch.georgia.gov/prior-authorization-process-and-criteria . The State's published MAC and specialty reimbursement rates may be found at https://www.mmis.georgia.gov/portal/PubAccess.Pharmacy/GMAC%20List/tabId/83/Default.aspx . DCH is currently in the process of contracting supplemental rebates and
33	Is there any financial reserve or funding required by the department beyond DOI risk-based capital?	General	No additional reserves are required. All Suppliers are required to maintain an irrevocable letter of credit.
34	What are the expected benefit and/or program changes for fiscal year 2017's program? Will CMOs receive expected rate adjustment factors for the changes?	General	To date, DCH does not know the expected benefit and program changes for FY 2017. As DCH and its actuaries work through the FY 2017 rate development process, we will inform Care Management Organizations (CMOs) of the expected material program changes and associated rate adjustments.
35	Please provide a breakdown of Georgia Families, P4HB and Georgia Families eligibles by cohort, region, county and age.	Attachment A - State entity eRFP, Page 2, Section 1.1.2. Eligibility for Participation in Georgia Families or Georgia Families 360	Please reference materials provided in the Suppliers' Library.
36	For the purposes of coordination and planning, DCH has divided the State, by county, into six (6) Service Regions. Aside from adjusting capitation rates by each region, in what other substantive ways will DCH use the six regional distinctions in operating the Georgia Families program?	Attachment A - State Entity eRFP, Section 1.1.4 Service Regions, Page 6	There are no other substantive ways in which DCH will use the six (6) Service Regions in operating the Georgia Families program. There is no stratification by regions since the CMOs have statewide responsibilities for providing services.
37	Will the state consider hosting a bidder's conference for qualified suppliers? If yes, please provide an expected date.	Attachment A - State Entity eRFP, Section 1.4 - Schedule of Events, Page 10	DCH is not considering a bidders' conference.
38	Please clarify whether responses for the Georgia Families 360o program in attachment H are considered mandatory for purposes of evaluating suppliers for Georgia Families.	Attachment A - State Entity eRFP, Section 4.5 Additional Scored Responses, Page 19	Additional Scored information is only required for those Suppliers submitting proposals for the Georgia Families 360° program. Such information will not be considered in evaluating proposals for the Georgia Families program.
39	Please clarify when the RFP states that the supplier with the highest scoring proposal will be granted a contract for Georgia Families 360o, whether they intended to limit the evaluation to only those highest scoring bids for the 360o program (Attachment H) or for the total RFP including Georgia Families.	Attachment A - State Entity eRFP, Section 4.5 Additional Scored Responses, Page 19	The Georgia Families 360° Contract award is intended to be offered to the highest scoring proposal resulting from the combined score of Suppliers within the competitive range of mandatory score (Georgia Families) and Additional Scored results. Only those Suppliers ranking within the competitive range using mandatory scored responses (Georgia Families) will receive a combined mandatory scored and additional score result.
40	When will fiscal year 2017 rates be developed? Will selected plans have an opportunity to participate in rate discussions?	Attachment A - State Entity eRFP, Section 5 - Capitation Rate Methodology, 5.1 - General Description of Capitation Rate Methodology, Page 20	The FY 2017 rates will be developed beginning in late CY 2015. Yes, contracted Care Management Organizations (CMOs) will have the opportunity to participate in rate discussions with DCH and its actuaries. As part of this discussion, DCH and its actuaries make available any trend, programmatic change, benefit change, enrollment change or other assumptions related to rate setting prior to submitting rates to CMS for approval.

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	Question	Referenced RFP Section	Response
41	Will DCH be responsible for premium tax payments? Will CMOs have any responsibility for administration or payment?	Attachment A - State Entity eRFP, Section 5.3 Health Insurance	CMOs must pay the Georgia insurance premium tax and the federal Health Insurer Fee. However, In order for the rates to be actuarially sound, DCH includes an adjustment for these taxes in each capitation rate cell.
42	Does the state plan to evaluate attachment H under its own scoring criteria or are the questions being evaluated toward one total score (1,000 points, inclusive of both Georgia Families and Georgia Families 360o)?	Attachment A - State Entity eRFP, Section 6.4 Scoring Criteria, Page 24	Questions in Attachment H (Additional Scored Questions) address Georgia 360° contract requirement, to be scored under its own criteria. The total 1000 available points are inclusive of Mandatory Scored and Additional Scored questions.
43	Please provide insight into the anticipated waiver renewal approval date for the P4HB program. Does the state anticipate any challenges with renewal? What happens if the state is unable to gain waiver approval for the program?	Attachment B - Terms and Definitions, Demonstration Period, Page 10	DCH expects to receive approval of the extension request for the P4HB program no later than the end of SFY 15 per CMS. No, the State does not anticipate any challenges for approval. If the State is unable to gain approval, DCH will develop a transition plan.
44	Do the uniform application and credentialing processes in any way prohibit CMOs from requiring additional information from providers to support operations and monitoring activities?	Attachment C - Additional Background Information of this RFP, Administrative Simplifications - c. Credentialing Verification Organization, Page 3	No, but such additional information may not be used in the credentialing and contracting of Providers.
45	Please clarify the state's expectation for the Implementation Plan with the RFP submission as opposed to the Implementation plan post contract award. Are these separate plans? If so, please describe the difference?	Attachment D – Requirements and Scope of Work, Section A. Implementation Planning, 2.CMO Project Plan, Page 3	Please refer to I.A.1.c of Attachment D.
46	Please provide a timeline for Readiness Review, including timeframes for the two phases of review. Please provide a description of the schedule and process for each review.	Attachment D – Requirements and Scope of Work, Section A - Project Management, 3. Readiness Review, Page 4	Details about the readiness reviews will be provided after Contract Award.
47	Please clarify if CMOs will be expected to do live demonstrations in a real time fashion to demonstrate claims payment, Member Assignment, etc. during readiness review.	Attachment D – Requirements and Scope of Work, Section A - Project Management, 3. Readiness Review, Page 4	At a minimum, Care Management Organizations will be required to provide demonstrations of claims payments, Encounter Data submission, Provider and Member website functionality, Member enrollment and Auto-Assignment capabilities, and Member Call Center readiness.

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	Question	Referenced RFP Section	Response
48	Will CMOs be expected to demonstrate Encounter functionality prior to go-live and based on mocked up claims/test data?	Attachment D – Requirements and Scope of Work, Section A - Project Management, 3. Readiness Review, Page 4	Yes, Care Management Organizations will be required to demonstrate these functions prior to the Operational Start Date.
49	Will DCH consider limiting hospital based care managers to only include specific facilities and/or specific disease states?	Attachment D – Requirements and Scope of Work, B - Supplier Staffing, 2. Key Staff, s. Hospital-based care managers, Page 8	DCH will consider such limitations, however, the Supplier must provide a detailed justification for such limitation.
50	Please provide a single source, full listing of services and benefits covered under each program, Georgia Families, Georgia Families 360o and P4HB.	Attachment D – Requirements and Scope of Work, C. Covered Services and Benefits, 1. Included Services, Page 10	Please refer to the State Plan on the DCH website at http://dch.georgia.gov/medicaid-state-plan
51	Please confirm that DCH will provide enrollment information via a daily 834 enrollment feed for participating CMOs.	Requirements and Scope of Work, I. Georgia Families; D. Special Coverage Provisions; 9. Perinatal Services, Page 27	Correct. DCH will provide enrollment information via the daily 834 file. DCH is working to transition all members to daily enrollment. Currently, certain populations are enrolled on a daily basis while others are enrolled on a monthly basis.
52	Please explain the state's intent with the following sentence: "The Supplier shall offer its Members freedom of selecting a PCP and a PCP if different from the PCP."	Attachment D – Requirements and Scope of Work, E. Member Enrollment, 2. Selection of a Primary Care Provider (PCP)/Medical Home, Page 32	The sentence should read: " The Supplier shall offer its Members freedom of selecting a PCP. "
53	Please provide utilization data for each of the P4HB sub-populations; Family Planning Services, Interpregnancy Care, Case Management - Resource Mothers Outreach Only	Attachment D – Requirements and Scope of Work, C. Covered Services and Benefits, 6. Member Identification Card, a. pink color; b. purple color; Attachment Card	Please refer to the information provided in the Suppliers' Library.
54	Please provide utilization data for member emailed inquires, including current average response time.	Requirements and Scope of Work, 8. Georgia Families	For 2014, the CMOs received an average of 220 provider emails per month and an average of 243 Member emails per month. Response times are not reported.

	Question	Referenced RFP Section	Response
55	Please confirm that the mentioned disenrollment survey is conducted at the discretion of the Supplier and for reasons defined by the Supplier.	Attachment D – Requirements and Scope of Work, H. Marketing, 2. Allowable Activities d. , Page 50	The Disenrollment survey is optional. However, if the Supplier chooses to conduct such a survey, it must be completed within forty-five (45) Calendar Days of the Member's disenrollment.
56	Please confirm expectation regarding provider network demographic validation. Is it intended for the Supplier to validate the demographic data on ALL providers quarterly, or is it intended to ensure assessment of 25% of the network quarterly, assuring 100% assessed annually?	Attachment D – Requirements and Scope of Work, I. Georgia Families Network, 3. Provider Network Composition, Page 52	DCH expects the Supplier to validate the demographic data on ALL Providers at least quarterly, assuring that 100% accuracy of the Provider network.
57	Please provide current utilization data on telemedicine usage in the Medicaid program.	Attachment D - Requirements and Scope of Work, 17. Geographic Access Requirements, b. Report Specifications, Page 60	Telemedicine utilization information will be provided in the Suppliers' Library.
58	Please clarify if an on-call process that allows real time authorizations would be acceptable to DCH.	Attachment D - Requirements and Scope of Work, J. Provider Services, 5. Provider Services Call Center, Page 75	DCH established a Centralized Prior Authorization Process in June 2013 for providers that is accessed via the Georgia Medical Management Information System (GAMMIS) https://www.mmis.georgia.gov . Phase I of the Centralized PA process encompassed: Newborn Delivery Notification, Pregnancy Notification, Inpatient Hospital Services, Outpatient Hospital Services, Ambulatory Services, In-state transplants, Hospital
59	The timeframes for standard and expedited Utilization Management decisions, as stated, are greatly accelerated when considered to accreditation & CMS standards (14 business days for standard decisions and 72 hours for expedited decisions). Given that a quick turn-around may promote uninformed decision-making (due to lack of receipt of pertinent information), and also a higher rate of member dissatisfaction stemming from member appeal, would the Department consider utilizing accreditation and CMS standards for UM decisions?	Attachment D - Requirements and Scope of Work, Section L. utilization Management and Coordination and Continuity of Care Responsibilities, 2. Prior Authorization and Pre-Certification, a. Standard Service authorizations, b. Expedited Services Authorizations, Page 91-92	DCH is not anticipating changes to the requirements stated in Attachment D. For Standard Service Authorizations, the turnaround time is three (3) Business Days.

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	Question	Referenced RFP Section	Response
60	Please confirm the entity which has accountability to provide Resource Mothers to the appropriate P4HB population. Please define the expected arrangement for engagement. Is this a service contracted by the Supplier, a practitioner credentialed in the Supplier's network, other?	Attachment D - Requirements and Scope of Work, L. Utilization Management and Coordination and Continuity of Care Responsibilities, 8. Coordination and Continuity of Care Responsibilities, g. Case Management, Page 102	The Supplier must provide the Resource Mothers for the P4HB population. This responsibility may be delegated to a Subcontractor or may be handled by the Supplier's internal staff.
61	Please confirm if any specific health risk assessment tool is prescribed for any member population included in the RFP.	Attachment D - Requirements and Scope of Work, Section	No, DCH does not prescribe any specific health risk assessment tool for any member population.
62	Is it the state's intent to have supplier's resubmit the Tax Compliance form as prepared for the RFQC process?	Attachment E – Supplier General Information Worksheet, 6. Tax Compliance Form, Question 6	This response confirms that the Tax Compliance Form should be re-submitted in response to Question 6 on Attachment E.
63	Please provide a link to the Contract Exceptions document that is to be uploaded with Question 2 in Attachment F. If there is no document the state has prepared, please describe the process and acceptable document formats the state would prefer for this uploaded attachment.	Attachment F – Mandatory Response Worksheet, Question 2	The State has prepared a document for contract exceptions which has been uploaded as Attachment Q.
64	Please confirm the Respondent is only required to submit the Word version of "Contractor Affidavit under O.C.G.A. §13-10-91(b)(1)" as found at: http://www.audits.ga.gov/NALGAD/section_3_affidavits.html	Attachment F – Mandatory Response Worksheet, Question 4	Please go to the Georgia Department of Audits and Accounts web site at http://www.audits.ga.gov/NALGAD/section_3_affidavits.html to locate the proper affidavit for use with this requirement. Submission of a copy in Word will be acceptable.
65	Please confirm document "SPD-SP012 – Certificate of Non-Collusion" as found at: http://doas.ga.gov/StateLocal/SPD/Seven/Pages/Home.aspx is the correct and only form respondent must submit as the additional attachment for Attachment F question 5.	Attachment F – Mandatory Response Worksheet, Question 5	This response confirms that SPD-SP012 – Certificate of Non-Collusion may be found at: http://doas.ga.gov/StateLocal/SPD/Seven/Pages/Home.aspx
66	Please confirm current contracts that were effective within the last 5 consecutive calendar years may be submitted as references.	Attachment G- Mandatory Response Worksheet, Question 9	Please respond to Question 9 of Attachment G using the last five (5) full consecutive calendar years.
67	Can the state clarify whether or not employees of RHCs are considered employees of the DCH and therefore CMOs could be limited in their outreach to these organizations during the RFP period?	Attachment G- Mandatory Response Worksheet, Question 48	DCH does not employ RHC staff.

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	Question	Referenced RFP Section	Response
68	Are suppliers able to obtain access to the 7400 file for confirming Medicaid IDs?	Attachment G-Mandatory Response Worksheet, Question 49	Enrolled provider information can be accessed via the Georgia Medical Management Information System (GAMMIS) https://www.mmis.georgia.gov .
69	For Public Health Centers, FQHC, RHC, and similar facilities, are plans expected to list the facility sites only in the Excel file, or should the Excel file include the affiliated physicians? If affiliated physicians should be included, what specialty should plans use in the Excel file?	Attachment G-Mandatory Response Worksheet, Question 49	Detailed information should be submitted for Public Health Centers, FQHCs, RHCs, and similar facilities. Files should include detailed information pertaining to the affiliated physicians.
70	Please confirm the state will accept Statewide Geographic Access reports produced by any "Geo Access" software (i.e. the state does not require bidders to use only the trademarked GeoAccess® GeoNetworks® software tool).	Attachment G-Mandatory Response Worksheet, Questions 49-51	DCH does not dictate the 'Geo Access' software that Suppliers use.
71	Does DCH intend to impose a page limit on these questions? If so, please provide the page limit for each question.	Attachment G-Mandatory Response Worksheet, Questions 26-28, 40, 49, 51, 68	Requirements regarding page limits will be removed from the submission instructions.
72	Please provide the correct section heading for questions 90-95 of attachment G. Seems as if the section heading "Utilization Management and Care Management" is incorrectly listed twice, for questions 68-81 and questions 90-95.	Attachment G-Mandatory Response Worksheet, Questions 68-81, 90-95	Attachment G, Questions 68-81 are to be referenced as Utilization Management and Care Management and Questions 90-95 are to be referenced as "Admin Services" as indicated. The heading titled "Utilization Management and Care Management" in line 102 is incorrect. Please refer to the Revised Attachment G for corrected information.
73	Questions 79 and 80 appear to be duplicates. Does the state expect suppliers to provide the same response to both questions? If not, please clarify expectations for suppliers responses.	Attachment G-Mandatory Response Worksheet, Questions 79-80	Question 79 was duplicated in error. Question 80 states: Describe the responsibilities of case managers and how they will assist Members based on their level of need. Describe the range of case manager expertise to adequately respond to varying degrees of need among Members. What is the Supplier's proposed case manager to Member ratio? Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D
74	Please clarify whether a supplier that submits less than the minimum references for "part a - client references" can still be considered responsive for Georgia Families 360o.	Attachment H - Additional Scored Response Worksheet, Question 116, part a) OR 2.1.6. Rejection of Proposals; State's Right to Waive Immaterial Deviation	Responsive means the Supplier, whether a company or an individual, has submitted a timely offer which materially conforms to the requirements and specifications of the solicitation. Responsiveness to the proposal is not determined by the quality of a reply to a portion of an additional scored question.
75	Please provide the state's anticipated credentialing policies and procedures prior to the second round of the question and answer period. Additionally, will the CVO adhere to NCQA standards for credentialing? Lastly, when does the state anticipate finalizing the decision to initiate CVO operations?	Attachment I - Georgia Families Contract, Section 2.7 - Network, 2.7.1.2, page 51	DCH will not provide the credentialing policies and procedures prior to the second round of questions and answers. Yes, the CVO will adhere to NCQA standards for credentialing. The anticipated operational start date for the CVO is July 1, 2015. Should this date change, the selected Suppliers will be notified.

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	Question	Referenced RFP Section	Response
76	<p>According to this link, GA does not utilize an 820 file for capitation transactions. http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/61/14/102662840GA_Medicaid_Contingency_Plan_for_NPI_1-9-08.pdf</p> <p>1. Will the CMO receive a member level premium file? 2. Is the CMO responsible for premium capitation reconciliation?</p>	Attachment I – Georgia Families Contract, 4.1.7 -Reporting Requirements, Page 61	DCH uses an 820 file. Yes, the CMO will receive a member level premium file. It would be expected that the CMO would conduct its own premium capitation reconciliation as a matter of good business practice, although it's not a contractual requirement.
77	Please confirm the state will accept zip code searchability for the electronic Provider Directory.	Attachment I - Georgia Families Contract, Section 4.3.5.2 - Provider Directory, Page 72	Search capabilities at a minimum should include provider name, specialty, city, county, zip code, and whether the Provider is accepting new patients.
78	Please describe the process DCH will use to communicate credentialing information and network participation status for the CMO's. For example, will CMOs receive a master provider file? If so, with what frequency (daily, weekly, monthly)? If no master file, will CMOs have access to a clearinghouse/database type of tool maintained by DCH? How is it anticipated that DCH/CMO interface will occur to support regular, routine monitoring of a credentialed practitioner/provider, as required for accreditation and regulatory compliance.	Attachment I - Georgia Families Contract, Section 4.8.1.2 – General Provisions, Page 103	Suppliers will receive the 7400 file daily. CMOs should routinely monitor contracted Providers, i.e., checking federal and state exclusions databases, etc.
7.9	Please provide DCH's sample report layout for all CMO reporting requirements.	Attachment I - Georgia Families Contract, Section 4.8.18.1.4 – Other Reports, Page 117	DCH will provide the templates and specifications for all required reports prior to the Operational Start Date.
80	Will the statutory timeframe for paper or electronic claims in O.C.G.A. § 33-24-59.5 apply to claims under this contract?	Attachment I – Georgia Families Contract, 25.5.1.3.2 – Damages/Performance Guarantees –Category 4 - Claims Processing Standards, Page 245	Per O.C.G.A. § 33-21A-7, each Care Management Organization shall utilize the same timeframes and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims as the timeframes and deadlines that the Department of Community Health uses on claims it pays directly.
81	O.C.G.A. § 33-24-59.5, lists the interest rate as 12% per annum for clean, unduplicated initial claims. However, this rate is listed as 18% in the contract. Which percentage rate should be used to calculate interest in this scenario? Also, please confirm that 20% is still applicable for claims that were initially denied or underpaid.	Attachment I – Georgia Families Contract, 25.5.1.3.1 – Damages/Performance Guarantees –Category 4 - Claims Processing Standards, Page 245	Per O.C.G.A. § 33-21A-7, for all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously
82	Please confirm the inpatient co-payment of \$12.50 is per admit as opposed to daily. Additionally please describe if CMOs have the authority to waive such a co-pay.	Attachment I – Georgia Families Contract, Attachment J - Applicable Co-Payments, Page 288	The \$12.50 co-payment is per admission. Services may not be denied to Members based on the inability to pay a co-payment.

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	Question	Referenced RFP Section	Response
83	Can the state provide a timeline for release of "Attachment K – Information Management and Systems"? Will the state consider releasing the document prior to the second round of questions to allow for an opportunity to ask questions? If not, will there be an additional opportunity for Supplier's to ask questions related to the attachment?	Attachment I – Georgia Families Contract, Page 289, Attachment K – Information Management and Systems ATTACHMENT K INFORMATION MANAGEMENT AND SYSTEMS (Requirements to be	Attachment K will be posted in the Suppliers' Library.
84	Please confirm that column five should include the current calendar year average number of Medicaid members per month.	Attachment M - Georgia Families Supplier Reference Form	Suppliers should use CY 2014.
85	Please provide the line item description for the value on line 6, between "Gross Revenue Totals" and "Premium Tax". For example, on page 1 there is a column titled "Medicaid (MCD)" and on line 6 there is a value of (2.58) with no line item description. Please provide the value and definition of this number.	RFP Supplier's Library - Document 2014_CMO_Medical_Loss_Ratio_Summary	The line item description for the line which falls between Gross Revenue and Premium Tax is Health Insurer Fee (HIF) w/Premium Tax. This reflects the revenue accrual to account for the HIF revenue the plans will collect from DCH to pay for the HIF. Note that not all CMOs reported a HIF accrual in the submissions used to create the CMO Medical Loss Ratio Summary. In order to understand the revenue and MLRs without the HIF accrual which was not submitted by all plans, this line could be ignored from the revenue total. Please note, as stated as a footnote to the exhibit: "Data presented
86	Please confirm if the MLRs provided include innovative and enhanced benefits. If so, can the state provide a list of such benefits in place at the time. If not, can the state provide a similar list of the benefits that were excluded.	RFP Supplier's Library, Document 2014_CMO_Medical_Loss_Ratio_Summary	Enhanced benefits are excluded from the MLR. It is not clear what is meant by "Innovative benefits". The excluded benefits vary by CMO. DCH will not be providing additional information.
87	Please define the units measured for each Service Category (e.g. days, admits).	RFP Supplier's Library - Document GF_Rate_Certification_FY15_09242014_Procurement, Pages: all	Please refer to the documents certification documents provided in the Suppliers' Library for context.
88	Please provide the process or an explanation as to why the "total" line's low band rate is higher than the high band rate; however, after applying the admin % the effect is reversed and the low rate comes in lower than the high rate on the "total Premium Rate" line. Please explain the difference in the admin % the state has used in calculations.	RFP Supplier's Library - Document GF_Rate_Certification_FY15_09242014_Procurement, Pages: all	The rate range for Georgia Families was developed mainly by varying administrative load assumptions and incremental managed care savings assumptions to be consistent to the previous rate setting approaches. The low end of the rate range assumes a lower administrative load coupled with lower incremental managed care savings while the high end assumes a higher administrative load coupled with higher incremental managed care savings. The relatively wide range of administrative load reflected the observed difference in reported admin as a percentage of rates among the participating plans

	Question	Referenced RFP Section	Response
89	Please provide RFP Supplier's Library documents Q through W in excel format.	RFP Supplier's Library - Documents: q. 2014_CMO_Medical_Loss_Ratio_Summary.r. GA_Certification_P4HB_FY1314_05232014.s. GA_RateCertification_P4HB_FY15_05232014.t. GF_360_Rate_Certification_03032014_06302015.u. GF_360_DCH_GA_Certification_CY14_092713_Final.v. GF_Rate_Certification_FY14_06182014_Procurement.w. GF_Rate_Certification_FY15_09242014_Procurement.	The Excel versions of these files will be posted in the Suppliers' Library.
90	Attachment I, Section 4.8.15.2 states, "...The Contractor may cover certain dental services provided by a dental hygienist in a Public Health setting in accordance with all applicable laws and rules. The Contractor may also provide for services in a school environment by mobile dentistry providers." Do the provision of dental services by dental hygienists in a Public Health setting or services in a school by a mobile dental unit fulfill the access requirements of section 4.8.17?	Attachment I, Section 4.8.15.2	Please refer to Attachment I, Section 4.8.15.2 and to the federal CMS EPSDT policy. Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the periodicity schedule and at other intervals as Medically Necessary.
91	Dental Home, Primary Dental Provider and Dental Specialty Provider are all defined in Attachment B. The reading of these three definitions appears to require that Primary Dental Providers are limited to General Dentists. With the common provider for children ages 1 - 5 and older being Pediatric Dentists, please confirm that Pediatric Dentists may be designated as Primary Dental Providers.	Attachment B, Definitions of "Dental Home," "Primary Dental Provider (Dentist)," and "Dental Specialty Provider."	Pediatric dentists may be designated as Primary Dental Providers.
92	Attachment H, Question 118 states, "Where the Supplier has used job titles in the staffing model that differ from those identified in the RFP, a crosswalk of those titles." Please confirm a crosswalk like the one described here should also be provided for staffing questions asked in Attachment G.	Attachment G, Q22 compared to Attachment H, Q118	Suppliers should provide a similar crosswalk when responding to Attachment G.
93	Attachment F, Question 5 requests that Supplier submit a required Non-Collusion Form with its proposal. Please provide clarity regarding where this form can be located by Suppliers for submission with the proposal.	Attachment F, Question 5	The SPD-SP012 – Certificate of Non-Collusion Form may be found at: http://doas.ga.gov/StateLocal/SPD/Seven/Pages/Home.aspx

	Question	Referenced RFP Section	Response
94	Attachment H, Question 118 requests, "A listing of Key Staff members identified in the RFP, including names, titles, job descriptions, degrees and qualifications and full-time equivalents (FTEs) who are dedicated one hundred percent (100%) to the Georgia Families 360 program with no other responsibilities outside this resulting Contract, as well as their locations and whether each Key Staff position will be filled by a Supplier's employee or Subcontractor."...Key Staff must be full-time employees located in Georgia with no other client responsibilities other than the Georgia Families, Georgia Families 360° or P4HB programs." Please confirm that the same Key Staff Members can serve Georgia Families, Georgia Families 360 and P4HB populations.	Attachment H: Q118 and Attachment I: Definitions	Key Staff may provide oversight of other lines of business and programs that service DCH populations.
95	Please confirm the definition of "Full-Time Provider," found in Attachment I should be "Full-Time Practice" to match the corresponding definition of "Part Time Practice," found in Attachment I, Definitions (p.30) which is focused on office location hours being more or less than 16.	Attachment B and Attachment I	Full Time Provider' and 'Full Time Practice' reflect office hours of at least sixteen (16) hours or more per week. Part time hours are less than sixteen (16) hours per week.
96	Attachment D, Section L.8.c (p.96) states, "The requirement for the creation of a treatment plan for Members who are determined to need a course of treatment or regular care Monitoring ..." It is our understanding that a treatment plan is prescribed by a treating physician (as defined by NCQA), and that a Care Plan is a written personalized plan which, under the single assessment process, details a member's comprehensive integrated health and social care needs and outlines a strategy to address each (as defined by NCQA). Please confirm that the Chief Medical Officer will not need to sign off on treatment plans as defined by NCQA, but would instead review and approve care plans as also defined by NCQA.	Attachment D, Section L.8.c (pg. 96)	The RFP will be amended to replace the term 'treatment plan' with the term 'care plan' or 'plan of care'.
97	Attachment D, section L.8.c (p.96): "... This treatment plan shall be approved in a timely manner by the Chief Medical Officer (CMO) and in accordance with any applicable State Quality assurance and Utilization Review standards." Please confirm that a licensed designee(s) and properly supervised by the CMO can fulfill this requirement.	Attachment D, section L.8.c (p.96)	The plan of care may be signed off by the Supplier's Chief Medical Officer or the Chief Medical Officer's licensed and supervised designee. The Attachments D, I and J will be amended accordingly.
98	Shriners Hospitals for Children - Section refers to Attachment T, which is blank. The 12/31/08 Memorandum of Understanding for PeachCare Partnership Program indicates use of the Greenville,SC and Tampa, FL locations. However these locations currently treat only Orthopedic cases. Neither location currently serves burn conditions. Will the MOU be updated to reflect current capabilities of Shriners Hospitals?	Attachment I, Section 4.8.24	Suppliers will be notified when and if the MOU is updated or revised.
99	Attachment D, Section L: Under the Integration of Physical and Behavioral Health Services section on page 100, there is a sentence that is not complete: "The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Member's Behavioral Health status to the _____, with the Member's or the Member's legal guardian's consent." Who is supposed to receive the initial and quarterly (or more frequently) summaries regarding a Member's Behavioral Health status? Please provide clarification regarding where supports should be submitted.	Attachment D, Section L pg.100	This should read: The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the PCP, with the Member's or the Member's legal guardian's consent.

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	Question	Referenced RFP Section	Response
100	Should DSM-V be substituted for DSM-IV-R in Attachment D, Section K as this is the new diagnostic manual?	Attachment D, Section II: Under K.1 Health Information Technology Exchange item ix) on page 177 "Record of all diagnoses applicable to the Georgia Families 360° Members, with emphasis on Behavioral Health diagnoses utilizing either DSM IV-R or ICD-9 or ICD-10 national code sets as based on Claims submitted."	Yes, the Supplier should utilize the most current Diagnostic and Statistical Manual of Mental Disorders, which should be Version V (DSM-5) at the Contract Effective Date.
101	Please confirm that we must recognize both NCQA Recognition and The Joint Commission's certification as valid PCMH designations for medical homes.	Attachment I, p. 107 (TJC designation) and Attachment D	Yes, Suppliers must recognize both.
102	Attachment I, 4.14.2.2 (page 177) now includes "or representative" under who can request a decision on a denial of service. Please provide definition of "representative."	Attachment I, Section 4.14.2.2 (page 177)	A representative is the Member's parent or legal guardian.
10.3	In Attachment I, 4.16, the document contains sections 4.16.3 and a 4.16.5, but does not contain a section for 4.16.4. Please confirm that the contract is not missing a section.	Attachment I, Section 4.16.3-4.16.3.5	Attachment I will be corrected accordingly.
104	Attachment I, Section 4.12.1.3 states that "the Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date." Please confirm that only NCQA accreditation will suffice to satisfy this requirement.	Attachment I, Section 4.12.1.3	Yes, only NCQA accreditation will satisfy this requirement.
105	Attachment D, Section M lists 13 performance measures for Value-Based Purchasing. Attachment U (located in Attachment I) lists 14 measures. Please confirm which is correct.	Attachment D, Section M - Quality Management and Performance Improvement, 13- Value Based Purchasing Program, c. VBP Incentive Payment: compared with Attachment I, 7.2.2 and Attachment U to Attachment I.	There are fourteen (14) Value Based Purchasing performance measures.
106	In Attachment G, questions 105-114 describe hypothetical scenarios, all of which end with direction regarding the type of response the state is seeking (ex: from the angle of a Member Services rep, case management rep, etc.). In Attachment H, questions 161-164 similarly describe hypothetical scenarios, but do not include similar direction regarding the type of response the state is seeking. For questions 161-164, please provide guidance as to what is being requested.	Attachment H, Questions 161-164	DCH wants the Supplier to provide responses which demonstrate its best critical thinking about what would be entailed in responding to each scenario for this population. Such response should demonstrate the Supplier's Case Management expertise.

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	Question	Referenced RFP Section	Response
107	Attachment I, Section 25.5.1.3.2 (p. 247) references failure to pay Providers interest at an 18% annual rate. O.C.G.A. 33-24-59.5 changed the interest rate to 12% effective 1/1/13. Please confirm that 12% will continue to be enforced.	Attachment I, Section 25.5.1.3.2 (p. 247)	Per O.C.G.A. § 33-21A-7, for all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously
108	In the event there are no Pediatricians who practice in a geographic area according to the standards outlined in Attachment I, please confirm that this requirement can be met by a Primary Care Physician who sees children under the age of 21, i.e. family medicine or family practice physicians.	Attachment I, Page 116, Fig 1 Geographic Access Standards by Provider Type	Confirmed. If there are no pediatricians in a geographic area, this requirement can be met by a PCP who sees children under the age of 21, i.e. family medicine or family practice physician. If treatment by a pediatrician is determined to be Medically Necessary, the Supplier must provide Care Coordination as appropriate by a pediatrician or specialist. This includes arranging for non-emergency transportation if necessary.
109	If a Telemedicine presentation site has restricted access to the public (i.e. a school-based telehealth site), can they be excluded from the requirement to be included in the Provider Directory?	Attachment I, Page 111, Section 4.8.12	No, telemedicine sites with restricted access should not be excluded.
110	Please confirm that the definition of "Subcontractor" as stated in Attachment B, p. 36 does not include Providers.	Attachment B, page 36, Definition of Subcontractor. See also Attachment I & J, Definition of Subcontractor, Attachments I & J (see sections 3.05, 8.6.5.5, 16.1.7, 18.1.1, 27.3 in Attachment I for example of when a Provider may not be held to same obligations as a Subcontractor)	This definition does not include Providers.
111	Please confirm that the Full Time Provider Locations by Capacity only applies to the PCP Provider Types.	Attachment D, Section I (pg. 60) located at 17.a.6, Full Time Provider Location and Capacity	Full time Provider locations by capacity apply to Primary Care Provider types as well as dentists.
112	To adequately represent the provider network for purposes of responding to the RFP, please let us know where we can find the most recent eligibility files that include membership data by zip code. Please confirm that DCH will be providing these files for use during the RFP response process.	Attachment D, Section I (pg. 59) located at 17.a.1. 1: Data Standards - Eligibility files	Enrolled provider information can be accessed via the Georgia Medical Management Information System (GAMMIS) https://www.mmis.georgia.gov .
113	To leverage best practices, generate administrative efficiencies, and enhance continuity of care coordination, please confirm that Key Staff may oversee other lines of business (such as serving Georgians covered by both Medicaid and Medicare).	Attachments B, definition of Key Staff	Key Staff may provide oversight of other lines of business and programs that service DCH populations.
114	Please confirm that Questions 15 and 16 requesting information about Supplier, Supplier's Parent Company and <u>Supplier's</u> subsidiaries (not the subsidiaries of the Parent Company, Suppliers affiliate or "sister" companies).	Attachment G, Questions 15 and 16	Subsidiaries apply to the Parent Company.

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	Question	Referenced RFP Section	Response
115	Attachment G, Question 16 does not provide a look-back period for Supplier to use in connection with disclosing their terminated contracts. Please confirm that a three-year lookback period is sufficient.	Attachment G, Question 16	For Question 16 of Attachment G, Suppliers must use the last three (3) consecutive full calendar years.
116	Attachment D, Section D.11 (pg. 29) states, "The Supplier shall permit all initial outpatient Behavioral Health	Attachment D, Section D.11 (pg. 29): Mental	Yes, diagnostic testing will be for Behavioral Health diagnoses only.
117	To satisfy the provider network adequacy requirements of the eRFP, please confirm suppliers are able to freely communicate with state owned/run health care facilities, clinics, and other providers during the procurement	Attachment A, Section 2.1.2 "Restrictions on Communicating with	Supplier may contact providers to obtain signed letters of intent as part of the Supplier's response to the RFP.
118	Please confirm that the responses for the Georgia Family portion of the proposal (Attachments E-G) will be scored and finalized prior to review and scoring of the Georgia Families 360 portion of the proposal (Attachment H).	N/A	Submissions that include responses to Attachments E, F, and G will be evaluated for both Georgia Families and Georgia Families 360° contracts. The Georgia 360° Contract award is intended to be offered to the highest scoring proposal resulting from the combined score of Suppliers within the competitive range of mandatory score and Additional Scored results; therefore, consideration of points earned in the Mandatory Scored requirements will occur before considering scores earned in the Additional Scored requirements (if applicable).
119	Will the scoring for the Georgia Families program be independent from the scoring for Georgia Families 360 such that if a supplier that does not respond to the Additional Scored Responses 115 through 164 related to Georgia Families 360 will not be adversely impacted in any way relative to the scoring and selection for the Georgia Families program?	Attachment A, Section 4.5: "Additional Scored Responses"/Section 6.2.2/Section 6.2.1	Mandatory Scored questions listed in Attachment G are required for contract consideration. Additional Scored questions in Attachment H are required for consideration of the contract available for Georgia Families 360°. A decision to not respond to Additional Scored Questions will not adversely impact scoring and consideration of selection for Georgia Families.
120	Is a supplier able to submit a response for the GA Families contract only and not pursue the Georgia 360 contract?	Attachment A, Section 4.5: "Additional Scored Responses"/Section 6.2.2/Section 6.2.1	Suppliers are not required to respond to the Additional Scored questions for the Georgia Families 360° program.
121	Please confirm that a supplier is not required to submit the Additional Scored Responses document if they are not intending to pursue the Georgia 360 contract award.	Attachment A, Section 4.5: "Additional Scored Responses"/Section 6.2.2	Suppliers are not required to respond to the Additional Scored questions for the Georgia Families 360° program.
122	Please provide a further breakdown of the total 1,000 points showing the distribution of the total by scored functional area/discipline for the Mandatory Scored and/or Additional Scored responses	Attachment A, Section 6.4: "Scoring Criteria"	No other breakdown, other than the details listed in section 6.4 of the RFP, will be communicated.
123	Please confirm that an individual meeting the requirements of more than one Key Staff position may fill multiple roles.	Attachment D, pg. 7 Section B.2 Key Staff	Key Staff may provide oversight of other lines of business and programs that service DCH populations.
124	Please confirm that either current contracts and/or Letters of Intent (LOIs) with providers can be used to demonstrate network adequacy requirements.	Attachment G, Question 48.b./Question 49	All Suppliers must submit letters of intent (LOIs) as detailed in Attachment D of the RFP.
125	Attachments I and J require an irrevocable letter of credit for contractual performance to cover 10% annual value of contract (per eRFP attachments I and J, LOC calculation is defined as 37.5% of the average incurred Capitation payments for January, February and March). In the past GA DCH contract, surety bonds and letters of credit were accepted forms of guarantees. Please confirm surety bonds or letters of credit are both acceptable forms of guarantee.	Attachment I, Section 28.1, and Attachment J, Section 28.1	DCH will require an irrevocable letter of credit.

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	Question	Referenced RFP Section	Response
126	Attachment I (located at Attachment D attached to the document) refers to the SP 800-53 version of the NIST Baseline Controls. Please confirm that the use of HITRUST Security Framework is sufficient to meet this requirement.	Attachment I (at Attachment D to the Contract), Business Associate Agreement - Section 1 - regarding NIST Baseline Controls.	The HITRUST Common Security Framework is more of a high level Risk Management Methodology and Healthcare Community of Interest Framework Guideline and may not address all applicable NIST Moderate-Impact-Baseline Security Controls required to meet the Administrative, Technical, and Physical Security Requirements of the HIPAA Privacy and Security Rule Laws and Regulations.
127	Attachment I (at Attachment D) states, "In addition to the safeguards described above, Contractor shall include access controls that restrict access to PHI to the individuals listed on the D-1 and D-2, as amended from time to time, shall implement encryption of all electronic PHI during transmission and at rest." Please confirm the state will continue to allow forms of safeguarding PHI at rest other than encryption.	Attachment D, Business Associate Agreement - Section 8.D - regarding encryption.	No. DCH will no longer allow forms of safeguarding PHI at rest. The Supplier shall implement encryption of all electronic PHI during transmission and at rest.
128	Requirement states, "MAC pricing schedule must be posted on the Supplier's web site." Can we choose to provide access only via a secure provider portal that requires provider registration?	Attachment D, pg. 24, 6.d.	DCH leaves the proposed solution to the Supplier. Any proposed solution must adhere to any legislation that is passed prior to the proposal due date.
129	Attachment D, Section 6 states, "Supplier shall not require Members to use a mail-order pharmacy to receive covered pharmacy benefits..." Please confirm that this statement does not limit our ability to require the use of a specialty pharmacy for the distribution of specialty medications.	Attachment D, pg. 25	DCH recognizes that many specialty drugs have limited distribution networks and are dispensed by specialty pharmacies.
130	Attachment D, Section 4.b (p. 132) states, "The Supplier shall provide DCH with a list of Authorized Users who may access patient health data from the Supplier's Systems. DCH shall review and approve the list, including revisions thereto, of the Supplier's Authorized Users who may access patient health data from the Supplier's systems." Please confirm that notification to DCH of Authorized Users will continue to suffice.	Schedule D, Section 4.b, page 132	Please refer to Attachment D, section I.N.4.b.
131	In Attachment A, Under Figure 1, PeachCare for Kids is defined to be Children less than 19 years of age. The current rate cells cover children through age 20. Should this have said less than 21 instead of less than 19?	Attachment A, Section 1.1.2	The PeachCare for Kids® program provides services to children through the month they turn 19 years old. The current PeachCare for Kids® rate cell description states through the age of 20. DCH is aware that the rate cell does not match the program's policies. However, DCH has left this cell descriptor because it is consistent with other programs using similar categorization of rates.
132	Given that the state has not historically administered partial month enrollment, what data will the actuaries use to develop the correct pro-rated membership months and claims?	Attachment A, Section 5.6	For FY17 rates, this change will be partially reflected in the Encounter and membership data used in rate development since the change will be implemented in the first half of CY 2015.
133	Will the expected increased utilization in dental costs due to dental homes be captured in any rate development?	Attachment I, Section 1.0.1.6	As part of the rate setting process, DCH will consider any changes to dental services, such as dental homes, that could impact utilization.
134	When a member temporarily loses eligibility for less than 60 days, will the CMOs still be responsible for the Member's claims during the temporary loss of eligibility and will the CMOs continue to receive premium from the State?	Attachment I, Section 2.3.10	No, DCH will not pay the Capitation Payments when Members lose eligibility. The CMO will not be responsible for the claims during the temporary loss of eligibility.
135	"Provider Complaints" can only be filed for non-actionable items, as "Action" is defined under 42 CFR 438.400(b). Non-actionable items include the dispute of policies, procedures, and other administrative functions. Provider Complaints filed under the "Provider Complaint System" have no right of appeal since these are non-actionable items. Additionally, O.C.G.A. §49-4-153(e)(1) supports this statement. Please confirm that Provider Complaints are non-actionable.	Attachment D, pg. 79 (Provider Complaint System)	Provider complaints regarding policies and procedures or other administrative functions are non-actionable items that have no right of appeal. The Official Code of Georgia outlines those instances wherein a provider rendering services pursuant to a managed care contract has the right to an appeal.
136	The definition of "Key Staff" as stated in Attachment B indicates "Key Staff must be full-time employees located in Georgia with no other client responsibilities other than the GF, GF360, and P4HB programs". Please confirm that these are the only Key Staff positions that are required to be located in Georgia.	Attachment B, pg. 22	The Key Staff definition in Attachment B is a summary of the more detailed Key Staff description provided in Attachment D. Suppliers should use the detailed Key Staff information in Attachment D when responding to questions in Attachment G of the RFP.
137	The lists of "Key Staff" in the definitions section of Attachment B provides for a different list of positions than that of the "Key Staff" section in Attachment D. Please confirm the titles and responsibilities of "Key Staff".	Attachment B, pg. 22 vs. Attachment D, pg. 7	The Key Staff definition in Attachment B is a summary of the more detailed Key Staff description provided in Attachment D. Suppliers should use the detailed Key Staff information in Attachment D when responding to questions in Attachment G of the RFP.

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	Question	Referenced RFP Section	Response
138	Attachment B provides a definition of a Clean Claim. Please confirm that the definition should include a claim for which Fraud "or abuse" is suspected.	Attachment B, pg. 6	Correct. The definition should include a claim for which Fraud or Abuse is suspected.
139	Attachment I, Section 4.15.2.1 indicates office hours are 8:30 - 5:30; however the definition of a Business Day reflects hours of 9:00 - 5:00. Please confirm which is correct.	Attachment I, Section 4.15.2.1 vs. Attachment B, definition of Business Day	The definition for Business Day should be amended to read 8:30 am to 5:30 pm.
140	Will DCH consider a provider materials notification process rather than an approval process whereby the Contractor would submit all Provider materials to DCH as notice of their use, but DCH would not be required to review and approve.	Attachment I, Section 4.9.1.3	No. The approval timeframe for Provider materials is thirty (30) Calendar Days.
141	Should the timeframe to acknowledge receipt of a Grievance/Administrative Review be done within 10 BUSINESS DAYS as noted in section 3a or 10 CALENDAR DAYS as noted in section 3c? DCH's current contract with the CMOs (4.14.1.5) requires 10 business days.	Attachment D, Section N 3a & 3c	The timeframe should be ten (10) Calendar Days.
142	Attachment I, Section 4.3 refers to DCH approval of member materials. If DCH does not respond to supplier's request for approval of member materials within 30 calendar days, please confirm no response within 30 calendar days is equivalent to approval of those materials.	Attachment I, Section 4.3	DCH's delayed response (greater than 30 Calendar Days) does not constitute approval of materials
143	Attachment I, Section 4.9 refers to DCH approval of Provider Materials, but does not state a timeframe for approval. For all Provider Materials requirements, please provide a timeframe for which DCH is required to respond to the contractor with an approval or rejection.	Attachment I, Section 4.9	The approval timeframe for Provider materials is thirty (30) Calendar Days.
144	In Section 5.0, please confirm that the timeliness standards and requirements apply to only those items listed in the Deliverables tables (5.7.1 & 5.7.2).	Attachment I, Section 5.0	Tables 5.7.1 and 5.7.2 in Attachment I include the timelines and standards for those deliverables identified. DCH reserves the right to request additional deliverables and to identify the timelines and standards
145	We understand that initial outpatient Behavioral Health (Mental Health and Substance Abuse) evaluation, diagnostic testing and assessment services are to be provided without Prior Authorization. Can the state verify that "diagnostic testing" does not include formal Psychological testing required to be performed by a Licensed Psychologist and that "diagnostic testing is limited to widely and publically available instruments used in the course of initial assessment and/or labs?	Attachment D, Section D. Special Coverage Provisions. Number 11, pg. 28	without a prior authorization do not include psychological testing for which a licensed psychologist is required to perform. DCH generally expects that diagnostic testing for Behavioral Health Conditions is performed through the use of widely accepted, validated, and reliability tested tools condoned by professionals/professional associations in the field.
146	Supplier is required to include in their network Tier 3 Care Management Entities. Will the CBAY (Money Follows the Person (MFP) and Balancing Incentive (BIP) Program) services continue to be covered by the State? Will Georgia Families members continue to be eligible for MFP and BIP services by applying through the State's delegated ABD ASO?	Attachment D, Section I. Georgia Families Provider Networks Number 11, pg. 56	CBAY services afforded under the BIP grant will end for new enrollments as of September 30, 2015. MFP services will continue for new enrollments through September 30, 2016. DCH does not have a "delegated ABD ASO".
147	Does the State have a standard of when a member in a Psychiatric Treatment Facility (PRTF) will be eligible under Long Term Care Coverage and become disenrolled from the CMO by DCH?	Attachment D, Section L. Utilization Management and Coordination and Continuity of Care Responsibilities	A Member may continue to stay in a PRTF as long as medical necessity and level of care criteria are met and no amount of time would make them eligible for Long Term Care Coverage which would trigger disenrollment from the CMO by DCH.
148	For members who are transitioning from an ongoing non-acute treatment in an Inpatient Facility to a new CMO who do not meet medical necessity criteria or do not require this level of care before the (30) Calendar Days Transition of Care period, will the new CMO be able to close out the existing prior authorization and authorize a lower level of care?	Attachment D, Section L. Utilization Management and Coordination and Continuity of Care Responsibilities, Number 4, Transition of Care	No, the new CMO may not close out the existing Prior Authorization and authorize a lower level of care. The Supplier must utilize the thirty (30) day transition period to determine the medical necessity for the prior authorized service and may choose to terminate the Prior Authorization at the end of the thirty (30) day transition period.

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	Question	Referenced RFP Section	Response
149	Will DFCS, DJJ and other sister agencies responsible for delivering services to Georgia Families 360 members have access to appropriate sections of the GaHIN or will all exchange of information between DFCS, DJJ and sister agencies have to be done via Suppliers Information System?	Attachment D, Section II. K Georgia Families 360 Information Management Systems, pg. 176	Both DFCS and DJJ are scheduled to be fully connected members to GaHIN by the time the resulting Contracts are awarded. However, there may still be limits as to what information is contributed by DFCS and DJJ. Therefore the Supplier must also have capacity for information exchange outside of GaHIN.
150	Attachment D, p. 32 states, "The Supplier shall offer its Members freedom of selecting a PCP and a PCP if different from the PCP." Please provide clarification of this statement.	Attachment D, pg. 32, fifth paragraph, first sentence	The sentence should read: " The Supplier shall offer its Members freedom of selecting a PCP. "
151	What is the "per item" nominal value of Member incentives that is allowed? Attachment D, pg. 49 suggests \$15, while Attachment D, pg. 107 shows \$10. Please provide clarification.	Attachment D, pg. 49 fourth paragraph, H.1.b vs. Att D pg. 107 first paragraph, first sentence.	The per item nominal value is \$10.00.
152	Please confirm that the Member incentives developed for the VBP program of the supplier must comply with the per item and annual limits stated in Attachment D at H.1.b.	Attachment D, pg. 113 third paragraph, first sentence.	For Member incentives developed for the VBP program, the Supplier must comply with the \$10.00 per item nominal value and the \$50.00 annual value. DCH will revise the Attachment D, I and J accordingly.
153	Attachment I, Section 4.3.7.6 lists Average Speed of Answer, Abandoned Call Rate, Blocked Call Rate, Average Hold Time as call center performance requirements. Section 4.17.8.4 lists 90% of calls are answered by the fourth ring, abandonment rate, average hold time, and call blocked rate. Please confirm which one applies - Average Speed of Answer, 90% of calls answered by the fourth ring, or both of them?	Attachment I, Section 4.3.7.6	Average Speed of Answer should be defined as follows: Ninety percent (90%) of calls are answered by a person within thirty (30) seconds with the remaining ten percent (10%) answered within an additional thirty (30) seconds by a live operator measured weekly.
154	The instructions for Attachment G state, "Offerors must answer all the questions in this spreadsheet in the cell provided." The questions as stated require responses that will take multiple pages to adequately address. The cell provided in the third column of the document is not large enough to provide thorough and effective responses to DCH's questions, or to meet the stated page limits. Please confirm that Suppliers may use the "Response by Offeror" cell to state compliance with the questions, but also supplement those responses with additional content supplied as attachments.	Attachment G: Instructions	Please review the instructions in Appendix G which further state that Suppliers should " upload documents if there is a Yes in the "Upload Attachs with Additional Information" column. Every question in Appendix G indicates "yes" and instructs the supplier to upload attachments with the naming convention indicated.
155	The instructions for Attachment H state, "Offerors must provide a thorough narrative description in the space provided in this spreadsheet." The questions as stated require responses that will take multiple pages to adequately address. The cell provided in the third column of the document is not large enough to provide thorough and effective responses DCH's questions, or to meet the stated page limits. Please confirm that Suppliers may use the "Response by Offeror" cell to state compliance with the questions, but also supplement those responses with additional content supplied as attachments.	Attachment H: Instructions	Please review the instructions in Appendix H which further state that Suppliers should " upload documents if there is a Yes in the "Upload Attachs with Additional Information" column. Every question in Appendix H indicates "yes" and instructs the supplier to upload attachments with the naming convention indicated. Please do not enter responses in the Excel spreadsheet.
156	Please confirm that the naming conventions detailed on page 62 of the eSource Supplier Guide are intended to be used for our completed required response documents (i.e., Attachments, E, F, G and H) and that the Attachment File Name column within Attachments E, F, G and H indicates how we should name the files that contain our responses to the individual questions?	eSource Supplier Guide and Instructions for Attachments	Please review the instructions in Appendix A for preparing responses for Team Georgia Marketplace. The eSource instructions may not be applicable to this solicitation. Instructions in Attachments F, G and H instruct that the Suppliers should " upload documents if there is a Yes in the "Upload Attachs with Additional Information" column. Attachment E instruction are to complete the form and to upload it. For technical assistance please call 404-657-6000.
157	Please confirm that the narrative responses to the questions in sections 4.4 and 4.5 are to be uploaded as attachments rather than pasted into the workbooks provided.	Attachment A sections 4.4, 4.5	Sections 4.4 and 4.5 of Attachment A correspond with the instructions in Appendix G and H correspond to which further state that Suppliers should " upload documents if there is a Yes in the "Upload Attachs with Additional Information" column. Every question in Appendix G and H indicates "yes" and instructs the supplier to upload attachments with the naming convention indicated. Please do not enter responses in the Excel spreadsheet.
158	Is there a list of covered services?	Attachment I, 4.5.1.1	Covered Services are detailed in the State Plan on the DCH website at http://dch.georgia.gov/medicaid-state-plan

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	Question	Referenced RFP Section	Response
159	Does DCH expect CMO's to use a standard transition of care form?	Attachment I, 4.11.4	DCH has not created a transition of care form template.
160	What is the process to request disenrollment from CMO for a member in a long term care facility >30 days? Is there a form?	Attachment I, 4.11.4.4	The nursing facility will typically work with the Member to apply for an Institutional Nursing Home Category of Aid. When that eligibility is approved and added to the system (typically retroactively), this will trigger the disenrollment from the CMO.
161	What is the expected timeframe to implement a Discharge Planning pilot program with an onsite nurses in the hospital?	Attachment I, 4.11.8.6.2	No later than December 31, 2016.
162	Can any of the committees listed in the contract be combined, for example QI and UM or must we maintain separate committees as described in the contract?	Attachment I, 4.11.1.5.1.1, 4.12.1.4	The Supplier must have a committee that addresses Utilization Management issues. This committee may have the same membership as the QI committee.
163	Is there a more recent Quality Management Strategy that describes the additional QI performance metrics/PIP's or is 2011 the most recent version?	Attachment A, 1.1.6 (suppliers library)	DCH is currently preparing a new Quality Strategy based on the 2012 CMS protocols.
164	Please confirm if the Patient Safety Plan must be separate and distinct or can it be integrated and described as part of the overall QI program?	Attachment I, 4.12.10	The Patient Safety Plan must be separate and distinct. It may be referenced in the overall QI Plan.
165	Please explain GA's approval process for membership related to the Quality Oversight Committee.	Attachment I, 4.12.1.4.2.2	The CMO must provide DCH with the names and brief bios of its proposed Quality oversight committee members. DCH will review the information to ensure the committee has a diverse membership structure. DCH may suggest modifications to the proposed member list prior to approval.
166	Please provide clarification of the term "Advanced Directives" as referenced in I.D.11 of Attachment D: Requirements and Scope of Work. Specifically does this refer to a Mental Health or Physical Health or both types of Advanced directives?	Attachment D, I.D.12	It applies to both types of Advanced Directives.
167	Are there any Mental Health or Substance Abuse services that are covered by an alternative funding source that would not be covered benefits under the supplier but would require collaboration for treatment purposes?	Blank	The Department of Behavioral Health and Developmental Disabilities has regulatory responsibility will provide through its contractors emergent services to individuals who present for care and for whom insurance coverage may not be known at the time of treatment. This may include, but is not limited to, crisis stabilization, mobile crisis, or crisis respite.
168	For every section for which there is a potential withhold, please share the current status by plan and for the state overall	Attachment U	Currently, only the Georgia Families 360° is subject to a VBP withhold. The withhold has not yet been distributed.
169	Please indicate the action that will be taken by the state if the 80% threshold is not met. For those children less than the age of two, is the requirement met if the most recent recommended evaluation is conducted, or do all visits need to have occurred for the plan to receive credit?	Attachment I, 4.7.3.9	Please refer to Section 25.3.1 of Attachment I regarding liquidated damages. Also, refer to Attachment D for the Health Check requirements.
170	Please define the criteria that DCH would use for terminating a contractor for convenience.	Attachment I, 24.1.1.2	Suppliers are required to comply with all State and Federal laws regarding Provider terminations. In order to ensure that the Supplier has an adequate network, we do not recommend terminations for convenience.
171	Please provide DCH's specific methodology or standards for determining prevalent non-English languages spoken as referenced in para 2.5.1. In particular, can DCH identify which Georgia counties must produce materials in languages other than English (e.g. DeKalb county = English & Spanish)	Attachment I, 2.5.1	DCH will provide its methodology for identifying the prevalent non-English languages spoken by Members and potential Members Post Contract Award. DCH will identify those counties that require materials to be presented in non-English prevalent language as well as the required languages. The methodology applies to written materials only. Oral interpretation services must be made available to all Members and potential Members for all non-English languages, not just those identified as prevalent.
172	What is the expected look back period to respond to 4.3.17. Is a three-year look back acceptable?	Attachment G, 4.3.17	Please confirm the Question number in Attachment G.
173	If possible, please clarify how DCH will work with a new CMO to ensure critical membership mass.	Attachment A, Section 1.1.5	This information will be provided after Contract Award.

Requesting State Entity:
Department of Community Health

	Question	Referenced RFP Section	Response
174	Please confirm whether Suppliers should collect LOIs from local Department of Health (DOH) offices or Community Service Boards (CSBs). If so, please indicate how that should be accomplished without violating the restrictions in Attachment A, Section 2.1.2., as many key DOH and CSB employees are employed by the state of Georgia.	Attachment A, Section 2.1.2. Restrictions on Communicating with Staff; Attachment G, Question 48	Supplier should obtain letters of intent from all Providers for whom the Supplier intends to contract. Suppliers may approach this providers for the purpose of obtaining such letters of intent.
175	Can DCH confirm that any amendments or other material revisions to the eRFP will be issued exclusively on the Team Georgia Marketplace™ system?	Attachment A, Section 2.1.7 – State’s Right to Amend and/or Cancel the eRFP	Solicitation updates will be communicated through Team Georgia Marketplace and the Georgia Procurement Registry.
176	Please clarify what information should be entered into the "Response by Offeror" column that is included in the Mandatory Scored Questions and the Additional Scored Questions attachments, and confirm that question responses for Attachments G and H should be uploaded to the procurement system using the file names specified in the Attachment File Names columns of Attachments G and H.	Attachment A, Section 4.4; Attachment G and H.	Please review the instructions in Appendix G and H which state that Suppliers should "upload documents if there is a Yes in the "Upload Attachs with Additional Information" column. Every question in Appendix G and H, columns indicate "yes" and instruct the supplier to upload attachments with the naming convention indicated. Please do not enter responses in the Excel spreadsheet.
177	Capitation rates for the first rate period (FY17 - July 1, 2016 through June 30, 2017) are expected to be completed on or around June, 2016. Will the State make available any trend, programmatic change, benefit change, enrollment change or other assumptions prior to the eRFP close date? Will Aon Hewitt or the State-contracted actuary responsible for rate-setting be made available for questions regarding projected FY17 rates?	Attachment A, Section 5.1 – General Description of Capitation Rate Methodology	To date, DCH does not know the expected benefit and program changes for FY 2017. As DCH and its actuaries work through the FY 2017 rate development process, we will inform Care Management Organizations (CMOs) of the expected material program changes and associated rate adjustments. The FY 2017 rates will be developed beginning in late CY 2015. Yes, contracted Care Management Organizations (CMOs) will have the opportunity to participate in rate discussions with DCH and its actuaries. As part of this discussion, DCH and its actuaries make available any trend, programmatic change, benefit change, enrollment change or refer to the "GF_Rate_Certification_FY15_09242014_Procurement document" and "GF_360_Rate_Certification_03032014_06302015 document" in the Suppliers' Library.
178	The identified factors leading to capitation rate adjustments include "... Benefit changes and other relevant items." Were specific adjustments made to address the impact of Sovaldi and other similar new treatments/technologies? If so, can DCH provide the utilization and unit cost assumptions used to calculate the corresponding rate adjustment?	Attachment A, Section 5.2 – Overview of Georgia Families and Georgia Families 360° Capitation Rate Methodology	Specifically, because most of these drugs, including Sovaldi, only impact costs for adult Members of the covered population and the Georgia Families rates cover primarily children, there was no reason to adjust most of the rate cells for these new drugs. The pharmacy trend for the adult rates cells was increased by 4.6% to reflect the expected costs of these drugs. The adjustment to the Georgia Families 360° program was considered immaterial as the majority of Members are children.
179	Attachment A Section 5.3 Health Insurance Providers Fee states that DCH will reimburse CMOs "for the amount of the Federal Health Insurance Providers Fee, including an actuarially sound adjustment for the estimated impact of the non-deductibility of the fee for federal and State tax purposes..." Exhibit 4B of the FY2015 Rate Certification shows a 0% HIF adjustment for the low rates. Should there be an adjustment for the HIF? If not, could DCH provide the rationale for why these rates don't reflect an HIF adjustment?	Attachment A, Section 5.3 Health Insurance Providers Fee; Supplier's Library, Georgia Families Rate Certification FY15, Exhibit 4B	DCH actuaries established a range of 0% to 5% to accommodate the HIF payment. The 0% adjustment would apply to accommodate any participating plan that met HIF exclusion criteria for certain not-for-profits and, therefore, would not be subject to the fee.
180	Section 5.5 states that "the Georgia Families Capitation rates will be actuarially sound even if the Supplier does not achieve the VBP performance criteria." Please clarify whether the actuarial soundness criteria would apply to the rates net of the 5% withhold without any consideration of an expected VBP payout by the State? Or is the state assuming some level of VBP will be earned?	Attachment A, Section 5.5, Future Capitation Rate Methodology	The actuarial soundness criteria will apply to the rates net of the 5% withhold; however, the DCH does assume that the VBP will be earned based on plan performance.

Requesting State Entity:
Department of Community Health

	Question	Referenced RFP Section	Response
181	If possible, please provide additional details about how the 1,000 potential points will be divided between Attachment G questions and Attachment H questions.	Attachment A, Section 6.4; Attachment G; Attachment H	No other breakdown, other than the details listed in section 6.4 of the RFP, will be communicated.
182	The eRFP indicates that a supplier can take exception to a contract provision; those proposed exceptions must be submitted along with the RFP response. Please clarify whether the Supplier will be limited to those proposed exceptions raised at the time of RFP submission, or that the Supplier will have the opportunity to propose an exception during negotiations in furtherance of reaching agreement on a particular item or issue.	Attachment A, Section 7.1	The Supplier will be limited to those proposed contract exceptions raised at the time of the RFP response submission.
183	Section 6.6.3 states that "the State Entity may elect to limit negotiations to the top three (3) ranked suppliers as determined by the Total Combined Score." In the event four CMOs are chosen, please confirm that the fourth will have an equal opportunity to negotiate.	Attachment A, Sections 1.1 and 6.6.3	The State can not commit to negotiating with a specific number of suppliers. Section 6.6.3 expresses that in determining the competitive range, that the state may limit negotiations to the top three (3) ranked suppliers.
184	As defined in Attachments B and D, will OB/GYN providers be considered Primary Care Providers (PCP) and responsible for providing all required primary care services (listed and identified) to all members, for purposes of determining GeoAccess map capacity? Will OB/GYNs be considered a specialist or a PCP?	Attachment B - Definitions and Acronyms, Primary Care Provider; Attachment D, Section I, 4.a.5 – Primary Care Providers	Please refer to Attachment D, Section I, 4.a.5 for the list of practitioners considered to be PCPs. OB/GYN practitioners may also be considered to be specialist providers and not included in the Geo Access map for PCPs. The CMO must determine in which category the OB/GYN provider will reside since they may only reside in one for Geo Access purposes.
185	Please provide the location of a comprehensive list that denotes or outlines all covered services (medical and non medical related) offered through the Georgia Families Program. Please provide document location.	Attachment B, Definitions and Acronyms; Attachment C, Additional Background Information; Attachment D, Requirements Scope of Work	Please refer to the State Plan on the DCH website at http://dch.georgia.gov/medicaid-state-plan
186	There appears to be discrepancies between the titles and description of Key Staff between the definition of Key staff and the contract description of Key staff. Please clarify expectations regarding titles of Key Staff, which staff are considered Key Staff, and which Key staff must reside in GA, be full-time employees, and/or be dedicated to the GA product.	Attachment B, page 22; Attachment I, page 27 and Section 16.1.5; and Attachment J, page 34 and Section 16.1.5	The Key Staff definition in Attachment B is a summary of the more detailed Key Staff description provided in Attachment D. Suppliers should use the detailed Key Staff information in Attachment D when responding to questions in Attachment G of the RFP. Refer to Attachment D for requirements for Key Staff.
187	DCH monitors CMO performance using fifty-four (54) HEDIS measures. Please provide a complete list of the specific measures that will be utilized in this evaluation for the first contract year or those measures that may currently be in place.	Attachment C, Page 3 – Monitoring and Oversight Activities	The list of performance measures will be posted to the DCH specified website at the appropriate time. The majority of the specified measures are contained in the CMS Adult and Child Core Sets of measures.
188	The Scope of Work and Contract(s) indicate DCH will be using a CVO, but an anticipated time frame is not included. Please indicate when DCH expects the CVO to be credentialing providers and transmitting data to the CMOs.	Attachment D, I.I.22; Attachments I, Section 1.1.5.3.2, 4.8.21, and Attachments V and W; Attachment J, Section 4.8.21.1, 4.8.21, and Attachments V and W	The anticipated launch date of the CVO is July 1, 2015.

	Question	Referenced RFP Section	Response
189	If possible, please provide details on CMO responsibilities if the CVO is not ready to transmit credentialing data at the contract start date, including notice given to CMOs and effect on readiness preparations.	Attachment D, I.I.22; Attachments I, Sections 1.1.5.3.2, 4.8.21.5, and Attachments V and W; Attachment J, Sections 4.8.21.1, 4.8.21.5, and Attachments V and W	<p>The Supplier will be required to maintain written policies and procedures for the Credentialing and Re-Credentialing of all network providers, using standards established by the National Committee on Quality Assurance (NCQA), the Joint Commission on Accreditation Healthcare Organization (JCAHO, or the American Accreditation Healthcare Commission/URAC as well as State law and Federal regulations. The Supplier will be required to have a Credentialing Committee to make decisions regarding applications for credentialing. DCH will identify the time period in which providers are to be credentialed. Credentialing policies and procedures shall include the following: (1) verification of the existence and maintenance of credentials, licenses, certificates and insurance coverage of each provider from a primary source, (2) federal database checks, (3) a methodology and process for re-credentialing providers, (4) a description of the initial quality assessment of private practitioner offices and other patient care settings, (5) and procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges. The Supplier must have a process for notifying providers how to appeal decisions to deny the provider's application. On a quarterly basis, the Supplier shall make available to DCH the total number of provider applications by date that have been received, the number of applications pending a determination, credentialed, and approved and denied. The Supplier will be required to submit its Provider Credentialing and Re-Credentialing policies and procedures to DCH whenever updated. The Supplier will be required to notify DCH of the denial of a provider credentialing application either for program integrity-related reasons or due to limitations placed on the provider's ability to participate for program integrity-related reasons.</p> <p>Currently, the CVO Operational Start Date is scheduled for July 1, 2015. Should this change, all Suppliers will be notified in advance. Suppliers will be provided sufficient</p>
190	Please indicate whether the proposed rates would be amended to include credentialing services in the event a CVO is not operational for the Georgia Families contract term.	Attachment D, I.I.22; Attachments I, Sections 1.1.5.3.2, 4.8.21.5, and Attachments V and W; Attachment J, Sections 4.8.21.1, 4.8.21.5, and	If the CVO is not operational in FY 2017 then the rates will include credentialing costs.
191	Please provide details on how DCH anticipates testing system interfaces and data exchanges if a new CMO is selected. For example, will live data be used?	Attachment D, page 3	DCH anticipates testing system interfaces with the new CMO by using test data that DCH will set up and send to the CMOs on the interfaces DCH currently has set up in GAMMIS. Anytime DCH does UAT testing with a vendor, the test data is always used until the code change is placed in production. The interfaces DCH currently has set up for the CMO's transactions are in the EDI 820 and 834 file formats.
192	In order to account for all covered services in our networking plans, will DCH provide a list of Medicaid approved residential treatment providers?	Attachment D, Section C	The following Psychiatric Residential Treatment Centers are enrolled in Georgia Medicaid: Laurel Heights, Devereux, Lighthouse, Lake Bridge, Hillside, Coastal Harbor, and Youth Villages.

	Question	Referenced RFP Section	Response
193	In Attachment D, G.2: The Supplier shall make all written information available in English, Spanish and all other Prevalent Non-English Languages, as defined by DCH. For the purpose of this RFP, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH. How does DCH currently define other prevalent languages?	Attachment D, Section G.2	DCH will provide its methodology for identifying the prevalent non-English languages spoken by members and potential members post Contract Award.
194	Are pediatric dentists, for consideration of geographic access standards, considered general dental providers or subspecialists?	Attachment D, Section I	Pediatric dentists can be considered general dental providers for Members under 21 years of age.
195	Attachment I calls for Geographic Access Reports to identify provider specialist shortages as identified by DHC or Contractor. Please provide the definition of Provider Specialist and a list of provider specialties that are considered "specialists"?	Attachment D, Section I, 17.b.5., Attachment I, Section 4.8, Section 4.8.17, Section 4.8.17.2.2.1.5;	Provider Specialists are considered to be any provider that does not fall in the following practices: General Practice, Family Practice, Internal Medicine, OB/GYN, Physician Assistant or Nurse Practitioner.
196	Is the expectation that the analyses and maps be provided separately for each Benefit Program?	Attachment D, Section I.17	Yes, separate mapping for each program
197	For member or plan-initiated disenrollment, will there be an expectation for supporting Geo Access documentation to support a plan decision or request?	Attachment D, Section I.17	Yes, such documentation will be required.
198	Are all providers, including out-of-network covered service providers and self-referral service providers (such as family planning, etc.) to be mapped and reported?	Attachment D, Section I.17	Out-of-network providers should be mapped and reported. All contracted providers including 'self-referral' service providers should be mapped and reported.
199	Are there any requirements to provide Geo-based files for use in any member-focused provider directory or provider search functions maintained by other parties, such as the fiscal agent? Implementation?	Attachment D, Section I.17	Not at this time.
200	Will DCH be providing additional guidance regarding how "like" specialties should be grouped, or is such "grouping" at the discretion of the CMO?	Attachment D, Section I.17.a.5	Additional guidance will not be provided. DCH will review 'like specialty' groups submitted.
201	Does the requirement to list provider capacity for those with multiple locations only apply to PCPs? Is capacity synonymous with "panel size"?	Attachment D, Section I.17.a.6	Provider capacity applies to PCPs, dental providers and vision providers.

	Question	Referenced RFP Section	Response
202	Does the Office consider "direct route" in Geo Access/GeoCoder to be considerate of geographical barriers that may impact calculations of time and distance in building a network?	Attachment D, Section I.17.a.6	Please clarify the Question.
203	In instances where there is a time OR distance standard for a provider type, is the expectation that reports will consider the time OR distance standard in a single report (i.e. access is met if a member has access either by the time standard OR the distance standard). Or, should these be mapped as separate standards (i.e. access by time, plus access by distance)?	Attachment D, Section I.17.b.Figure1	DCH will consider time OR distance in a single report for access requirements.
204	DCH will designate the format of Microsoft Excel or Microsoft Project to be used for submission of the CMO Project Plan. Please clarify which versions of these applications or file extensions will be acceptable for the submission.	Attachment D, Section I.A.1.c – Implementation Planning	Suppliers may use Microsoft Excel 2010 or Microsoft Project 2010, or Microsoft 365 versions of these applications.
205	DCH requests the names of individual staff "... at the levels of effort proposed." Please clarify how DCH defines "proposed"—does this requirement apply only to Key Staff or to all staff working for the Supplier, any Subcontractors, Independent Contractors or Consultants, etc.?	Attachment D, Section I.B.1 – Assignment and Credentials	This applies to Key Staff and Subcontractor personnel.
206	Please verify that the language stating Suppliers must "Remedy the deficiency within two (2) Business Days" applies specifically to Section I.B – Supplier Staffing, under which it falls.	Attachment D, Section I.B.4 - Failure to Comply	These provisions apply to additional sections within the contract templates. We will revise Attachments I and J accordingly.
207	It is stated that, "The Supplier shall permit all initial BH evaluation, diagnostic testing and assessment services to be provided without prior authorization. And permit up to 3 per year for members under age 22." Is psychological testing considered to be amongst these categories that require prior authorization?	Attachment D, Section I.D.11.	No, psychological testing is not included amongst the initial services that must be provided without Prior Authorization.
208	If possible, please provide pharmacy utilization data for Georgia Families and Georgia Families 360 members to support Suppliers' business and strategy decisions.	Attachment D, Section I.D.6	Please refer to the capitation rate certification documents provided in the Suppliers' Library.
209	Attachment D, Section I.E.2 states that "The Supplier shall collaborate with the Supplier and Providers..." Should the second "Supplier" in that sentence read "PCP"?	Attachment D, Section I.E.2., "Selection of a Primary Care Provider (PCP)/Medical Home"	The sentence should read: " Supplier shall collaborate with the DCH and Providers to decrease potentially preventable admissions and Re-admissions and avoidable use of the emergency department."

	Question	Referenced RFP Section	Response
210	Attachment D, Section I.E.2 states that "The Supplier shall offer its Member freedom of selecting a PCP and a PCP if different from the PCP." Please clarify.	Attachment D, Section I.E.2., "Selection of a Primary Care Provider (PCP)/Medical Home"	The sentence should read: " The Supplier shall offer its Members freedom of selecting a PCP. "
211	Attachment D, Section I.I.23 states that "the DCH Enrollment Broker will assign a new PCP if the Member does not choose a new PCP within thirty (30) Calendar Days." However, Section I.E.2 states that "If a Member fails to select a PCP, or if the Member has been Auto-Assigned to the CMO, the Supplier shall Auto-Assign Members to a PCP." Please clarify.	Attachment D, Section I.E.2., "Selection of a Primary Care Provider (PCP)/Medical Home" and Attachment D, Section I.I.23., "Network Changes"	This should state 'Supplier' in both areas.
212	What are the rules for members to change PCD's; the mandate for members to only receive care at their PCD; and the role of the PCD in care coordination and referral to dental specialists?	Attachment D, Section I.E.3.	There are no DCH mandated rules at this time. Suppliers would document their procedure for review and approval.
213	Please clarify how the provisions (starting at "Prior to requesting Disenrollment of a Member...") in Attachment D, Section I.F.2 apply to Member subject to the fraud and eligibility criteria also outlined as a-h.	Attachment D, Section I.F.2., "Disenrollment Initiated by the Supplier"	<p>The language referred to states as follows: Prior to requesting Disenrollment of a Member, the Contractor shall document at least three (3) interventions over a period of ninety (90) Calendar Days that occurred through treatment, Case Management, and Care Coordination to resolve any difficulty leading to the request. The Contractor shall provide at least one (1) written warning to the Member, certified return receipt requested, regarding implications of his or her actions. This notice must be delivered within ten (10) Business Days of the Member's Action.</p> <p>In cases of suspected or probable member fraud and/or abuse, the Supplier must take an action against the Member to suspend, terminate or reduce services. The Supplier will be required to provide notice to the member of the action in accordance with federal rules and regulations and grant the member the right to appeal and the right to have an administrative hearing before an administrative law judge. For the remaining eligibility criteria outlined in subsections b-h, the Supplier must give adequate notice to the Member in accordance with federal rules and regulations.</p>
214	Please clarify where Suppliers can find the definition of "closed" pertaining to Attachment D, Section I.G.7.e., and Attachment I, Section 4.3.7.6.5.	Attachment D, Section I.G.7.e., and Attachment I, Section 4.3.7.6.5.	"Closed" means the issue has been resolved and completed.
215	If possible, please provide details regarding the requirements the CVO will have for providers, including behavioral health providers, insurance limits, EPSDT certifications, etc. Additionally, please indicate how much of this information would be available to CMOs, either through data exchanges or through the GAMMIS.	Attachment D, Section I.I.22; Attachment I, Sections 4.7, 4.8, 4.8.21.4, 4.10.3.1	Information regarding the CVO will be available prior to the CVO's go-live date of July 1, 2015.

Requesting State Entity:
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	Question	Referenced RFP Section	Response
216	Are out of state dental providers allowed to be part of contracted dental networks?	Attachment D, Section I.I.24	Out-of-state border dental providers may be contracted.
217	Attachment D, Section I.L.8.e. states that "The Supplier must require that Behavioral Health Providers to send initial and quarterly...summary reports of the Members' Behavioral Health status to the, with the Member's or the Member's legal guardian's consent." Please clarify to whom the reports should be sent.	Attachment D, Section I.L.8.e., "Integration of Physical and Behavioral Health Services"	This should read: The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the PCP, with the Member's or the Member's legal guardian's consent.
218	Attachment D, Section I.L.8.f., "Disease Management," states that "These programs must target the prevalent chronic diseases within the Supplier's population, as specified by DCH." Please clarify whether these targeted diseases have already been defined, and where that information can be found.	Attachment D, Section I.L.8.f., "Disease Management"	The vendor must analyze their data to identify the prevalent diseases within their population and discuss their findings with DCH.
219	Please indicate when and where the VBP Operations Manual will be available.	Attachment D, Section I.M.13.c	The VBP Operation Manual will be available sixty (60) Calendar Days prior to the Operational Start Date.
220	In Attachment D, Section M, it states that there are 13 measures tied to the VBP Incentive Payment, whereas it is stated that there are 14 Performance Measures tied to the VBP Incentive Payment in Attachment U of Attachment I. Please confirm the number of measures tied to the VBP Incentive Payment.	Attachment D, Section I.M.13.c, VBP Incentive Payment; Attachment I, Attachment U	There are fourteen (14) Value Based Purchasing performance measures.
221	Section M.17 states that "Report minimum requirements are provided in the Requirements Analysis Documents located on the DCH website." Please provide a link to where the Requirements Analysis Documents are located on the DCH website.	Attachment D, Section I.M.17, Reporting Requirements	These requirements will be made available after Contract Award.
222	Please clarify what types of "Quality and performance management Information as well as other system functions and Information" will be required to be accessible through the DCH Portal.	Attachment D, Section I.N.4.a; Attachment I, Sections 4.17.1.3, 4.17.7.8, 4.17.11, 4.17.11.5	All CMO contract-related reports must be accessible via the DCH portal.
223	Section N.4 states that "DCH and/or its designee shall provide detailed on-boarding information for use by the Supplier to establish interoperability with the GaHIN." If possible, please provide available on-boarding information, or indicate where it can be found.	Attachment D, Section I.N.4.b	On-boarding information will be provided after Contract Award. Please refer to Attachment D for other GaHIN requirements.
224	Please indicate how many Comprehensive Child and Family Assessment Providers are currently under contract.	Attachment D, Section II.B.1	There are 134 approved DFCS-contracted CCFA providers under contract to DHS, not DCH.

	Question	Referenced RFP Section	Response
225	Section B.1 states "A CCFA Provider must prepare a written Trauma Assessment report and submit such report to the Georgia Families 360° Supplier. The Supplier must then submit the written Trauma Assessment report to the CCFA Provider preparing the final CCFA report..." Please clarify whether the submitting CCFA Provider and the receiving CCFA Provider are two different CCFA Providers, and whether this is the standard process.	Attachment D, Section II.B.1	Section B.1 will be amended to read: "A Behavioral Health provider must prepare a written Trauma Assessment report and submit such report to the Georgia Families 360° Supplier." The Behavioral Health provider could also, but need not be, a CCFA provider contracted to DHS/DFCS. Care Management Organizations do not contract with CCFA providers, only BH providers. The standard process is for the CMO-contracted BH provider that conducts the Trauma Assessment to prepare a written report and submit to the Supplier. The Supplier must then submit the written report to the DFCS-contracted CCFA Provider that will prepare the final CCFA report.
226	Please clarify whether CCFA Providers can verbally report Trauma Assessment findings. If so, please indicate who holds responsibility for formally documenting the Trauma Assessment report.	Attachment D, Section II.B.1	The Behavioral Health providers who conduct the Trauma Assessment are expected to complete and report in writing the findings of the Assessment. If the Behavioral Health provider is unable to meet the timeframe for the written Trauma Assessment report, they may verbally report the Trauma Assessment findings and recommended treatment during the FC member's multi-disciplinary team (MDT) meeting and/or directly to the Supplier, the latter of whom is responsible for providing a summary of the verbal findings to the CCFA provider. In the case of a verbal report, the Supplier shall be responsible for assuring the CMO-contracted BH Provider submits the final written Trauma Assessment report to the DFCS-contracted CCFA Provider that will prepare the final CCFA report.
227	Please indicate how many of the 27,000 youth receiving Care Management services are receiving intensive care coordination and how many are receiving complex care coordination.	Attachment D, Section II.I.8	The current contract does not track by these distinct care coordination categories. Slightly less than two percent (2%) of the enrolled Georgia Families 360° Members receive complex care coordination.
228	Will non-HEDIS based VBP metrics follow the HEDIS-based timeline, which is calendar year based?	Attachment D, Section M.13	Please refer to Section I.M.13 Attachment D.
229	Stated in Attachment D, Section 9, "...the Supplier shall include in its Provider network Providers who are under the State Plan and enrolled as psychologists." For the purposes of building and mapping an adequate provider network for RFP submission, will DCH provide a full list of Psychologists?	Attachment D., Section 9	Enrolled psychology Providers can be accessed via the Georgia Medical Management Information System (GAMMIS) https://www.mmis.georgia.gov .

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	Question	Referenced RFP Section	Response
230	It is stated that, "The Supplier shall include in its network the three tiers of community Behavioral Health Providers listed below that meet the requirements of the Department of Behavioral Health and Developmental Disabilities, provided they have been credentialed to participate in Medicaid for that Provider type and agree to the Supplier's terms and conditions as well as rates." Will DCH provide a central source to identify all Tier 1, Tier 2 and Tier 3 providers?	Attachment D., Section 9	Attachment D, Section 9, of the RFP provides all the information a Supplier would need to be responsive to the RFP.
231	Currently, the Medicaid provider search does not include mental health and substance abuse providers. Is there a public source (or other method) available to identify if a provider is Medicaid enrolled (including private providers)?	Attachment D., Section 9	Enrolled provider information can be accessed via the Georgia Medical Management Information System (GAMMIS) https://www.mmis.georgia.gov .
232	Attachment F requires multiple required forms to be submitted along with Attachment F. Will DCH be providing the Non Collusion Form required by Question 5?	Attachment F, Questions 4, 5	The SPD-SP012 – Certificate of Non-Collusion Form may be found at: http://doas.ga.gov/StateLocal/SPD/Seven/Pages/Home.aspx
233	There are two "Utilization Management and Care Management" headings in Attachment G. Please amend the second such heading to "Admin Services" to align with the Attachment File Name column entries for those questions.	Attachment G, between Questions 89 and 90	Attachment G, Questions 90-95 are to be referenced as "Admin Services" as indicated. The heading titled "Utilization Management and Care Management" in line 102 is incorrect. Please refer to the Revised Attachment G for corrected information.
234	Please confirm whether position titles and reporting structures will fulfill the request for key employee information in Part b. of Question 101.	Attachment G, Question 101	Yes, such information will fulfill the key employee portion of subparagraph b. in Question 101 of Attachment G.
235	Please clarify the intent behind the verbiage stating "Georgia Families UM Responsibilities: Question 7" at the end of Question 79.	Attachment G, Question 79	The reference to "Georgia Families UM Responsibilities: Question 7" in question 79 remained from an earlier outline. The information has been deleted and should be disregarded. Please refer to the Revised Attachment G for updated information.
236	Please note that "Scenarios" appears to be misspelled in several locations in the RFP, particularly as it relates to file names for documents to be uploaded with our proposal.	Attachment G, Questions 105-114	Please reference the revisions to Attachment G for the corrected naming convention.
237	Questions 79 and 80 appear to be the same question. Please address.	Attachment G, Questions 79, 80	Question 79 was duplicated in error. Question 80 states: Describe the responsibilities of case managers and how they will assist Members based on their level of need. Describe the range of case manager expertise to adequately respond to varying degrees of need among Members. What is the Supplier's proposed case manager to Member ratio? Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D.

	Question	Referenced RFP Section	Response
238	The following sentence is duplicated in both questions 97 and 98: "...provide information about who will be trained on how to use the system, and how data captured in the system can be integrated into day-to-day operations of the CMO, particularly areas such as Case Management and financial and Quality functions." Please clarify whether this information should be included in both questions 97 and 98.	Attachment G, Questions 97 and 98	Question 98 in Attachment G will be amended to delete the following sentence: "Additionally, provide information about who will be trained on how to use the system, and how data captured in the system can be integrated into day-to-day operations of the CMO, particularly areas such as Case Management and financial and Quality functions."
239	Section 4.2.24.1 states that the "Memorandum of Understanding for the PeachCare Partnership Program" is "attached to this Contract as Attachment T"; however, Attachment T merely has a placeholder sheet. Please provide the MOU or indicate when the MOU will be available.	Attachment I, 4.8.24.1; Attachment I, Attachment T	Suppliers will be notified when and if the MOU is updated or revised.
240	Please indicate when DCH anticipates making Attachment K, Information Management and Systems, available to Suppliers.	Attachment I, Attachment K	Attachment K will be posted in the Suppliers' Library.
241	Please identify the process and specify the DCH defined code set or other criteria required to generate the NICU Supplemental Payments to the CMOs for Georgia Families Members.	Attachment I, Section 1.4, Definitions "Neonatal Intensive Care Unit (NICU) Supplemental Payments"	<p>NICU Supplemental Payments are generated based on specific Tricare V.30 DRGs (612, 631, 633, 636, 651,681) which must be submitted to DCH for payment. In addition, DRGs 633, 636, and 651 must also be flagged as exceeding the hospital outlier threshold in order to qualify for payment. The outlier thresholds are as follows: DRG 633 = \$349,386; DRG 636 = \$327,988; and, DRG 651 = 209,376.</p> <p>The NICU Supplemental Payment request should be submitted on a monthly basis in a tab-delimited flat file that is sent to DCH via SFTP. DCH will validate the submitted files using a set of edits and audits. Those records on the file that fail to pass these edits and audits will be rejected and included on a response file that the CMO will receive one week later. The CMO will then have the opportunity to correct any rejects and resubmit the following month.</p> <p>The NICU Supplemental Payment is limited to one payment per Member per lifetime.</p> <p>For further detail, please refer to the "Process for NICU Data Submission and Verification" document added to the Suppliers' Library.</p>

	Question	Referenced RFP Section	Response
242	Please identify the process and specify the DCH defined code set or other criteria applied to paid claims data to generate the Obstetrical Delivery Payment to CMOs.	Attachment I, Section 1.4, Definitions "Obstetrical Delivery Payment"	The Obstetrical Delivery Payment request should be submitted on a monthly basis as a tab-delimited flat file that is sent via SFTP. There are certain CPT and Diagnosis Codes specific to maternity and delivery that must be on the claim to generate a successful payment. Once the file is submitted, the Obstetrical Delivery Payment process will validate the submitted files utilizing a set of edits and audits. Those records on the file that fail to pass these edits and audits will be rejected and included on a response file one week after completion of the Obstetrical Delivery Payment processing. The CMO will then have the opportunity to correct any rejects and resubmit the following month. For further detail, please refer to the "Process for DVP Data Submission and Verification" document added to the Suppliers' Library.
243	Section N.4.i states that Suppliers are required to test that their BC-DR plan can "restore System functions per the standards outlined elsewhere in the Contract." Time standards are provided in Section 14.6.1.4 ("within a twelve (12) hour period"); however, there do not seem to be standards that specify which services, business functions, or applications. Please provide guidance about which services, functions, or applications DCH expects to be operational at the 12-hour mark.	Attachment I, Section 14.6.1.4; Attachment D, Section I.N.4.i	DCH will provide this information prior to the Operational Start Date.
244	Please clarify if reimbursement to CAH at 101% of cost may be achieved based on published CAH rates or if cost settlement by CMOs is required. Please specify whether "101% of cost" applies to all IP and OP services. Per the Hospital Services Provider Handbook, CAH services are reimbursable at 100% of cost. Please clarify this discrepancy.	Attachment I, Section 4.10.4.4; Critical Access Hospital (CAH) Contracting and Provider Handbook, Part II, Policies and Procedures for Hospital Services (January 2015),	There are not published Critical Access Hospital (CAH) rates, but it is allowable for the CMO to set rates that result in reimbursement at or above 101% of the CAH's cost without having a cost settlement, if agreed to by the CAH. If the CMO and CAH are not able to agree upon an alternative payment rate, the CMO will need to perform a cost settlement to reimburse the CAH at 101% of cost. The reference to reimbursement of CAHs at 100% of cost in the Part II Hospital Manual refers to fee for service payments made directly by DCH to CAHs.
245	The contracts state that "The Contractor shall house indexed images of documents used by Members and Providers to transact with the Contractor in the appropriate database(s) and document management systems to maintain the logical relationships between certain documents and certain data." Please indicate whether DCH has defined the "certain" documents/data (e.g., claims, authorizations, EOBs, RAs) for which relational data must be maintained.	Attachment I, Section 4.17.3.5; Attachment J, Section 4.17.3.5	Information referenced in this section will be provided after Contract Award.
246	There is reference to an "updated version of the provider network listing spreadsheet for all requested provider types". Is this spreadsheet available for use currently in support of network development?	Attachment I, Section 4.3.5.4	Yes. DCH has posted the Provider Network Listing Spreadsheet in the Suppliers' Library.
247	Are providers required to be EPSDT certified or encouraged?	Attachment I, Section 4.7	DCH is not aware of an EPSDT certification.
248	According to 4.9.2.2 – "These bulletins can be mailed hard copy or can be disseminated via email, provided hard copies are available and Providers are informed of how to request in hard copy." Is faxing an acceptable means of distribution for provider bulletins?	Attachment I, Section 4.9.2.2	Faxing is an acceptable means of distribution for provider bulletins only if confirmation of delivery and receipt are provided.
249	Will the CMO have full subrogation recovery rights?	Attachment I, Section 8.4.1.4	No, the CMO will not have full subrogation rights.

	Question	Referenced RFP Section	Response
250	Will DCH provide third party liability information on a separate proprietary file?	Attachment I, Section E. Member Enrollment	TPL information will be provided to the Supplier in an approved format which meets the standards and guidelines acceptable by DCH.
251	Will the CMO have a process to send newly identified TPL to the state, i.e., weekly file feeds?	Attachment I, Section E. Member Enrollment	Yes. The Supplier must have a process to send newly identified TPL information to DCH. DCH will identify the format prior to the Operational Start Date.
252	Does the 20% interest clause apply for normal third party liability cost avoidance claims? If the 20% interest clause does apply to third party liability cost avoidance claims, does the source of the TPL information (state, CMO, or CMO vendor) impact this clause?	Attachment I, Section N. a. General Provisions; Attachment I, Section N. a. General Provisions	Per O.C.G.A. § 33-21A-7, for all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment. The 20% interest clause does not apply to normal third party liability cost avoidance claims.
253	Are CMOs required to request permission before investigating any and all excluded providers after the time that the exclusion is identified and reported to the state? Please provide guidelines surrounding the initiation of investigations and for referring suspected FWA cases. How many days from suspicion are Suppliers required to refer FWA activities?	Attachment I, Sections 4.13.2.1.13 and 4.13.3.3; Attachment D, Section I.N.2.b.14.	Yes. The Supplier will be required to request permission before investigating any and all excluded providers after the time that the exclusion is identified and reported to the state. DCH will provide guidelines for the initiation of investigations and for referring suspected Fraud Waste and Abuse Cases prior to the Operational Start Date.
254	Attachment U, Figure Z references a baseline measurement period of CY 2013 for HEDIS measures to support value based programs. Will DCH provide the historical HEDIS detail information (data needed to calculate a numerator and denominator) to support the baseline?	Attachment U, Figure Z	All DCH performance measure reports are available online at the DCH website.
255	Please confirm whether including the question text from Attachments F, G, and H on a cover sheet preceding the question response will count against the page limits.	Attachments F, G, and H	Requirements regarding page limits will be removed from the submission instructions.

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	Question	Referenced RFP Section	Response
256	Please provide historical claims data extracts from Georgia Families and Georgia Families 360 programs for medical, behavioral, and pharmacy to support Suppliers' business, strategy and clinical decisions.	Attachments G and H	Please refer to the Suppliers' Library.
257	Should required attachments, which are excluded from page limits, be included within the same electronic file as the required narrative response, or should they be uploaded as separate files? If they should be uploaded as separate files, what convention should be followed for the Attachment File Names?	For example - Attachment G, Question 93, Compliance Plan	For each question instructing the supplier to upload attachments, please submit 1 document using the naming convention indicated. Please see column E of attachments G for "Attachment File Name" or naming convention requested.
258	Please quantify the average provider reimbursement percentage relative to 100% Medicaid that the September 2012 through August 2013 experience represents, split by Inpatient Hospital, Outpatient Hospital and Professional. Note: we are requesting aggregate information on the total program, not proprietary information on specific plans or providers; this is critical financial information for a new entrant to understand to be able to evaluate the adequacy of the rates for their plan.	Georgia Families Rate Range Development (July 2014-June 2015)	DCH will not provide this information.
259	Please specify whether the CMOs are required to cost settle for Hospital Services or for other provider types. If so, please specify which provider types are impacted, the process utilized, and how this was incorporated into CMO rates development.	Provider Handbook, Part II, Policies and Procedures for Hospital Services (January 2015), Chapter 1000, Basis for Reimbursement	There are not published Critical Access Hospital (CAH) rates, but it is allowable for the CMO to set rates that result in reimbursement at or above 101% of the CAH's cost without having a cost settlement, if agreed to by the CAH. If the CMO and CAH are not able to agree upon an alternative payment rate, the CMO will need to perform a cost settlement to reimburse the CAH at 101% of cost. The reference to reimbursement of CAHs at 100% of cost in the Part II Hospital Manual refers to fee for service payments made directly by DCH to CAHs. For all other Providers, cost settlements are not required.
260	Will DCH provide claims data to review and analyze, similar to what was provided for the 2014 ABD RFP?	General question	No. Please refer to the Suppliers' Library
261	Please confirm that the responses to attachments F, G, and H should be submitted in the provided Excel files. Should the response be written in Calibri 12 point font (the same as the provided Excel file)?	Attachment A. eRFP, 2. Instructions to Supplier, 2.2.3 Preparing a Response, pp. 14 - 15	Please use Calibri (11 point).
262	Are there any specific instructions or formatting requirements for attachments, such as file names, page limits, etc.?	Attachment A, eRFP, 2. Instructions to Supplier, 2.2.3 Preparing a Response, pp. 14 - 15	Please upload attachments using the naming convention indicated in column E of attachments G and H. Page limit recommendations will be removed.

	Question	Referenced RFP Section	Response
263	How will DCH measure page length?	Attachment A. eRFP, 2. Instructions to Supplier, 2.2.3 Preparing a Response, pp. 14 - 15	Requirements for page lengths indicated on pages 14 and 15 referenced in Attachment A, 2.2.3, number 2, states " Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. ". Any references to the physical length of the page should be disregarded as there is no intention to measure the size of the page.
264	Does the requirement of excluding cost relate to outcomes of programs implemented by the CMO?	Attachment A. eRFP, 4. eRFP Proposal (Bid) Factors, 4.2 Supplier General Information, p. 19	Presenting information in the form of a dollar amount may be viewed as "cost/pricing information". To comply with the requirement to "not include costs", consider presenting data as a percentage in lieu of using dollar amounts.
265	Will DCH be providing a further breakdown of the points for the "Mandatory Scored" and/or "Additional Scored" Responses?	Attachment A. eRFP, 6. Proposal Evaluation, Negotiations and Award, 6.4 Scoring Criteria, p. 24	No other breakdown, other than the details listed in section 6.4 of the RFP, will be communicated.
266	Can the supplier waive member cost sharing (copayments) as an enhanced benefit offering?	Attachment D. Requirements & SOW, D. Special Coverage Provisions, #13 Member Cost-Sharing, p. 30	A Supplier may not waive Member copayments.
267	What is the date that it is expected that the Credentialing Verification Organization (CVO) will have completed the credentialing and recredentialing of Providers for the contracted CMOs?	Attachment D. Requirements & SOW, I. Georgia Families Provider Network, #22 Provider Credentialing, p. 65	The anticipated launch date of the CVO is July 1, 2015.
268	Please clarify the intent of the following statement: "Specify that the Supplier shall not be responsible for any payments owed to Providers for services rendered prior to a Member's Enrollment with the Supplier, even if the services fell within the established period of retroactive eligibility." According to Part I Policies and Procedures for Medicaid/Peachcare for Kids Manual, the provider has the choice to continue to bill the member or bill Division within 6 months. Does this imply that Medicaid FFS will reimburse the provider if option 2 is selected regardless of the member being retroactively enrolled in an MCO?	Attachment D. Requirements & SOW, K. Provider Contracts and Payments, y. p. 84	There is no retro-enrollment in Managed Care. Thus, the language is clear as written. The Supplier shall not be responsible for any payments owed to Providers for services rendered prior to a Member's Enrollment with the Supplier, even if the services fell within the established period of retroactive eligibility.
269	Does the following statement apply to retro-active terminations, and if so, will the original CMO be provided with information on who to recover payments from (i.e., if the member switches CMOs): " ... if the Supplier made payment for a patient for whom it was not responsible, then the Supplier may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider."	Attachment D. Requirements & SOW, K. Provider Contracts and Payments, 4. Provider Payment, p. 86	The referenced language applies to Third Party Liability matters. For example, if a Member has primary insurance coverage which is not identified until after services have been rendered by a Provider enrolled in the Supplier's network, the Supplier must pursue the legally responsible party (primary payer). The Supplier may not recoup the reimbursement they have already paid to the network Provider thereby forcing the network Provider to pursue the legally responsible third party.

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	Question	Referenced RFP Section	Response
270	Is there an opportunity for DCH to conduct a demonstration of the Prior Authorization Portal?	Attachment D. Requirements & SOW, L. Utilization Management and Coordination and Continuity of Care Responsibilities, 2. Prior Authorization and Pre-Certification, p. 91	On-line training is available on the Georgia Medical Management Information System (GAMMIS) https://www.mmis.georgia.gov .
271	Are the forms and processes related to the Medical Review Process provided in the Supplier's Library? If not, will they be provided?	Attachment D, Requirements & SOW, L. Utilization Management and Coordination and Continuity of Care Responsibilities, 2. Prior Authorization and Pre-Certification, p. 91	"Forms and processes" will not be provided in the Suppliers' Library. Please refer to Attachment D, section I.L.2, for information related to Prior Authorization and Pre-Certification.
272	This section indicates the Supplier shall submit pharmacy data to DCH's Pharmacy Rebate Vendor for the purposes of processing rebates. Please clarify if DCH retains all pharmacy rebates and whether or not the pharmacy capitation rates contained in the Rate Range Development document are gross or net of the rebate amounts.	Attachment D. Requirements & SOW, L. Utilization Management and Coordination and Continuity of Care Responsibilities, 8.Coordination and Continuity of Care Responsibilities, d. Coordination with	The CMO rates are gross of the federally mandated rebates since DCH retains those rebates. The CMOs are able to negotiate their own rebates directly with manufacturers and the pharmacy capitation rates are net of those rebates.
273	Can DCH provide a url address for the Requirements Analysis Documents located on the DCH website?	Attachment D. Requirements & SOW, Section M. Quality Management and Performance Improvement, 17. Reporting Requirements, p. 114	These requirements will be made available after Contract Award.
274	In Attachment G, questions 79 and 80 appear to be the same question. Does the supplier need to answer both questions?	Attachment G, Mandatory Scored Response, Questions 79 and 80	Question 79 was duplicated in error. Question 80 states: Describe the responsibilities of case managers and how they will assist Members based on their level of need. Describe the range of case manager expertise to adequately respond to varying degrees of need among Members. What is the Supplier's proposed case manager to Member ratio? Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D

	Question	Referenced RFP Section	Response
275	Attachment K: Information Management and Systems, found in Attachment I: Georgia Families Contract, states "Requirements to be Defined by DCH and Provider at a Later Date." Can DCH provide additional detail on the timing of when this information will be available?	Attachment I. Georgia Families Contract, Attachment K, Information Management and Systems, p. 289	Attachment K will be posted in the Suppliers' Library.
276	The rates are based on the experience of the current CMOs and reflect the CMOs' TPL collections. Please provide the average TPL recovery percentage.	Georgia Families Rate Range Development document, Section AA.3.6 Third Party Liability	The data used to determine the capitation rates is net of TPL. CMO TPL collection amounts are not available.
277	Rates were developed based on 9/1/12 thru 8/31/13 utilization and cost data. CMOs have contracted rates with providers that may or may not be at 100% of FFS. Can DCH supply information on provider contracting percentages included in the base data?	Georgia Families Rate Range Development document, p.12	No, DCH is unable to supply information on Provider contracting percentages.
278	The first two sentences are contradictory. Please confirm that a competitive sealed proposal submission will not be required for this proposal.	Section 1.2 eRFP Certification, page 9	Thus, competitive sealed proposals will be submitted in response to this eRFP.
279	Must CMOs respond to both Georgia Families and Georgia 360° sections of the RFP to be compliant with submission requirements, or can CMOs respond to only one of the Georgia Families or Georgia 360 ° sections of the RFP?	Section 6.2.1 Review of Mandatory and Mandatory Scored Questions and Section 6.2.2 Review of Additional Scored Information Questions, page 23	The technical responses are first evaluated on a pass/fail basis to determine each supplier's compliance with administrative and mandatory requirements. Of those responses meeting the administrative and mandatory requirements, the "Mandatory scored" and "Additional scored" responses are then scored to determine the relative technical value of each supplier's response. Each technical score will then be combined with a cost score assigned to the supplier's pricing to determine the supplier's overall score or value
280	If the contract is initially for one year and it begins on the date of award (~July 6, 2015), then it appears the initial contract year ending June 30, 2016, expires before the Operational Start Date, which is July 1, 2016. If this is true, will DCH extend the initial contract one additional year to cover the initial program year?	Attachment D, Scope of Work, Section IA.1, page 2 and Attachment A, Section 1.7 Contract Term, page 11	In this instance, DCH will exercise its option to renew for the next fiscal year.

	Question	Referenced RFP Section	Response
281	<p>Question 49 states: Demonstrate progress toward developing network capabilities for statewide access by providing signed Letters of Intent with physicians, specialists, Mental Health providers, dentists, hospitals, pharmacies, therapists, etc. for Georgia Families program networks that shall include the information, at a minimum:</p> <p>a. An Excel worksheet listing every provider with a signed Letter of Intent. The worksheet must include the name of the provider, the provider's address(es), county/counties, Service Region, provider's Medicaid Identification Number(s) and provider type.</p> <p>b. Using the Geo Access tool, Statewide Geographic Access report of all providers with LOIs color coded by provider type by Service Region.</p> <p>Please clarify whether DCH is requiring Bidders to submit only the Provider Network Excel worksheet and GeoAccess reports, as specifically stated in the question, or if Bidders must also submit copies of signed Letters of Intent along with the required Provider Network Excel worksheet and GeoAccess reports.</p>	Attachment G – Mandatory Scored Questions, Question 49. Provider Network	All Suppliers must submit letters of intent (LOIs) as detailed in Attachment D of the RFP.
282	How will CMOs determine if responses, meeting page limitations, will fit into the Excel worksheet cells?	Attachment G – Mandatory Scored	Please review the instructions in Appendix G and H which state that Suppliers should "upload documents if there is a Yes in the "Upload Attachs with Additional Information" column. Every question in Appendix G and H, columns indicate "yes" and instruct the supplier to upload attachments with the naming convention indicated. Please do not enter responses in the Excel spreadsheet.
283	What is the font and font size that CMOs should use to respond?	Attachment G – Mandatory Scored	Please use Calibri (11 point).
284	Will the state provide the FY2014 and FY2015 Rate Certification Tables contained in the data book in Excel format to facilitate data analysis?	Georgia Families Rate Certification	The Excel versions of these files will be posted in the Suppliers' Library.
285	Since Attachment G is provided as an Excel template, how do Suppliers determine that they have complied with page limit requirements in each of their responses?	Attachment G – Mandatory Scored	Requirements regarding page limits will be removed from the submission instructions.
286	Questions 79 and 80 are identical. Which question may Suppliers delete to eliminate duplication?	Attachment G – Mandatory Scored Questions, Question 79/Question 80. Utilization Management and Care Management	Question 79 was duplicated in error. Question 80 states: Describe the responsibilities of case managers and how they will assist Members based on their level of need. Describe the range of case manager expertise to adequately respond to varying degrees of need among Members. What is the Supplier's proposed case manager to Member ratio? Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D

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	Question	Referenced RFP Section	Response
287	At the end of Question 79 is a line that states, "Georgia Families UM Responsibilities: Question 7." To what is this referring?	Attachment G – Mandatory Scored Questions, Question 79. Utilization Management and Care Management	The reference to "Georgia Families UM Responsibilities: Question 7" in question 79 remained from an earlier outline. The information has been deleted and should be disregarded. Please refer to the Revised Attachment G for updated information.
288	In the Business Continuity & Disaster Recovery section, can the Supplier prepare a report of the results of these tests and present to DCH staff within 21 days instead of five (5) Business Days of test completion to allow for debriefing, recommendations, document preparations, Gov't Contracts review, etc.	Business Continuity & Disaster Recovery - Attachment D, Page 137, "I" :	No. DCH requires the Supplier to prepare a report of the results of the tests and present the results to DCH within five (5) Business Days of the test completion date.
289	Please clarify expectations on what types of vendors would be addressed under Question 27c? If the Supplier does not use any vendors to evaluate medical necessity, is Question 27c not applicable?	Attachment G – Mandatory Scored Question 27c	If the Supplier does not use a Material Subcontractor to evaluate medical necessity, Question #27c in Attachment G is not applicable.
290	Does the following section pertain to the time, post award, when Suppliers will be required to contract Providers and the providers must be aware of their participation and the terms of the contract? Can a Supplier use a rental network solely for the purpose of filing a LOI network as long as that rental network has notified providers they would be submitted in the Supplier's LOI network submission?	Attachment D, SOW, Provider Selection and Retention Policies and Procedures, Page 52, Paragraph 2	Yes, this section pertains to the post Notice of Award period. The Supplier must have an LOI directly with each Provider, not with a rental network.
291	Does DCH have a significant traditional provider list so that Suppliers may know which different specialty types are currently serving the Georgia Families members? If there is no list, is it up to each Supplier to determine which Specialists in Figure 1 are needed to provide the services to cover the benefits for Georgia Families members?	Attachment D, SOW, 17. Geographic Access Requirements, Figure 1	DCH is not able to provide a list of such providers.
292	The RFP question 9b asks for a different client reference for each Material Subcontractor. Can the State confirm that when the Material Subcontractor(s) is owned by the same parent company, separate specific references for contracts held by each material subcontractor will still be required.	Attachment G, question 9b	Separate references are required for Material Subcontractors.
293	Please provide a list of all of the covered services by CPT code for each of the behavioral health services.	N/A	Behavioral Health codes include both CPT and HCPCS codes. The codes are provided in the Supplier's Library and are specifically the Fee-for-Service codes approved in the Medicaid state plan for Community Behavioral Health Rehabilitation Services and Psychological Services. Other Behavioral Health related code are available under Physician services or Childrens Intervention Services.
294	The section discusses delivery of home and community based behavioral health services which may be incentivized by the supplier for providers who engage in person centered service delivery. With regard to the incentive can DCH clarify that this is through administrative or financial incentives?	Attachment D, Mental Health and Substance Abuse, page 28	The incentives the Supplier wishes to provide should be based in the model proposed and could include both or either (administrative and/or financial incentives).

	Question	Referenced RFP Section	Response
295	The requirement lists Mental Health Providers: Does this also apply to substance abuse providers? Also, in reference to page 63 mental health providers/wait time. Does this also apply to substance use providers?	Attachment D, Geographic Access Requirements, Figure 1, pg 61 and page 63	Attachment D references to Mental Health Geo Access and related requirements are inclusive of substance abuse treatment.
296	Is it the expectation that peers will be under the age of 18 or are they peers who are specially trained in working with youth but not limited to being under 18 years of age?	Attachment D, pages 28 and 55	It is expected that the Supplier shall utilize Youth Certified Peer Support Specialists who are under 22 years of age to provide peer services to Members of the same or similar ages.
297	Does the care manager have to be physically located in the hospital or can the care manager regularly frequent the hospital to visit with staff and patients?	SOW, page 8	The hospital-based care manager's work station should be located in the hospital setting. This care manager may serve several hospitals.
298	Please clarify any missing language (noted in red) in this statement under e. Integration of Physical and Behavioral Health Services. <i>"The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the, with the Member's or the Member's legal guardian's consent."</i>	Attachment D, page 100	This should read: The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the PCP, with the Member's or the Member's legal guardian's consent.

	Question	Referenced RFP Section	Response
299	Please provide companion guide and technical requirements for required interfaces, including prior authorization, portal enrollment, and provider credentialing and member portal requirements.	NA	<p>Response</p> <p>EDI interface FTP allows an external value added network (VAN) or trading partner to submit transactions via FTP.</p> <p>PA Interfaces</p> <ol style="list-style-type: none"> 1. CMO Prior Auth Extract Daily. This is a Daily Extract of Prior Authorizations for Georgia Families 360° CMO members. 2. CMO Prior Auth Extract Monthly. This is a Monthly Extract of Prior Authorizations sent to CMOs. 3. CMO Prior Auth Input File. This Input file received for the CMO for Prior Authorizations processing. 4. CMO Prior Auth Response File. This Response file of Prior Authorizations is returned to CMOs. 5. CMO Women's Health Medicaid Prior Auth Extract Daily. This is a Daily list of Prior Authorizations for WHM members that the CMOs receive. <p>Member Interfaces</p> <ol style="list-style-type: none"> 1. Standardized Member Extract. This is the standardized member extract file that is created by the MMIS for outside organizations. <p>Provider Interfaces</p> <ol style="list-style-type: none"> 1. CMO Network File. This interface is received from each CMO weekly. The file is normally transmitted on Fridays. The CMO sends a unique file with additions, terminations, and deletions that pertain only to its network of member providers. The records on this file are used to make the appropriate updates in the interChange provide file. 2. CMO Provider Extract. This interface is sent to the CMO daily. A full file is sent everyday, although each CMO does not process it on a daily basis. The file consists of the full complement of GA Medicaid providers who are or were active within the GA Medicaid program sometime during the prior 2 years. Providers who are exclusively
300	Please clarify the required ID timeline requirements for the GA 360 product. The contract lists both a 7(4.3.7.1.1) and 5 days (4.3.7.6) for issuing an ID card. What determines when the 5 day versus 7 day timeframe must be met?	Georgia Families 360° Shell Contract, ID card, page 81	The requirement is seven (7) Calendar Days.
301	Can you please confirm whether the reference to "third parties" in the definition of "Subcontractor" in Attachment B excludes affiliated entities of the Respondent?	Attachment B: Definitions and Acronyms, p.36	No. Third parties include affiliate entities of the Respondent.
302	Beginning on the Operational Start Date, the Supplier's Geographic Access analysis, using the Geo Access tool, must include the below data standards and reporting specifications. This RFP section refers to providing geo access analysis beginning on the Operational Start Date, Are geo access analysis and reports required to be submitted with this rfp submission?	RFP Attachment D, Geographic Access Requirement, 59	Please refer to the Geo-Access reporting requirements for the RFP submission in Question 49 of Attachment G.

	Question	Referenced RFP Section	Response
303	<p>In addition to the Geographic Access data reports, the Supplier shall submit the following separate reports: a. Providers and associated locations with closed panels (any Provider which the Supplier recognizes as no longer accepting new Members) and those Providers and associated locations with less than Full-Time Provider hours. The separate reports must include a listing of the Providers by name and location, Provider type and an analysis of the total number of Providers with closed panels or less than Full-Time Provider hours expressed as a percentage of the Supplier's total contracted Providers for the state and then for each Service Region. Are these provider listings to be included with this RFP submission; is there a DCH formatted template that should be used</p>	RFP Attachment D, 18. Other Reports, 62	<p>Yes, information regarding closed panels and less than Full-time Providers is required in the RFP response. No, DCH does not have a template.</p>
304	<p>Specialists standard - It is our assumption that all specialists based on how the "specialists" category is listed on figure 1 should be grouped together and not broken out by individual specialties. Is this assumption correct or are they to be broken out by specialty and what are those specific specialties that should be included separately for the geos?</p>	RFP Attachment D, Figure 1. Geographic Access Standards by Provider Type, 61	Specialists may be grouped together unless the Supplier has the capability to list each specialty by type.
305	<p>Mental Health standard - It is our assumption that all specialists based on how the "Mental Health" category is listed on figure 1 should be grouped together and not broken out by individual specialties. Is this assumption correct or are they to be broken out by specialty and what are those specific specialties that should be included separately for the geos?</p>	RFP Attachment D, Figure 1. Geographic Access Standards by Provider Type, 61	Mental Health Providers may be grouped together unless the Supplier has the capability to list each Mental Health Provider by type.
306	<p>Therapy (Physical Therapists, Occupational Therapists and Speech Therapists) standard - It is our assumption that all specialists based on how the "Therapy (Physical Therapists, Occupational Therapists and Speech Therapists)" category is listed on figure 1 should be grouped together and not broken out by individual specialties. Is this assumption correct or are they to be broken out by specialty and what are those specific specialties that should be included separately for the geos?</p>	RFP Attachment D, Figure 1. Geographic Access Standards by Provider Type, page 61	Physical Therapists, Occupational Therapists and Speech Therapists be must listed by Provider type.
307	<p>The Supplier shall assure that all network Providers have been appropriately credentialed by DCH or its Agent, maintain current licenses, and have appropriate locations to provide the Covered Services – are we able to obtain a list of the providers that meet this criteria today to include their Medicaid ID's and NPI's?</p>	RFP Attachment D, General Provisions, paragraph 3, page 51	For the purpose of responding to this RFP, DCH will not provide a listing of providers with Medicaid ID numbers and NPIs. Access to Medicaid provider information may be found at https://www.mmis.georgia.gov/portal/default.aspx

Requesting State Entity:
Department of Community Health

	Question	Referenced RFP Section	Response
308	All reports are to be submitted in the established DCH format with all required data elements. Failure to submit all Attestations and complete reports in the established DCH format with all required data elements may result in Liquidated Damages up to \$5,000 per day against the Supplier. Would DCH be providing this format with all of the required data elements for the RFP submission?	RFP Attachment D, Provider Network Composition, page 52	DCH will provide all templates and report specifications prior to the Operational Start Date.
309	The Supplier shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented appropriately on all claims and associated documents. The Supplier will emphasize to Providers the need for a unique GA Medicaid ID number for each practice location unless DCH changes this requirement at a future date. We were also required to include "b. If Provider does not have a Medicaid Identification Number, Provider commits to apply to be a Medicaid provider;" in our LOI. The DCH website shows NPI required for providers in place of Medicaid ID for providers who are able to obtain an NPI. https://dch.georgia.gov/national-provider-identifier-npi - Are Medicaid ID's required for providers or are providers required to have NPI's.	RFP Attachment D, Providers Network Composition, page 53	For the purpose of responding to this RFP, Suppliers must provide the Medicaid ID number on the letter of intent (LOI). DCH will not provide a listing of providers with Medicaid ID numbers and NPIs. Access to Medicaid provider information may be found at https://www.mmis.georgia.gov/portal/default.aspx
310	Based on the language provided in the Part II Policies and Procedures for Hospital Services, section 906 (Limited Emergency Room and Outpatient Services), it states that coding of certain diagnoses that represent diseases and conditions that are recognized as medical emergency situations on a claim will result in the claim being treated as an emergency service. According to Attachment D Requirements and SOW of the RFP under Emergency Services, it states an emergency Medical condition shall not be defined or limited based on a list of diagnoses or symptoms. 1. Please confirm if Emergency room services are payable regardless of the diagnosis.	Attachment D- Requirements and SOW, Special coverage provisions/ Emergency Services	All emergency room services are payable.
311	Please advise if we can engage with the Public Health Department during the procurement black-out period to obtain LOIs since they are a provider of service.	General Question - Attachment A	Suppliers may contact the Department of Public Health for the purpose of obtaining signed letters of intent.
312	If a new CMO does not achieve at least 200,000 Georgia Families members from the described open enrollment & auto-assignment process, what additional steps would be taken to satisfy the assumption of the new CMO achieving a membership level of 'at least 200,000' Georgia Families Members as stated in 1.1.5(b)?	Attachment A, section 1.1.5, Transition Planning, page 6 of 27	Additional information about the auto-assignment process and algorithm will be provided after Contract Award.
313	What is the minimum membership threshold that a new CMO can expect in total?	Georgia Families Contract, section 2.3, Eligibility and Enrollment, page 48 of 341	Please refer to Section 1.3 of Attachment A.
314	When will plans find out if rates will be risk adjusted for state fiscal year 2017? Or, are the changes listed in section 5.5 of Attachment A only regarding subsequent periods?	Attachment A, section 5.5, Future Capitation Rate Methodology, page 22	CMOs will be informed as to whether the DCH will risk adjust for FY 2017 during the FY 2017 rate development process scheduled to begin towards the end of CY 2015.

Requesting State Entity:
Department of Community Health

	Question	Referenced RFP Section	Response
315	Will PeachCare to LIM rate cells remain separate or will they be rolled into LIM rates? Will all other rate cells remain the same as structured in state fiscal year 2015 with respect to age bands, programs/populations, regions, etc.?	Attachment A, section 5.2, Overview of Georgia Families and Georgia Families 360° Capitation Rate Methodology, page 20	It is expected that Peach Care to LIM rate cells will remain separate and all other rate cells will remain the same as structured in SFY15 for the new contract. Note that the NICU Supplemental Payment may be eliminated and NICU costs integrated into the appropriate rate cell. DCH, however, may make changes to the rate structure as necessary to ensure actuarial soundness and maintain operational efficiency.
316	Will a databook with a more recent base year be provided for the Georgia Families and Georgia Families 360 programs? If so, when could we expect these documents to be available? Will the databook include all covered services? Will additional information on adjustments made to the data be provided similar to what is included in the rate certifications?	Attachment A, section 5, Capitation Rate Methodology, page 20	No, the Suppliers' Library contains the most recent databooks for Georgia Families and Georgia Families 360° (FY 2014 and FY 2015).
317	Since the initial rates for Georgia families 360 program were started off-cycle (March 3, 2014 - December 31, 2014), can the State confirm that the rates will move to a state fiscal year cycle for SFY 2017?	Attachment A, section 5.2, Overview of Georgia Families and Georgia Families 360° Capitation Rate Methodology, page 20	The Georgia Families 360° rates were extended to June 30, 2015 and will move to a state fiscal year cycle for SFY 2017.
318	Does the State expect to continue selecting rates around the midpoint for Georgia Families 360° and around the lower bound of Georgia Families for state fiscal year 2017? What information regarding the range will be available prior to bid submission?	Attachment A, section 5.2, Overview of Georgia Families and Georgia Families 360° Capitation Rate Methodology, page 21	As stated in Attachment A, for Georgia Families, DCH has generally established rates at the low end of the rate range. DCH expects to continue this approach in FY 2017. For Georgia Families 360° in FY 2017, DCH expects to set rates, prior to adjusting for the Value Based Purchasing Withhold, near the midpoint of the Capitation Rate range. Please refer to the Georgia Families and Georgia Families 360° Rate Range Certification documents in the Suppliers' Library for detail on the rate ranges.
319	Are there MLR requirements for either the Georgia Families or Georgia Families 360 programs? If so, will the health insurer fee be excluded from that calculation?	Attachment A, section 5, Capitation Rate Methodology, page 20	There are no minimum MLR requirements for the Georgia Families or Georgia Families 360° programs.
320	How are Pharmacy Rebates handled in the capitation rate setting process for state fiscal year 2017?	Attachment A, Capitation Rate Methodology, page 20	Pharmacy rebates are included as an adjustment to the overall prescription drug costs from the Encounter Data. The capitation rates are net of pharmacy rebates.
321	When will the Georgia Families 360° encounter data be available?	Attachment A, section 5.2, Overview of Georgia Families and Georgia Families 360° Capitation Rate Methodology, page 20	The Georgia Families 360° encounter data will be available for the FY 2017 rate development process.

	Question	Referenced RFP Section	Response
322	Are any significant methodological changes not listed in Attachment A expected in the capitation rate setting process?	Attachment A, section 5, Capitation Rate Methodology , page 20	DCH is not aware of any significant methodological changes at this time.
323	<p>RFP Section 4.2 states "Each supplier must complete all of the requested information in the attached file entitled Supplier's General Information Worksheet. DO NOT INCLUDE ANY COST/PRICING INFORMATION IN YOUR RESPONSE TO THIS WORKSHEET."</p> <p>Please confirm if Georgia economic impact dollar amounts, such as community investment dollars, local employee salaries, and claims paid are considered "cost/pricing information" that Suppliers are not allowed to speak to within the technical proposal response.</p>	Attachment A, Section 4.2	<p>Presenting information in terms of Georgia economic impact dollar amounts, such as community investment dollars, local employee salaries, and claims paid may be considered "cost/pricing information".</p> <p>To comply with the requirement in 4.2, consider presenting data as a percentage in lieu of using dollar amounts.</p>
324	<p>According to RFP Section 6.4 "Scoring Criteria," please provide more detail on how the 1,000 points are distributed by section and/or question if an Offeror is interested in participating in both the Georgia Families and Georgia Families 360° Programs.</p> <p>Similarly, please provide detail on how the 1,000 points are distributed by section and/or question if an Offeror is not interested in participating in the Georgia Families 360° program (For example, if Offerors exclude Attachment G "Additional Scored Responses").</p>	Attachment A, Section 6.4	No other breakdown, other than the details listed in section 6.4 of the RFP, will be communicated.
325	The Requirements in Attachment D (Requirements and Scope of Work), Sections I.N.5.d (page 143) and I.N.7 (page 145) appear to be duplicative; please clarify if the identical language should be interpreted differently.	Attachment D, Sections I.N.5.d and I.N.7	Attachment D will be amended to delete Section I.N.5.d.
326	Please clarify what is meant by an "Acute Care" clinical initiative. For example, is the Georgia Department of Community Health (DCH) seeking for Suppliers to propose inpatient or hospital clinical related initiatives, and/or initiatives related to a different topic(s)?	Attachment G, Question No. 84	Acute care services include all promotive, preventive, curative, rehabilitative or palliative actions, whether oriented towards individuals or populations, whose primary purpose is to improve health and whose effectiveness largely depends on time-sensitive and, frequently, rapid intervention. The Supplier must implement two (2) clinically based initiatives, using rapid cycle process improvement methodologies, that seek to improve
327	<p>Section I.N.1.c of Attachment D (page 119) states the following: "The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim counts as an error for that Encounter (this is regardless of how many other errors are detected in the TCN.)"</p> <p>The requirement language appears to be missing text and/or is not clear; can DCH please provide the missing text, if applicable.</p>	Attachment D, Section I.N.1.c	The sentence should read: "The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim that counts as an error for that Encounter (this is regardless of how many other errors are detected in the TCN.)"

	Question	Referenced RFP Section	Response
328	<p>Does the written notification requirement contained in Attachment D, I.K.1.hh (page 84) apply to reimbursement adjustments tied to events noted in section I.K.1.gg (page 84) where the Commissioner of DCH directs the Supplier to make such adjustments to reflect budgetary changes to the Medical Assistance program? Please confirm that this notification requirement only applies to reimbursement changes specific to an individual provider contract and excludes reimbursement adjustments directed and/or implemented by DCH.</p> <p>If any adjustments were to occur, will the executed amendment signed by the provider, suffice as the written form of provider acceptance?</p>	Attachment D, Sections I.K.1.gg and I.K.1.hh	<p>Suppliers are not obligated to utilize the Medicaid fee schedule or the same version of DRG used by DCH. Suppliers are not required to use the same Medicaid reimbursement methodology. For example, the Supplier and a hospital may agree to an alternative DRG version or per diem fee schedule rather than using the same DRG version as Fee-for-Service Medicaid. However, if the State budget includes a Provider rate change, Suppliers must pass through that change to Providers. For example, if the State budget requires an increase in hospital rates, the Supplier would be required to pass through the rate increase regardless of its payment methodology with hospitals.</p> <p>If the rate change is mandated by the State's General Assembly, the Supplier is not required to negotiate or obtain the Provider's agreement with respect to the rate change.</p>
329	<p>Section I.L.8.e of Attachment D (page 100) states the following: "The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks as set forth in section J.2."</p> <p>The requirement language appears to be missing text and/or is not clear; can DCH please provide the missing text, if applicable.</p>	Attachment D, Section I.L.8.e	This should read: The Supplier must require that Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of the Members' Behavioral Health status to the PCP, with the Member's or the Member's legal guardian's consent.
330	<p>Section I.L.8.k of Attachment D (page 97) states the following: "Requirements for patient-center care including of Members addressing both developmental and chronic conditions; and;"</p> <p>The requirement language appears to be missing text and/or is not clear; can DCH please provide the missing text, if applicable.</p>	Attachment D, Section I.L.8.k	Subparagraph k. should read: "Requirements for patient-centered care to meet the of Members, addressing both developmental and Chronic Conditions; and..."
331	<p>Questions 22.b (Attachment G) and 118.d (Attachment H) ask Suppliers to provide Resumes and "three (3) references for each proposed Key Staff member." Please confirm whether the requirement to provide references applies only to individuals holding Key Staff positions specifically identified in the RFP, or whether the requirement also applies to other Key Staff positions that Suppliers identify in their respective Responses.</p>	Attachment G, Question No. 22; Attachment H, Question No. 118	References apply to Key Staff identified in Attachment D of the RFP.
332	<p>A number of RFP questions throughout Attachments G and H do not reference page limits (For example, Questions 26, 27, 28, and 51 of Attachment G). Recognizing the State's interest in receiving brief and concise responses, does the State intend to publish page limits for these questions?</p>	Attachment G, Attachment H	Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. Requirements regarding page limits will be removed from the submission instructions.

	Question	Referenced RFP Section	Response
333	Attachment G, Questions 90-95 appear to be incorrectly labeled with the row heading entitled "Utilization Management and Care Management," when each of the individual question Attachment names refer to "Administrative Services" (Attachment D). Please confirm "Administrative Services" is the correct row heading for Questions 90-95 instead of "Utilization Management and Care Management."	Attachment G, Question No. 90-95	Attachment G, Questions 90-95 are to be referenced as "Admin Services" as indicated. The heading titled "Utilization Management and Care Management" in line 102 is incorrect. Please refer to the Revised Attachment G for corrected information.
334	Questions 104 (Attachment G) and 160 (Attachment H) requests a sample Turnover Plan, as well as a detailed description of proposed processes and approaches to turnover planning. Please confirm if Suppliers can include the sample Turnover Plan as an Attachment so that the 3 pages of narrative can be dedicated to a description of the approach.	Attachment G, Question No. 104; Attachment H, Question No. 160	Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. Requirements regarding page limits will be removed from the submission instructions.
335	<p>Please clarify the following regarding Question 49 (Attachment G):</p> <ul style="list-style-type: none"> • Is it the State's intention to require Suppliers to provide actual signed Letters of Intent (LOIs) with the proposal, understanding that this requirement will add thousands of pages to each Supplier's response? • If LOIs are required with the proposal, please confirm that Suppliers who have secured fully executed contracts for the Georgia Families and Georgia Families 360° Programs may submit executed contracts in order to demonstrate network access. • Should Suppliers provide a narrative response, in addition to providing the required Excel worksheet and Geo Access reports? If so, please clarify the required page limit that Suppliers should utilize. 	Attachment G, Question No. 49	All Suppliers must submit signed letters of intent (LOIs) as detailed in Attachment D of the RFP. The Supplier may provide a narrative response in addition to the information required in Attachment D of the RFP.
336	<p>In lieu of obtaining non-binding LOIs from individual subcontracted pharmacies to represent the Suppliers potential pharmacy network, would it be acceptable for Suppliers to obtain an LOI from our Pharmacy Benefit Manager (PBM), which can include the PBM's commitment to make available its robust contracted network of pharmacies?</p> <p>Along the same lines, can Suppliers obtain one LOI from our vendors who are responsible for providing our dental and vision provider networks, which would also include a complete list of contracted providers?The LOI for network providers would state its intent to provide a robust network of providers by including a current listing of which would be attached to the LOI as an Excel spreadsheet illustrating all contracted (pharmacy, vision, or dental) providers in Georgia as of the LOI executed contract date and attesting to the evergreen nature of these agreements (i.e., no specified termination date).</p>	Attachment G, Question No. 50	Suppliers may submit a signed letter of intent from a PBM with a list of all contracted pharmacies. For vision and dental provider networks, a signed letter of intent must be obtained from each participating provider.

	Question	Referenced RFP Section	Response
337	Regarding Question 55 (Attachment G), please confirm if the "examples of successful Telemedicine programs the Supplier has implemented" should be included in the 5-page limit.	Attachment G, Question No. 55	Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. Requirements regarding page limits will be removed from the submission instructions.
338	Question 25 (Attachment G) asks Suppliers to discuss "enhanced services" and refers Suppliers to "Section I.C Covered Services and Benefits of Attachment D," which provides a specific definition of enhanced services. "Value Added Services" requirements are included in "Section I.D Special Coverage Provisions." There does not appear to be a question specifically related to "Value Added Services," within Attachment G. Please confirm the specific question number in which "Value Added Services" should be discussed within the Supplier's response.	Attachment D, Sections I.C and I.D.; Attachment G, Question No. 25	The Supplier should clarify its question.
339	Question 64.c (Attachment G) requests Suppliers to provide "A workplan that outlines education and training activities, including frequency of office visits to conduct activities." Please confirm if the workplan should be included with the 5 page limits or should it be included as an Attachment to the response?	Attachment G, Question No. 64	Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. Requirements regarding page limits will be removed from the submission instructions.
340	Question 15 of Attachment G requires a page limit of 3 pages. Can Suppliers provide additional information in an Attachment, similar to the instructions provided for Questions 13, 14, 16, 17, and 18 (Attachment G)?	Attachment G, Question No. 15	Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. Requirements regarding page limits will be removed from the submission instructions.
341	Regarding Questions 8 and 12 (Attachment G), please clarify if the page limits apply to each of the Supplier and Material Subcontractor organizations, or if they apply to each question collectively.	Attachment G, Question No. 8 and 12	Answer each question in sufficient detail for evaluation while using judgment with regards to the length of response. Requirements regarding page limits will be removed from the submission instructions.

	Question	Referenced RFP Section	Response
342	<p>Many requirements throughout the RFP are requesting information, such as client references, services to be performed, and organizational experience of the "Supplier" or "Offeror." Please confirm that the related information being requested of affiliate companies will be acceptable. Companies that are likely to respond to this RFP are often structured with a single legal entity operating within a state; therefore, client references, for example, from other state Medicaid programs may be for affiliate companies of the responding entity, but nonetheless, would represent the full scope and experience across the Offeror's organization. If such requirements were restricted to client references holding contracts with the responding entity, companies that were created to solely serve the Medicaid population in Georgia would not meet minimum mandatory requirements, as requested throughout the RFP.</p> <p>For similar purposes, please clarify the definition of a "subsidiary."</p>	Attachment G, Attachment H, Attachment D	A subsidiary is a wholly owned entity of the Supplier's Parent Company. Information from affiliate companies is not acceptable.
343	Question 112 (Attachment G), under the "Scenarios" heading, is not structured as the other Scenario-related questions are. Please confirm if Suppliers should create a scenario about how a member might access well visits for the three age groups.	Attachment G, Question No. 112	Describe the process the Supplier will use to ensure Members attend their preventive health visits.
344	Please confirm that Question 80 is a duplicate of Question 79 and Suppliers do not need to address each question separately.	Please confirm that Question 80 is a duplicate of Question 79 and Suppliers do not need to address each question separately.	Question 79 was duplicated in error. Question 80 states: Describe the responsibilities of case managers and how they will assist Members based on their level of need. Describe the range of case manager expertise to adequately respond to varying degrees of need among Members. What is the Supplier's proposed case manager to Member ratio? Refer to section I.L: Utilization Management and Coordination and Continuity of Care Responsibilities – Case Management of Attachment D

	Question	Referenced RFP Section	Response
345	<p>RFP Attachments G and H include a column (Column C) for "Response by Offeror." The cells designated for responses are character limited. In order to provide a comprehensive response to each question and to make it easier for evaluators to review, are Offerors permitted to refer to a separate Word or PDF Attachment in Column C, and in the Attachment, include a full response to the question?</p> <p>If full responses to questions in separate Word/PDF Attachments are permitted:</p> <p>a. Does DCH have any formatting preferences, such as margin size, font style and size, inclusion of graphics/tables, etc.?</p> <p>b. What kind of information should the Offeror include in the Column C "Response by Offeror" cells (For example, a sentence simply referring the evaluators to the specific Attachment containing the full response to the question)?</p>	<p>RFP Attachments G and H include a column (Column C) for "Response by Offeror." The cells designated for responses are character limited. In order to provide a comprehensive response to each question and to make it easier for evaluators to review, are Offerors permitted to refer to a separate Word or PDF Attachment in Column C, and in the Attachment, include a full response to the question?</p> <p>If full responses to questions in separate Word/PDF Attachments are permitted:</p> <p>a. Does DCH have any</p>	<p>Please review the instructions in Appendix G and H which state that Suppliers should "upload documents if there is a Yes in the "Upload Attachs with Additional Information" column. Every question in Appendix G and H, columns indicate "yes" and instruct the supplier to upload attachments with the naming convention indicated. Please do not enter responses in the Excel spreadsheet. No formatting preferences have been indicated other than the naming convention. Column C should remain blank.</p>
346	<p>Question 142 (Attachment H) asks Suppliers to "Provide a workplan to contract with Georgia Families 360° Providers, with accountabilities and timelines." Please confirm if the workplan should be included within the 2 page limit requirement.</p>	<p>Attachment H, Question No. 142</p>	<p>Requirements regarding page limits will be removed from the submission instructions.</p>
347	<p>Attachment I (Georgia Families Contract), Section 25.5.1.3 (page 245) and Attachment J (Georgia Families 360° Contract), Section 25.5.1.3 (page 320) reflects the claims processing rate of 97% with an interest rate of 18% up to 20%. Within the vicinity of recent years, the claims processing rate was changed to 95%, with a 12% in interest. Please confirm if it is the State's intent to move the claims processing rate back to 97%, with the interest as outlined (in Attachments I and J) or was this an oversight and not updated within the RFP requirements?</p>	<p>Attachment I, Section 25.5.1.3; Attachment J, Section 25.5.1.3</p>	<p>The claims processing rate should be ninety-seven percentage (97%).</p>

	Question	Referenced RFP Section	Response
348	<p>Please clarify the following regarding Value Based Purchasing (VBP) Measures, related to Attachments I (Georgia Families Contract), J (Georgia Families 360° Contract), and U (Value Based Purchasing Measures):</p> <ul style="list-style-type: none"> • For the VBP measures, would DCH consider establishing a “Quality Compass Target” vs. “Year over Year Improvement Percentage Targets” for benchmarking <ul style="list-style-type: none"> • Would DCH consider using “Regional” vs. “National Quality Compass” percentiles for VBP • For CAHPS related VBP measures, would DCH consider changing to a rating measure, such as “Rating of Health Plan.” 	<p>Please clarify the following regarding Value Based Purchasing (VBP) Measures, related to Attachments I (Georgia Families Contract), J (Georgia Families 360° Contract), and U (Value Based Purchasing Measures):</p> <ul style="list-style-type: none"> • For the VBP measures, would DCH consider establishing a “Quality Compass Target” vs. “Year over Year Improvement Percentage Targets” for benchmarking • Would DCH consider using “Regional” vs. “National Quality Compass” percentiles for VBP • For CAHPS related 	<p>DCH has established the Value Based Purchasing measures and targets as described in the RFP documents - including the CAHPS measures and targets. DCH utilizes national Quality Compass percentiles.</p>

	Question	Referenced RFP Section	Response
349	<p>Please clarify the following regarding the Planning for Healthy Babies (P4HB) Program, as it relates to Category 2 liquidated damages for performance measures, referenced in Attachment I (Georgia Families Contract), Section 25.3 and Attachment M (Demonstration Quality Strategy), Section VII:</p> <p>Will there be an opportunity to immediately auto-enroll members into the P4HB programs, to their existing, assigned Care Management Organization?</p>	<p>Please clarify the following regarding the Planning for Healthy Babies (P4HB) Program, as it relates to Category 2 liquidated damages for performance measures, referenced in Attachment I (Georgia Families Contract), Section 25.3 and Attachment M (Demonstration Quality Strategy), Section VII:</p> <p>Will there be an opportunity to immediately auto-enroll members into the P4HB programs, to their existing, assigned Care Management Organization?</p>	<p>Details about auto-assignment will be provided after Contract Award.</p>
350	<p>In Attachment I (Georgia Families Contract), Section 4.11.10.6 (page 159), based on the levels of case management listed, (Levels 1-3), is the intent of DCH that the entire Georgia Families population go into case management or should the program still be focused on those members with the most complex needs for intervention? If the intent is for all Georgia Families population, using current membership, certain Offerors would have a large number of members participating in case management, which would create extensive staffing requirements in order to manage the population. Please confirm DCH's intent.</p>	<p>Attachment I, Section 4.11.10.6</p>	<p>DCH's intent is that Members who are risk-stratified and determined to be in need of Case Management will be case managed. The levels of Case Management and the functions of each level are described in Attachment D.</p>
351	<p>Please clarify the following regarding Attachment I (Georgia Families Contract), Section 4.11.2.5 (page 145), related to Prior Authorization and Pre-Certification requests:</p> <ul style="list-style-type: none"> The contract states that the Contractor shall use the DCH portal for all services, however the current capability is only utilized for Inpatient Services, Newborn and Prenatal Notifications, and Hospital Based Outpatient Services. Currently, this includes all Behavioral Health services, including ancillary vendors (For example, dental, vision, and pharmacy vendors). Please confirm if the State is planning to expand their portal capability, prior to the Go-live Date of the contract. If the answer to the above question is "no," then can the contract be amended to allow for the use of Suppliers' own portals and/or can Suppliers utilize their own portal until the State's portal has been updated to receive all types of authorizations? 	<p>Attachment I, Section 4.11.2.5</p>	<p>DCH established a Centralized Prior Authorization Process in June 2013 for providers that is accessed via the Georgia Medical Management Information System (GAMMIS) https://www.mmis.georgia.gov. Phase I of the Centralized PA process encompassed: Newborn Delivery Notification, Pregnancy Notification, Inpatient Hospital Services, Outpatient Hospital Services, Ambulatory Services, In-state transplants, Hospital outpatient therapy, Appeals and Reconsideration requests and Submission of initial and additional clinical data. Phase II of the Centralized PA Process will be effective June 2015 and will include Children Intervention Services for Therapy, Durable Medical Equipment and Behavioral Health Services (Inpatient).</p> <p>A Supplier may not use its own Prior Authorization portal.</p>

	Question	Referenced RFP Section	Response
352	Please clarify the following regarding Attachment I (Georgia Families Contract), Section 4.11.2.7 (page 146): <ul style="list-style-type: none"> The contract states the Standard turnaround time has changed from 14 calendar days to 3 business days or other established timeframe. Can the State clarify the meaning of "other established timeframes?" Please clarify if 3 days represents "business days" vs. "calendar days," as current State reports are based on calendar days. 	Attachment I, Section 4.11.2.7	For Standard Service Authorizations, the turnaround time is three (3) Business Days or other established timeframe. The phrase "other established timeframe" refers to any additional timeframes established by DCH. DCH will notify the Suppliers if the timeframes are adjusted.
353	Regarding Attachment I (Georgia Families Contract), Section 4.8.9.1.3 (page 109) related to "Tier 3: Specialty Providers," is the intent to add the provider types of Certified Peer Specialists and Care Management Entities for Georgia Families members, as this is typically resources used for the foster care population since the severity of complexity is not as intense as the Georgia Families 360° members provided for these type of services. Please confirm.	Attachment I, Section 4.8.9.1.3	Tier 3 Specialty Providers by definition include Certified Peer Specialists and others who do not provide a comprehensive array of behavioral health services. Certified Peer Specialty services and Care Management Entity services are not exclusive to the Georgia Families 360° population only, Therefore, these services would be available to all Georgia Families program members.
354	In Attachment K (DCH Liquidated Damages), Section 25.3 regarding Category 2 liquidated damages for performance measures (for both the Georgia Families and Georgia Families 360° Programs), please confirm if DCH would consider using "Regional" benchmarks.	Attachment K, Section 25.3	No, DCH would not consider regional benchmarks.
355	RFP Section 6.6.1 states the following: "After each round of negotiations (if any), the supplier will submit revisions to its proposal factors and/or cost proposal, which revisions will be scored by the Evaluation Team in accordance with the same criteria used to evaluate the initial responses from the suppliers." The RFP requirements do not include a cost proposal; therefore, please provide information/guidance about submitting a revision to the cost proposal.	Attachment A, Section 6.6.1	The RFP requirements do not include a cost proposal; therefore, no revision to the cost proposal will be requested.
356	Attachment D, Section I.1.18.a, Attachment I (GA Families Contract), Section 4.3.5.3, and Attachment J (GA Families 360° Contract), Section 4.3.6.3 make reference to "specialists." Since Specialist providers are not designated as PCP's, they are not paneled members that are currently managed. Is it the expectation from DCH that Specialist providers are designated as paneled members?	Attachment D, Section I.1.18.a; Attachment I, Section 4.3.5.3; Attachment J, Section 4.3.6.3	No, it is not DCH's expectation that the specialty providers are designated as paneled providers.
357	According to the DOAS website, the CMO "....Request for Proposal (RFP) is subsequent to an electronic Request for Qualified Contractors (eRFQC) ES-RFQC-40199-465. Only Suppliers that were determined to meet the qualifications specified within the RFQC, are eligible to respond to this RFP." Can you share which suppliers are considered qualified to bid?	General	The qualified contractors which met pre-qualification criteria established for eligibility to complete for a contract through this solicitation are: <ol style="list-style-type: none"> Amerigroup Georgia AmeriHealth Caritas Peach State Health Plan, Inc. WellCare CareSource Georgia Molina Healthcare Humana United Healthcare Gateway Health Plan, Inc.

	Question	Referenced RFP Section	Response
358	When can we anticipate RFP documents/supporting materials to be uploaded to the GA Marketplace site?	General	The solicitation is active and the materials have been available beginning February 9, 2015. For technical assistance with locating the documents, please call the helpdesk at 404-657-6000.
359	<p>A question was raised by internal staff regarding continuing communication with State employees during this period. I am interpreting the section below to mean that we may continue communication with State (DCH) staff as it relates to our current contract. Please confirm or correct as you deem necessary.</p> <p>Assuming I am correct, are we required to copy you on all communications?</p> <p>2.1.2. Restrictions on Communicating with Staff</p> <p>From the issue date of this eRFP until the final award is announced (or the eRFP is officially cancelled), suppliers are not allowed to communicate for any reason with any State staff except through the Issuing Officer named herein, or during the Bidders/Offerors' conference (if any), or as defined in this eRFP or as provided by existing work agreement(s). Prohibited communication includes all contact or interaction, including but not limited to telephonic communications, emails, faxes, letters, or personal meetings, such as lunch, entertainment, or otherwise. The State Entity reserves the right to reject the response of any supplier violating this provision.</p>	General	Correct. For those Care Management Organizations that have an existing contract with DCH, internal staff may continue to communicate with State employees during this period regarding matters involving their current contracts.
360	I tried accessing the attachments for the following procurement but could not. Can I open/access the attachments if I am not on the Qualified Contractors list for ES-RFQC-40199-465?	General	For technical assistance with locating the documents, please call the helpdesk at 404-657-6000.
361	We qualified for the RFQ and our staff at home office are trying to view the documents that were just posted, but can't open the attachments. Is there a new password that needs to be used? Do you perhaps have the documents on stick drive?	General	No external materials will be provided. For technical assistance with locating the documents, please call the helpdesk at 404-657-6000.
362	<p>We received an e-mail alerting us to the posting of the GA Families RFP. We have visited the site to view and download the document, but have not been able to access it. When we go to the event, it appears that there are no attachments listed. We are also having difficulty signing into our account.</p> <p>I am on the phone with the procurement help desk, but I also wanted to reach out to you to see if the attachments are perhaps not finished with the posting process, or if this is an issue that others are experiencing as well.</p> <p>Any insight or guidance that you can provide would be greatly appreciated!</p>	General	For technical assistance with locating the documents, please call the helpdesk at 404-657-6000. No external materials will be provided.

	Question	Referenced RFP Section	Response
363	I have a few questions about the Event Id# 41900-DCH0000100 Round 1 Version 1. I have not been able to download the actual RFP. Can you assist?	General	For technical assistance with locating the documents, please call the helpdesk at 404-657 6000. No external materials will be provided.

Supplier Q & A Template

RFX Number: 41900 DCH0000100 RFX Title: GA Families and GA Families 360° Care Management Organization

Requesting State Entity: Georgia Department of Community Health

Date: April 20, 2015

Issuing Officer: Dana Harris

RFX Initially Posted to Internet: February 9, 2015

eMail Address: Dana.Harris@doas.ga.gov

Telephone: 404-657-4322

The purpose of this document is to provide answers to supplier questions. Please see Questions and Answers included herein.

Note: This document is intended for informational purposes only. Any changes to the RFX must occur through a published addendum (or through publication of a new version of the RFX in Team Georgia Marketplace™). If multiple Q & A documents are posted, the most recent Q & A shall govern in the event of a conflict.

#	Question	Referenced RFP Section	Response
1	We anticipate using a 2 year look back period to respond to Attachment G Question # 17, is this acceptable?	Attachment G, Question #17	For Question 17 of Attachment G, Suppliers must use the last three (3) consecutive full calendar years.

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2	Our understanding is that the references requested for Material Subcontractors in Attachment G Question #9 (b.) are meant to come from the Medicaid Agencies who run the programs that the subcontractor indirectly contracts with (as a subcontractor to a Medicaid Health Plan) rather than the Health Plans that were the primary contractors for those agreements with the Medicaid Agencies, is this correct?	Attachment G, Question #9 (b.)	Yes, it is correct that the references for Material Subcontractors must come from Medicaid agencies where the Material Subcontractor has successfully provided services under capitated risk-based contracts within the last five (5) consecutive calendar years.
3	Does the Enrollment Broker in GA conduct any kind of needs assessment at the time when an enrollee is selecting a plan (for example, do they identify pregnant enrollees at the time of enrollment)? If so, are these results shared with the Health Plan they choose?	Attachment G, Question #35	The enrollment broker does not conduct a needs assessment of the Member at the time the Member selects the Care Management Organization (CMO).
4	Please provide a job description for the Resource Mother position referenced in Attachment N to the GA Families Contract (Attachment I)	Attachment I (Attachment N)	Please refer to Attachment N of Attachment I (Georgia Families Contract) to the RFP.
5	Questions #27 and #28 in Attachment G seem very similar, please clarify what information they are looking for in question #27 that they would not expect to see in a response to question #28?	Attachment G, Questions #27, #28	Question #27 of Attachment G references the suppliers understanding of the federal EPSDT benefit and all required components including informing activities. Question #28 is asking the supplier to describe their methodology for ensuring their members access the federal EPSDT benefit in order to drive improvements in health outcomes.

6	Please provide clarification for expectations for Question 22.b., which requires 3 references for each proposed Key Staff Member. Are 3 references required for those staff that are already employees of the Supplier? In addition, are 3 references required for all Key Staff positions listed in Attachment D: I. B. 2.)?	Attachment G Question #22(b), Attachment D Section I (B) (2)	Yes, references will be required for those Key Staff that are already employees of the Supplier. References may be internal or external.
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<p>7</p>	<p>Please provide additional information on the job qualifications and accountabilities envisioned for the Key Staff position: A Strategic Planner to support clinical Quality improvement</p>	<p>Attachment D Section I (B) (2) (f)</p>	<p>Quality Improvement (QI) must align with the Supplier's vision and mission. QI must take into account environmental factors impacting the organization and its proposed QI activities (the environmental scan); the organization's strengths, weaknesses, opportunities and threats (SWOT analysis); the goal(s) to be achieved and the objectives that will lead to the achievement of the goal(s); strategies that will align with the objectives; and the tactics/interventions to be implemented to drive improvement. The strategic planner supporting QI must be well versed in strategic planning principles and their alignment with rapid cycle process improvement.</p>
<p>8</p>	<p>In response to Round 1 Q&A written questions #149, DCH stated that, "Both DFCS and DJJ are scheduled to be fully connected members to GaHIN by the time the resulting Contracts are awarded. However, there may still be limits as to what information is contributed by DFCS and DJJ. Therefore the Supplier must also have capacity for information exchange outside of GaHIN." What information is the GaHINMIS currently exchanging and will be exchanged at time of contract award between sister agencies and current supplier?</p>	<p>Attachment D, Section II. K Georgia Families 360 Information Management Systems, pg. 176; Question 149, Round 1 Q&A</p>	<p>To clarify, in the previous response, DCH used the term "exchange" to describe the sharing of information that may need to occur between state agencies and the successful Supplier outside of information available through GaHIN. Information available through membership in GaHIN is not exchanged, but is contributed by each participating member and other members in turn may access it. DCH currently contributes claims data. DJJ and DFCS have access to see information, but do not contribute</p>

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9	<p>In response to Round 1 Q&A written questions #227, DCH stated that, “The current contract does not track by these distinct care coordination categories. Slightly less than two percent (2%) of the enrolled Georgia Families 360° Members receive complex care coordination.”</p> <p>Are all children in the 360 population enrolled in intensive care management or in complex care management? Or are there also “regular” care management/different levels of care for the remaining children in the 360 program?</p>	Attachment D, Section II.I.8; Question 227, Round 1 Q&A	All children enrolled in Georgia Families 360° are not enrolled in intensive or complex case management. Care Coordination activities align with the Member's needs.
10	<p>In response to Round 1 Q&A written questions #251, DCH stated that, “Yes. The Supplier must have a process to send newly identified TPL information to DCH. DCH will identify the format prior to the Operational Start Date.”</p> <p>Will there be a response file from DCH indicating the load rate and possible reconciliations?</p>	Attachment I, Section E. Member Enrollment; Question 251, Round 1 Q&A	No. There will not be a response file from DCH indicating the load rate and/or possible reconciliations.
11	<p>In response to Round 1 Q&A written questions #249, DCH stated that, “No, the CMO will not have full subrogation rights.”</p> <p>What types of cases will the CMO be able to pursue and what specifically is excluded?</p>	Attachment I, Section 8.4.1.4; Question 249, Round 1 Q&A	The previous response was written in error. The Supplier will have full subrogation rights
12	<p>In response to Round 1 Q&A written questions #63, DCH stated that, “The State has prepared a document for contract exceptions which has been uploaded as Attachment Q.”</p> <p>The State refers to Attachment Q, Contract Exceptions as being uploaded and available. We do not see Attachment Q on the GA Marketplace site. Please advise when this will be shared.</p>	Attachment F – Mandatory Response Worksheet, Question 2; Question 63, Round 1 Q&A	Attachment Q, the Contract Exceptions Form is uploaded and is available for use, as applicable.

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13	Will the State provide an affidavit template for redaction purposes, or further instructions on how the affidavit should be loaded, including file naming convention, to the GA Marketplace site upon submission?	Addendum 1, 2. Georgia Department of Community Health Open Records Policy	No template will be provided. Consult statutory guidance at O.C.G.A. § 50-18-72. Regarding naming convention, include entity's name/partial name in title with "Affidavit for GF RFP" or "Affidavit for 360 RFP", as applicable.
14	Addendum 1 states that "DCH requires Offerors to submit redacted versions of their proposals or other submissions in addition to un-redacted versions. " Does this mean that Offerors are to upload TWO distinct proposals? If so, please provide instructions for submission.	Addendum 1, 2. Georgia Department of Community Health Open Records Policy	No. Please upload one (1) unredacted proposal. In the event of an open records request during the NOIA period, suppliers may be contacted to provide a redacted version.
15	In response to Round 1 Q&A written questions #255, DCH stated that, "Requirements regarding page limits will be removed from the submission instructions." Revised Attachment H still contains page limits. Will DCH be uploading a re-revised Attachment H which removes page limits?	Attachments F, G, and H; Question 255 Round 1, Q&A	The page limit requirements were intended to be removed. Any remaining references to page limit requirements should be disregarded.
16	Please verify the Batch and Online Transaction Specifications that Suppliers must support. There are 4010 versions listed for two transactions (ASC X12N 275 (004010X107) and ASC X12N 278/279 (004010X094), which were retired in 2012. The GAMMIS has not published a companion guide for either of these. Additionally, the 275 transaction is not commonly used, and the 279 identifier does not correspond to an ASC X12N transaction.	III. Batch and Online Transaction Specifications for Data Exchange, Attachment K Georgia Families Contract Attachment I -- Posted 03/19/2015, page 11	The 275/276 and 278/279 transactions are not supported in the GAMMIS.

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17	Is the member incentive limitation of \$50 annually per Member restricted to a rolling 365-day period or the calendar year?	Attachment D - Requirements and Scope of Work, Section H.1.b Marketing, p.49	The reference is to a calendar year. The maximum aggregate is \$50.00 per Member per year.
18	May the proposed contractor obtain the necessary State Taxpayer Identification Number, Sales and Use Tax Number and Withholding Tax Number post notification of potential contract award?	Attachment E - Supplier General Information Worksheet, Item 6, Tax Compliance Form	Validation of tax compliance will occur prior notification of the intent to award a contract; therefore, the information presented on the form should be accurate. The information provided in the form will be submitted to the Georgia Department of Revenue ("DOR") for a determination as to whether the supplier is a "prohibited source" (as defined by O.C.G.A. §50-5-82) or whether there are any other
19	In response to Question #255 of DCH's 1st Round of Responses to Questions (published on March 18, 2015), DCH states that "requirements regarding page limits will be removed from the submission instructions" and the referenced RFP sections are Attachments F, G, and H. Amended Attachment F and G have been revised in accordance with the Response to Question #255, but Attachment H still contains language regarding page limits. Please confirm it was the State's intent to also remove language regarding page limits from Attachment H.	Attachment H	The page limit requirements were intended to be removed. Any remaining references to page limit requirements should be disregarded.

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<p>20</p>	<p>Per Attachment D, Section 18 (Other Reports, page 62), DCH requests that Suppliers submit Letters of Intent (LOIs) to represent their network, which do not contain information on provider office hours or open/closed panel status. If DCH would like to obtain this information, it would have to be provided through provider contracts.</p> <p>Would DCH consider allowing provider contracts to be submitted as support in the proposal OR, given that business information is not captured within LOIs, please confirm that Suppliers can assume a provider operates normal business hours of 8 AM-5 PM EST, (Monday through Friday), and is currently open to new members - unless told otherwise by the provider.</p>	<p>Attachment D, Section 18</p>	<p>No, DCH will not allow provider contracts to be submitted as support in the proposal. Suppliers should NOT assume that a provider operates normal business hours of 8AM - 5PM and are currently open to new Members. Suppliers must verify this information.</p>
<p>21</p>	<p>In Question Numbers 63, 71, 73, 77, and 89 of Attachment G, DCH appears to be looking for information about best practices from other states that might be implemented in Georgia. In health plans that are licensed only in Georgia, these programs and best practices would be from sister Medicaid organizations that serve similar populations.</p> <p>Please confirm that health plans that solely operate within Georgia should identify and discuss those innovative approaches/best practices that have successfully been implemented in other states by affiliates, will meet response requirements.</p>	<p>Attachment G</p>	<p>The questions referenced here are all clinical questions. Suppliers operating solely in Georgia must identify innovative approaches/best practices that have been successfully implemented by subsidiaries of the Supplier's Parent Company operating in other states.</p>

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22	<p>Please confirm that it is not the intent of DCH to include all members as a part of Case Management, but rather, for those members with a qualifying health problem, as outlined in Attachment I (Georgia Families Contract), Section 4.11.10.6.1 (page 159). For example, a member with no history of a chronic illness, inpatient admissions, or emergency room visits within a 6 month time period would not automatically be enrolled in case management until an acute condition developed into a recurring or uncontrolled health problem.</p>	Attachment I , Section 4.11.10.6.1	Case management services must be available to Members identified through the processes outlined in Section 4.11.10 of Attachment I.
23	<p>In the response to Question #238, of DCH’s 1st Round of Responses to Questions (published on March 18, 2015), DCH indicates that Question No. 98 in Attachment G will be amended to delete the following sentence: "Additionally, provide information about who will be trained on how to use the system, and how data captured in the system can be integrated into day-to-day operations of the CMO, particularly areas such as Case Management and financial and Quality functions." However, the revised Attachment G for Question No. 98 still lists this sentence. Please confirm that this sentence should be excluded from Question No. 98.</p>	Attachment G, Question No. 98	Question 98 in Attachment G is amended to delete the following sentence: "Additionally, provide information about who will be trained on how to use the system, and how data captured in the system can be integrated into day-to-day operations of the CMO, particularly areas such as Case Management and financial and Quality functions."
24	<p>Regarding Question No. 17 (Attachment G, Supplier Organization), please confirm that Suppliers may exclude any breach that involves fewer than five enrollees. Breaches involving a small number of individuals are generally caused by a human error (For example, double stuffed envelopes, incorrect fax number), and are not representative of the Supplier's dedication to privacy compliance on an enterprise or systemic basis.</p>	Attachment G, Question No. 17	Per Question #17 in Attachment G, please describe each breach and the Supplier's response. Do not include items that are excluded per 45 CFR 164.402. The look-back period is the last three (3) consecutive full calendar years.

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25	<p>Please confirm, for the purposes of Attachment G, Question No. 17, if DCH will consider defining the look-back period for the Supplier, in connection with their reported PHI breaches.</p> <p>Please confirm that a three year look-back period (the last three consecutive full calendar years), consistent with DCH's Response to Question #115 (published on March 18, 2015), will be acceptable for this response.</p>	Attachment G, Question No. 17	Yes. DCH defines the look-back period for the Supplier as the last three (3) consecutive full calendar years.
26	Regarding Question No. 17 (Attachment G, Supplier Organization), please confirm if DCH will consider limiting the scope of this response to those breaches involving publicly funded managed care programs, similar to those covered under this contract.	Attachment G, Question No. 17	No, DCH will not consider limiting the scope of this response to those breaches only involving publicly funded managed care programs.
27	Attachment G, Question No. 104, sub-item b, asks for “an overview of the support the Supplier will provide for the turnover activities for up to 90 Calendar Days.” Please confirm that the “90 calendar days” applies to after the contract termination effective date.	Attachment G, Question No. 104.b	Yes, the 90 Calendar Days applies to after the Contract termination date.
28	Per Attachment J (Georgia Families 360° Contract), Sections 16.4.3.5.5 and 16.4.3.5.6, please confirm the intent of the requirement is that the CMO should provide Family and Youth Peer Support Specialist staff as FTEs, available for Members, or that CMOs will have access to these resources in the community?	Attachment J, Sections 16.4.3.5.5 and 16.4.3.5.6	The Supplier must employ at minimum one (1) FTE Certified Peer Specialist-Youth (CPS-Y) and one (1) FTE Certified Peer Specialist-Parent (CPS-P) to serve as internal consulting resources to care coordination teams. Additionally, as indicated in Sections 4.6.11.1 and 4.8.9.1.3.2, the Supplier must have participating CPS-Y and CPS-P providers in its network.

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29	<p>Attachment I (Georgia Families Contract), Section 4.3.7.6.5 and Attachment J (Georgia Families 360° Contract), Section 4.9.5.6.5 states “One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.” Can DCH please define “open” for this performance measure?</p>	<p>Attachment I, Section 4.3.7.6.5; Attachment J, Section 4.9.5.6.5</p>	<p>"Open" means an unresolved inquiry.</p>
30	<p>As a follow-up to DCH’s 1st Round of Responses to Questions (For example, Question #80 and #81), published on March 18, 2015, respective to Attachment I (Georgia Families Contract), Sections 25.5.1.3.1 and 25.5.1.3.2, the responses provided do not align with the Georgia State law, effective 2012 per O.C.G.A. 33-24-59.5. Please confirm which annual percentage rate (12% or 18%) should be used to calculate interest for claims processed within 15 business days.</p>	<p>Attachment I, Sections 25.5.1.3.1 and 25.5.1.3.2</p>	<p>Two sections of the Official Code of Georgia are applicable. The first section is O.C.G.A. § 33-21A-7 which is the Medicaid Care Management Organization Act. Chapter 21A of Title 33 of the Official Code of Georgia applies to Medicaid Care Management Organizations. This section provides that for all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the CMO (Supplier), the CMO (Supplier) shall pay, in addition to the amount determined to be owed, interest of 20% per annum, calculated from 15 days after the date the claim was submitted. A Care Management Organization (Supplier) shall pay all interest required to be paid under O.C.G.A. § 33-21A-7 or O.C.G.A. § 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.</p>

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31	<p>Please clarify the following regarding Attachment J (Georgia Families 360° Contract), Section 4.7.3.5, regarding dental requirements for members participating in the Georgia Families 360° Program:</p> <ul style="list-style-type: none"> • What year of age are members qualified to begin dental exam visits? • Are dental exam visits conducted annually or bi-annually? • If dental exam visits are conducted bi-annually, but the Kenny A. Consent Decree indicates annually, which frequency takes precedence as being in compliance? 	Attachment J, Section 4.7.3.5	The dental periodicity schedule is referenced in Section 4.7.3.5 of Attachment J. Dental services are a component of the EPSDT program which follows the Bright Futures periodicity schedule. Guidance is provided there for the age at which dental examinations begin. Kenny A requirements, which are more stringent, take precedence over the periodicity schedule.
32	<p>Attachment I (Georgia Families Contract) and Attachment J (Georgia Families 360° Contract), Section 4.4.1.1.2 indicates that the Contractor is prohibited from "Offering any favors, inducements or gifts, promotions, and/or other insurance products worth more than \$15.00 at one time and not more than \$50 annually per Member." Please confirm if this requirement applies to "Potential Members."</p>	Attachment I , Section 4.4.1.1.2; Attachment J, Section 4.4.1.1.2	Yes, this requirement applies to potential Members/enrollees.
33	<p>Attachment I (Georgia Families Contract) and Attachment J (Georgia Families 360° Contract), Section 4.4.1.1.3 indicates that the Contractor is prohibited from "Providing meals for Potential Members, regardless of value." Please clarify the State's definition of "meal." For example, for large community events (e.g., Community Presentations, Health Screenings), would refreshments or snacks available to general audience of attendees, such as water and chips, be considered a "meal."</p>	Attachment I , Section 4.4.1.1.3; Attachment J, Section 4.4.1.1.3	Refreshments and light snacks are permitted. Supplier must ensure that items provided can not be reasonably considered a meal. Multiple items may not be "bundled" and provided as if a meal.
34	<p>If a mobile dental provider is a general dental practitioner that is able and willing to carry out all Dentist responsibilities in accordance with the Contract provisions and licensure requirements and will be responsible for coordinating Referrals, as needed, with Dental Subspecialty Providers and all subsequent dental care, can they be designated a Primary Dental Provider?</p>	Follow-up to Question 91 in Round 1 Q&A document	In order for a mobile dental unit to serve as a dental home, it must be staffed, equipped, and function at the same level and provide the same quality of service as if it was a brick and mortar dental office.
35	<p>In the first round of Q&A, the response to Question #63 indicated that the State has prepared a document for contract exceptions which has been uploaded as Attachment Q. We have been unable to locate this document. Please provide details regarding how to access Attachment Q.</p>	Attachment F – Mandatory Response Worksheet, Question 2	Attachment Q, the Contract Exception Form is uploaded and is available for use, as applicable.
36	<p>Please confirm the required Average Speed of Answer for member and provider calls is 80% of calls answered within 30 seconds, and 100% of calls answered within 1 minute.</p>	Attachment I, Section 4.3.7.6.1 and Section 4.9.5.6.1	Please see the RFP requirements for "Member and Call Center" and "Provider Services Call Center."
37	<p>Please confirm the Average Hold Time (AHT) requirement for member and provider calls is the measurement of the time from when a call enters the hold queue to when a member/provider services representative initially answers the call.</p>	Attachment I, Section 4.3.7.6.4 and Section 4.9.5.6.4	Per the RFP, "Hold Time" refers to the average length of time callers are placed on hold by a call center representative. See Average Hold Time.

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38	Will DCH reconsider allowing provider contracts to be recognized in addition to Letters of Intent in order to demonstrate progress toward provider network adequacy?	Attachment G, Questions 48 and 49	No, DCH will not allow submission of provider contracts.
39	The RFP states 97% of clean claims must be processed within 15 business days or interest of 18% will be applied. Please note that O.C.G.A. 33-24-59.5 was updated in 2012 to change the law to 95% of clean claims must be processed within 15 working days for electronic claims or 30 calendar days for paper claims or interest of 12%.	Attachment I, Section 25.5.1.3	Suppliers must comply with the provisions outlined in O.C.G.A. 33-24-59.5 and O.C.G.A. 33-21A-7.
40	Attachment F, Question 4 requires the Supplier to submit an Immigration and Security Form, as also directed in Attachment L. Please confirm that only a Contractor Affidavit is required to be submitted with RFP responses.	Attachment F, Question 4 and Attachment L	Please submit the forms for Contractor and Subcontractor, as applicable to the proposed business structure.
41	Please define what you mean by "missed appointments"? Does this mean that according to claims, encounter or medical record data the member is due for a well child visit and they did not have a visit yet? Or is this that the member scheduled an appointment with the provider and did not show up for the appointment?	Attachment D: Section 4, e, EPSDT Tracking System	Missed appointments include both scenarios described in the question. Refer to Attachment I, Sections 4.7.1.3 and 4.7.5.2 for additional information regarding missed appointments.
42	Attachment G, Questions 13, 14 and 17 do not provide a look-back period for Supplier to use in connection with disclosing their requested information. Please confirm that a three-year look back period is sufficient.	Attachment G: Questions 13, 14 and 17	Suppliers must use the last three (3) consecutive full calendar years as the look back period.
43	Please provide the document referenced as Attachment Q – Contract Exceptions Document as it cannot be located in the current Procurement Library	Supplier_Q_and_A_Round_1, #63	Attachment Q, the Contract Exception Form is uploaded and is available for use, as applicable.

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44	Please confirm a plan that submits a zipped file inclusive of the Excel worksheet listing every provider with a signed Letter of Intent (49a) and Geo Access tool, Statewide Geographic Access report (49b) and additionally a zipped file that includes copies of signed LOIs from each provider will meet the requirements.	Attachment G – Mandatory Scored Response Worksheet, Q49	Team Georgia Marketplace supports file attachments up to 50 megabytes each. It is important to follow the naming convention provided without adding dashes or special characters. Each file name can not exceed 50 characters. Compressed file formats, preferably using WinZip, may be uploaded that include several attachments, as long as the compressed file meets the 50 megabyte limitation. Technical Issues with uploading attachments should be reported to the DOAS helpdesk at 404-657-6000.
45	Please clarify the state's scoring and response criteria for the "Cost Score assigned to the supplier's pricing to determine the supplier's overall score or value"	Attachment G – Mandatory Scored Response Worksheet, Q49	No cost score will be included in the evaluation.
46	Please provide applicable dental data requirements to or from CAHPS.	Attachment B – Terms and Definitions, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Page 7	There is no reference to dental data requirements in the definition for CAHPS found in Attachment B, page 7.
47	Please define if the Expedited Review definition applies to dental services as well as medical?	Attachment B – Terms and Definitions, Expedited Review, Page 14	Yes, the expedited review definition applies to dental services.

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48	What access standard applies to (4)- Telemedicine presentation sites? This type of provider was not listed in Figure 1.	Attachment D – Requirements and Scope of Work, Section I, Georgia Families Provider Network 17. Geographic Access Requirements, Page 61	Telemedicine access standards are consistent with referenced rural Provider access standards, i.e., PCPs and Pediatricians - 15 miles; Obstetric Providers, Specialists, Hospitals, Mental Health Providers - 45 minutes or 45 miles, etc.
49	Can DCH provide a listing of Medicaid Certified pharmacies currently registered in the state of Georgia? This listing is necessary to ensure capabilities for point of sale claims adjudication.	Attachment D: Section I. Georgia Families Provider Network, 17 – Geographic Access Requirements, Figure 1. Geographic Access Standards by Provider Type, Page 6	DCH will not provide a listing of pharmacies. Access to Medicaid Provider information may be found at https://www.mmis.georgia.gov/portal/default.aspx
50	<p>1. Please clarify whether the CVO or Fiscal Agent will provide Supplier with a file of the DCH Credentialed network.</p> <p>2. How frequently (e.g. weekly, monthly) will the provider information be provided to the Supplier?</p> <p>3. Will the demographic information supplied by CVO or Fiscal Agent be considered the source data of the provider network or will Supplier be responsible for updating demographics and coordinating updates with CVO and/or Fiscal Agent?</p>	Attachment D – Requirements and Scope of Work, Georgia Families Provider Network, 22.b., Page 69	Yes, DCH will notify Suppliers of those providers who have been credentialed and recredentialed. This information will be provided on a daily basis to the Supplier. The demographic information supplied by the CVO will be considered the source data of the provider network. Supplier is responsible for notifying DCH if Supplier becomes aware that the provider's demographic information has changed.
51	Please confirm the requirement in question 16 of attachment G is specific to the Supplier or Parent company's Medicaid contracts.	Attachment G – Mandatory Scored Response Worksheet, Q16	This requirement applies to both Medicaid and commercial contracts.

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52	<p>Please confirm the state is only requesting significant privacy breaches as defined by any event that has required immediate reporting to the Office of Civil Rights (OCR) / and or CMS which would include any privacy breach impacting 500 or more member or provide an additional threshold which would be applicable to the state’s request.</p> <p>Additionally, please provide a time period for which DCH is requesting this information. For example, the last two years.</p>	Attachment G – Mandatory Scored Response Worksheet, Q17	Please describe each breach and the Supplier's response. Do not include items that are excluded per 45 CFR 164.402. The look-back period is the last three (3) consecutive full calendar years.
53	For network adequacy purposes, eligibility information provided by the state was provided by region, can the state provide this information at the zip code level to improve network adequacy analysis?	Attachment G – Mandatory Scored Response Worksheet, Q49	DCH will not provide the zip code level information.
54	Please confirm Question 106 and Question 112 should not be treated as scenarios and CMOs should respond to these questions in the standard narrative fashion.	Attachment G – Mandatory Scored Response Worksheet, Q106 and Q112	<p>For Question 106 of Attachment G, describe the process the Supplier will ensure dental access and Utilization of an annual dental visit for two (2) through twenty (20) year olds who reside in both urban as well as rural service delivery areas.</p> <p>As stated in the first Round of Questions & Answers, for Question 112, describe the process the Supplier will use to ensure Members attend their preventive health visits.</p>
55	In the Suppliers Library, a Provider Listing Report Template was posted on Posted 03/19/2015. Within the template, and on tab-3 Unique Provider Count, there is “0” in the Specialist column on the 27th row. Please clarify if this “0” in the Specialist column is an error, or if there was a Specialty type inadvertently omitted?	Attachment I - Georgia Families Contract, Section 4.3.5.4, Page 73	The "0" in the Specialist column is an error. The revised template has been posted in the Suppliers' Library.

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56	Please confirm the Provider Listing Report Template is not related to the provider network excel worksheet detailed in Attachment G, question 49 letter a.	Attachment I – Georgia Families Contract, Section 4.3.5.4, Page 73 Supplier’s Library Additional Document 1. Provider Listing Report Template Attachment G – Mandatory Scored Response Worksheet, Q49	The referenced documents are not the same. The Excel worksheet referenced in Question 49 of Attachment G captures the providers with signed LOIs.
57	Please confirm the file provided from the GA DCH portal to a CMO be a real-time interface or a batch interface?	Attachment I - Georgia Families Contract, Section 4.11.2.5, Page 145	Currently, the CMOs receive data every twenty (20) minutes from 6 AM until 11 PM on a daily basis.
58	For purpose of the prior authorization portal, will the state provide the data format that such authorizations will be provided to the health plan? For example, will the state use a 278 file? If not, what data format and at what frequency will this data be provided to the health plan?	Attachment I – Georgia Families Contract, Section 4.11.2.6, Page 145	Currently the CMOs receive an XML layout as the XML layout gives greater flexibility in adding/removing attributes than a 278 file. The XML layout closely resembles what is currently used for PA data exchanged between the MMIS and other PA vendors. The CMOs receive data every twenty (20) minutes from 6 AM until 11 PM on a daily basis.

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59	Please confirm the timeline for NCQA accreditation of Commendable or Excellent should be three (3) years as written in Attachment D and not two (2) years as written in Attachment I.	Attachment I – Georgia Families Contract, Section 4.12.1.3., Page 160 and Attachment D – Requirements and Scope of Work, Page 104	The information in Attachment D is correct. Attachment I will be corrected to read three (3) years.
60	Complex Care Coordination services are required for Georgia 360 Members with a previous mental health inpatient stay or an inpatient stay for a psychosocial disorder. Are there parameters regarding a previous mental health inpatient stay (e.g., any lifetime history; within the last year)? How is a "psychosocial disorder" inpatient stay defined?	Attachment D, I.8.iii	The timeline for identifying previous inpatient hospitalizations for complex care coordination should be proposed in the Supplier's approach. A psychosocial disorder is a mental illness caused or influenced by life experiences, as well as maladjusted cognitive and behavioral processes.
61	As a follow up to question 26 of the Q&A: Please confirm that a Member will not be considered eligible for GA Families 360 and enrolled with a CMO until the CMO receives the Member's name on the DCH eligibility file. Are there other forms of electronic notification, such as from DJJ, that are the functional equivalent of an eligibility file? If so, please specify.	Question 26 Q&A Georgia Family 360; Question #31	Written notification on the approved e-form submitted by DFCS or DJJ is sufficient and functionally equivalent notice to the receipt of an eligibility file. This notice typically occurs PRIOR TO the Member appearing on the enrollment eligibility file.

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62	<p>Will there be occasions when the CMO is required to provide or coordinate care prior to receiving the eligibility file from DCH, DFCS or DJJ? If so, please confirm that the CMO will be paid for Members whose eligibility is established via an alternative notification process.</p>	Georgia Family 360; Question #31	<p>The Supplier is required to provide care coordination services beginning immediately upon receipt of notification, regardless of notification type. The capitated rate is set to account for any gaps between initial notification and receipt of the eligibility file.</p>
63	<p>As a follow-up to Question 26 in Round 1 Q&A response: "The Supplier is expected to begin Care Coordination upon receipt of an electronic notification from DCH, DFCS, or DJJ that the member is eligible for Georgia Families 360°. Accordingly, the Member is considered eligible for Georgia Families 360° when the Supplier receives notice from DCH, DFCS, or DJJ."</p> <p>Please specify the various forms of electronic notification a CMO would receive from the agencies referenced in this response and when a CMO would receive them.</p>	Question 26 Q&A Georgia Family 360; Question #31	<p>Notification will primarily be provided through a single approved e-form that is authorized for use as notification. Notification via the e-form is to be provided immediately upon entry into care and updated as necessary following the 72-hour hearing. In emergent situations, an email may serve as notification.</p>

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64	<p>Question 115 asks the Suppliers to present findings and recommendations from the Supplier's review of the Claims data provided...</p> <p>DCH's response to this question indicated that the claims data requested could be found in the Suppliers' Library. The information in the Suppliers' Library appears to be consolidated rate development information, which does not include diagnosis and procedure codes, member characteristics or other data needed to complete a thorough analysis of GA Families 360 Members.</p> <p>While Suppliers can provide a high level summary of the findings, the results would not be comprehensive or to the level of specificity needed to provide meaningful recommendations. If this is the only information that will be made available to Suppliers, would DCH consider removing sub-part b in Question 115? Otherwise, the current Georgia Families 360 incumbent will have an unfair advantage since only they will have detailed claims data for analysis.</p>	Mandatory Questions; GA Families 360 Q#115	Additional information related to top diagnoses, procedures and prescription drug usage for Members in the GA Families 360° program have been posted to the Supplier's Library as FY15 GA Families and GA Families 360 - Final Exhibit. This set of data is to be the sole data reference in responses to question 115 of Attachment H. Responses that disregard this advisement will be scored accordingly.
65	Please clarify how DCH intends to evaluate and score Supplier's progress toward developing network capabilities for statewide access. If DCH will not be scoring the response to this question, how does DCH intend to use the information provided by the Supplier?	Mandatory Questions; 49	DCH will evaluate Suppliers' network responses for statewide representation at the provider type level.
66	Are we correct in assuming that progress on the LOIs requested in Question 49 will not be scored as part of the 1000 evaluation points awarded to Suppliers and that plans will be expected to demonstrate network adequacy by readiness review?	Not Referenced	DCH will evaluate Suppliers' network responses for statewide representation at the provider type level.

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67	<p>As a follow-up to Round 1 Question 152 response: "For Member incentives developed for VBP program, the Supplier must comply with the \$10.00 per item nominal value and the \$50.00 annual value. DCH will revise the Attachment D, I and J accordingly.</p> <p>Please confirm that DCH will continue its current process of allowing CMOs to request permission to exceed the \$50 annual value in the event an incentive supports improved outcomes for measures included in the VBP program?</p>	Attachment D, pg. 113 third paragraph, first sentence.	No, DCH will not accept any requests to exceed the \$50 annual value. The maximum aggregate amount is \$50 per Member per year.
68	<p>Please confirm that resumes, job descriptions, and qualifications and staffing levels for this question are only expected for the following Key Staff positions listed in Sections 16.1.5, and 16.1.5.1-16.1.5.17 of the Georgia Families Contract: CMO Project Manager, Executive Administrator, Medical Director , Quality Improvement Director, Chief Financial Officer, Strategic Planner, Utilization Management Director, Information Management and Systems Director, Pharmacist, Dental Consultant, Mental Health Coordinator, Member Services Director, Provider Services Director, Provider Relations Liaison, Grievance/Complaint Coordinator, Compliance Officer, and Prior Authorization/Pre-Certification Coordinator.</p>	Mandatory Questions; Q22 Georgia Families Contract; Sections 16.1.5, subsections 16.1.5.1 - 16.1.5.17	Please refer to Attachment D, Key Staff, for the listing of Key Staff.
69	<p>Question 28 of the Q&A asked: Please confirm that bidders submitting a proposal for the Georgia Families 360 program (Questions 115-164 - Attachment H) need not address foster care in their responses to questions 7-114 (Attachment G). DCH's reply stated: Questions in Attachment H (Additional Scored Questions) address Georgia 360° contract requirements. New Question: Please confirm that DCH's response means that the responses to the Mandatory Scored questions in Attachment G and the responses for the Additional Scored questions in Attachment H should be separate and distinct. In other words, DCH will not expect to see Georgia Families 360 content in questions 7-114.</p>	Georgia Families 360; Attachments G and H	The responses should be separate and distinct.

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70	<p>Based on DCH's response to Question 155 and 157 of the Q&A, are we correct in understanding that Suppliers should not submit any proposal narrative responses into the Attachment G & H Excel Spreadsheets provided? If so, are we also correct in understanding that we can submit our proposal narrative responses in Word or PDF formats?</p>	<p>Q&A Questions 155 and 157 Attachment A; Section 2.2 .3; Attachment G & H: Instructions</p>	<p>Suppliers should not submit any proposal narrative responses into the Attachment G & H Excel Spreadsheets provided. Please submit the proposal narrative responses in Word or PDF formats and do not allow the file size to exceed 50 megabytes. If compressed files are submitted, it is recommended to use WinZip.</p>
71	<p>Question 278 of the Q&A asked DCH to confirm that a competitive, sealed proposal submission would not be required for this proposal, since the first two sentences in the Attachment A provision appear to contradict each other. DCH's response to this question appears to be truncated. Please confirm that a competitive, sealed proposal will not be required for this proposal.</p>	<p>Section 1.2 eRFP Certification, page 9</p>	<p>With the exception of reverse auctions and informal pricing requests for purchases less than \$25,000, all solicitation methods are conducted through a formal sealed bidding process; thus, competitive sealed proposals will be submitted in response to this eRFP. In the formal sealed bidding process, suppliers' submitted offers are kept confidential and not opened by the state entity until after the solicitation has closed.</p>
72	<p>DCH clarified that "treatment plan" would be replaced with "care plan" or "plan of care". Please clarify if the expectation is that Members enrolled in all levels of Case Management have a care plan that is reviewed by the Chief Medical Officer, or whether DCH simply intended for the CMO to be the arbiter of any denial of a service on the provider's treatment plan? Requiring the Chief Medical Officer to review every care plan would be an unusual departure from standard industry practice and would add a significant burden in light of other CMO responsibilities.</p>	<p>Attachment I, 4.11.8.2.3 Coordination and Continuity of Care Responsibilities</p>	<p>Further revisions will be made to the contract to clarify the requirements. DCH expects the medical officer responsible for oversight of the care management function to have knowledge of members actively case managed who are not achieving their goals allowing for interactions between the medical officer and the Member's PCP to occur.</p>

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73	<p>In the Q and A Round 1 - DCH response was: "Out-of-network providers should be mapped and reported. All contracted providers including 'self-referral' service providers should be mapped and reported." (1) Please confirm that DCH intends for CMOs to map and report out-of-network Providers. (2) If this is the case, please define "out of network Providers," since as stated, this could potentially represent a large number of providers. Is DCH referring to non-contracted Providers for whom LOIs have been collected? Please confirm.</p>	<p>Attachment D, Section I.17 Geographic Access Requirements Q and A Round 1 Q#198</p>	<p>DCH expects Suppliers to map and report Out-of-Network Providers. An Out-of-Network Provider is a non-participating provider or a Provider without a contract. DCH is not referring to non-contracted Providers for whom LOIs have been collected.</p>
74	<p>Requirement 4.11.2.5 states "the Contractor and its network Providers (except Pharmacy Providers) shall use DCH's central Prior Authorization Portal for communicating Prior Authorization..." Does the term Pharmacy Providers include Prescribers seeking PAs for drugs?</p>	<p>Attachment I, 4.11.2.5 (Prior Authorization and Pre-Certification)</p>	<p>Prior Authorizations for medications, whether dispensed through a pharmacy or administered in an outpatient setting by a physician, are not requested through the centralized PA portal.</p>
75	<p>In the revised Attachment G, the reference to sample materials was deleted from Question 41. Please clarify if this deletion means that DCH no longer wants the Suppliers to provide sample materials with their response.</p>	<p>Attachment G, Revised, question 41</p>	<p>Suppliers may submit sample materials.</p>
76	<p>Complex Care Coordination services are required for Georgia 360 Members with a previous mental health inpatient stay or an inpatient stay for a psychosocial disorder. Are there parameters regarding a previous mental health inpatient stay (e.g., any lifetime history; within the last year)? How is a "psychosocial disorder" inpatient stay defined?</p>	<p>Attachment D, Part II, Section I.8.xiv.iii</p>	<p>The timeline for identifying previous inpatient hospitalizations for complex care coordination should be proposed in the Supplier's approach. A psychosocial disorder is a mental illness caused or influenced by life experiences, as well as maladjusted cognitive and behavioral processes.</p>

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77	Describe how the CMO will receive notification when a 360 Member transitions between Foster Care, Adoption Assistance and/or Juvenile Justice in order to facilitate resolving eligibility and enrollment discrepancies.	Georgia Families 360; Additional Mandatory Questions 132	Ultimately, the eligibility file will provide official notification. The sister agencies are responsible for sending an e-form to the CMO whenever there is a change to or from foster care, adoption assistance or juvenile justice involvement.
78	<p>"Regarding the sentence in Question #51: Refer to section I.I: Georgia Families Provider Network – Provider Selection and Retention Policies and Procedures of Attachment D.</p> <p>Question #50 of the RFP cites section I.I: Georgia Families Provider Network – Provider Selection and Retention Policies and Procedures of Attachment D - so presumably the Supplier will address requirements for that part of Attachment D in Question #50. Attachment D.I.I.17 & 18 seem to more closely align with a description of the Geo Access software as requested by DCH in Question #51.</p> <p>Given the subject of Question #51 (Geo Access software), shouldn't the Contract reference for Question 51 be to Section I.I.17: Georgia Families Provider Network - Geographic Access Requirements and Section I.I.18 - Other Reports?</p>	Att. G, Question 51	Yes. The Geographic Access Requirements and Other Reports sections are the applicable sections for Question 51.
79	Do kids identified as medically fragile in the Adoptive Assistance program move to the Gap Program?	Additional Mandatory Question 136	Many, but not all, medically fragile children are in the GAPP (the Georgia Pediatric Program). All youth enrolled in GAPP are currently carved out of the CMO. There is no requirement that compels the move of any medically fragile child to GAPP whether a recipient of Adoption Assistance or not.
80	Regarding the sentence: Adhere to Internet Engineering Task Force/Internet Engineering Standards Group standards for data communications, including TCP and IP for data transport; we assume the State means "Internet Engineering Steering Committee". Are we correct in our assumption?	Att.D.Part I, Section N.4.c.3	Essentially, the assumption is correct. DCH was referring to the Internet Engineering Steering Group (IESG).

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81	<p>Responses to several questions from the Q&A (numbers 5, 20, 71, 255, 262, 285, 332, 334, 337, 339, 340, 341, and 346) state that "Requirements regarding page limits will be removed from the submission instructions"; however, the revised Attachment H still includes page limits. Please confirm that DCH intends to keep the page limits for Attachment H and only remove page limits for Attachment G.</p>	<p>Q&A Questions 5, 20, 71, 255, 262, 285, 332, 334, 337, 339, 340, 341, 346</p>	<p>The page limit requirements were intended to be removed. Any remaining references to page limit requirements should be disregarded.</p>
82	<p>What is the timeline for a member with a previous mental health inpatient stay? Referenced in 4.11.8.17.4</p>	<p>Georgia Family 360 Contract; 4.11.8.17.4</p>	<p>The timeline for identifying previous inpatient hospitalizations for complex care coordination should be proposed in the Supplier's approach.</p>
83	<p>What is the definition of the word 'resiliency' as it relates to Question 126?</p>	<p>Additional Mandatory Question; Q126 360 Special Coverage and Provisions</p>	<p>Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems and other serious stressors. Resilience, as a concept and construct, is the context-specific ability to respond to stress, anxiety, trauma, crisis, or disaster. It means "bouncing back" from difficult experiences and having the skills to respond positively to future stressors.</p>

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84	Please clarify whether the Behavioral Health Homes referenced in question 39 of Attachment G will be inclusive of adults and children.	Attachment G - question 39	Yes, the requirement to integrate care through a Behavioral Health home applies to both adults and children enrolled in the CMO.
85	Will the health plan be at risk for all transplant types? (for example: bone marrow/stem cell + all solid organs)	Attachment G - question 39, 4.11.4.3.1.2, Inpatient Acute Coverage Responsibility, 148	Question 39 of Attachment G deals with Behavioral Health homes. Section 4.11.4.3.1.2 of Attachment I addresses the transition of members. The Supplier is responsible for coverage of medically necessary services.
86	Please clarify the difference between Interpretation and Translation Services.	Attachment D: Requirements and Scope of Work - Georgia Families Member Services 10. Interpretation Services 11. Translation Services	Please see the definitions in Attachment B and Attachments I and J.
87	Based on Attachment I, GA Families Contract, Section 1.1.5.3.2 under Administrative Simplifications; and Section 4.8.21 Provider Credentialing, please confirm that the Credentialing Verification Organization (CVO) is contracted by DCH and is 100% accountable for all network credentialing and re-credentialing including liability.	Attachment I, GA Families Contract, Section 1.1.5.3.2 under Administrative Simplifications; and Section 4.8.21 Provider Credentialing	Correct. The CVO is contracted by DCH and is 100% accountable for all network credentialing and recredentialing including liability.

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88	The State is selecting a single CVO. Can Bidders propose that the State use more than one CVO?	Attachment I, GA Families Contract, Section 1.1.5.3.2 under Administrative Simplifications; and Section 4.8.21 Provider Credentialing	No, the State will use one single CVO.
89	The State indicated there is no appealing the CVO's final determination. Will the state allow Bidders to have an appeal process? If so, please describe the process.	Attachment I, GA Families Contract, Section 1.1.5.3.2 under Administrative Simplifications; and Section 4.8.21 Provider Credentialing	No. Suppliers may not have a separate appeal process.
90	Bidders must include providers in their networks if they meet criteria per the CVO's determination. Can this also be subject to Bidders approval as well?	Attachment I, GA Families Contract, Section 1.1.5.3.2 under Administrative Simplifications; and Section 4.8.21 Provider Credentialing	The credentialing and contracting processes are two separate and distinct processes. Suppliers may determine which providers they wish to contract with.

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91	Based on Attachment I, GA Families Contract, Section 1.1.5.3.2 under Administrative Simplifications; and Section 4.8.21 Provider Credentialing, please confirm if delegation of credentialing would be allowed by supplier to large network hospitals or provider groups and not require credentialing with the Credentialing Verification Organization (CVO). If yes, please explain process.	Attachment I, GA Families Contract, Section 1.1.5.3.2 under Administrative Simplifications; and Section 4.8.21 Provider Credentialing	Delegated credentialing is allowed for IPAs.
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<p>92</p>	<p>DCH indicates it implemented standardized Prior Authorization request forms and an electronic web portal through which Providers submit all Prior Authorization requests. Does the State require all Health plan (CMO) incoming Prior auth requests come through that State-run portal?</p> <p>What state-run systems the CMO is required to use in this model?</p>	<p>Attachment C - DCH implemented standardized Prior Authorization</p>	<p>The schedule for the centralized Prior Authorization process was designed to be rolled out in phases. See below: Phase I A - effective 06/01/2013 1. Newborn Delivery Notification Forms 2. Pregnancy Notification Forms Phase I B – effective 07/01/2013 1. PAs for the following Place of Service (POS) -Inpatient Hospital services -Outpatient Hospital services -Ambulatory Surgery services 2. In-State Transplants 3. Hospital Outpatient Therapy 4. Appeals and Reconsiderations request 5. Submission of initial and additional clinical data attachments Phase 2 - Targeted 07/01/2015: -DME -Therapy (Physical, Speech, and Occupational) -Services handled by CMO third party vendors (dental, vision, radiology etc.) -Behavioral Health inpatient PAs</p>
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<p>93</p>	<p>bidders submitted several Round 1 Q&A questions regarding the uploads for Attachment G. For example, Q 257 asked: “Should required attachments, which are excluded from page limits, be included within the same electronic file as the required narrative response, or should they be uploaded as separate files? If they should be uploaded as separate files, what convention should be followed for the Attachment File Names? For example - Attachment G, Question 93, Compliance Plan.”</p> <p>The State’s response: “For each question instructing the supplier to upload attachments, please submit 1 document using the naming convention indicated. Please see column E of attachments G for ‘Attachment File Name’ or naming convention requested.”</p> <p>We are deeply concerned that complying with the state’s requirement to combine all attachments into a single file for each question comprised of multiple, sometimes large attachments, may be extremely technically challenging to both bidders and the State’s Team Georgia Marketplace website due to the massive amount of data that the state is requiring in response to key questions.</p> <p>For example, Attachment G, Question 49 a. and b. require submission of a Provider Network file in Excel along with complete provider network GeoAccess reports. As the State also made clear in its Round 1 Q&A responses, bidders must further submit letters of intent (LOIs) for all providers to comply with requirements of this single question. These three requirements for Question 49 alone constitute nearly 20,000 pages of data, making a single PDF file of that size</p>	<p>Attachment G—Mandatory Scored</p>	<p>To adhere to the technical guidelines, please ensure that the file size does not exceed 50 megabytes.</p>
<p>94</p>	<p>In Attachment D, I.N Administrative Services, #3a references an administrative review and also the appeals process. Can you clarify or confirm that “administrative review” is referring to an appeal?</p>	<p>Attachment D, I.N Administrative Services, 3. Internal Grievance/Appeals Systems a. General Requirements</p>	<p>An Administrative Review is the second level of review in the appeals process before the matter is presented to an Administrative Law Judge. An Administrative Review is part of the appeals process.</p>

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95	Attachment D, I.N Administrative Services, 3b references a “Formal Grievance Committee” that a parent has the option to have review a denial that has been maintained after Supplier review. The address to request this is DCH. Is this Formal Grievance Committee under the umbrella of the DCH? It states “decisions are written when reviewed by DCH and the Formal Grievance Committee”. Is this in lieu of a State Fair Hearing? Is this only applicable to PeachCare for KIDS?	Attachment D, I.N Administrative Services, 3. Internal Grievance/Appeals Systems b. Member medical Review process for PeachCare for Kids.	Team Georgia Marketplace supports file attachments up to 50 megabytes each. It is important to follow the naming convention provided without adding dashes or special characters. Each file name can not exceed 50 characters. Compressed file formats, preferably using WinZip, may be uploaded that include several attachments, as long as the compressed file meets the 50 megabyte limitation. Technical Issues with uploading attachments should be reported to the DOAS helpdesk at 404-657-6000.
96	Usually the member’s written consent is required if an authorized representative is filing an appeal or grievance on the member’s behalf (unless an expedited appeal). In Attachment D, I.N Administrative Services, 3c does not specifically state that written consent is required for a grievance. Please confirm that written consent is required.	Attachment D, I.N Administrative Services, 3. Internal Grievance/Appeals Systems b. Grievance Process	Written consent is required.
97	Can DCH provide an estimate of when it will provide historical claims data to CMOs awarded contracts under this RFP?	General question	When DCH sends eligibility files prior to the Contract Effective Date, Suppliers will receive historical claims extract.
98	The RFP speaks to 200,000 members as what should be used for member assumptions for each CMO. Is this a guaranteed minimum enrollment figure?	Attachment A. eRFP, 1.1.5 Transition Planning, p. 6	Please refer to Attachment A of the RFP.

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99	Can members change dental home and behavioral health home providers without cause at any time?	Attachment D, SOW, 2. Selection of a PCP/Medical Home and 3. Selection of a Dental Home, pp. 32 - 34	Yes, Members can change their dental home and/or behavioral health home provider without cause at any time.
100	Does the 30 second to live voice requirement start at call start or after IVR picks up?	Attachment G. Scored Response, question 65. Regarding call center operations.	Per Attachment D (Provider Services Call Center), the caller must elect to speak to a live representative. See Attachment D for explanation of Average Speed of Answer.
101	In the response to question 63 of the first round of questions and answers, it states that a contract exception form has been uploaded as Attachment Q. However, it does not appear to have been made available as of yet.	First Round of Questions and Answers, Question 63	Attachment Q, the Contract Exception Form is uploaded and is available for use, as applicable.
102	Section 3 a of the Addendum 2 states “within thirty Calendar Days of Contract Award, the Supplier must submit to DCH a data model of the Supplier’s reporting repository, the proposed data layout for weekly data file submissions and a corresponding data dictionary”. Will DCH please clarify that the Suppliers are to propose a data layout for weekly data file submissions and a data dictionary instead of using the GAMMIS 5010 Encounter 837D Companion Guide, GAMMIS 5010 Encounter 837I Companion Guide and GAMMIS 5010 Encounter 837P Companion Guide posted on Georgia.Gov website.	Addendum 2 Section 3.a	The Supplier must propose the data model, data layout and data dictionary for the file submissions to DCH’s enterprise data warehouse vendor. However, this does not preclude DCH in the future from requesting GAMMIS 5010 Encounter 837D, 837I and 837P layouts for submission to the enterprise data warehouse vendor.

EXHIBIT 2
CONTRACTOR'S PROPOSAL
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ATTACHMENT A

DRUG-FREE WORKPLACE CERTIFICATE

This certification is required by regulations implementing the Drug-Free Workplace Act of 1988 and O.C.G.A. § 50-24-1 *et seq.* The certification set out below is a material representation of fact upon which DCH relied when entering into **Contract #[X]** with **[CONTRACTOR]** (hereinafter referred to as the “Contract”). False certification or violation of the certification shall be grounds for suspension of payments, termination of the contract, or government-wide suspension or debarment.

By signing this Drug-Free Workplace Certificate, Contractor certifies that it will provide a drug-free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession or use of a controlled substance or marijuana is prohibited in Contractor’s workplace and specifying the actions that will be taken against employees for violations of such policy;
2. Establishing a drug-free awareness program to inform employees about:
 - a. The dangers of drug abuse in the workplace;
 - b. Contractor’s policy of maintaining a drug-free workplace;
 - c. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - d. The penalties that may be imposed upon employees for drug abuse violations;
3. Providing each employee with a copy of the statement provided for in paragraph (1) of this certification;
4. Notifying each employee in the statement provided for in paragraph (1) that, as a condition of employment, the employee shall:
 - a. Abide by the terms of the statement; and
 - b. Notify Contractor of any criminal drug statute conviction for a violation occurring in the workplace no later than five Calendar Days after such conviction;
5. Notifying DCH within ten Calendar Days after receiving notice under subparagraph 4(b) from an employee or otherwise receiving actual notice of such conviction;
6. Taking one of the following actions, within 30 days of receiving notice under subparagraph 4(b), with respect to any employee who is so convicted;
 - a. Taking appropriate personnel action against such an employee, up to and including termination; or
 - b. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency;
7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1, 2, 3, 4, 5, and 6.

Further, Contractor certifies that it will include in any agreement or contract with a subcontractor a provision that such subcontractor will provide a drug-free workplace for his employees by complying with the provisions of paragraphs (1), (2), (3), (4), and (6) of this subsection and by notifying Contractor of any criminal drug statute

conviction for a violation occurring in the workplace involving the subcontractor or its employees within five Calendar Days of receiving notice of the conviction. Contractor will notify the contracting principal representative pursuant to paragraph (5) of this subsection.

[CONTRACTOR]

BY: _____
*SIGNATURE

Date

Please Print/Type Name Here

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT B

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT, AND OTHER RESPONSIBILITY MATTERS



Federal Acquisition Regulation 52.209-5, Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters (March 1996)

(A) The Contractor certifies, to the best of its knowledge and belief, that:

(1) The Contractor and/or any of its Principals:

A. Are are not presently debarred, suspended, proposed for debarment, or declared ineligible for award of contracts by any Federal agency;
Have have not within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract or subcontract; violation of federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, evasion, or receiving stolen property; and
Are are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity with commission of any of the offenses enumerated in subdivision (a)(1)(i)(B) of this provision.

(2) The Contractor has has not within a three-year period preceding this offer, had one or more contracts terminated for default by any federal agency.

(3) "Principals," for purposes of this certification, means officers, directors, owners, partners, and persons having primary management or supervisory responsibilities within a business entity (e.g., general manager, plant manager, head of a subsidiary, division, or business segment; and similar positions).

This certification concerns a matter within the jurisdiction of an Agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under 18 U.S.C. § 1001.

(B) The Contractor shall provide immediate written notice to the Contracting Officer if, at any time prior to contract award, the Contractor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

- (C) A certification that if any of the items in paragraph (a) of this provision exist will not necessarily result in withholding of an award under this solicitation. However, the certification will be considered in connection with a determination of the Contractor's responsibility. Failure of the Contractor to furnish a certification or provide such additional information as requested by the Contracting Officer may render the Contractor nonresponsible.
- (D) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of a Contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
- (E) The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available to the Government, the Contracting Officer may terminate the contract resulting from this solicitation for default.

[CONTRACTOR]

BY: _____
 *SIGNATURE

 Date

 Please Print/Type Name Here

 *TITLE

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT C

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
NON-PROFIT ORGANIZATION DISCLOSURE FORM**

Notice to all DCH Contractors: Pursuant to Georgia law, non-profit organizations that receive funds from a state organization must comply with audit requirements as specified in O.C.G.A. § 50-20-1 *et seq.* (hereinafter “the Act”) to ensure appropriate use of public funds. “Non-profit Organization” means any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized primarily for profit; and uses its net proceeds to maintain, improve or expand its operations. The term non-profit organization includes non-profit institutions of higher education and hospitals. For financial reporting purposes, guidelines issued by the American Institute of Certified Public Accountants should be followed in determining non-profit status.

The Department of Community Health (DCH) must report contracts with non-profit organizations to the Department of Audits and must ensure compliance with the other requirements of the Act. Prior to execution of any contract, the potential contractor must complete this form disclosing its corporate status to DCH. This form must be returned, along with proof of corporate status, to: Director, Contracts Administration, Georgia Department of Community Health, 40th Floor, 2 Peachtree Street, N.W., Atlanta, Georgia 30303-3159.

Acceptable proof of corporate status includes, but is not limited to, the following documentation:

- Financial statements for the previous year;
- Employee list;
- Employee salaries;
- Employees’ reimbursable expenses; and
- Corrective action plans.

Entities that meet the definition of non-profit organization provided above and are subject to the requirements of the Act will be contacted by DCH for further information.

COMPANY NAME: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

CORPORATE STATUS: (check one) For Profit _____ Non-Profit _____

I, the undersigned duly authorized representative of _____ do hereby attest that the above information is true and correct to the best of my knowledge.

Signature

Date

**ATTACHMENT D
BUSINESS ASSOCIATE AGREEMENT**

This Business Associate Agreement (hereinafter referred to as “Agreement”), effective this ____ day of _____, _____ (hereinafter the “Effective Date”) is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as “DCH”) and [CONTRACTOR] (hereinafter referred to as “Contractor”) as **Attachment D** to **Contract No. [X]** between DCH and Contractor dated _____ (hereinafter referred to as the “Contract”).

WHEREAS, DCH is a hybrid entity, as defined in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), and is required by HIPAA to enter into a Business Associate Agreement with certain entities that provide functions, activities, or services on behalf of or in support of health care components of DCH, which functions, activities or services involve the use of Protected Health Information as defined by HIPAA (“PHI”);

WHEREAS, Contractor, under the Contract provides functions, activities, or services involving the use of PHI;

NOW, THEREFORE, for and in consideration of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, DCH and Contractor (each individually a “Party” and collectively the “Parties”) hereby agree as follows:

1. Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms have in HIPAA and in Title XIII of the American Recovery and Reinvestment Act of 2009 (the Health Information Technology for Economic and Clinical Health Act, or “HITECH”), and in the implementing regulations of HIPAA and HITECH. Implementing regulations are published as the Standards for Privacy and Security of Individually Identifiable Health Information in 45 C.F.R. Parts 160 and 164. Together, HIPAA, HITECH, and their implementing regulations are referred to in this Agreement as the “Privacy Rule and Security Rule.” If the meaning of any defined term is changed by law or regulation, then this Agreement will be automatically modified to conform to such change. The term “NIST Baseline Controls” means the baseline controls set forth in National Institute of Standards and Technology (NIST) SP 800-53 established for “moderate impact” information.
2. Except as limited in this Agreement, Contractor may use or disclose PHI only to the extent necessary to meet its responsibilities as set forth in the Contract provided that such use or disclosure would not violate the Privacy Rule or the Security Rule, if done by DCH. Furthermore, except as otherwise limited in this Agreement, Contractor may:
 - A. Use PHI for internal quality control and auditing purposes.
 - B. Use or disclose PHI as Required by Law.
 - C. After providing written notification to DCH’s Office of Inspector General, use PHI to make a report to a health oversight agency authorized by law to investigate DCH (or otherwise oversee the conduct or conditions of the DCH) about any DCH conduct that Contractor in good faith believes to be unlawful as permitted by 45 C.F.R. 164.502(j)(1). Notwithstanding the foregoing, Contractor shall not be required to provide prior written notice to DCH’s Office of Inspector General if Contractor is provided written instruction otherwise by the health oversight agency authorized by law to investigate DCH.

- D.** Use and disclose PHI to consult with an attorney for purposes of determining Contractor's legal options with regard to reporting conduct by DCH that Contractor in good faith believes to be unlawful, as permitted by 45 C.F.R. 164.502(j)(1).
3. Contractor represents and warrants that only individuals designated by title or name on Attachments D-1 and D-2 will request PHI from DCH or access DCH PHI in order to perform the services of the Contract, and these individuals will only request the minimum necessary amount of information necessary in order to perform the services.
 4. Contractor represents and warrants that the individuals listed by title on Attachment D-1 require access to PHI in order to perform services under the Contract. Contractor agrees to send updates to Attachment D-1 whenever necessary. Uses or disclosures of PHI by individuals not described on Attachment D-1 are impermissible.
 5. Contractor represents and warrants that the individuals listed by name on Attachment D-2 require access to a DCH information system in order to perform services under the Contract. Contractor agrees to notify the Project Leader and the Access Control Coordinator named on Attachment D-2 immediately, but at least within 24 hours, of any change in the need for DCH information system access by any individual listed on Attachment D-2. Any failure to report a change within the 24 hour time period will be considered a security incident and may be reported to Contractor's Privacy and Security Officer, Information Security Officer and the Georgia Technology Authority for proper handling and sanctions.
 6. Contractor agrees that it is a Business Associate to DCH as a result of the Contract, and represents and warrants to DCH that it complies with the Privacy Rule and Security Rule requirements that apply to Business Associates and will continue to comply with these requirements. Contractor further represents and warrants to DCH that it maintains and follows written policies and procedures to achieve and maintain compliance with the HIPAA Privacy and Security Rules that apply to Business Associates, including, but not limited to policies and procedures addressing HIPAA's requirements that Business Associates use, request and disclose only the minimum amount of PHI necessary to perform their services, and updates such policies and procedures as necessary in order to comply with the HIPAA Privacy and Security Rules that apply to Business Associates and will continue to maintain and update such policies and procedures. These policies and procedures, and evidence of their implementation, shall be provided to DCH upon request.
 7. The Parties agree that a copy of all communications related to compliance with this Agreement will be forwarded to the following Privacy and Security Contacts:
 - A. At DCH: HIPAA Privacy and Security Specialist
Office of General Counsel
hipaa@dch.ga.gov

[name]
Agency Information Security Officer
[e-mail address]
[phone number]

B. At Contractor: _____

8. Contractor further agrees that it will:

- A. Not request, create, receive, use or disclose PHI other than as permitted or required by this Agreement, the Contract, or as required by law.
- B. Establish, maintain and use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or the Contract. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.
- C. Implement and use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DCH. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.
- D. In addition to the safeguards described above, Contractor shall include access controls that restrict access to PHI to the individuals listed on D-2 and D-2, as amended from time to time, shall implement encryption of all electronic PHI during transmission and at rest.
- E. Upon DCH's reasonable request, but no more frequently than annually, obtain an independent assessment of Contractor's implementation of applicable HIPAA Privacy and Security Controls and the additional safeguards required by this Agreement with respect to encryption of stored and transmitted DCH PHI, provide the results of such assessments to DCH, and ensure that corrective actions identified during the independent assessment are implemented. Contractor shall bear the costs associated with the independent assessment and for the implementation of corrective actions identified as the result of the assessment.
- F. Mitigate, to the extent practicable, any harmful effect that may be known to Contractor from a use or disclosure of PHI by Contractor in violation of the requirements of this Agreement, the Contract or applicable regulations. Contractor shall bear the costs of mitigation, which shall include the reasonable costs of credit monitoring or credit restoration when the use or disclosure results in exposure of information commonly used in identity theft.
- G. Maintain a business associate agreement with its agents or subcontractors to whom it provides PHI, in accordance with which such agents or subcontractors are contractually obligated to comply with at least the same obligations that apply to Contractor under this Agreement, and ensure that its agents or subcontractors comply with the conditions, restrictions, prohibitions and other limitations regarding the request for, creation, receipt, use or disclosure of PHI, that are applicable to Contractor under this Agreement and the Contract.
- H. Report to DCH any use or disclosure of PHI that is not provided for by this Agreement or the Contract of which it becomes aware.

- I.** Make an initial report to the DCH in writing in such form as DCH may require within three (3) business days after Contractor (or any subcontractor) becomes aware of the unauthorized use or disclosure. This report will require Contractor to identify the following:
- i. The nature of the impermissible use or disclosure (the “incident”), which will include a brief description of what happened, including the date it occurred and the date Contractor discovered the incident;
 - ii. The Protected Health Information involved in the impermissible use or disclosure, such as whether the full name, social security number, date of birth, home address, account number or other information were involved);
 - iii. Who (by title, access permission level and employer) made the impermissible use or disclosure and who received the Protected Health Information as a result;
 - iv. What corrective or investigational action Contractor took or will take to prevent further impermissible uses or disclosures, to mitigate harmful effects, and to prevent against any further incidents;
 - v. What steps individuals who may have been harmed by the incident might take to protect themselves; and
 - vi. Whether Contractor believes that the impermissible use or disclosure constitutes a Breach of Unsecured Protected Health Information.

Upon request by the DCH HIPAA Privacy and Security Officer or the DCH Information Security Officer, Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and a proposed corrective action plan. Upon approval of a corrective action plan by the DCH, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH within five (5) business days of DCH’s request for proof of implementation.

- J.** Report to the DCH HIPAA Privacy and Security Officer and the DCH Agency Information Security Officer any successful unauthorized access, modification, or destruction of PHI or interference with system operations in Contractor’s information systems as soon as practicable but in no event later than three (3) business days of discovery. If such a security incident resulted in a use or disclosure of PHI not permitted by this Agreement, Contractor shall also make a report of the impermissible use or disclosure as described above. Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and, if appropriate, a proposed corrective action plan designed to protect PHI from similar security incidents in the future. Upon DCH’s approval of Contractor’s corrective action plan, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH.
- K.** Upon DCH’s reasonable request and not more frequently than once per quarter, report to the DCH Agency Information Security Officer any (A) attempted (but unsuccessful) unauthorized access, use, disclosure, modification, or destruction of PHI or (B) attempted (but unsuccessful) interference with system operations in Contractor’s information systems. Contractor does not need to report trivial incidents that occur on a daily basis, such as scans, “pings,” or other routine attempts that do not

penetrate computer networks or servers or result in interference with system operations.

- L. Cooperate with DCH and provide assistance necessary for DCH to determine whether a Breach of Unsecured Protected Health Information has occurred, and whether notification of the Breach is legally required or otherwise appropriate. Contractor agrees to assist DCH in its efforts to comply with the HIPAA Privacy and Security Rules, as amended from time to time. To that end, the Contractor will abide by any requirements mandated by the HIPAA Privacy and Security Rules or any other applicable laws in the course of this Contract. Contractor warrants that it will cooperate with DCH, including cooperation with DCH privacy officials and other compliance officers required by the HIPAA Privacy and Security Rules and all implementing regulations, in the course of performance of this Contract so that both parties will be in compliance with HIPAA.
- M. If DCH determines that a Breach of Unsecured Protected Health Information has occurred as a result of Contractor's impermissible use or disclosure of PHI or failure to comply with obligations set forth in this Agreement or in the Privacy or Security Rules, provide all notifications to Individuals, HHS and/or the media, on behalf of DCH, after the notifications are approved by the DCH. Contractor shall provide these notifications in accordance with the security breach notification requirements set forth in 42 U.S.C. §17932 and 45 C.F.R. Parts 160 & 164 subparts A, D & E as of their respective Compliance Dates, and shall pay for the reasonable and actual costs associated with such notifications.

In the event that DCH determines a Breach has occurred, without unreasonable delay, and in any event no later than thirty (30) calendar days after Discovery, Contractor shall provide the DCH HIPAA Privacy and Security Officer a list of Individuals and a copy of the template notification letter to be sent to Individuals. Contractor shall begin the notification process only after obtaining DCH's approval of the notification letter.

- N. Make any amendment(s) to PHI in a Designated Record Set that DCH directs or agrees to pursuant to 45 CFR 164.526 within five (5) business days after request of DCH. Contractor also agrees to provide DCH with written confirmation of the amendment in such format and within such time as DCH may require.
- O. In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, Contractor shall, within five (5) business days following DCH's request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH, provide DCH access to the PHI in an individual's Designated Record Set. However, if requested by DCH, Contractor shall provide access to the PHI in a Designated Record Set directly to the individual to whom such information relates.
- P. Give the Secretary of the U.S. Department of Health and Human Services (the "Secretary") or the Secretary's designees access to Contractor's books and records and policies, practices or procedures relating to the use and disclosure of PHI for or on behalf of DCH within five (5) business days after the Secretary or the Secretary's designees request such access or otherwise as the Secretary or the Secretary's designees may require. Contractor also agrees to make such information available for review, inspection and copying by the Secretary or the Secretary's designees during normal business hours at the location or locations where such information is maintained or to otherwise provide such information to the Secretary or the Secretary's designees in such form, format or manner as the Secretary or the Secretary's designees may require.

- Q. Document all disclosures of PHI and information related to such disclosures as would be required for DCH to respond to a request by an Individual or by the Secretary for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. By no later than five (5) business days of receipt of a written request from DCH, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH HIPAA Privacy and Security Officer, Contractor shall provide an accounting of disclosures of PHI regarding an Individual to DCH. If requested by DCH, Contractor shall provide an accounting of disclosures directly to the individual. Contractor shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the DCH upon request.
- R. In addition to any indemnification provisions in the Contract, indemnify the DCH from any liability resulting from any violation of the HIPAA Privacy and Security Rules or Breach that arises from the conduct or omission of Contractor or its employee(s), agent(s) or subcontractor(s). Such liability will include, but not be limited to, all actual and direct costs and/or losses, civil penalties and reasonable attorneys' fees imposed on DCH.
- S. For any requirements in this Agreement that include deadlines, pay performance guarantee payments of \$300.00 per calendar day, starting with the day after the deadline and continuing until Contractor complies with the requirement. Contractor shall ensure that its agreements with subcontractors enable Contractor to meet these deadlines.

9. DCH agrees that it will:

- A. Notify Contractor of any new limitation in the applicable Notice of Privacy Practices in accordance with the provisions of the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such limitation will affect Contractor's use or disclosure of PHI.
- B. Notify Contractor of any change in, or revocation of, authorization by an Individual for DCH to use or disclose PHI to the extent that DCH determines in the exercise of its sole discretion that such change or revocation will affect Contractor's use or disclosure of PHI.
- C. Notify Contractor of any restriction regarding its use or disclosure of PHI that DCH has agreed to in accordance with the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such restriction will affect Contractor's use or disclosure of PHI.
- D. Prior to agreeing to any changes in or revocation of permission by an Individual, or any restriction, to use or disclose PHI, DCH agrees to contact Contractor to determine feasibility of compliance. DCH agrees to assume all costs incurred by Contractor in compliance with such special requests.

10. The Term of this Agreement shall be effective on the Effective Date and shall terminate when all of the PHI provided by DCH to Contractor, or created or received by Contractor on behalf of DCH, is destroyed or returned to DCH, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this section.

- A. **Termination for Cause.** Upon DCH's knowledge of a material breach of this Agreement by Contractor, DCH shall either:

- i. Provide an opportunity for Contractor to cure the breach of Agreement within a reasonable period of time, which shall be within thirty (30) calendar days after receiving written notification of the breach by DCH;
- ii. If Contractor fails to cure the breach of Agreement, terminate the Contract upon thirty (30) calendar days' notice; or
- iii. If neither termination nor cure is feasible, DCH shall report the breach of Agreement to the Secretary of the Department of Health and Human Services.

B. Effect of Termination.

- i. Upon termination of this Agreement, for any reason, DCH and Contractor shall determine whether return of PHI is feasible. If return of the PHI is not feasible, Contractor agrees to continue to extend the protections of this Agreement to the PHI for so long as the Contractor maintains the PHI and shall limit the use and disclosure of the PHI to those purposes that made return or destruction of the PHI infeasible. If at any time it becomes feasible to return or destroy any such PHI maintained pursuant to this paragraph, Contractor must notify DCH and obtain instructions from DCH for either the return or destruction of the PHI.
- ii. Contractor agrees that it will limit its further use or disclosure of PHI only to those purposes DCH may, in the exercise of its sole discretion, deem to be in the public interest or necessary for the protection of such PHI, and will take such additional actions as DCH may require for the protection of patient privacy and the safeguarding, security and protection of such PHI.
- iii. This Effect of Termination section survives the termination of the Agreement.

11. Interpretation. Any ambiguity in this Agreement shall be resolved to permit DCH and Contractor to comply with applicable laws, rules and regulations, the HIPAA Privacy Rule, the HIPAA Security Rule and any rules, regulations, requirements, rulings, interpretations, procedures or other actions related thereto that are promulgated, issued or taken by or on behalf of the Secretary; provided that applicable laws, rules and regulations and the laws of the State of Georgia shall supersede the Privacy Rule if, and to the extent that, they impose additional requirements, have requirements that are more stringent than or have been interpreted to provide greater protection of patient privacy or the security or safeguarding of PHI than those of the HIPAA Privacy Rule.

12. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations or liabilities whatsoever.

13. All other terms and conditions contained in the Contract and any amendment thereto, not amended by this Agreement, shall remain in full force and effect.

(Signatures on following page)

IN WITNESS WHEREOF, Contractor, through its authorized officer and agent, has caused this Agreement to be executed on its behalf as of the date indicated.

[CONTRACTOR]

BY: _____
SIGNATURE

DATE

TITLE*

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT D-1

List of Individuals Permitted to Receive, Use and Disclose DCH PHI

The following Position Titles, as employees and/or representatives of Contractor, need access to DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

- _____
- _____
- _____
- _____
- _____

Transfers of PHI must comply with DCH Policy and Procedure 419: Appropriate Use of Information Technology Resources.

Approved methods of secure delivery of PHI between Contractor and DCH:

- Secure FTP file transfer (preferred)
- Encrypted email or email sent through “secure tunnel” approved by DCH Information Security Officer
- Email of encrypted document (password must be sent by telephone only)
- Encrypted portable media device and tracked delivery method

Contractor must update this list as needed and provide the updated form to DCH. Use of DCH Protected Health Information by individuals who are not described on this Attachment D-1, as amended from time to time, is impermissible and a violation of the Agreement. Contractor must update this Attachment D-1 as needed and provide the updated form to DCH.

DCH Project Leader Contact Information:
[contact info to be placed here]

ATTACHMENT D-2

Part 1:

Please initial beside the correct option. Please select only one option.

_____ Contractor DOES NOT need any user accounts to access DCH Information Systems. Do not complete Part 2 of this form.

_____ Contractor DOES need user accounts to access DCH Information Systems. Please complete Part 2 of this form.

Part 2:

Please complete the table below if you indicated that Contractor DOES need any user accounts to access DCH Information Systems. Please attach additional pages if needed.

List of Individuals Authorized to Access a DCH Information System Containing PHI

The following individuals, as employees and/or representatives of Contractor, need access to DCH Information Systems containing DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

Full Name	Employer	DCH Information System	Type of Access (Read only? Write?)

The DCH Project Leader must submit a completed DCH Network Access Request Form for each individual listed above. Access will be granted and changed in accordance with DCH Policy and Procedure 435: Managing Authorization, Access and Control of Information Systems.

Contractor must notify the Project Leader identified in the Contract and the DCH Access Control Coordinator (dchois@dch.ga.gov and helpdesk@dch.ga.gov) immediately, but at least within 24 hours, after any individual on this list no longer needs the level of access described. Failure to provide this notification on time is a violation of the Agreement and will be reported as a security incident.

Contractor must update this Attachment D-2 as needed and provide the updated form to DCH.

DCH Project Leader Contact Information:

[contact info to be placed here]

ATTACHMENT E

VENDOR LOBBYIST DISCLOSURE AND REGISTRATION CERTIFICATION FORM



Pursuant to Executive Order Number 10.01.03.01 (the "Order"), which was signed by Governor Sonny Perdue on October 1, 2003, Contractors with the state are required to complete this form. The Order requires "Vendor Lobbyists," defined as those who lobby state officials on behalf of businesses that seek a contract to sell goods or services to the state or those who oppose such a contract, to certify that they have registered with the State Ethics Commission and filed the disclosures required by Article 4 of Chapter 5 of Title 21 of the Official Code of Georgia Annotated. Consequently, every vendor desiring to enter into a contract with the state must complete this certification form. False, incomplete, or untimely registration, disclosure, or certification shall be grounds for termination of the award and contract and may cause recoupment or refund actions against Contractor.

In order to be in compliance with Executive Order Number 10.01.03.01, please complete this Certification Form by designating only one of the following:

- Contractor does not have any lobbyist employed, retained, or affiliated with the Contractor who is seeking or opposing contracts for it or its clients. Consequently, Contractor has not registered anyone with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.
Contractor does have lobbyist(s) employed, retained, or affiliated with the Contractor who are seeking or opposing contracts for it or its clients. The lobbyists are:

Three horizontal lines for listing lobbyist names.

Contractor states, represents, warrants, and certifies that it has registered the above named lobbyists with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.

[CONTRACTOR]

BY: *SIGNATURE

Date

Please Print/Type Name Here

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT F

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



CENTER FOR MEDICARE

DATE: September 18, 2013

TO: Medicare Advantage (MA) Organizations, Prescription Drug Plan (PDP) Sponsors, CY 2014 Medicare-Medicaid Plans, and Medicare Cost Contractors (excluding PACE and Employer Group/800 series only contracts)

FROM: Danielle R. Moon, J.D., M.P.A., Director, Medicare Drug & Health Plan Contract Administration Group

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SUBJECT: Contract Year 2014 Translated Marketing Materials Requirements and Methodology

Background

Medicare Part C and Part D sponsors (plan sponsors), are required to translate marketing materials into any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package (PBP) service area.¹ Pursuant to the Medicare Marketing Guidelines, plan sponsors that have service areas that meet the 5% threshold must provide the translated marketing materials listed in Table 1 on their websites and in hard-copy upon beneficiary request.² Translation requirements for Medicare Medicaid Plans (MMPs) are discussed in an April 10, 2013 Health Plan Management System (HPMS) memo entitled *Translation Requirements for CY 2013 Medicare-Medicaid Plans (MMPs)*.

CMS Translations of Model Marketing Materials

CMS has translated several of the Part C and D 2014 model marketing materials in order to alleviate some of the translation burden on plan sponsors and provide consistency among translated materials. The specific Part C and D materials translated by CMS and the languages for which these translations are available are listed in Table 1. Please note that we did not translate all documents that must be translated.

¹ 42 C.F.R. §§ 422.2264(e), 423.2264(e) (2012).

² Prescription Drug Benefit Manual, Chapter 2, Medicare Marketing Guidelines and Managed Care Manual, Chapter 3, Medicare Marketing Guidelines, Section 30.5 (June 28, 2013).

The translated materials are available on the CMS website at the following locations:

- For Managed Care ANOC/EOC materials: <http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html> Click on the zip file named “2014 Model Materials-Translations”
- For Part D model marketing materials, including the Provider Directory: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Part-D-Model-Marketing-Materials.html> Click on the zip file named “2014 Part D Models Translated”
- For enrollment forms: <http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html> Click on the zip file named “CY2012 Translated Enrollment Forms”

Table 1: 2014 Marketing Materials Translated by CMS

2014 Marketing Material Translated by CMS	Version	Language(s)
ANOC/EOC	MA-PD (HMO)	Spanish and Chinese
	PDP	Spanish
	PFFS	Spanish and Chinese
	PPO	Spanish and Chinese
	MA-only	Spanish and Chinese
Enrollment forms	MA & MA-PD	Spanish and Chinese*
	PFFS	Spanish and Chinese*
	PDP	Spanish*
Formulary	Comprehensive	Spanish and Chinese
	Abridged	Spanish and Chinese
Pharmacy Directory	Part D	Spanish and Chinese
Provider Directory	Part C	Spanish and Chinese
Transition Letter	Part D	Spanish and Chinese

* These documents have remained unchanged since contract year 2012.

Translations of MMP materials can be found on the Financial Alignment Initiative web page at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html>. Currently, only select Massachusetts MMP translated materials are posted, and other states’ MMP materials will be posted on a flow basis. In each state-specific MMP marketing guidance document, we provide details regarding the specific translations CMS will provide to MMPs operating in those states.

Update of Material Language Lookup Module Data

To aid plan sponsors and MMPs in determining for which languages they need to produce marketing materials, CMS recently updated the Health Plan Management System (HPMS) Material Language Lookup module with language translation data for each 2014 plan benefit package (PBP), including MMPs. CMS' contractor, Fu and Associates (Fu), determined which 2014 PBPs needed to provide translated materials by using the U.S. Census Bureau's American Community Survey (ACS) data. Appendix A contains the step-by-step methodology Fu used to identify the percentage of non-English speakers in each PBP's service area. Please be aware that the data in the Material Language Lookup module is based upon the service area data CMS displayed in HPMS for a PBP as of July 11, 2013. If changes to your plan's service area were reflected in HPMS after July 11, 2013, then your organization *cannot* rely on the data in the Material Language Lookup module and must conduct its own analysis using the methodology in Appendix A.

MMPs should refer to the April 10, 2013 HPMS memo for a description of how the Medicare or the state-specific translation standard will apply to MMPs operating in a particular state. For MMPs, HPMS will always reflect the translation information for the more stringent of the two standards, as applicable. Please note that the Material Language Lookup module only includes CY2014 MMP data; it no longer includes CY2013 data for MMPs that started operating in 2013.

Plan sponsors should visit the Material Language Lookup module and review the data for each 2014 contract and PBP to determine whether they need to translate marketing materials and upload the requisite translated materials into HPMS consistent with the Medicare Marketing Guidelines.³ With the exception of PBPs that include Puerto Rico in their service area, only those PBPs listed in the module are required to produce translated materials. "NA" indicates that a PBP does not need to provide translated materials. Any plan operating in Puerto Rico must provide materials in Spanish. If you cannot find your organization's data by contract ID, try using the multi-contract entity (MCE) ID associated with the contract. PACE, Employer group contracts (i.e., "E" contracts) and employer group PBPs (i.e., 800 series) are not included in the Material Language Lookup module.

To access the HPMS Material Language Lookup module, please follow this path: HPMS Home Page > Monitoring > Marketing Review > Material Language Lookup > Select a contract ID or MCE number. The Material Language Lookup results display the contract ID, PBP (plan) ID, and non-English language(s) needed for marketing materials.

Translated Materials Monitoring

CMS will be monitoring whether 2014 PBPs that meet the 5% threshold provide translated materials on their websites during the annual enrollment period (AEP) and whether plan sponsors have uploaded translated marketing materials into HPMS.

³ Prescription Drug Benefit Manual, Chapter 2, Medicare Marketing Guidelines and Managed Care Manual, Chapter 3, Medicare Marketing Guidelines, 90.2.1 (June 28, 2013).

Frequently Asked Questions and Answers

Question 1: Are sponsors required to use the CMS-produced translations of the models, or may they arrange for their own translations of the models?

Answer 1: Sponsors may continue to produce their own translations of the model documents, if they so choose.

Question 2: If sponsors use the CMS-produced translations of the models, may they modify certain word choices? For instance, Spanish speaking beneficiaries in Puerto Rico may be familiar with certain translations of health care terminology that may differ from how those terms are typically translated for Spanish speakers in the 50 states.

Answer 2: Yes, sponsors should adapt the translations to accommodate the particular language needs of their members.

Question 3: Did CMS' language analysis include 2014 "pending" counties that were in the system as of July 11, 2013?

Answer 3: Yes, pending counties were included in the analysis.

Question 4: What should sponsors do if they identify any problems with the CMS-produced translations?

Answer 4: Plan sponsors should report the concern to CMS (Linda.Gousis@cms.hhs.gov).

If you have any questions about this memo, please contact Linda.Gousis@cms.hhs.gov or (410) 786-8616.

Appendix A: Methodology to Identify Plan Benefit Packages (PBPs) With Limited-English-Proficient (LEP) Populations

The purpose of this document is to help Medicare Part C and D plan sponsors verify the language use and translation requirements for each plan benefit package (PBP) service area. Plan sponsors must translate specific marketing materials into any language that is the primary language of at least 5% of the individuals in a PBP service area. These steps assume that you will be downloading data and working with them in a program of your choice (Excel, SPSS, STATA, SAS, etc.). Specific instructions for using the programs are not given.

Step 1: Service Areas

A. Obtain plan's 2014 service area data from the Health Plan Management System, Data Extract Facility, Service Area (e.g., ServiceAreaIndPlanLocalMA.txt). If your service area covers multiple counties, rather than states, you will be calculating percentages at the county level.

B. If your service area covers a partial county; treat it as though it covered the whole county.

Step 2: Determine Percentage of LEP Population in Each State or County

For this step, you will need to download data from one or more of the following three U.S. Census Bureau's American Community Survey datasets:

- A. American Community Survey (ACS) 2011 1-year estimates,
- B. American Community Survey (ACS) 2009-2011 3-year estimates, and/or
- C. American Community Survey (ACS) 2007-2011 5-year estimates.

All of these datasets are available on the census bureau website (www.census.gov) and more detailed instructions are provided below.

The ACS surveys are conducted on an ongoing basis and have been sent to several hundred thousand people per month. ACS surveys represent more current information than the Decennial Census, though for recent surveys (the 1-year estimates) was only available for counties with populations greater than 65,000; the 3-year estimate was only available for counties with populations greater than 20,000. The 5-year estimate covers all counties.

Step 2.1: Obtaining Data

To obtain the data needed to determine statistics for the populations of language speakers in your service area and the ability to speak English at home follow these steps.

- A. Go to www.census.gov.
- B. Click on **American Fact Finder** in the **Data** selection tab of the website.

- C. Click on **Advanced Search** button, then click **Show Me All**. In the **Refine your search results** box, type in: “**Language Spoken at Home**” and select **Enter**.
- D. Click on the **Geographies** box on the left side of the webpage, and under the --select a geographic type— select **County -050-**. Ignore the **select a state** box, and then select **All Counties within United States** in the last box and click on **ADD TO YOUR SELECTIONS**. After the site has done “...Loading...,” click on **CLOSE X** to close the pop-up box in this **Geographies** section.
- E. Go to the list of resulting tables and after scrolling down, check the three boxes identifying **B16001: Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over**. (The tables downloaded will provide 1, 3, and 5 year estimates of language proficiency by county used for the calculations).
- F. At the bottom of the list, click on **Download** and when prompted, click on **OK**.
- G. When notified that your file is complete, click **DOWNLOAD** in the resulting selection box.
- H. Save the download file and unzip it. The data files are 3 .csv files: **ACS_11_1YR_B16001_with_ann.csv**, **ACS_11_3YR_B16001_with_ann.csv**, **ACS_11_5YR_B16001_with_ann.csv**. There are also three associated .txt files and a Readme file which provide file descriptions and notes. Save the files with your chosen program (Excel, etc.) in a subdirectory that identifies these as County files.
- I. Next, download language statistics by State, as opposed to County by returning to Step C. above and repeating it.
- J. Click on the **Geographies** box on the left side of the webpage, and under the --select a geographic type— select **State**. In the next box select **All States within United States** in the last box and click on **ADD TO YOUR SELECTIONS**. After the site is done “...Loading...,” Click on the **CLOSE X** selection in this **Geographies** section.
- K. Go to the list of resulting tables and check the three boxes identifying **B16001: Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over**. (The tables downloaded will provide 1, 3, and 5 year estimates of language proficiency by state that can be used for the Regional MA and PDP calculations).
- L. At the bottom of the list, click on **Download** and when prompted, click on **OK**.
- M. When notified that your file is complete, click **DOWNLOAD**.
- N. Save the download file and unzip it. The data files are 3 .csv files: **ACS_11_1YR_B16001_with_ann.csv**, **ACS_11_3YR_B16001_with_ann.csv**, **ACS_11_5YR_B16001_with_ann.csv**. There are also three associated .txt files and a Readme file which provide file descriptions and notes. Save the files with your chosen program (Excel, etc.) in a subdirectory that identifies these as State files.

O. Everything you need to calculate LEP percentages are in the county and state files downloaded above. The files contain the following information for states or counties. The information includes the geographic identifier, the county or state population total (estimate) and the county or state estimates for the numbers of people who can speak English less than well. (Note: Every language variable has a Margin of Error (MOE) estimate after it. You can ignore these. Also note that the individual language estimates are ultimately aggregated according to the documentation in Appendix B.)

Columns 2/3 (Excel: B, C)—Geographic County/State descriptors
Column 4 (Excel: D)—Total population total estimate for geographic area.
(Denominator)
Column 12 (Excel: L), 18, 24, 30 etc.....Estimate of Spanish, French, French Creole, Italian, etc.) population who can speak English Less than Well. (Numerator).

P. If there are any states/counties in your plan’s service area where the data field was blank or that were not in the 1-year ACS estimate dataset, (e.g. **ACS_11_1YR_B16001_with_ann.csv**) then use the 3 Year dataset (**ACS_11_3YR_B16001_with_ann.csv**) to obtain the denominator and numerator information.

Q. If there are any states/counties in your plan’s service area where the data field was blank or that were not in the 1-year ACS estimate OR the 3-year ACS estimate, then you will need to use data from the 5 year ACS estimate (**ACS_11_5YR_B16001_with_ann.csv**) to obtain data for the missing counties or states.

Note on Missing States/Counties:

If you are obtaining data from multiple datasets, you will have to merge the datasets before performing the calculation steps in the next section. When you do this, be careful to only add data for the states/counties that are missing in the more recent datasets. (For instance, 3-Year ACS data would be added to 1-Year ACS data, without replacing any data for the states/counties that are in the 1-Year ACS set.)

Step 2.2: Calculating the 5% Less Than Very Well (LTVW) Population Percentages

A. Note that the quality of English spoken at home variables (B Series) need to be aggregated, as necessary to the appropriate categories based on the Appendix B crosswalk.

B. Once you have obtained the population and language data for all states and/or counties in your plan’s service area, make sure that you have merged all datasets (ACS 1-Year, ACS 3-Year, and/or ACS 5-Year, if applicable).

C. Using the variable “Total Population” (see Obtaining Data step 2.1.K.), sum this variable across all states and/or counties in your plan’s service area to create a **Grand Total Population** for your service area (this will be your denominator for all languages).

D. For each language other than English (see Obtaining Data steps 2.1.K), sum the number of individuals who speak that language and English less than very well in all states and/or counties in your plan's service area to create a **Grand Total of Individuals Who Speak a Given Language and English Less Than Very Well** for your service area (this will be your numerator for each specific language calculation).

E. For each language, divide the **Grand Total of Individuals Who Speak a Given Language and English Less Than Very Well** in the service area by the **Grand Total Population** in the service area. For every language for which this number is 5% or greater, the plan must provide translated marketing materials.

Appendix B: Differences in Language Variables between 2000 Census and ACS

This table describes how to combine the language categories in the 2000 Decennial census in order to match the categories in the American Community Surveys

Language Category in 2000 Census	Language Category in ACS
English	English
Spanish or Spanish Creole	Spanish
French (incl. Patois; Cajun) French Creole	French
German Yiddish Other West Germanic Languages	German
Russian Polish Serbo-Croatian Other Slavic Languages	Slavic
Italian Portuguese or Portuguese Creole Scandinavian Languages Greek Armenian Persian Gujarathi Hindi Urdu Other Indic Languages Other Indo-European Languages	Other Indo-European
Korean	Korean
Chinese	Chinese
Vietnamese	Vietnamese
Tagalog	Tagalog
Japanese Mon-Khmer; Cambodian Miao; Hmong Thai Laotian Other Asian Languages Other Pacific Island Languages	Other Asian Pacific Island
Navajo Other Native North American Languages Hungarian Arabic Hebrew African Languages Other and unspecified languages	Other

ATTACHMENT G

CAPITATION PAYMENT

RATES AS DETERMINED BY DCH AND APPROVED BY CMS

ATTACHMENT H



NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing**. Your request for a hearing, along with a copy of the adverse action letter, must be *received* within **thirty (30) days** of the date of the letter. Please mail your request for a hearing to [Managed Care Organization] at the following address:

[CMO Address Line 1]
[CMO Address Line 2]
[CMO Address Line 3]
[CMO Address Line 4]

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. Georgia Legal Services Program

1-800-498-9469

(Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. Georgia Advocacy Office

1-800-537-2329

(Statewide advocacy for persons with disabilities or mental illness)

3. Atlanta Legal Aid

404-377-0701 (DeKalb/Gwinnett Counties)

770-528-2565 (Cobb County)

404-524-5811 (Fulton County)

404-669-0233 (So. Fulton/Clayton County)

678-376-4545 (Gwinnett County)

ATTACHMENT I
LIST OF COUNTIES BY SERVICE REGIONS

Atlanta	Central	East	North	SE	SW
Barrow	Baldwin	Burke	Banks	Appling	Atkinson
Bartow	Bibb	Columbia	Catoosa	Bacon	Baker
Butts	Bleckley	Emanuel	Chattooga	Brantley	Ben Hill
Carroll	Chattahoochee	Glascok	Clarke	Bryan	Berrien
Cherokee	Crawford	Greene	Dade	Bulloch	Brooks
Clayton	Crisp	Hancock	Dawson	Camden	Calhoun
Cobb	Dodge	Jefferson	Elbert	Candler	Clay
Coweta	Dooly	Jenkins	Fannin	Charlton	Clinch
DeKalb	Harris	Lincoln	Floyd	Chatham	Coffee
Douglas	Heard	McDuffie	Franklin	Effingham	Colquitt
Fayette	Houston	Putnam	Gilmer	Evans	Cook
Forsyth	Jones	Richmond	Gordon	Glynn	Decatur
Fulton	Lamar	Screven	Habersham	Jeff Davis	Dougherty
Gwinnett	Laurens	Taliaferro	Hall	Liberty	Early
Haralson	Macon	Warren	Hart	Long	Echols
Henry	Marion	Washington	Jackson	McIntosh	Grady
Jasper	Meriwether	Wilkes	Lumpkin	Montgomery	Irwin
Newton	Monroe		Madison	Pierce	Lanier
Paulding	Muscogee		Morgan	Tattnall	Lee
Pickens	Peach		Murray	Toombs	Lowndes
Rockdale	Pike		Oconee	Ware	Miller
Spalding	Pulaski		Oglethorpe	Wayne	Mitchell
Walton	Talbot		Polk		Quitman
	Taylor		Rabun		Randolph
	Telfair		Stephens		Seminole
	Treutlen		Towns		Schley
	Troup		Union		Stewart
	Twiggs		Walker		Sumter
	Upson		White		Terrell
	Wheeler		Whitfield		Thomas
	Wilcox				Tift
	Wilkinson				Turner
	Johnson				Webster
					Worth

ATTACHMENT J

APPLICABLE CO-PAYMENTS

Children under age twenty-one (21), pregnant women, nursing facility residents, members enrolled in breast and cervical cancer programs, and Hospice care Members are exempted from co-payments.

There are no co-payments for family planning services or for emergency services except as defined below.

Services cannot be denied to anyone based on the inability to pay these co-payments.

Service	Additional Exceptions	Co-Pay Amount
Ambulatory Surgical Centers		A \$3 co-payment to be deducted from the surgical procedure code billed. In the case of multiple surgical procedures, only one \$3 amount will be deducted per date of service.
FQHC/RHCs		A \$2 co-payment on all FQHC and RHC.
Outpatient		A \$3 member co-payment is required on all non-emergency outpatient hospital visits
Inpatient	Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility are exempted from the inpatient co-payment.	A co-payment of \$12.50 will be imposed on hospital inpatient services
Emergency Department		A \$3 co-payment will be imposed if the Condition is not an Emergency Medical Condition

**ATTACHMENT K
INFORMATION MANAGEMENT AND SYSTEMS**

To meet programmatic, reporting and management requirements, CMO systems will serve as either a) the authoritative host of key data and documents or b) the host of valid, replicated data and documents from other systems. The following table lays out the requirements for managing (capturing, storing and maintaining) data and documents for the major **information types and subtypes** associated with the aforementioned programmatic, reporting and management requirements:

K.1.1 Member Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
1.1	Unique member identifier (UMI)	Authoritative host; retain relationship to Fiscal Agent-assigned member identifier	The UMI should span member’s lifetime and should serve as an index to obtain member-specific information across multiple sub systems/databases of a single CMO.
1.2	Fiscal Agent-assigned member identifier	Receive original record and updates from Fiscal Agent	Retain relationship to UMI
1.3	Member enrollment and enrollment status changes in Contractor’s CMO	Receive original record and updates from DCH or its agent	The CMO shall retain in its “live” systems the most recent 7-year history (or less if member dies within 7-year period) of enrollment status changes, including multiple re-enrollments and dis-enrollments of the same member, indexed by linked to the member’s UMI and Fiscal Agent-assigned member identifier.
1.4	Member demographic profile	Reconcile as needed to data kept by DCH or its agent	Includes family relationships, age, sex, pregnancy and incarceration flags, standardized address linked to CMO service region and standard location codes (zip code, municipality, county, etc.).
1.5	Member financial, insurance and employment profile	Casualty/Tort and TPL: exchange data with DCH or its agent. Other: reconcile as needed to data kept by DCH or its agent	<p>Consists of Casualty/Tort data (that may need to be provided by multiple CMOs) and TPL data (that may need to be exchanged between DCH and multiple CMOs), including:</p> <ul style="list-style-type: none"> Casualty/Tort <ul style="list-style-type: none"> • Member Name • Demographic information (SSN/DOB, DOD/Address and County) • Case Type (Auto, Slip and fall, nursing Home Negligence, Assault, Medical Malpractice, etc.)

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
			<ul style="list-style-type: none"> • Accident Date • Case Status (Open/Close) • Case Total Lien Amount) • Liable Party • Lien and Court Information (Docket #, Court Name) • Member's Attorney • Insurance (3rd party) <p>TPL</p> <ul style="list-style-type: none"> • Member ID and name • Carrier ID and name • Policy holder name • Policy holder SSN# • Policy Number • Policy Type • Relationship Code • Coverage Code • Effective and termination dates <p>Data may also include capitation rate cell to which the Member is associated.</p>
1.6	Member assignments to PCP and, if applicable, to CMO sub programs/"plan options"	Authoritative host	The CMO shall retain in its "live" systems the most recent 7-year history (or less if member dies within 7-year period).

K.1.2 Provider Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
2.1	Unique provider identifier (UPI)	Authoritative host; retain relationship to Fiscal Agent-assigned Provider ID	The UPI will meet the requirements of the National Provider ID (NPI) standards of HIPAA and will retain relationships to existing Georgia IDs. NPI requirements include identifying providers using the NPI or utilizing standards consistent with NPI and HIPAA requirements that identify a unique number of a provider. Maintain an on-line cross-reference of all old provider numbers to a new provider numbers and historical information linked to the NPI.
2.2	Provider CMO affiliation	Authoritative host	The CMO will retain a 7-year history (or less if member dies within 7-year period) of enrollment status changes, including multiple re-enrollments and dis-enrollments of the same provider; indexed by and linked to the provider's UPI.

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
2.3	Contractor-Provider agreement document	Authoritative host	Signed; indexed by and linked to the provider's UPI.
2.4	Provider location(s)	Reconcile as needed to data kept by DCH or its agent	Include location codes that enable map and Geographic Information System (GIS) based rendering of network coverage and capacity by provider type and geographic area. Include standardized office/practice addresses.
2.5	Provider credentialing Information	Credential delegated entities as defined by DCH. Authoritative host for non-mandated Providers (year 1) – receive original record and updates from Fiscal Agent; Authoritative host for all Providers thereafter	At a minimum: licensure status, board eligibility/certification. Includes indexed images of applicable documents. Disclosure of ownership data as well as managing employee information must be captured.
2.6	Provider specialties, affiliation and relation to other provider information	Authoritative host; reconcile as needed to data kept by DCH or its agent	Certified specialties, professional affiliations, group/practice associations, hospital admitting privileges, and sponsoring physician, if applicable. Includes indexed images of applicable documents.
2.7	Provider descriptive	Authoritative host for non-mandated Providers (year 1) – receive original record and updates from Fiscal Agent; Authoritative host for all Providers thereafter	Race, sex, language spoken by provider and staff, education and training. CMO Practice Hours, Accessibilities, Training, Work History, and Liability Insurance or a copy of the CVO provider profile
2.8	Provider Database Checks	Authoritative Host; interface with List of Excluded Individuals/Entities (LEIE), Death Master File (DMF) and the System for Award Management (SAM) Excluded Party List	Database checks of providers, owners and managing employees at initial enrollment, re-credentialing and monthly
2.9	Exclusions and Sanctions	Authoritative Host; online or paper applications	Applications must require mandated exclusion/sanction questions
2.10	Service Location and Correspondence Addresses	Authoritative host; reconcile as needed to	Physical location of office as well as address for correspondence

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
		data kept by DCH or its agent	
2.11	Provider Agreement/Enrollment Form; Policy manuals	Authoritative host; enrollment applications	Documentation that providers and their agents have read and are familiar with CMO policies
2.12	Provider medical and service profile	Authoritative host; reconcile as needed to data kept by DCH or its agent	Member assessments, reported incidents, malpractice cases, etc. Includes indexed images of applicable documents.
2.13	Provider financial	Authoritative host; reconcile as needed to data kept by DCH or its agent	At a minimum: FEINs/tax IDs, 1099s. Includes indexed images of applicable documents, and Pay To Address.

K.1.3 Service-Specific Utilization and Financial (“Encounter”) Data and Related Documents

Data to be extracted from claims management systems and other sources as needed.

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
3.1	Claim data including subsequent claim adjustment	Authoritative host; provide to State or its agent following format and procedure identified by DCH.	Capture data elements per applicable standard format/layout to be adopted by all CMOs (UB-92, CMS-1500, ADA, NCPDP). Capture EPSDT flags where applicable; all claim adjustments shall be logically linked to the original claim (parent/child data relationship). Contractor shall retain up to seven years of Claims history per Member (less if Member dies within 7-year period).
3.2	Encounter data from sub-capitated provider	Authoritative host; provide to State or its agent following format and procedure identified by DCH.	Encounter data from sub-capitated provider shall be equivalent (in terms of fields captured per record) to data obtained from claim submission (ref. 3.1). Contractor shall retain up to seven years of history of this type of Encounter data per Member (less if Member dies within 7-year period).

Special Considerations:

- 3.1 CMO systems will flag all services related to Federal EPSDT requirements, including diagnostic and treatment services resulting from an EPSDT screening service, for the purposes of consolidated EPSDT activity reporting (e.g. CMS form 416) and other management applications.

K.1.4 Utilization Management and Care Coordination Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
4.1	In-network specialist referrals	Authoritative host	7-year history (or less if member dies within 7-year period) of all medical management transactions by member. Capture and retain link/logical relationship to subsequent claim(s).
4.2	In-network authorizations	Authoritative host	7-year history (or less if member dies within 7-year period) of all medical management transactions by member. Capture and retain link/logical relationship to subsequent claim(s).
4.3	Out-of-network service referrals and authorizations	Authoritative host	7-year history (or less if member dies within 7-year period) of all medical management transactions by member. Capture and retain link/logical relationship to subsequent claim(s).
4.4	“Transition” service authorizations	Receive original record from DCH or its agent	Service authorizations issued by DCH, its agent, or another CMO prior to a transfer, during period prior to enrollment in CMO. Retain history of all of these authorizations. Capture and retain link/logical relationship to subsequent claim(s).

K.1.5 Health Status, Clinical and Outcomes Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
5.1	Focused studies	Authoritative host	Unique ID per study; codify results for summarization and analysis based on scheme TBD
5.2	Member (clinical) safety – reported incidents/occurrences	Authoritative host	Unique ID per study; codify results for summarization and analysis based on scheme TBD

K.1.6 Member Inquiry Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
6.1	Inquiry data (electronic or paper-based submission)	Authoritative host	Retain relationship to UMI; content of fields in online or paper-based forms codified for summarization and analysis according to CMO-specific scheme.
6.2	Inquiry processing status changes	Authoritative host	Maintain 7-year history (or less if member dies within 7-year period) of inquiry processing, the Contractor staff that have participated in addressing the inquiry or interacted with Member, date/time of interactions and intermediate status changes or updates. Status of inquiry to be codified for summarization and analysis according to CMO-specific scheme.
6.3	Inquiry resolution	Authoritative host	Includes date of resolution; codify for summarization and analysis according to CMO-specific scheme.
6.4	Inquiry forms (paper-based submission)	Authoritative host	Retain relationship to UMI

K.1.7 Provider Inquiry Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
7.1	Inquiry data (electronic or paper-based submission)	Authoritative host	Retain relationship to UPI; content of fields in online or paper-based forms codified for summarization and analysis according to CMO-specific scheme.
7.2	Inquiry processing status changes	Authoritative host	Maintain 7-year history (or less if Provider dies within 7-year period) of inquiry processing, the Contractor staff that have participated in addressing the inquiry or interacted with Provider, date/time of interactions and intermediate status changes or updates. Status of inquiry to be codified for summarization and analysis according to CMO-specific scheme.
7.3	Inquiry resolution	Authoritative host	Includes date of resolution; codify for summarization and analysis according to CMO-specific scheme.

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
7.4	Inquiry forms (paper-based submission)	Authoritative host	Retain relationship to UPI

K.1.8 Member Grievance and Appeal Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
8.1	Unique grievance/appeal ID	Authoritative host	Scheme must not conflict or overlap with scheme used by Fiscal Agent.
8.2	Grievance and appeal data including categorization – type/subtype (electronic or paper-based submission)	Authoritative host	Retain relationship to UMI; content of fields in online or paper-based forms codified for summarization and analysis according to scheme TBD.
8.3	Grievance and appeal processing status changes	Authoritative host	Maintain 7-year history (or less if member dies within 7-year period) of transaction processing, the Contractor staff that have participated in addressing the issues or interacted with Member, date/time of interactions and intermediate status changes or updates. Status of grievance/appeal to be codified for summarization and analysis according to CMO-specific scheme.
8.4	Grievance and appeal resolution	Authoritative host	Includes date of resolution; codify for summarization and analysis according to CMO-specific scheme.
8.5	Grievance and appeal forms (paper-based submission)	Authoritative host	Retain relationship to UMI

K.1.9 Provider Complaint Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
9.1	Unique Complaint ID (UCI)	Authoritative host	Scheme must not conflict or overlap with scheme used by Fiscal Agent.
9.2	Complaint data including categorization – type/subtype (electronic or paper-based submission)	Authoritative host	Content of fields in online or paper-based forms codified for summarization and analysis according to scheme TBD.
9.3	Complaint processing status changes	Authoritative host	Maintain 7-year history (or less if Provider dies within 7-year period) of transaction processing, the Contractor staff that have participated in addressing the issue(s) or interacted with Provider, date/time of interactions and intermediate status changes or updates. Status of complaint to

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
			be codified for summarization and analysis according to CMO-specific scheme.
9.4	Complaint resolution	Authoritative host	Includes date of resolution; codify for summarization and analysis according to CMO-specific scheme.
9.5	Complaint forms (paper-based submission)	Authoritative host	Retain relationship to UPI.

K.1.10 Member and Provider Feedback Data and Related Documents

Results of satisfaction surveys and other studies or research vehicles.

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
10.1	Survey/study ID	Authoritative host	Maintain 7-year history of feedback obtained from surveys, studies, etc.
10.2	Survey/study question	Authoritative host	Retain relationship to survey/study ID.
10.3	Survey/study response	Authoritative host	Where applicable, retain relationship to UMI/UIP. Codify as needed for summarization and analysis according to CMO-specific scheme.

K.1.11 Financial Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
11.1	Financial transaction	Authoritative host	Adhere where applicable to Generally Accepted Accounting Principles (GAAP). All financial transaction data as captured must also conform to State and Federal auditing standards and guidelines.
11.2	Medical loss ratio (MLR) and related	Authoritative host	Refer to MLR requirement in contract.
11.3	Cash disbursements journal		CMO general ledger system should generate a report of actual cash disbursements to providers.

K.1.12 Claims Management and Related Financial Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
12.1	Unique Claim ID (UCI)	Authoritative host	UCI scheme must not conflict or overlap with scheme used by Fiscal Agent

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
12.2	Claims processing and status	Authoritative host	Includes longitudinal record of claims date/time stamped multiple status changes (submitted, received, pending, denied, reopened, adjudicated, final settled, etc.) during its life
12.3	Claims payments (all: initial, interim, final)	Authoritative host	Discrete, date/time stamped payments
12.4	Cost avoidance and post payment recovery	Authoritative host	Tie to individual claims (roll up as needed)
12.5	Quality reporting		CMO must generate upon request, reliable reports of all data necessary for the External Quality Review Organization to complete its work.

Special Considerations:

- 12.1 Contractor systems shall distinctly track payments made to FQHCs and RHCs.
- 12.2 Contractor systems shall track claims incurred but not paid by Member and capitation rate cell.
- 12.3 Contractor systems shall retain a 7-year history of changes in procedure pricing (basis for claims payments); where procedure pricing is tied to a particular provider, provider group or provider type, the appropriate linkages to these will be retained as well.

K.1.13 Program Integrity and Compliance Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
13.1	Investigation ID	Authoritative host; reconcile as needed to data held by DCH or its agent	Refers to internal investigations; if applicable, tie back to specific claim(s), provider(s), member(s)
13.2	Investigation type	Authoritative host	Codify as needed for summarization and analysis according to scheme TBD
13.3	Investigation attributes	Authoritative host	Source of complaint; alleged persons or entities involved; nature of complaint (narrative); approximate dollars involved, etc. Codify as needed for summarization and analysis according to scheme TBD
13.4	Investigation progress and status changes	Authoritative host	Codify as needed for summarization and analysis according to CMO-specific scheme
13.5	Investigation resolution	Authoritative host	Include corrective actions taken and, where applicable, referral to DCH. Codify as needed for summarization and analysis according to scheme TBD

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
13.6	Exclusions	Screening to exclude certain providers and to alert appropriate parties of each exception	Documented evidence of provider screening, the results of such screening, and the related notifications. See, for examples, 42 CFR 438.610, 42 CFR 455.104, 42 CFR 1002.3(b)(3)

K.1.14 System Availability and Performance Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
14.1	Recorded/monitored response time by System/system function	Authoritative host	Based on statistically valid sampling methodology that covers appropriate number of users by user class. By system function (e.g. highlight ECM and CCE) if possible.
14.2	Reported unavailability events by System/system function	Authoritative host	Captured in IT service management system. Reconcile to data captured in 14.1. By system function if possible. Includes resolution and correction actions taken where applicable.
14.3	Business continuity-disaster recovery test results	Authoritative host	By system function if possible. Includes resolution and correction actions taken where applicable.
14.4	System user interactions with Systems Help Desk (SHD)	Authoritative host	Capture and provide based on SHD performance measures laid out in Contract Section 4.17.8.
14.5	System change management activity	Authoritative host	Includes, where applicable, referral to DCH for review and approval.

K.1.15 System Activity Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
15.1	Call center metrics	Authoritative host	Maintain 1-year daily history of Hourly totals: call length; hold time; call abandonment rate
15.2	Web site hits (non-interactive components)	Authoritative host	Maintain 1-year daily history of hourly hits
15.3	Web portal logins (interactive components/system functions)	Authoritative host	Maintain 1-year daily history of hourly logins and access to system functions (not only submitted transactions but Every instance where the associated function is accessed, if possible.

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K.1.16 Information Security Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
16.1	System access security event	Authoritative host	Includes reports or identification of security breaches associated with System access. Capture by system function or data element/document type where applicable. Identify source/cause of breach and corrective actions taken where applicable. Tag as HIPAA-related violation when applicable.
16.2	Physical security event	Authoritative host	Includes reports or identification of security breaches associated with unauthorized access to specific facilities and access to documents within that facility. Capture by location or data element/document type if applicable. Identify source/cause of breach and corrective actions taken where applicable. Tag as HIPAA-related violation when applicable.

Special Considerations:

16.1 When applicable Contractor systems shall retain Federal or State mandated forms/reports/documents associated with these events.

K.1.17 System Management Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
17.1	System problem or defect	Authoritative host	Maintain history of proactively identified or reported problems/defects and associated resolution/corrective action for the life of the contract. Capture by system function if possible and where applicable. If the problem was the underlying cause of a system unavailability or performance event, establish a logical relationship between the problem/defect and the event.
17.2	System change	Authoritative host	Maintain history of changes for the life of the contract. Capture by system function if possible and where applicable. If the change is part of the resolution/corrective action associated with a System problem/defect, establish a logical relationship between the change and the problem/defect.

**Georgia Families and Georgia Families 360
Care Management Organization (CMO) Contract
Attachment K.2: Compliance with Standard Coding Schemes**

A CMO system that is required to or otherwise contains the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed:

- Logical Observation Identifier Names and Codes (LOINC)
- Health Care Financing Administration Common Procedural Coding System (HCPCS)
- Home Infusion EDI Coalition (HEIC) Product Codes
- National Drug Code (NDC)
- National Council for Prescription Drug Programs (NCPDP)
- International Classification of Diseases (ICD-10)
- American Dental Association Current Dental Terminology (CDT)
- American Medical Association Current Procedural Terminology (CPT)
- American Medical Association Healthcare Common Procedure Coding System (HCPCS)
- Diagnosis Related Group (DRG)
- Claim Adjustment Reason Codes
- Remittance Remarks Codes

The CMO shall comply with the requirements for use of the Health Plan Identifier (HPID) in standard transactions in accordance with applicable federal rules and regulations and the timeframes mandated by the Department of Health and Human Services or successor entity.

**Georgia Families and Georgia Families 360
Care Management Organization (CMO) Contract
Attachment K.3: Batch and Online Transaction Specifications for Data Exchange**

CMO systems must conform to the Accredited Standards Committee (ASC) X12 Version 5010 transaction standards or any future replacement version as mandated by HIPAA.

**Georgia Families and Georgia Families 360
Care Management Organization (CMO) Contract
Attachment K.4: Performance Data to Be Captured by Call Center Systems**

Call center systems must be able to capture data required to create statistical profiles over a defined timeframe of the following industry-standard call center performance measure:

- Speed of answer/hold time
- Abandon rate
- Response time
- Call duration
- Number of calls taken by call center resource
- First contact resolution rates

ATTACHMENT L

DEMONSTRATION COVERED SERVICES

Family Planning Demonstration Services: Services provided to P4HB participants must be provided by a physician or an advanced practice nurse.

Services Include:

- Family planning initial or annual exams
- Follow up, brief and comprehensive visits
- Contraceptive services and supplies
- Patient education and counseling
- Counseling and referrals to:
 - Social services
 - Primary health care providers
- Family planning lab tests:
 - Pregnancy tests
 - Pap Smear and Pelvic exam
 - A colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are coverable as a family planning-related service under this Demonstration. Colposcopies which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital are not covered under this waiver as family planning-related services
- Screening, treatment and follow up for sexually transmitted infections (STIs), except HIV/AIDS and Hepatitis
 - Antibiotic treatment for STIs when the infections are identified during a routine family planning visit.
 - A follow up visit for the treatment/drugs may be covered
 - Subsequent follow-up visits to re-screen for STIs based on the Centers for Disease Control and Prevention guidelines
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/ drugs may be covered.
- Treatment of major complications related to the delivery of Demonstration related services such as:
 - Treatment of a perforated uterus due to an intrauterine device insertion;
 - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
 - Treatment of surgical or anesthesia-related complications during a sterilization procedure.
- Tubal Ligation (Sterilization)
 - Treatment and follow-up of an STI diagnosed at the time of sterilization.

- Family Planning pharmacy visits
- Folic acid and/or a multivitamin with folic acid.
- Select immunizations for aged 19 and 20. The Contractor shall provide all P4HB participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the Advisory Committee on Immunization Practices (ACIP) guidelines as needed
- P4HB participants age 18 receive vaccines at no cost under the Vaccines for Children (VFC) program
- Additionally women who have delivered a very low birth weight baby following implementation of the Demonstration will be eligible for Interpregnancy Care services including the Resource Mother Outreach benefit.
 - Interpregnancy Care (IPC) covered services:

In addition to the family planning and family planning related services listed above, P4HB participants enrolled in the IPC component of the waiver will receive:

- Primary Care services, up to 5 office/outpatient visits
 - Limited Dental Services
 - Management and treatment of chronic diseases
 - Substance abuse treatment including detoxification and intensive outpatient rehabilitation
 - Case Management/Resource Mother Outreach
 - Prescription drugs (non-family planning) for the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery
 - Non-emergency transportation
- Resource Mother Outreach only

Resource Mothers Outreach only services are available to women who are currently enrolled in and are receiving Title XIX services and benefits but who meet all other IPC Demonstration eligibility criteria.

ATTACHMENT M

DEMONSTRATION QUALITY STRATEGY

In order to assess and improve the quality of services delivered under this Demonstration, DCH will implement a rigorous quality strategy and evaluation process formally documented as the Demonstration Evaluation Design. This design or plan will be developed with assistance from Emory University, the independent contractor charged with evaluating the effectiveness of the Demonstration. The evaluation design must incorporate key goals, objectives and a set of performance measures that align well with the logical sequence through which the Demonstration can and will affect Provider's behavior such that the key outcomes - longer inter partum intervals, lower low birth weight rates and cost savings - can be achieved. The evaluation design must receive final approval from CMS. Reporting to CMS will occur on a quarterly and annual basis with a final report due to CMS at the end of the Demonstration period. Contractor reporting will be due on a quarterly and annual basis as identified below and in the CMS Special Terms and Conditions.

The Evaluation Design will include:

- Key Goals, Objectives and Performance Targets
- Program Hypotheses
- Performance Measures
- Analysis pertaining to the achievement of the Performance Targets
- Assessment of the rate at which the Demonstration was implemented
- Assessment of the Demonstration Providers' understanding of program eligibility, service coverage and payment rates across sites of care
- Assessment of the Providers' satisfaction with the Demonstration
- Assessment of the per Demonstration year changes in family planning visits regardless of payer source, per poor and near poor women in Georgia
- Determination of averted births among P4HB participants and tests of budget neutrality
- The relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for "targeted" versus control group women
- The relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among "targeted" and control groups
- The relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

Key Goals:

If participation in the Demonstration penetrates the eligible population to the extent hoped for and P4HB Participants are consistent users of family planning and IPC services and supplies, the DCH anticipates the following major outcomes can be achieved:

- Reduction of Georgia's low birth weight and very low birth weight rates over the course of the Demonstration period
- Reduction in the number of unintended pregnancies in Georgia

- Reduction in Georgia’s Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy related services.

Program Objectives

- Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the three year term of the Demonstration. Achievement of this objective will be measured by:
 - Total family planning visits pre and post the Demonstration;
 - Use of contraceptive services/supplies pre and post the Demonstration;
- Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant. Achievement of this objective will be measured by:
 - Use of inter-pregnancy care services (primary care and Resource Mothers Outreach) by women with a very low birth weight delivery;
- Decrease unintended and high-risk pregnancies among Medicaid eligible women and increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women. Achievement of this objective will be measured by:
 - Average inter-pregnancy intervals for women pre and post the Demonstration;
 - Average inter-pregnancy intervals for women with a very low birth weight delivery pre and post the Demonstration;
- Decrease in late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women. Achievement of this objective will be documented by:
 - The number of repeat teen births assessed annually
- Decrease the number of Medicaid-paid deliveries beginning in the second year of the Demonstration, thereby reducing annual pregnancy-related expenditures. Achievement of this objective will be measured by:
 - The number of Medicaid paid deliveries assessed annually
- Increase consistent use of contraceptive methods by incorporating Care Coordination and patient-directed counseling into family planning visits. Achievement of this objective will be measured by:
 - Utilization statistics for family planning methods
 - Number of Deliveries to P4HB participants
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women who are in need of services but who are not receiving them. Achievement of this objective will be measured by:
 - Enrollment statistics for the Demonstration.
- Increase the overall savings in Medicaid spending attributable to this Demonstration. Achievement of this objective will be measured by:
 - Documentation of achievement of financial savings targets

Program Hypotheses

- That the Demonstration will bring sufficient numbers of women into the program to increase the overall use of family planning services/supplies and will promote the more consistent use of effective contraceptive methods among program users.

That increased use of contraceptives will lead to reduced unintended pregnancies and in turn, unintended births among this population of women (as well as improved inter-pregnancy intervals). That teens are at high risk of unintended pregnancy a related hypothesis is that the rate of unintended births and repeat teen births will also fall post implementation of the waiver. That these changes will be sufficient to lower the number of overall Medicaid paid deliveries/births and hence, costs, such that the state and federal government will realize a net cost savings despite increased spending on family planning services.

Performance Reporting

In order for the program objectives to be achieved there must be sufficient outreach, uptake, and implementation of the Demonstration benefits. The performance measures identified below and in the CMS Special Terms and Conditions must be reported by the Contractor quarterly and annually or as identified in the CMS Special Terms and Conditions.

I. Assessment of the rate at which the Demonstration was implemented using Enrollment, Participation and Use of Services as Performance Measures:

- These reports are to be submitted to DCH within 30 Calendar Days from the close of the previous quarter (e.g., April 30 for the quarter ending March 31).
- Total number of Demonstration Enrollees per CMO stratified by Demonstration component – Family Planning only; IPC; Resource Mothers only
- Total number of Demonstration Enrollees per CMO stratified by age, race and ethnicity, county;
- Average months enrolled per CMO by Age, Race/Ethnicity and County;
- Proportion of LIM population per CMO enrolled in Resource Mothers Outreach
- Total number of P4HB participants per CMO stratified by age, race, ethnicity, county;
- Number of IPC P4HB participants per CMO stratified by age, race and ethnicity, county;
- Number of P4HB participants per CMO in the Resource Mothers only Outreach
- Overview of the Geographic variations in enrollment per CMO;
- Rate of use per CMO of:
 - All Family Planning Services by type;
 - All Contraceptives by type (inclusive of hormonal and non-hormonal contraceptives);
 - Counts of primary care visits for those in the IPC component of the Demonstration.
- Utilization statistics per CMO for all IPC services and IPC services by type

Sufficient “take up” of the Demonstration can only occur if both providers and women understand their new eligibility and coverage. An explanatory design component of the evaluation will help understand if there are barriers in the provider system that could prevent take up and/or visit rates.

II. Assessment of the Demonstration Providers’ s’ understanding of program eligibility, service coverage and payment rates across sites of care

- These semi-annual survey reports are due October 1st and April 1st.

Contractor shall submit a report semi-annually of Provider Surveys conducted by the Contractor with analysis reports highlighting responses to questions regarding knowledge and understanding of the Demonstration, level of participation and training/outreach.

- Contractor shall submit a report semi-annually of P4HB participant Surveys conducted by the Contractor with analysis reports highlighting responses to questions pertaining to satisfaction with eligibility and enrollment processes. The report shall address the following subjects:
 1. Satisfaction with CMO selection process
 2. Satisfaction with educational materials regarding the Demonstration
 3. Satisfaction with service options and services
 4. Satisfaction with contraceptive method
 5. Contraceptive failures/unintended births
 6. Satisfaction with provider selection
 7. Results and analysis of semi-annual member satisfaction surveys

The above data will be gathered through standardized semi-annual Provider and P4HB Participant Surveys administered by each CMO. Survey tools will be developed by the Demonstration's evaluator and made available to the Contractor for review and comment prior to being finalized. A summary of the Contractor's Provider and P4HB Participant survey data and qualitative interviews must be compiled by the Contractor and submitted to DCH by October 1st and April 1st of each Demonstration Year beginning with October 1st of Demonstration year 1.

III. Assessment of the per Demonstration year changes in family planning visits

- These annual reports are due June 30th. Total Demonstration expenses per CMO and stratified by Demonstration component – Family Planning Only, IPC, and Resource Mothers Outreach only
- The average per person expenditures for the IPC component per CMO
- The total expenditures per CMO for the first year infant life costs stratified by birth weight categories
- The average per person expenditures per CMO for the first year of life costs stratified by birth weight categories
- The total expenditures for VLBW deliveries per CMO
- The average per person expenditures for VLBW deliveries per CMO

IV. Determination of the number of averted births among P4HB Participants and tests of budget neutrality

- These annual reports are to be submitted within 45 calendar days of the end of the 4th quarter.
- Total Pregnancies per CMO stratified by age, race/ethnicity, county/region
- Total Pregnancies per Demonstration population paid per CMO stratified by age, race/ethnicity, county/region, FP only and IPC
- Contraceptive failures per CMO stratified by age, race/ethnicity, county/region

- Actual Live Births per CMO stratified by Age, Race/Ethnicity, county/region and weight categories

V. Determination of the relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for “targeted” versus control group women

- To be calculated by the Demonstration evaluator

VI. Assessment of the relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among “targeted” and control groups:

- These annual reports are to be submitted within 45 calendar days of the end of the 4th quarter.
- CMO documentation of events that occurred during the quarter or are anticipated to occur in the near future affecting the CMO’s health care delivery; benefits; enrollment; grievances; quality of care; access; other operational issues
- Total Births – Live Births and Fetal Deaths stratified by age, race/ethnicity, county/region per CMO
- Unintended Births-Percent of Births Reported as Unwanted or Mistimed per CMO

VII. Assessment of the relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

- These annual reports are due June 30th. Average number of months between pregnancies to the same woman (number of months between initial birth/fetal death event and subsequent birth/fetal death event – the gestational age of the subsequent event) per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in low birth weight or very low birth weight per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in a preterm delivery per CMO

Performance Measures

The Contractor’s failure to meet these goals shall result in a Category 2 Liquidated Damage as defined in Section 25.3 of the Contract.

- Reduction of Contractor membership’s LBW and VLBW rates over the course of the Demonstration period as measured by 10% cumulative reduction from CY 2010 baseline in the Contractor’s LBW and VLBW rates by January 31, 2015.
- 4% reduction in the Pregnancy Rate in the Contractor’s membership over the Demonstration period ending January 31, 2015.

Quarterly Report Data per CMO: Reports are to be submitted to DCH within 30 Calendar Days from the close of the previous quarter (e.g., April 30 for the quarter ending March 31).

- Demonstration expenditures including administrative costs;
- Total number of Demonstration enrollees;
- Total number of P4HB participants
- Total number of Demonstration enrollees stratified by age, race and ethnicity;
- Total number of P4HB participants stratified by age, race and ethnicity
- Total number of IPC enrollees stratified by age, race and ethnicity
- Total number of IPC P4HB participants stratified by age, race and ethnicity
- Total number of Family Planning only enrollees stratified by age, race and ethnicity
- Total number of Family Planning only P4HB participants stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only Enrollees stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only P4HB participants stratified by age, race and ethnicity
- Total number of P4HB participants utilizing services
- Utilization statistics for Family Planning only services by type
- IPC Problem and Strength Identification Quarterly Summary
- Total number of Care Plans for IPC Participants
- Utilization statistics for IPC Services by type;
- Contraceptive types utilized;
- Geographic variations in enrollment;
- Total number of P4HB participants (Participants include all individuals who obtain one or more covered family planning services through the Demonstration);
 - Events occurring during the quarter, or anticipated to occur in the near future that affect:
 - health care delivery
 - benefits
 - enrollment
 - grievances
 - quality of care
 - access
 - pertinent legislative activity
 - eligibility verification activities
 - other operational issues;
- Action plans for addressing any policy and administrative issues identified; and
- Evaluation activities and interim findings.

Annual Report Data per CMO – for Demonstration year 1, appropriate baseline calculations should also be reported using Calendar Year 2010 as the baseline year. Baseline calculations to include but not be limited to: total deliveries, pregnancy rate, total births, number of still births, LBW and VLBW rates, etc.

- Top five (5) Chronic Diseases/Conditions affecting P4HB participants in the IPC Demonstration component;
- The total number of deliveries to Contractor’s Medicaid Members;
- The pregnancy rate for Contractor’s Medicaid Members;

- The number of deliveries to the P4HB participants stratified by Demonstration component: FP Only; FP and IPC; Resource Mothers Only.
- The number of total births to the Contractor's Medicaid Members stratified by birth weight categories;
- The number of live births to P4HB participants in the FP only component of the Demonstration stratified by birth weight categories – Normal (2,500 grams or more), LBW (1,500 grams to 2,499 grams), VLBW (less than 1,500 grams);
- The number of live births to P4HB participants in the IPC component of the Demonstration stratified by birth weight category;
- The number of stillbirths to the IPC P4HB participants;
- IPC Problem and Strength Identification Yearly Summary
- The number of estimated averted births (using the baseline fertility rate) in the waiver application;
- The total and average per person Medicaid expenditures for the Demonstration;
- The total and average per person Medicaid expenditures for the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for the first year infant life costs stratified by birth weight categories;
- The number of VLBW deliveries to Contractor's P4HB participants;
- The number of VLBW deliveries that occur to P4HB participants in the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for VLBW deliveries;
- Results of P4HB participant and Provider satisfaction surveys.

ATTACHMENT N

RESOURCE MOTHER OUTREACH

Resource Mother:

The Resource Mother provides a broad range of paraprofessional services to P4HB participants in the Interpregnancy Care component of the Planning for Healthy Babies Program and their families. She performs certain aspects of case management including the provision of assistance in dealing with personal and social problems and may provide supportive counseling to P4HB participants and their families and/or serve as a liaison for social services.

The Contractor has the responsibility for training the Resource Mother and must utilize the standardized Resource Mothers Training Manual specified by DCH. DCH will also provide the Resource Mother Job description and technical support for the Resource Mother Outreach program.

The Contractor must ensure the Resource Mother Outreach is effective through monitoring of the Resource Mother's performance including an evaluation of the Resource Mother's P4HB participant contact activities and contact documentation.

The Resource Mother will carry out the following responsibilities:

- Complete P4HB participant intakes based on interviews with P4HB participants, their families, significant others and appropriate community agencies.
- Demonstrate skillful use of observation and assessment tools to evaluate the P4HB participant's needs and monitor the P4HB participant's progress towards treatment goals.
- Meet with P4HB participants via phone or in person to increase participants' adoption of healthy behaviors, including healthy eating choices and smoking cessation; increase participants' adoption of healthy behaviors such as healthy eating choices and smoking cessation.
- Support P4HB participants' compliance with primary care medical appointments including assistance with non-emergency transportation arrangements; serve as the liaison between P4HB participants and family members, significant others, nurses, physicians, and organizational components to facilitate communication, linkage and continuity of service.
- Consult with physicians, nurses, social workers, and case managers about problems identified and assist in the development of an appropriate action plan.
- Document compliance with appointments and enrollment and participation in planned services and benefits in the P4HB participant's case management record and/or required Demonstration forms.
- Prepare and disseminate pertinent reports for/to supervisors, colleagues and other appropriate individuals. Maintain program statistics for purposes of evaluation and research.

- Submit all data, forms and documentation per Demonstration guidelines.
- Provide short-term case management and referral services to P4HB participants with emergency situations.
- Support P4HB participants' compliance with medications to treat chronic health conditions including assisting the P4HB participant with obtaining needed medications and reinforcing the need for medication compliance.
- Assist the P4HB participant with the coordination of social services support for family and life issues; implement and organize the delivery of specific social services within the community and maintain an updated resource file.
- Assist Participants in locating and utilizing community resources including legal, medical, financial assistance, and other referral services; assist with linking mothers to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Provide emotional support following substance abuse treatment;
- Provide mentoring for P4HB Participants;
- Assist mothers of VLBW babies to obtain regular preventive health visits and appropriate immunizations for their child;
- Link the VLBW infant's mother with community resources such as WIC;
- Provide the mother with the peer and emotional support needed to meet the health demands of her VLBW infant;
- Encourage the VLBW infant's mother to implement the parenting and child safety concepts taught during classes the mother will be encouraged to attend.

Technical Competencies of the Resource Mother

- Successfully complete Resource Mother training module and participate in ongoing in-service training as provided
- Knowledge of agency policies and procedures.
- Ability to coordinate and organize the delivery services.
- Ability to monitor client's progress toward meeting established goals.
- Knowledge of client's treatment goals.
- Ability to interview clients and/or families using established techniques.
- Ability to develop client profile.
- Knowledge of agency confidentiality policies.
- Knowledge of state and federal confidentiality laws and regulations.
- Knowledge of available community resources.
- Ability to make appropriate referrals.
- Knowledge of crisis intervention.

- Ability to develop P4HB participant service plan to assist P4HB participant in attaining social, educational and vocational goals.
- Ability to contact health care professionals to obtain additional background information.
- Knowledge of target population.
- Knowledge of agency specific software.
- Knowledge of available databases.
- Ability to prepare reports and case history records.
- Knowledge of eligibility requirements.
- Knowledge of what qualifies as an emergency situation.

Entry Qualifications

- High school diploma or GED and two years of experience in a social services related position or Bachelor's degree in a social services related field
- Valid driver's license
- Reliable vehicle with motor vehicle insurance coverage
- Good communication skills. Comfortable communicating with both professionals (physicians, nurses, social workers, etc.) and with lay persons

ATTACHMENT O

**TABLE OF CONTRACTED RATES
AS DETERMINED BY DCH AND APPROVED BY CMS**

Attachment O is a table displaying the contracted rates by rate cell for each contracted region. These rates will be the basis for calculating capitation payments in each contracted Region.

Rate Cell	P4HB Capitation Rates
Family Planning - All Regions Interpregnancy Care - All Regions	

For members receiving full Medicaid benefits through a CMO or fee-for-service, the following rate will be paid for Resource Mother services. For members enrolled in a CMO, this rate will be in addition to any capitation paid to provide medical services to the member.

Rate Cell	P4HB Capitation Rates
Resource Mother Services Only- All Regions	

ATTACHMENT P
STATEMENT OF ETHICS

Preamble

The Department of Community Health has embraced a mission to improve the health of all Georgians through health benefits, systems development, and education. In accomplishing this mission, DCH employees must work diligently and conscientiously to support the goals of improving health care delivery and health outcomes of the people we serve, empowering health care consumers to make the best decisions about their health and health care coverage, and ensuring the stability and continued availability of health care programs for the future. Ultimately, the mission and goals of the organization hinge on each employee's commitment to strong business and personal ethics. This Statement of Ethics requires that each employee:

- Promote fairness, equality, and impartiality in providing services to clients
- Safeguard and protect the privacy and confidentiality of clients' health information, in keeping with the public trust and mandates of law
- Treat clients and co-workers with respect, compassion, and dignity
- Demonstrate diligence, competence, and integrity in the performance of assigned duties
- Commit to the fulfillment of the organizational mission, goals, and objectives
- Be responsible for employee conduct and report ethics violations to the DCH Inspector General and to the DCH Ethics Officer
- Engage in carrying out DCH's mission in a professional manner
- Foster an environment that motivates DCH employees and vendors to comply with the Statement of Ethics
- Comply with the Code of Ethics set forth in O.C.G.A. Section 45-10-1 et seq.

Not only should DCH employees comply with this Statement of Ethics, but DCH expects that each vendor, contractor, and subcontractor will abide by the same requirements and guidelines delineated. Moreover, it is important that employees and members of any advisory committee or commission of DCH acknowledge the Statement of Ethics.

Ethical Guidelines

1. Code of Conduct

All employees of DCH are expected to maintain and exercise at all times the highest moral and ethical standards in carrying out their responsibilities and functions. Employees must conduct themselves in a manner that prevents all forms of impropriety, including placement of self-interest above public interest, partiality, prejudice, threats, favoritism and undue influence. There will be no reprisal or retaliation against any employee for questioning or reporting possible ethical issues.

2. Equal Employment

The Department is committed to maintaining a diverse workforce and embraces a personnel management program which affords equal opportunities for employment and advancement based on objective criteria. DCH will provide recruitment, hiring, training, promotion, and other conditions of employment without regard to race, color, age, sex, religion, disability, nationality, origin, pregnancy, or other protected bases. The Department expects employees to support its commitment to equal employment. The failure of any employee to comply with the equal employment requirements provided in DCH Policy #21 may result in disciplinary action, up to and including termination.

3. Harassment

DCH will foster a work environment free of harassment and will not tolerate harassment based on sex (with or without sexual conduct), race, color, religion, national origin, age, disability, protected activity (*i.e.*, opposition to prohibited discrimination or participation in a complaint process) or other protected bases from *anyone* in the workplace: supervisors, co-workers, or vendors. The Department strongly urges employees to report to the Human Resources Section any incident in which he or she is subject to harassment. Additionally, any employee who witnesses another employee being subjected to harassment should report the incident to the Human Resources Section. If DCH determines that an employee has engaged in harassment, the employee shall be subject to disciplinary action, up to and including termination, depending on the severity of the offense.

4. Appropriate Use of DCH Property

Employees should only use DCH property and facilities for DCH business and not for any type of personal gain. The use of DCH property and facilities, other than that prescribed by departmental policy, is not allowed. Furthermore, the use of DCH property and facilities for any purpose which is unlawful under the laws of the United States, or any state thereof, is strictly prohibited. Employees who divert state property or resources for personal gain will be required to reimburse the Department and will be subject to the appropriate disciplinary action, up to and including, termination.

5. Secure Workplace

DCH is committed to maintaining a safe, healthy work environment for its employees. Accordingly, it is DCH's expectation that employees refrain from being under the influence of alcohol or drugs in the workplace because such conduct poses a threat to the employee, as well as others present in the workplace. Additionally, DCH has a zero tolerance policy regarding violence in the workplace. Specifically, DCH will not condone the threat of, or actual assault or attack upon, a client, vendor, or other employee. If an employee engages in violent behavior which results in an assault of another person, he or she will be immediately terminated.

6. Political Activities

Although the DCH recognizes that employees may have an interest in participating in political activities and desires to preserve employees' rights in participating in the political process, employees must be aware of certain allowances and prohibitions associated with particular political activities. DCH encourages employees to familiarize themselves with DCH Policy #416 to gain understanding about those instances when a political activity is disallowed and/or approval of such activity is warranted.

7. Confidentiality

DCH has a dual mandate in terms of confidentiality and privacy. Foremost, as a state agency, DCH must comply with the Georgia Open Records Act and Open Meetings Act. The general rule that is captured by those laws is that all business of the agency is open to the public view upon request. The exceptions to the general rule are found in various federal and state laws. In order to protect the individuals' health information that is vital to the delivery of and payment for health care services, DCH sets high standards of staff conduct related to confidentiality and privacy. Those standards are reinforced through continuous workforce training, vendor contract provisions, policies and procedures, and web-based resources.

8. Conflicts of Interest

Employees should always strive to avoid situations which constitute a conflict of interest or lend to the perception that a conflict of interest exists. Specifically, employees must avoid engaging in any business with the DCH which results in personal financial gain. Similarly, employees must encourage family members to avoid similar transactions since they are subject to the same restrictions as employees. DCH encourages its employees to seek guidance from the Office of General Counsel regarding questions on conflicts of interest.

9. Gifts

Employees are strictly prohibited from individually accepting gifts from any person with whom the employee interacts on official state business. Gifts include, but are not limited to, money, services, loans, travel, meals, charitable donations, refreshments, hospitality, promises, discounts or forbearance that are not generally available to members of the public. Any such item received must be returned to the sender with an explanation of DCH's Ethics Policy.

10. Relationships with Vendors and Lobbyists

DCH values vendors who possess high business ethics and a strong commitment to quality and value. Business success can only be achieved when those involved behave honestly and responsibly. Therefore, it is critical that employees ensure that vendors contracting with DCH are fully informed of DCH policies concerning their relationships with DCH employees and that these policies be uniformly applied to all vendors. Among other requirements, DCH expects that each vendor will honor the terms and conditions of its contracts and agreements. If DCH determines that a vendor has violated the terms and conditions of a contract or agreement, the vendor shall be held responsible for its actions.

Employees must ensure that fair and open competition exists in all procurement activities and contracting relationships in order to avoid the appearance of and prevent the opportunity for favoritism. DCH strives to inspire

public confidence that contracts are awarded equitably and economically. DCH will apply the state procurement rules, guidelines, and policies. Open and competitive bidding and contracting will be the rule.

DCH recognizes that lobbyists, both regulatory and legislative, may from time to time seek to meet with DCH employees to advance a particular interest. DCH recognizes that employees may have personal opinions, even those that may be contrary to a position that DCH has adopted. DCH employees, however, must recognize that the public, including legislators and lobbyists, may have difficulty differentiating between the official DCH position and a personal opinion. Accordingly, employees should always work directly with the Director of Legislative Affairs in preparing any responses to requests or questions from elected officials and their staff or lobbyists.

11. Mandatory Reporting

If I have knowledge of any ethics violation, I am aware that I am responsible for reporting such violation to the DCH Inspector General and the DCH Ethics Officer. My good faith reports will be free from retaliation. If I am a supervisor, I am aware that I am responsible for reporting such violation and for forwarding any such report from a member of my staff to the DCH Inspector General and the DCH Ethics Officer. As a supervisor, I am additionally responsible for ensuring that the employees who report to me are aware of and comply with the ethical standards and policies that are applicable to their positions.

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understands the Georgia Department of Community Health's *Statement of Ethics*;
- B. It agrees to comply with the provisions of the Georgia Department of Community Health's *Statement of Ethics*;
- C. It is a contractor.

[CONTRACTOR]

BY: _____
*SIGNATURE

Date

Please Print/Type Name Here

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT Q

DCH ETHICS IN PROCUREMENT POLICY

DCH Ethics In Procurement Policy	Policy No. 402
Effective Date: April 10, 2006 Revised and Restated: April 2, 2012	Page 1 of 12

I. THE COMMITMENT

The Department is committed to a procurement process that fosters fair and open competition, is conducted under the highest ethical standards, is fully compliant with all legal authority, and has the complete confidence and trust of the public it serves. To achieve these important public purposes, it is critical that current vendors and those making proposals to provide goods or services to the Department, as well as employees of the Department, members of the Board of Community Health, and independent contractors, consultants and temporary staffing agency employees currently on an assignment with DCH, have a clear understanding and an appreciation of, the DCH Ethics in Procurement Policy (the “Policy”).

II. SCOPE

This Policy is applicable to all Vendors and DCH Workers, as those terms are defined below.

III. ETHICAL PROCUREMENT STANDARDS

In order to maintain an ethical procurement process, DCH Workers and Vendors must act in accordance with the following standards:

A. Fulfilling Legitimate Business Needs

The procurement of goods and services will be limited to those necessary to accomplish the mission, goals, and objectives of the Department.

B. Identifying and Resolving Conflicts of Interest

Conflicts of interest shall be promptly identified and resolved early in the Procurement process. A “conflict of interest” exists when an individual possesses personal, financial or professional interests that compete, conflict or otherwise interfere with the individual’s actual or perceived ability to act in the best interests of the Department or carry out that individual’s duties in an impartial manner. A conflict of interest situation can arise when an individual takes actions or has interests that may make it difficult to perform his or her work objectively and effectively. Conflicts of interest also arise when an individual, or a family member of that individual, receives personal benefits as a result of the individual’s action, decision, or disclosure of Confidential Information in a Procurement.

C. Avoiding the Appearance of Impropriety

DCH Workers must take care to avoid any appearance of impropriety and must promptly disclose to their supervisors any material transaction or relationship that reasonably could be expected to give rise to a conflict of interest. Similarly, anyone engaged in a business relationship with the Department should avoid any appearances of impropriety.

D. Maintaining Impartiality

DCH Workers must maintain an impartial, arms' length relationship with anyone seeking to influence the outcome of a Procurement.

E. Declining Gifts

DCH Workers are prohibited at all times from soliciting, demanding, accepting, or agreeing to accept Gifts from Vendors, including Gifts from consultants, independent contractors or temporary staffing agency employees currently on assignment with DCH.

F. Avoiding Misrepresentations

DCH Workers and Vendors may not knowingly falsify, conceal or misrepresent material facts concerning a Procurement.

G. Obtaining Sufficient Authorization

DCH Workers may not obligate the Department without having received prior authorization from an approved official. Engaging in such activity is a misrepresentation of authority. DCH Workers who are consultants, independent contractors or temporary staffing agency employees shall not represent themselves as having the authority of a DCH employee.

H. Reporting Possible Conflicts of Interests

DCH Workers and Vendors involved in Procurements must promptly report possible conflicts of interests to DCH in accordance with Section V "General Requirements" of the Policy.

A DCH Worker's failure to act in accordance with these standards, or failure to follow the guidelines set forth herein shall be grounds for disciplinary action, up to and including, termination of the working relationship with DCH. Similarly, a Vendor's failure to comply with this Policy will result in appropriate action as determined by governing state and/or federal law, rules and regulations, and other applicable Department policies and procedures.

IV. DEFINITIONS

For purposes of this policy:

"Affiliate Vendor Team" shall include, but not be limited to, owners, employees, directors, officers, contractors, and consultants of a Vendor that directly or indirectly assist the Vendor in the preparation of response to a Procurement. For individual consultants, independent contractors and temporary staffing agency workers, the "Affiliate Vendor Team" includes the owners, employees, directors, officers,

contractors and consultants of the company for whom the individual consultant, independent contractor or temporary staffing agency worker works.

“Confidential Information” shall mean all information not subject to disclosure pursuant to the Open Records Act, O.C.G.A. §50-18-70 et seq. For all Procurements governed by the State Purchasing Act, O.C.G.A. §50-5-50 et seq., “Confidential Information” shall also include records related to the competitive bidding and proposal process which, if disclosed prior to the issuance of the public notice of intent to award would undermine the public purpose of obtaining the best value for the Department. Such records include, but are not limited to, cost estimates, bids, proposals, evaluation criteria, evaluations of Vendors’ bids/proposals, negotiation documents, offers and counter-offers, and records revealing preparation for the Procurement.

“DCH” and “Department” shall mean the Georgia Department of Community Health.

“DCH Worker” shall mean any person who works for the Department as an employee or as an independent contractor, consultant or temporary staffing agency employee on assignment with the Department, as well as members of the Board of Community Health.

“DOAS” shall mean the Georgia Department of Administrative Services.

“Evaluation Team” shall mean a designated group of DCH Workers who review, assess, and score documents submitted to the Department in response to a Procurement Solicitation. An Evaluation Team for a Staffing Recruitment includes the individuals responsible for reviewing resumes submitted in response to the Staffing Recruitment Solicitation, interviewing prospective staffing agency workers, and approving the selection of the individuals.

“Family Member” shall mean a spouse, adult living in the household of the DCH worker, and relatives of the DCH Worker, his or her spouse, or an adult living in the household of the DCH Worker. Relatives include the following: parent/stepparent, grandparent, child, grandchild, brother (full, half, step), sister (full, half, step), uncle, aunt, nephew, niece, and first cousin.

“Financial Interest” shall mean an ownership interest in assets or stocks of the Vendor, current employment with the Vendor, or prospective employment with the Vendor. “Financial Interest” does not include an ownership interest in a Vendor that is part of a widely held investment fund (such as a mutual fund, regulated investment company, common trust fund maintained by a bank or similar financial institution, pension or deferred compensation plan, or any other investment fund), if the individual has no ability to control the financial interests held by the fund AND (A) The fund is publicly traded or available; or (B) The assets of the fund are widely diversified, meaning it holds no more than 5% of the value of its portfolio in the securities of any one issuer, other than the U.S. Government, and no more than 20% in any particular economic or geographic sector.

“Gifts” shall mean anything of value, including but not limited to the following: goods, money, advances, personal services, entertainment, lodging, parking, real property or the use thereof, commissions, promises of future employment, stocks, bonds, notes or other investment interests in an entity, rights of action, intellectual property, gratuities, loans, extensions of credit, forgiveness of debts, memberships, subscriptions, travel or means of personal transportation, meals, tickets to events, charitable donations, refreshments, hospitality, and promises, discounts or forbearance that are not generally available to members of the public. A Gift need not be intended to influence or reward a DCH Worker.

“Issuing Officer” shall mean the Procurement Professional designated in the Procurement Solicitation to be the Vendor’s only point of contact with the Department following the public advertisement of the Procurement Solicitation until such time as the results of the Procurement Solicitation are publicly announced or the Procurement Solicitation is cancelled. The Issuing Officer is responsible for managing all communication during this time period, including, but not limited to, answering Vendors’ questions, contacting Vendors for clarification requests, negotiations, and contract discussions.

“Kickback” shall mean compensation of any kind directly or indirectly accepted by a DCH Worker from or on behalf of a Vendor seeking/competing for or doing business with the Department, for the purpose of influencing the award of a contract or the manner in which the Department conducts its business. Kickbacks include, but are not limited to, money, fees, gifts, employment opportunities for a DCH Worker or Family Member, commissions or credits. DCH Workers who are employed by a Vendor, such as consultants, independent contractors and temporary staffing agency workers, may receive payment from the Vendor associated with the work performed on a DCH assignment. However, any payment received by the consultant, independent contractor or staffing agency worker as a result of another DCH Worker’s services for the Department may be a prohibited kickback. For example, a consultant who owns a consulting company may receive compensation for his or her work on an assignment with DCH. However, if he or she employs an individual who then becomes a consultant for DCH, any mark-up or payment received as a result of the employee’s services for DCH shall be disclosed for evaluation by DCH and may be considered a kickback.

“Procurement” shall mean buying, purchasing, renting, leasing, or otherwise acquiring any supplies, services, or construction. The term also includes all activities that pertain to obtaining any supply, service, or construction, including description of requirements, selection and solicitation of sources, preparation and award of contract, as well as the disposition of any Protest. A Procurement is not limited to, but specifically includes, procurements which are either exempt or non-exempt either by statute or under DOAS rules, a procurement of professional services, a Staffing Recruitment and procurements under any other approved procurement vehicle.

“Procurement Manual” shall mean the most current version of the Georgia Procurement Manual released by DOAS.

“Procurement Professional” shall mean the Department’s Office of Procurement Services (OPS) staff member assigned to and responsible for managing the Procurement process, including, but not limited to, needs identification and fact-finding, market research, requests for information, development of requirements and specifications, determination of the Procurement strategy and management of the Procurement solicitation, evaluations and awards. The Procurement Professional is charged with adhering to the highest ethical standards and ensuring that Procurements are executed in a fair and impartial manner, consistent with applicable laws, rules and regulations, which may include the Georgia Procurement Manual (GPM), the Georgia State Purchasing Act and Department procurement policies.

“Procurement Solicitation” shall mean the Department’s solicitation of offers from Vendors for the needed supplies, services or construction. Procurement Solicitation shall include, but not be limited to, requests for quotes, requests for qualified contractors, requests for proposals, requests for approvals, requests for pre-qualifications, reverse auctions and any other approved solicitation method.

“Prohibited Contact” applies only to a Procurement subject to DOAS rules and refers to a Vendor’s contact with DCH Workers other than through the Issuing Officer after the public advertisement of a Procurement Solicitation and until such time as the results of the Procurement Solicitation are publicly announced or the Procurement Solicitation is cancelled. During that time period, “Prohibited Contact” shall mean contact with any DCH Worker, other than the Issuing Officer, whereby it could be reasonably inferred that such contact was intended to influence, or could reasonably be expected to influence, the outcome of a Procurement Solicitation. This prohibition includes, without limitation, personal meetings, meals, entertainment functions, telephonic communications, letters, faxes and e-mails, as well as any other activity that exposes the DCH Worker to direct contact with a Vendor. This prohibition does not include contacts with DCH Workers for the purpose of discussing existing on-going Department work which is unrelated to the subject of the Procurement Solicitation or existing consulting assignments. Inquiries regarding the status of a Procurement should always be directed to the Issuing Officer.

“Protest” shall mean a written objection by an interested party to Procurement Solicitation, or to a proposed award or award of a contract, with the intention of receiving a remedial result.

“Protestor” shall mean an actual bidder/offeror who is aggrieved in connection with a Procurement Solicitation or intended or actual contract award and who files a Protest.

“Requirements Team” shall mean a designated group of DCH Workers who develop a Procurement Solicitation. A Requirements Team for the selection of professional services, consultant or temporary staffing agency employee includes the individuals responsible for drafting the request for such professional, consultant or staffer and approving the posting of the request. A DCH Worker is not a member of a Requirements Team simply because he or she identifies potential Vendors or meets with potential Vendors or current Vendors to discuss Departmental needs and review relevant information. A Requirements Team is formed once it is determined that a Procurement Solicitation or request for services is necessary to meet a Departmental need.

“Staffing Recruitment” shall mean a Procurement for the specific purpose of selecting temporary staffing agency employees in accordance with DOAS statewide contracts.

“Staffing Recruitment Professional” shall mean the Department’s Office of Human Resources staff member assigned to and responsible for managing the Staffing Recruitment process. The Staffing Recruitment Professional is charged with adhering to the highest ethical standards and ensuring that Staffing Recruitments are executed in a fair and impartial manner, consistent with applicable laws, rules and regulations.

“Staffing Recruitment Solicitation” shall mean a Procurement Solicitation for the specific purpose soliciting offers as part of a Staffing Recruitment.

“Vendor” shall mean any individual or entity seeking to do business or doing business with the Department, including, without limitation, contractors, professionals, consultants, suppliers, manufacturers seeking to act as the primary contracting party, officers and employees of the foregoing, any subcontractors, sub consultants and sub suppliers at all lower tiers, as well as any person or entity engaged by the Department to provide a good or service. A professional, consultant or temporary staffing agency and its employee who desires to be placed on an assignment with DCH is a Vendor. Once selected, the professional, consultant or temporary staffing agency employee remains a Vendor, but is also a DCH Worker.

V. General Requirements

A. *Responsibilities of Procurement Professionals, Staffing Recruitment Professionals and DCH Workers who are on a Requirements Team or Evaluation Team*

1. Procurement Professionals and Staffing Recruitment Professionals must ensure that DCH Workers participating in any Procurement activities have sufficient understanding of the Procurement and evaluation process and the applicable DCH and DOAS rules and regulations and policies associated with the processes.
2. Requirements Team members are tasked with developing standards of work, Procurement Solicitations and related documents in an objective and impartial manner. Typically, a Procurement Professional or Staffing Recruitment Professional facilitates the activities of a Requirements Team and a designated DCH Worker who is a Requirements Team member serves as the Head of the Requirements Team. Often, Requirements Team members are uniquely qualified to develop this material because of their experience with the industry. This experience may have been gained through employment or performance of services with Vendors. These Requirements Team members also maintain professional relationships that enable them to gather valuable information about current products and services. While participating on the Requirements Team, it is essential that Requirements Team members use their experiences and contacts solely to benefit the Department. They must place aside any personal and/or professional biases or prejudices that may exist when developing standards of work, Procurement Solicitations and related documents. A DCH Worker serving on a Requirements Team must not allow the DCH Worker's or Family Member's personal or professional relationships (e.g., friendships, dating, prior or current employment) with employees, principals, directors, officers, etc. of a Vendor or individuals on the Affiliate Vendor Team to interfere with the ability to prepare these Procurement Solicitations fairly and objectively in the interests of the Department. Such relationships may give rise to the appearance of, and/or create an actual conflict of interest and must be promptly disclosed in writing to the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Requirements Team prior to the DCH Worker's participation on the Requirements Team using the Attestation Form attached as Exhibit A to this Policy (or Exhibit C to this Policy for a Staffing Recruitment), or a similar form provided by the Ethics Officer.
3. The designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer before making a determination as to whether a DCH Worker who has made any written disclosures on the Attestation Form or for whom there is a potential conflict of interest is permitted to participate on the Requirements Team. The Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists, and will notify the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Requirements Team. The Ethics Officer may recommend actions that are necessary to assure the objectivity and fairness of the Procurement Solicitation and to prevent the appearance of a conflict of interest. If an actual conflict or appearance of conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to exclude the individual from the Requirements Team or prepare a written description of the actions that will be taken to "cure" the conflict and assure the objectivity and fairness of the Procurement Solicitation. The designated Procurement Professional or Staffing Recruitment Professional

shall maintain this written description of actions and ensure compliance with its terms. In some cases, disclosure of the conflict may be sufficient to “cure” the conflict.

4. Evaluation Team members are tasked with conducting objective, impartial evaluations, and, therefore, must place aside any personal and/or professional biases or prejudices that may exist. A DCH Worker serving on an Evaluation Team must not allow the DCH Worker’s or DCH Worker’s Family Member’s personal or professional relationships (i.e. friendships, dating, prior or current employment) with employees, principals, directors, officers, etc. of a Vendor or individuals on the Affiliate Vendor Team to interfere with the rendering of fair and objective determinations. Such relationships may give rise to the appearance of, and/or create an actual conflict of interest and must be promptly disclosed in writing to the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Evaluation Team prior to the Worker’s participation on the Evaluation Team using the Attestation Form attached as Exhibit B to this Policy (or Exhibit C to this Policy for a Staffing Recruitment), or a similar form provided by the Ethics Officer.
5. The designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer before making a determination as to whether a DCH Worker who has made any written disclosures on the Attestation Form or for whom there is a potential conflict of interest is permitted to participate on the Evaluation Team. The Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists, and will notify the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Evaluation Team. The Ethics Officer may recommend actions that are necessary to assure the objectivity and fairness of the Evaluation and to prevent the appearance of a conflict of interest. If an actual conflict or appearance of conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to exclude the individual from the Evaluation Team or prepare a written description of the actions that will be taken to “cure” the conflict and assure the objectivity and fairness of the Evaluation. The designated Procurement Professional or Staffing Recruitment Professional shall maintain this written description of actions and ensure compliance with its terms. In some cases, disclosure of the conflict may be sufficient to “cure” the conflict.
6. In the event that the Department determines that a conflict of interest does exist and a DCH Worker on a Requirements Team or Evaluation Team failed to make the appropriate disclosure, the Department will evaluate whether the conflict is of sufficient magnitude to disqualify the DCH Worker from further participation on the Requirements Team and/or the Evaluation Team. Furthermore, in the event that the Department determines that the conflict of interest did negatively impact the final Procurement Solicitation or the outcome of a Procurement, such DCH Worker may be subject to disciplinary action, up to and including termination of employment.
7. In the event the Department becomes aware that a DCH Worker maintains a relationship of any sort that may be a conflict of interest or may have the appearance of a conflict of interest with respect to a Procurement, the designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer, after which the Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists. Based on that determination and the impact of the conflict or the appearance of a conflict, the Ethics Officer may recommend actions that are necessary to cure the conflict or the appearance of a conflict. If an actual or appearance of a conflict exists, it is the responsibility of the designated

Procurement Professional or Staffing Recruitment Professional to take appropriate action, up to and including the disallowance of the DCH Worker's participation in any Procurement activities.

8. Prior to participating on a Requirements Team or an Evaluation Team, each DCH Worker (including the Head of the Requirements Team and Head of the Evaluation Team) and the designated Procurement Professional or Staffing Recruitment Professional must execute the appropriate Attestation Form in Exhibit A or B to this Policy (or Exhibit C to this Policy for a Staffing Recruitment).

B. Responsibilities of DCH Workers who are not on a Requirements Team or Evaluation Team

All DCH Workers should be mindful of the importance of confidentiality during any Procurement. Even if a DCH Worker is not serving in the capacity of a member on the Evaluation Team or Requirements Team, all DCH Workers must refrain from engaging in conduct with a Vendor that could result in a conflict of interest or be considered a Prohibited Contact.

C. Responsibilities of DCH Workers who are also Vendors

A DCH Worker who is a consultant or temporary staffing agency employee on an assignment with DCH is also a Vendor. Consultants or temporary staffing agency employees shall provide professional, objective and impartial advice and services, and at all times hold the Department's interests paramount, without any consideration for future work for themselves or members of the Vendor Affiliate Team. In addition to the general obligations of a DCH Worker and Vendor, such individuals shall do the following in order for the Department to identify potential or perceived conflicts of interest that may impact procurements:

1. Disclose to the supervising DCH employee and Director of Human Resources every current and former employer
2. Disclose to the supervising DCH employee and Director of Human Resources the name of every current DCH Worker with whom the individual or the individual's Family Member has a current or pre-existing personal or professional relationship
3. Disclose to the supervising DCH employee and Director of Human Resources any project for another client that may give rise to an actual or perceived conflict of interest
4. Appropriately identify him or herself as an employee of the entity that actually pays his or her compensation and state that he or she is on a contract assignment with DCH
5. Ensure that he or she only performs work that is within the scope of the current assignment
6. Coordinate with the supervising DCH employee to ensure that his or her level of access to Confidential Information is limited to the scope of the current assignment

D. DOAS rules applicable

DOAS rules and regulations may apply to a Procurement, which DOAS rules and regulations may also be applicable to conflicts of interest and may be more restrictive than the provisions of this

Policy. It is the responsibility of all DCH Workers to comply with DOAS rules and regulations, when applicable.

VI. VENDOR RESPONSIBILITIES

A. Gifts and Kick-Backs

Vendors may neither offer nor give any Gift or Kick-backs, directly or indirectly, to a DCH Worker. Similarly, no Vendor may offer or give any Gift or Kick-backs, directly or indirectly, to any member of a DCH Worker's Family. Such prohibited activity may result in the termination of the contract, in those cases where the Vendor has executed a contract with the Department. In the event that a potential Vendor who has submitted a response to a Procurement Solicitation engages in such activity, the Department shall act in accordance with DOAS protocol.

B. Family Relationships with DCH Workers

If a Vendor has a family or personal relationship with a DCH Worker, a Gift that is unconnected with the DCH Worker's duties at the DCH is not necessarily prohibited. In determining whether the giving of an item was motivated by personal rather than business concerns, the history of the relationship between the Vendor and DCH Worker shall be considered. However, regardless of the family or personal relationship between a Vendor and a DCH Worker, a Gift is strictly forbidden where it is being given under circumstances where it can reasonably be inferred that it was intended to influence the DCH Worker in the performance of his or her official duties.

C. Vendor Submittals

The Department expects all Vendors to be forthcoming, always submitting true and accurate information in response to a Procurement Solicitation or with regard to an existing business relationship. If the Department determines that the Vendor has intentionally omitted or failed to provide pertinent information and/or falsified or misrepresented material information submitted to the Department, the Department shall act in accordance with applicable state law and DOAS procurement policies and procedures.

Vendors must calculate the price(s) contained in any bid in accordance with the Georgia Procurement Manual.

D. Business Relations

A Vendor may not be allowed to conduct business with the Department for the following reasons:

1. Falsifying or misrepresenting any material information to the Department as set forth hereinabove;
2. Conferring or offering to confer upon a DCH Worker participating in a Procurement (which the entity has bid or intends to submit a bid) any Gift, gratuity, favor, or advantage, present or future; and

3. Any other reasons not explicitly set forth herein that are contained in the Georgia Procurement Manual or applicable Department policy.

E. *Prohibited Contact*

The Vendor is precluded from engaging in Prohibited Contact upon the release of a Procurement Solicitation or posting of a request for consulting or temporary staffing services, during the evaluation process, and any time prior to the Department's public announcement of the results of the Procurement Solicitation, filling of the temporary position, or the Department's cancellation of the Procurement Solicitation.

VII. USE OF CONFIDENTIAL INFORMATION

DCH Workers will not use Confidential Information for their own advantage or profit, nor will they disclose Confidential Information to any potential Vendor or to any unauthorized recipient. DCH Workers will comply with all confidentiality requirements set forth in DCH policies and applicable law.

VIII. ADDRESSING VIOLATIONS

A. *The Process*

All DCH Workers are responsible for bringing violations to the attention of the Issuing Officer under Procurement protocols, the Procurement Professional or the Staffing Recruitment Professional or to a supervisor/manager if the affected DCH Worker is not a part of the Procurement. The supervisor/manager and/or the designated Procurement Professional or Staffing Recruitment Professional shall promptly report such violation to the Ethics Officer. If for any reason it is not appropriate to report a violation to the DCH Worker's immediate supervisor or the designated Procurement Professional or Staffing Recruitment Professional, DCH Workers will report such violations or concerns to the Ethics Officer or the Office of Inspector General. Procurement Professionals, Staffing Recruitment Professionals and managers are required to report suspected ethics violations to the Ethics Officer and the Office of Inspector General, who have specific responsibility for investigating all reported violations.

Confirmed violations will result in appropriate disciplinary action, up to and including termination from employment. In some circumstances, criminal and civil penalties may be applicable.

The Ethics Officer or Inspector General will notify the DCH Worker making the report of the suspected violation of receipt of such report. All reports will be promptly investigated and appropriate corrective action will be taken if warranted by the investigation.

B. *Good Faith Filings*

Anyone filing a complaint concerning a violation of this Policy must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Good faith reporting of suspected policy violations by others shall not jeopardize a DCH Worker's employment with the Department. However, any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

C. *Confidentiality*

Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. Additionally, all DCH Workers are expected to cooperate in the investigation of such violations. Failure to cooperate in an investigation may result in disciplinary action, up to and including termination from employment.

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understands the Georgia Department of Community Health’s *Ethics in Procurement Policy*;
- B. It agrees to comply with those provisions of the Georgia Department of Community Health’s *Ethics in Procurement Policy* applicable to Contractor;
- C. It shall cooperate in good faith with the Georgia Department of Community Health so that the Georgia Department of Community Health and its workers will be in compliance with the *Ethics in Procurement Policy*; and
- D. It is a contractor.

[CONTRACTOR]

BY: _____
*SIGNATURE

Date

Please Print/Type Name Here

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT R

CODE OF ETHICS AND CONFLICT OF INTEREST POLICY

Georgia Department of Community Health

Code of Ethics and Conflict of Interest Policy	Policy No. 401
Effective Date: November 1, 2006 Revision Date: January 26, 2011	Page 1 of 10

- References:**
1. O.C.G.A. §45-10-1 et seq.;
 2. O.C.G.A. § 21-5-1, et seq.;
 3. Governor’s Executive Order Establishing a Code of Ethics for Executive Branch Officers and Employees, January 10, 2011;
 4. DCH Ethics Statement
 5. DCH Ethics in Procurement Policy

I. Purpose

The purposes of this policy are to assist DCH Employees and Board members in maintaining the highest standards of ethics and to provide guidelines that DCH Employees and Board members should follow in order to avoid a conflict of interest or the appearance of conflict.

II. Definitions

For the purposes of this policy, the following terms shall have the following meanings:

- A. “Agency” shall mean any agency, authority, department, board, bureau, commission, corporation, committee, office, or instrumentality of the State of Georgia.
- B. “Board member” shall refer to all members of the Board of Community Health established under O.C.G.A. § 31-2-3.
- C. “Commissioner” shall mean the Commissioner of the Department of Community Health.
- D. “Department” shall refer to the Department of Community Health established under O.C.G.A. § 31-2-4.
- E. “Employee” shall mean any person who is employed by the Department.
- F. “Expenses” shall mean the provision of food, beverages, travel, lodging, and registration fees that are attendant to an Employee’s participation in a public meeting related to official or professional duties. Expenses are limited to those items that are directly associated with the business or professional duties and are not attributable to personal, social or recreational activities.

- G. "Family Member" means a spouse, parent, grandparent, child, brother, sister, uncle, aunt, nephew, niece, first cousin, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepchild, stepbrother, stepsister, half brother or half sister.
- H. "Gifts" shall mean, for the purposes of this Policy, money, advances, personal services, gratuities, loans, extensions of credit, forgiveness of debts, memberships, subscriptions, travel, meals, charitable donations, refreshments, hospitality, promises, discounts or forbearance that are not generally available to members of the public. A Gift need not be intended to influence or reward an Employee.
- I. "Honorarium" shall mean payment to a professional person for services for which no fee is required. Honorarium excludes such things as a certificate or other token of appreciation, which has nominal value and may be accepted as a ceremonial courtesy.
- J. "Indirectly" is intended to cover, but not be limited to, any scheme, device or plan which circumvents the literal language of this Policy but provides material financial benefits to a Board member or an Employee or such person's Family Member. "Limited powers" shall mean those powers exercised by Public Officials, which affect and influence a specific agency. "Lobbyist" shall have the meaning set forth in O.C.G.A. Section 21-5-70(5).
- K. "Nepotism" shall mean demonstrating favor on the basis of Family Member relationship in employment decisions such as hiring, promotions, transfers, or terminations.
- L. "Part time" shall mean employed for less than thirty (30) hours per week for a continuous period of fewer than twenty-six (26) weeks.
- M. "Public Official" shall mean any person elected or appointed to a state office wherein the person has administrative and discretionary authority to receive and expend public funds and perform certain duties that impact the public.
- N. "State-wide powers" shall mean those powers exercised by Public Officials which affect and influence all of state government.
- O. "State" shall mean the State of Georgia.
- P. "Substantial interest" shall mean the direct or indirect ownership of more than 25 percent of the assets or stock of any business.
- Q. "Transacting business" shall mean to sell or lease any personal or real property, surplus personal or real property, or services on one's behalf or on behalf of any third party as an agent, broker, dealer, or representative.
- R. "Vendor" shall mean the definition set forth in O.C.G.A. Section 45-1-6(a)(5), as well as any person seeking or opposing a certificate of need.
- S. "Value" shall mean actual retail price or cost attributable to a gift minus taxes and/or gratuities or a reasonable estimate based upon customary charges for like goods or services.

III. Code of Ethics

In fulfilling designated duties and responsibilities, Employees and Board members should be mindful of the following principles:

- A. Uphold the Constitution, laws, and legal regulations of the United States and the State.
- B. Give a full day's labor for a full day's pay and perform duties with earnest effort and best thought.
- C. Never discriminate unfairly by extending special favors or privileges, whether for remuneration or not, and never accept, for personal gain or for a Family Member, favors or benefits under circumstances which might be construed by reasonable persons as influencing the performance of governmental duties.
- D. Make no private promises of any kind binding upon the duties of office, since a government Employee has no private word, which can be binding on public duty.
- E. Refrain from engaging in business with the government, either direct or indirectly, which is inconsistent with the conscientious performance of governmental duties.
- F. Never use confidential information in the performance of governmental duties as a means of making a profit.
- G. Expose corruption.
- H. Seek to find and employ more efficient and economical ways of getting tasks accomplished.
- I. Uphold these principles, ever conscious that public office is a public trust.

IV. Transacting Business

A. DCH Board members and Employees

1. DCH Board members and Employees must refrain from transacting business with the Department for personal gain or on behalf of another party. However, it is allowable for DCH Board members and Employees to conduct business with other Agencies as long as the business transaction does not result in a benefit for the Department.
2. Part-time Employees, however, are allowed to transact business with the Department under the following circumstances:
 - a. the transaction resulted from a sealed competitive bid; or
 - b. the transaction does not exceed \$250.00 in benefit to the Employee, or transactions in a given calendar year do not, in the aggregate, exceed \$9,000.

3. A business in which DCH Board members or Employees maintain a substantial interest may not transact business with the Department.

B. Family Members

If a Family Member of a Public Official or Employee maintains a substantial interest in a business, that business may not engage in a business relationship with the Department. Because Family Members are subject to the same ethical constraints as Public Officials and/or Employees, Family Members may conduct business with other Agencies only as long as the business transaction does not result in a benefit for the Department. This prohibition stems from the presumption that the Public Official or Employee, by virtue of his or her Family Member's relationship, has benefited from the business transaction.

C. Exceptions

The following transactions are permitted:

1. A transaction by a full-time or part-time Public Official or part-time Employee that does not exceed \$250.00, or in the alternative, transactions, which in the aggregate in any given year, do not exceed \$9000 in value.
2. A transaction involving the sale of real property through eminent domain.
3. A transaction involving the purchase of health, life, disability, retirement or pension benefits as a part of compensation.
4. A transaction involving a Public Official or Employee and the sale of property or services, where State funds pay for the transaction, and the property or service remains with a third party who is restricted from selling the property or services to an Agency.
5. A transaction between a DCH Board member or Employee and a public contractor.
6. Any transaction involving an emergency purchase by the Department which must be made to protect the health, safety, or welfare of the citizens or property of Georgia; provided, however, that such emergency shall be attested to in writing by the DCH Division Chief under whose scope of responsibility the purchase is made.
7. A transaction wherein a Public Official or DCH Board member is the only source of supply within the State; provided, however, that the limitation to such exclusive, sole source shall be attested to in writing by the DCH Division Chief under whose scope of responsibility the transaction is made.
8. A transaction occurring before March 1, 1983.
9. A transaction involving the provision of Medicaid or Medicare related services and benefits to an Employee or his Family Member; provided, however, in the case of an Employee, he or she shall have no decision-making authority or influence over the determination of eligibility for or amount of such services or benefits.

10. Any transaction between a DCH board member or Employee and an entity within the University System wherein the transaction has been approved by the unit of the University System.
11. Any transaction occurring prior to a Public Official's qualification to run for office or acceptance of an appointment to a public office if the transaction predates the qualifying or acceptance date.
12. Any transaction, wherein the course of business, a DCH Board member or Employee collects sales tax, license fees, excise taxes, or commission as compensation for the performance of a service or good.

D. Disciplinary Actions and Other Remedial Actions

In the event that a DCH Board member or Employee participates in impermissible transactions and/or fails to comply with the reporting requirements in Paragraph V, the following consequences may result:

1. Removal from the Board by the Governor;
2. Termination from employment;
3. Civil fines not to exceed \$10,000; and
4. Restitution to the State for any financial benefit received as a result of the business transaction.

Similarly, if any business in which the DCH Board member's or Employee's Family Member has a substantial interest participates in an impermissible transaction, the business may be subject to the following consequences:

1. Civil fines not to exceed \$10,000; and
2. Restitution to the State for any financial benefit received a result of the business transaction.

V. Other Conflicts of Interest

A. Procurement

The Department is committed to a procurement process that fosters fair and open competition, is conducted under the highest ethical standards, and enjoys the complete confidence of the public. To achieve these important public purposes, it is critical that Employees and Board members have a clear understanding of, and an appreciation for, the ethics in procurement. See DCH Policy No. 402, "Ethics in Procurement" for further guidance.

B. Gifts

Employees are prohibited from accepting gifts from any person with whom the Employee interacts on official state business. To the extent that gifts of nominal value are offered, (i.e., gifts with value of less than \$25.00), they may be shared with other members of the DCH. Exceptions shall include perishable items, such

as a basket of fruit, which may be accepted and promptly placed in a common area of state property for sharing among a group.

Employees are allowed, however, to accept a gift on behalf of any Agency or the Office of the Governor or when ceremonial courtesies require such an acceptance. Upon acceptance, the Employee should transfer the gift to DCH, the Office of the Governor, or in the alternative, to a charitable organization on behalf of DCH or the Office of the Governor.

If a Vendor has a personal relationship with the Employee, a Gift that is unconnected with the Employee's duties at the DCH is not necessarily prohibited. In determining whether the giving of an item was motivated by personal rather than business concerns, the history of the relationship between the Vendor and Employee shall be considered. However, regardless of the personal relationship between a Vendor and an Employee, a Gift is strictly forbidden where it is being given under circumstances where it can reasonably be inferred that it was intended to influence the Employee in the performance of his or her official duties.

C. Honoraria

Honoraria are payments to a professional person for services for which no fee is required. Honorarium excludes such things as a certificate or other token of appreciation, which has nominal value and may be accepted as a ceremonial courtesy. Employees are not allowed to accept honoraria.

D. Service on Boards

In general, Employees are restricted from serving as a corporate officer or director of for-profit or publicly held organizations. Notwithstanding the foregoing, each circumstance may be assessed on a case-by-case basis to determine if an actual conflict of interest exists, which would determine whether the Employee could provide such service.

Employees may provide pro bono services to non-profit organizations as long as such services do not negatively impact the Employee's ability to perform his or her duties effectively and with objectivity.

E. Dual Employment

See DCH Policy No. 411 for guidance regarding secondary employment.

F. Political Activities

See DCH Policy No. 416 for guidance regarding political activities.

G. Nepotism

The manner in which Family Members are employed in any organization may lend to an appearance of conflict of interest. The Governor's Executive Order Establishing a Code of Ethics for Executive Branch Officers and Employees prohibits an Employee from advocating for or causing the advancement, appointment, employment, promotion, or transfer of a Family Member to a position

within the Department. Additionally, Georgia law restricts the Commissioner and Board members from engaging in that same activity wherein the salary of the Employee is \$10,000 annually or more.

In that the Department desires to assist supervisors in making equitable decisions regarding work assignments, promotions, performance evaluations, disciplinary actions, and all other actions which have a direct impact on an individual's employment, the Department reserves the right to impose the following restrictions:

1. Family Members of individuals currently employed by the Department may be hired only if they will not be working directly for or supervising a Family Member.
2. If Family Members are currently employed, they cannot be transferred into a direct reporting relationship.
3. If the Family Member relationship is established after employment and there is a direct reporting relationship, the manager shall make the determination as to which Employee shall be subject to transfer, if such transfer does not adversely affect the business needs of the Department.

This policy shall in no means violate state and federal laws regarding discrimination on the basis of marital status.

VI. Lobbyists

Employees must ensure that any vendor who submits bids and/or responses to request for proposals, submits an application for a certificate of need, or seeks confirmation of status, letter of non-reviewability, or opposition has certified on forms prescribed by the Department that any lobbyist employed or retained by the vendor has registered with the Government Transparency and Campaign Finance Commission and made the appropriate disclosures.

VII. Reporting Requirements

A. Annual Filing by All Board Members

Each Board member is required to file an annual affidavit relating to the impact of official actions on the member's private, financial and business interests. This affidavit must be filed with the Government Transparency and Campaign Finance Commission by January 31 of each year.

B. Annual Filing by Board Members and Employees Who Engaged in Certain Business Transactions

DCH Board members and Employees must report, on a form prescribed by the Government Transparency and Campaign Finance Commission, an itemized list of business transactions with the State of Georgia or any state agency. This disclosure statement, containing the previous year's business transactions, must be submitted to the Government Transparency and Campaign Finance Commission no later than January 31 of each year. A copy of this report should be submitted to the General Counsel.

Board members and Employees are not required to submit such disclosure statements if they have not transacted business or if such transactions include only those set forth in Paragraph IV(C)(1).

C. Annual Personal Financial Disclosure Filing by Commissioner

The Commissioner shall be required to file, on an annual basis, a financial disclosure statement, including all information contained in O.C.G.A. Section 21-5-50.

D. Report of Expenses and Fees

As a rule, all expenses for an Employee to participate in conferences, meetings and other activities on behalf of DCH shall be paid by DCH. Expenses include food, beverages, travel and lodging. In limited exceptions, a person or entity, on behalf of an Employee, may offer to pay or waive registration fees when such fees are attendant to the Employee's participation in a public meeting related to official or professional duties; provided, however, that in no event may such fees be paid or waived by a contractor, vendor, potential bidder or lobbyist. Fees are limited to those items that are directly associated with the business or professional duties and are not attributable to personal, social or recreational activities.

A report of such fees must be filed with DCH's Ethics Officer no later than thirty (30) days after the fees have been paid or waived. The report should include:

1. Name and address of the person paying the registration fees; and
2. The description and value of each registration fee.

E. Report of Gifts

If an Employee receives a gift on behalf of DCH or the Office of the Governor, the Employee must file a report with DCH's Ethics Officer no later than thirty (30) days after the receipt of the gift. The report should include:

1. Name and address of the person giving the gift
2. The date the gift was given
3. The monetary value of the gift
4. An explanation of the disposition of the gift

VIII. Guidance

In the event that a DCH Board member or Employee has reason to believe that a conflict of interest might exist in a particular circumstance, the Board member or Employee should seek guidance from the DCH Inspector General.

In those situations where a DCH Board member has in fact identified a conflict involving a matter before the DCH Board, the Board member should immediately recuse himself or herself from any discussion or voting on the matter. The withdrawal of the Board member from consideration of the matter should be entered in the minutes of the meeting of the Board and made a part of the permanent records of the Department.

IX. Mandatory Reporting

Any and every employee who has knowledge of any ethics violation is responsible for reporting such violation to the DCH Inspector General and the DCH Ethics Officer. Good faith reports will be free from retaliation. Supervisors are responsible for reporting such violation and for forwarding any such report from any member of the supervisor's staff to the DCH Inspector General and the DCH Ethics Officer. Supervisors are additionally responsible for ensuring that the employees under his or her supervision are aware of and comply with the DCH ethical standards and policies.

Reporting suspected policy violations by others shall not jeopardize an Employee's tenure with the Department. Anyone reporting a possible violation of this policy must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation.

Any Department employee may report information, in good faith, concerning the possible violations of this policy in any Department programs or operations. No DCH employee will take action against, direct others to take action against, recommend personnel action against, approve personnel action against, or threaten another Department employee for questioning or reporting in good faith possible violations of this policy.

X. Acknowledgement of Policy

Each Board member and Employee shall sign an acknowledgement that he or she:

- A. Has received a copy of the policy;
- B. Has read and understands the policy or, at least, is aware of the policy and is accountable for compliance with it;
- C. Agrees to comply with the policy;
- D. Agrees to submit the Financial Disclosure Statement as required by this policy, if required; and
- F. Agrees to the disclosure of business transactions with the State.

ATTACHMENT S

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	[Contractor]
Contract Title:	Provision of Services to Georgia Families
Contract No.:	

CONTRACTOR AFFIDAVIT

By executing this affidavit, the undersigned Contractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the Contractor identified above has registered with, is authorized to use, and uses a federal work authorization program*, in accordance with the applicable provisions and deadlines established in O.C.G.A. § 13-10-91, and will continue to use a federal work authorization program throughout the period of the Contract.

The undersigned further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of services pursuant to this Contract with the Public Employer, Contractor will secure from such subcontractor(s) similar verification of compliance with O.C.G.A. § 13-10-91 on the attached Subcontractor Affidavit. Contractor further agrees to maintain records of such compliance and provide a copy of each such verification to the Public Employer at the time the subcontractor(s) is retained to perform such service.

EEV / E-Verify™ Company Identification Number**
**Must be a 5 or 6 digit number

E-Verify Authorization Date

BY: Signature of Authorized Officer or Agent
of Contractor

Signature Date

Printed Name of Authorized Officer or Agent

Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE

____ DAY OF _____, 20__

Notary Public

[NOTARY SEAL]

My Commission Expires: _____

*any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-603.

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	[Contractor]
Contract Title:	Provision of Services to Georgia Families
Contract No.:	

ADDITIONAL INSTRUCTIONS TO CONTRACTOR: Please list below all subcontractors and sub-subcontractors (if any) used to perform services under the Contract. In addition, you must attach a copy of the signed and notarized affidavit (third page of this form) from each of the subcontractors and sub-subcontractors listed below. Contractor is responsible for providing a copy of the signed and notarized affidavit to the Public Employer within five (5) days of the addition of any new subcontractor or sub-subcontractor used to perform under the Contract. If there are no subcontractors providing services to DCH, this page is not required.

Contractor's Name:	
Subcontractors:	

Sub-Subcontractors (if any)	
Name of Subcontractor:	Name of Sub-subcontractor:

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	[Contractor]
Contract Title:	Provision of Services to Georgia Families
Contract No.:	
Subcontractor's Name:	
Sub-Subcontractor's Name:	

SUBCONTRACTOR OR SUB-SUBCONTRACTOR AFFIDAVIT

By executing this affidavit, the undersigned Subcontractor/Sub-subcontractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the Subcontractor/Sub-subcontractor which is engaged in the performance of services under contract with the Contractor (or Subcontractor as applicable) on behalf of the Public Employer, has registered with, is authorized to use, and uses a federal work authorization program*, in accordance with the applicable provisions and deadlines established in O.C.G.A § 13-10-91, and will continue to use a federal work authorization program throughout the period of the Contract.

The undersigned further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of services pursuant to this Contract, the undersigned will secure from such subcontractor(s) similar verification of compliance with O.C.G.A. § 13-10-91 in the form of this affidavit. The undersigned further agrees to maintain records of such compliance and provide a copy of each such verification to the Public Employer at the time the subcontractor(s) is retained to perform such service.

Please initial beside only one choice below:

1. I am an authorized representative of the Subcontractor identified above.
2. I am an authorized representative of the Sub-Subcontractor identified above.

 EEV / E-Verify™ Company Identification Number**
****Must be a 5 to 6 digit number**

 E-Verify Authorization Date

 BY: Signature of Authorized Officer or Agent
 of Subcontractor/Sub-Subcontractor (as applicable)

 Signature Date

 Printed Name of Authorized Officer or Agent

 Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

____ DAY OF _____, 20__

[NOTARY SEAL]

 Notary Public
 My Commission Expires: _____

*any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-603.

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understands the Georgia Department of Community Health’s *Code of Ethics and Conflict of Interest Policy*;
- B. It agrees to comply with those provisions of the Georgia Department of Community Health’s *Code of Ethics and Conflict of Interest Policy* applicable to Contractor;
- C. It shall cooperate in good faith with the Georgia Department of Community Health so that the Georgia Department of Community Health and its workers will be in compliance with the *Code of Ethics and Conflict of Interest Policy*; and
- D. It is a contractor.

[CONTRACTOR]

BY: _____
*SIGNATURE

Date

Please Print/Type Name Here

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT T



STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Sonny Perdue
GOVERNOR

**MEMORANDUM OF UNDERSTANDING
FOR THE
PEACHCARE PARTNERSHIP PROGRAM**

18th This Memorandum of Understanding (“MOU”) is made and entered into this day of February, 2008 by and between the State of Georgia, acting through the Office of the Governor of Georgia and the Georgia Department of Community Health (collectively referred to as “DCH”), Shriners Hospitals for Children, for and on behalf of its Greenville and Tampa Hospitals, which it owns and operates (hereinafter collectively referred to as “Shriners”), Amerigroup Managed Care Corporation, Inc. (“Amerigroup”), Peach State Health Plans, Inc. (“Peach State”), and WellCare of Georgia, Inc. (“WellCare”).

WHEREAS, the promotion of quality in children’s health care is a priority for the State of Georgia; and

WHEREAS, the State of Georgia created the PeachCare for Kids Program to increase the quality of health care available to Georgia children; and

WHEREAS, DCH is the single state agency designated to administer Medical Assistance in Georgia under Title XIX of the Federal Social Security Act, as amended, and O.C.G.A. § 49- 4-140 et. seq. (the “Medicaid Program”), and is charged with ensuring the appropriate delivery of health care services to Medicaid and PeachCare for Kids Program recipients; and

WHEREAS, DCH has engaged Amerigroup, Peach State and WellCare, (hereinafter collectively referred to as the “Care Management Organizations”) to provide certain services related to the PeachCare for Kids Program; and



WHEREAS, Shriners possesses a network of pediatric specialty hospitals focusing on orthopaedic conditions, burn injuries, spinal cord rehabilitation and cleft lip and palate repair (“Services”); and

WHEREAS, Shriners has generously offered to make available their specialized services as they relate to orthopaedic and burn conditions (“Eligible Services”) at no cost or charge to children enrolled in the PeachCare for Kids Program, who qualify for such medical care at the Tampa and Greenville Hospitals; and

WHEREAS, Shriners, DCH and the Care Management Organizations recognize:

(a) That the provision of comprehensive and coordinated, medical treatment is in the best interest of pediatric patients; some of whom require additional follow-up care and therapy;

(b) Desire to arrange for the Services of Shriners for the benefit of children who are covered by the Care Management Organizations’ plans who may be eligible for admission to Shriners; and

(c) Are willing to collaborate with each other in order to deliver comprehensive healthcare to children who qualify for such Services.

NOW, THEREFORE, in consideration of the mutual agreements and covenants hereinafter set forth, and for other good and valuable consideration, the receipt, adequacy and sufficiency of which are hereby acknowledged, the parties do hereby covenant and agree as follows:

1. Responsibilities of the Office of the Governor of Georgia

a. Advise and inform members of the PeachCare for Kids Program through the designated state agency, the Georgia Department of Community Health, of the availability of the Services rendered by Shriners.

2. Responsibilities of the Georgia Department of Community Health

a. Advise the Care Management Organizations of the Services available through and by Shriners.

b. Direct the Care Management Organizations to refer members of the Peach Care for Kids Program to Shriners for evaluation and assessment for treatment purposes; when appropriate.



- c. Review any submitted reports from Shriners and Care Management Organizations regarding member hospitalizations.
- d. Periodically evaluate the level of cost savings attributable to services provided through the use of Shriners.
- e. Consider the level of cost savings attributable to services provided through the use of Shriners when determining Care Management Organization reimbursement.

3. Responsibilities of the Care Management Organizations

- a. Identify members of the Peach Care for Kids Program that may benefit from the Services offered by Shriners, if determined appropriate for referral, based upon Shriners criteria, evaluation and application process.

Prior to advising any member of a referral to Shriners, the Care Management Organizations shall first contact Shriners to determine whether the healthcare services needed by the member are available at Shriners. If so, Shriners shall provide the member with a Shriners patient application form for completion and submission for consideration.

- b. Notify all referred members in writing that Shriners are not considered health care providers as defined by the Medicaid/Peach Care for Kids Programs. The notice must be approved by DCH and Shriners prior to its use and shall include the following data:
 - i. Shriners is not a PeachCare/Medicaid Provider nor shall it be required to participate as one under this Memorandum of Understanding or in its rendering of Eligible Services.
 - ii. The member may decline the referral and continue to receive treatment from the PeachCare/Medicaid Providers contracted to the Care Management Organizations.
 - iii. The member's acceptance or refusal of the referral to Shriners will not affect the member's eligibility to receive services from the Care Management Organizations pursuant to the PeachCare for Kids Program;
 - iv. Shriners and its Hospitals are independent entities and are not representatives, agents, employees, or contractors of DCH. As such, DCH is not responsible for any acts or omissions committed



by Shriners nor is Shriners responsible for the acts of omissions committed by DCH.

c. Work in full collaboration with DCH and Shriners to ensure that any cost savings incurred by the Care Management Organizations and attributable to services provided through the use of Shriners will inure fully to the benefit of DCH and the PeachCare For Kids Program.

d. The Care Management Organizations agree that the medical care provided by Shriners shall be for Eligible Services only. Shriners shall have no responsibility to provide any other Services or assist financially in any other healthcare treatments that are not considered Eligible Services. Payments for any healthcare services provided to members by any other party other than Shriners that are covered by the Care Management Organizations shall be the sole responsibility of such Care Management Organizations.

e. The Care Management Organizations will cooperate with Shriners in the coordination of treatment for members and shall see to the prompt transfer of members from Shriners when such persons are no longer in need of Eligible Services.

f. If a member requires diagnostic studies or treatment which is not available from Shriners, but is essential for the members care, such studies or treatment shall be provided by or be the responsibility of the applicable Care Management Organization.

g. The Care Management Organizations agree to make arrangements and provide coverage for all healthcare services for members that Shriners cannot provide on premises for conditions being treated which are covered by Care Management Organizations Plan Benefits in accordance with the terms of the applicable Care Management Organizations Coverage Plan, including all primary care and treatment of other medical conditions and services by healthcare providers at the community level, such as rehabilitative services, diagnostic services and durable medical equipment.

h. To ensure proper coordination of care for members, Shriners and the Care Management Organizations shall each identify a care coordinator of their respective institutions for each member who becomes a patient at Shriners; whether for inpatient or outpatient services.

4. Responsibilities of Shriners

- a. Provide written notice to members of the Peach Care for Kids Program receiving treatment from Shriners, outlining the following:



- i. Shriners is a provider of certain health care services.
 - ii. The Services rendered by Shriners are provided independently of any insurance or government sponsored health care programs in which a person may be enrolled and without charge to its patients, families or any third party reimbursement plan, whether public or private in nature.
- b. Shriners shall have the authority in consultation with the member, his or her parents or legal guardian, to make all clinical decisions regarding the admission, treatment and discharge of members under its care for conditions being treated by Shriners. The Care Management Organizations will defer to Shriners for determination of such care and medical treatment as rendered by Shriners.
 - c. Provide DCH and the Care Management Organizations with monthly reports indicating the number of members of the PeachCare for Kids Program treated by Shriners and the Eligible Services received by each member. The information and format of such monthly reports shall be determined by authorized representatives of the parties and shall in no way require Shriners to modify its current quality utilization reporting formats but shall be sufficient in content to allow the Care Management Organizations and DCH to determine the level of costs savings.

5. Term and Termination

- a. **Term.** The term of this Agreement ("Term") shall be for a period of one (1) year, commencing on the 18th day of February, 2008, and shall renew upon its anniversary under like terms and conditions unless terminated sooner.
- b. **Termination without Cause.** Either party may terminate this Agreement at any time, for any reason, upon sixty (60) days prior written notice to the non-terminating parties.
- c. **Termination for Cause.** Any party may terminate this Agreement for cause upon the provision of thirty (30) days prior written notice to the non-breaching parties.
- d. **Effect of Termination.** As of the effective date of the termination of this Agreement, neither party shall have any further rights or obligations hereunder except: (1) as otherwise provided herein; (2) for rights and obligations accruing prior to such effective date of termination; or (3) arising as a result of any breach of this Agreement.



6. Notices

All notices hereunder shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered or when deposited in the United States mail, postage prepaid, addressed as follows:

For the State of Georgia:

Project Leader:

Mark Trail
Division of Medical Assurances
Georgia Department Community Health
2 Peachtree Street, NW – 37th Floor
Atlanta, Georgia 30303-3159
Phone: (404) 657-1502
E-mail address: mtrail@dch.ga.gov

Contract Administration:

Clyde White
Georgia Department of Community Health
2 Peachtree Street, NW – 40th Floor
Atlanta, Georgia 30303-3159
Phone: (404) 651-9189
E-mail address: cwhite@dch.ga.gov

For Shriners:

With copy to (which shall not constitute Notice):

Shriners Hospitals for Children
P.O. Box 31356
Tampa, Florida 33631-3356
Attention: Legal Department

Shriners Hospitals for Children
Greenville Hospital
950 West Faris Road
Greenville, South Carolina 29605-4277
Attention: Administrator
Phone: (864) 271-3444



Shriners Hospitals for Children
Tampa Hospital
12502 USF Pine Drive
Tampa, Florida 33612-9499
Attention: Administrator
Phone: (813) 972-2250

For the Care Management Organizations:

Mel Lindsey
Acting, Chief Executive Officer
Amerigroup Community Care
303 Perimeter Center North, Suite 400
Atlanta, Georgia 30346

Mike Cadger
President & CEO
Peach State Health Plan
3200 Highlands Parkway SE, Suite 300
Smyrna, Georgia 30082

Michael Cotton
WellCare of Georgia, Inc.
211 Perimeter Center Parkway, Suite 800
Atlanta, Georgia 30346

It shall be the responsibility of all affected parties to inform Contract Administration of any change in address, in writing, no later than five (5) business days after the change. It shall be the responsibility of Contract Administration to inform all parties outlined under this Section 6, Notices, in writing, of such modification.

7. HIPAA

Each party under this MOU agrees to comply, to the extent required, with the applicable provisions of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. §1320d through d-8 ("HIPAA"), and the requirements of any applicable regulations promulgated thereunder including without limitation the federal privacy regulations as contained in 45 CFR Part 164 (the "Federal Privacy Regulations") and the federal security standards as contained in 45 CFR Part 142 (the "Federal Security Regulations"). Each party under this MOU agrees not to use or disclose any protected health information, as defined in 45 CFR 164.504, or individually identifiable health information, as defined in 42 U.S.C. §1320d



(collectively, the "Protected Health Information"), concerning a member other than as permitted or required by this MOU and the requirements of HIPAA (if applicable) or regulations promulgated under HIPAA, including, without limitation, the Federal Privacy Regulations and the Federal Security Regulations (if applicable), or as permitted or required by other federal or state law. Each party will promptly report to the other parties upon knowledge and verification, any use or disclosure of a member's Protected Health Information not provided for by this MOU or in violation of any applicable local, state or federal law, including HIPAA, the Federal Privacy Regulations, or the Federal Security Regulations of which a party becomes aware as such apply to this MOU. Notwithstanding the foregoing, no attorney-client, accountant-client, physician-patient or other legal privilege shall be deemed waived by virtue of this subsection.

8. Liaison Committee

A Liaison Committee composed of representatives from Shriners, DCH and the Care Management Organizations shall be established for the purpose of periodic program evaluation, as well as to assess other aspects of the relationship and to make recommendations, if any, for change or improvement.

9. Independent Authority

The parties shall maintain their separate and independent structure and management and they acknowledge that no party is the partner, agent, or employee of any other party under this MOU.

10. Medical Records

The parties agree that any medical records created shall be and remain their respective property; but that each shall have the right to obtain copies thereof, upon reasonable request, in accordance with authorized procedures and applicable laws and regulations.

11. Marketing

No party will utilize any other parties name, address and specialties, symbols or trademark in any marketing, promotional or media materials without the prior written consent of the applicable party. Notwithstanding the foregoing, the Care Management Organizations, may in all of its promotional materials, identify Shriners as a provider of Eligible Services to its members. These materials may contain Shriners name, addresses and telephone numbers, and a description of each Shriners facility and applicable Eligible Services.



12. Indemnification

Shriners is not required to indemnify either DCH or the Care Management Organizations for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against either DCH or the Care Management Organizations based on its management decisions, utilization review provisions or other policies, guidelines or actions.

13. Counterparts

This MOU may be executed in counterparts, all which shall constitute one (1) and the same instrument.

14. Amendment

No amendment, waiver, or discharge of any of the terms and provisions of this Agreement shall be binding upon the parties unless agreed to in writing by authorized representatives of the parties.

15. Entire Agreement

This MOU constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior agreements, whether verbal or written in nature, regarding the subject matter herein.

The Signature Page Immediately Follows.



IN WITNESS WHEREOF, authorized representatives of the parties hereto have executed this Agreement as evidenced below.

OFFICE OF THE GOVERNOR OF GEORGIA

Sonny Perdue 2/18/08
Sonny Perdue, Governor Date

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda M. Medows 2/18/08
Rhonda M. Medows, M.D., Commissioner Date

SHRINERS HOSPITALS FOR CHILDREN

Ralph W. Semb 2/18/08
Ralph W. Semb, President Date

AMERIGROUP MANAGED CARE CORPORATION

Melvin Lindsey 2/18/08
Melvin Lindsey, Acting CEO Date

PEACH STATE HEALTH PLANS, INC.

Mike Cadger 2/18/08
Mike Cadger, President & CEO Date

WELLCARE OF GEORGIA, INC.

Michael Cotton 2/18/08
Michael Cotton, Chief Operating Officer Date

**FIRST AMENDMENT
TO THE MEMORANDUM OF UNDERSTANDING FOR THE
PEACHCARE PARTNERSHIP PROGRAM**

ORIGINAL

This First Amendment ("Amendment") to the Memorandum of Understanding for the PeachCare Partnership Program is entered into this 27 day of MARCH, 2009 and is by and between the Georgia Department of Community Health (collectively, "DCH"), Shriners Hospitals for Children, for and on behalf of its Greenville and Tampa Hospitals, which it owns and operates (collectively "Shriners"), Amerigroup Managed Care Corporation, Inc. ("Amerigroup"), Peach State Health Plans, Inc. ("Peach State"), and WellCare of Georgia, Inc. ("WellCare") (collectively the "Parties").

WHEREAS, the Parties entered into the Memorandum of Understanding for the PeachCare Partnership Program (the "MOU") on February 18, 2008 to facilitate Shriners' provision of its specialized services relating to orthopaedic and burn conditions ("Eligible Services") to children enrolled in the State of Georgia's State Children's Health Insurance Program, the PeachCare for Kids Program, at no cost or charge to the individual, DCH, or Amerigroup, WellCare or Peach State (collectively, the "Care Management Organizations");

WHEREAS, the Office of the Governor of Georgia was a third-party beneficiary to the MOU;

WHEREAS, pursuant to Title XIX of the Federal Social Security Act, as amended, and O.C.G.A. § 49-4-140 *et. seq.* (the "Medicaid Program"), the Office of the Governor of Georgia is no longer a third party beneficiary to this Agreement and DCH has been duly authorized to act on behalf of the State of Georgia; and

WHEREAS, the Parties desire to amend the MOU to specify their agreement to certain additional terms and conditions regarding Shriners' provision of Eligible Services.

NOW THEREFORE, in consideration of the mutual agreements and covenants hereinafter set forth, and for good and valuable consideration, the receipt, adequacy and sufficiency of which are hereby acknowledged, the Parties do hereby agree as follows:

1. Section 2 of the MOU is amended by adding at the end the following new section:

"f. DCH represents and warrants that it shall not use, directly or in directly, any data or other information provided by Shriners to DCH or any Care Management Organization pursuant to this MOU to determine any past, present or future payments or credits to any Care Management Organization or any savings due to DCH under the Peach Care Program."

2. Section 3 of the MOU is amended by adding at the end the following new section:

"i. Each Care Management Organization represents and warrants that it shall not use, directly or in directly, any data or other information provided by Shriners to DCH or any Care Management Organization pursuant to this MOU to determine any past, present or future payments or credits to any Care Management Organization or any saving due to DCH under the Peach Care Program."

3. Section 3.b.i. of the MOU is amended by adding at the end of the section the following:

"Shriners is not obligated, by contract or otherwise, to provide Eligible Services to any individual, notwithstanding any Care Management Organization's referral of a member. Any refusal by Shriners to provide Eligible Services to a member does not affect such member's eligibility to receive services from the Care Management Organization and another provider under the PeachCare for Kids Program."

4. Section 4 of the MOU is amended by adding at the end the following new section:

“d. The Parties acknowledge that Shriners has no obligation under the MOU to determine independently, or to verify any claim by any Shriners employee or contractor, that such employee or contractor is not excluded from participating in any federal health care program. Shriners agrees that, in the event DCH and/or any Care Management Organization seeks confirmation that a Shriners employee or contractor is not excluded from participating in a federal health care program. Shriners shall cooperate with DCH and/or the Care Management Organizations by:

(i) providing the name of such employee(s) and/or contractor(s) to DCH or the Care Management Organization(s) so that DCH and/or the Care Management Organization(s) may conduct a review to determine the status of such individual or entity with respect to their eligibility to participate in federal health care programs; and

(ii) discussing with DCH and/or the Care Management Organization(s) the possible steps Shriners could consider taking, if any, upon determination that an employee or contractor of Shriners is excluded from participating in a federal health care program.”

5. Section 4.a.ii. of the MOU is amended by replacing the existing provision in its entirety with the following:

“The Eligible Services provided by Shriners are provided at Shriners’ sole discretion and independent of any government-sponsored health care programs, including the PeachCare for Kids Program, and any third-party payor plans in which a person may be enrolled. Further, the Eligible Services rendered by Shriners are provided without charge to patients, their families, government sponsored health care programs or any third-party reimbursement plans, such as the Care Management Organizations, whether public or private in nature.”

6. Section 4.b. of the MOU is amended by replacing the first sentence of the section with the following:

“Shriners shall have the sole authority to make all decisions regarding the provision of Eligible Services to Care Management Organizations’ members, including the eligibility, admission, treatment and discharge of such members for which Shriners determines it shall provide Eligible Services. Shriners shall consult with a member’s parent(s) or legal guardian regarding clinical issues as Shriners determines appropriate in the course of treating such member.”

7. The MOU is amended by replacing Section 4.c in its entirety with the following:

“Provide DCH and the Care Management Organizations with monthly reports indicating the number of individuals enrolled in the PeachCare for Kids Program treated by Shriners and the Eligible Services received by each individual. The information contained in such monthly reports shall be determined by authorized representatives of the parties and shall in no way require Shriners to modify its current quality utilization reporting criteria. Shriners shall provide such information at an aggregated level and in a hard-copy format mailed to the address identified in Section 6 of the MOU.”

8. The MOU is amended by adding at the end of Section 8 the following sentence:

“ Notwithstanding the foregoing, the Parties acknowledge and agree that Shriners is not considered to be, and shall not be identified by or to any Party or held out to a third-party as a participating provider of any Care Management Organization or DCH. The Parties represent and warrant that Shriners shall not be subject to any requirements applicable to such participating providers. In addition, neither the Liaison Committee nor any Party nor any Party’s directors, officers, or employees shall impose on Shriners any requirement applicable to a participating provider.”
9. The MOU is amended by replacing Section 11 in its entirety with the following:

“No party shall utilize any other Party’s name, address, specialties, symbols or trademark in any marketing, promotional or medial materials without such Party’s prior written consent. Notwithstanding the foregoing, the Care Management Organizations may indicate, in all of their promotional materials, that Shriners may provide Eligible Services to members and include Shriners’ name, address, telephone number, and a description of each Shriners facility; provided however, that any such indication that Shriners may provide Eligible Services to members shall be accompanied by the following statement: ‘Shriners’ provides health care services to individuals in its sole discretion and independent of an individual’s enrollment in any government-sponsored or third-party health care program. Identification of Shriners’ provision of health care services is not a representation that any individual will be selected for admission or treatment at Shriners.’”
10. Section 12 is amended by adding at the end the following sentence:

“The foregoing shall apply to any third-party claim or action brought against DCH and/or any Care Management Organization relating to the submission of false claims payable under any state or federal health care program.”
11. The MOU is amended by adding the following as a new Section 16:

“The Parties acknowledge and agree that Shriners’ provision of Eligible Services to members pursuant to this MOU is exclusively in connection with the Georgia PeachCare for Kids Program, and is independent of all other government-sponsored health care programs and plan benefit packages sponsored by DCH and the Care Management Organizations, including the Georgia Medicaid program. Furthermore, the Parties represent and warrant that none of the obligations or responsibilities applicable to providers participating in the Georgia Medicaid program, whether such participation is by contract or otherwise, shall apply to Shriners.”

(Signatures on following page)

SIGNATURE PAGE

IN WITNESS WHEREOF, the authorized representatives of the Parties hereto have executed this Agreement as evidenced below.

OFFICE OF THE GOVERNOR OF GEORGIA

N/A OFFice of Governor
Sonny Perdue, Governor

Date

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

[Signature]
Rhonda M. Medows, M.D., Commissioner

3/27/09
Date

ORIGINAL

SHRINERS HOSPITALS FOR CHILDREN

[Signature]
Ralph W. Semb, President

4/2/09
Date

APPR SHLGL DEPT. [Signature]

AMERIGROUP MANAGED CARE CORPORATION

[Signature]

3-27-09
Date

PEACH STATE HEALTH PLANS, INC.

[Signature]

3-27-09
Date

WELLCARE OF GEORGIA, INC.

[Signature]

3-27-09
Date

**Attachment U
Georgia Families**

Value Based Purchasing Measures

Figure Z: Value Based Purchasing Performance Measures and Targets - Georgia Families Core Measures

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
1	Preventive Care for Children: Well-child visits in the First 15 Months of Life – 6 or more visits – The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.		68.46		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
2	Preventive Care for Children: Childhood Immunization Status – Combo 10 – The percentage of children two years of age who had 4 DTaP; 3 IPV; 1 MMR; 3 HiB; 3 HepB; 1 VZV; 4 PCV; 1 HepA; 2 – 3 RV; and 2 Influenza vaccines by their second birthday.		40.28		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile
3	Developmental Screening: Developmental Screening in the first three years of life – The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.		42.82		70%		Absolute 10% improvement over CY 2017 rate		Absolute 10% improvement over CY 2018 rate
4	Preventive Care for Adolescents: Adolescents Well-Care Visits – The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.		52.55		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
5	Preventive Dental Services: Total Eligibles Receiving Preventive Dental Services – The percentage of individuals ages 1-20 who are enrolled for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental	52.65		60%		10% relative improvement above CY 2017 rate		10% relative improvement above CY 2018 rate	

**Attachment U
Georgia Families
Value Based Purchasing Measures**

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	service during the reporting period.								
6	Obesity Prevention: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile – Total – The percentage of members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, Counseling for nutrition, and Counseling for physical activity.		BMI %tile - 51.16; Nutrition Counseling – 61.11 Physical Activity; Counseling – 54.63		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile
7	Behavioral Health: Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase – The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Initiation Phase – 43.12; Continuation Phase – 59.22		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile	
8	Pregnancy-related Care: Prenatal and Postpartum Care – Postpartum Care – The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following: <i>Postpartum Care</i> - The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.		63.24		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 90 th percentile		HEDIS 2018 National 90 th percentile
9	Birth Outcomes: Rate of Infants with Low Birth Weight – The percentage of live births that weighed less than 2,500 grams during the reporting period.	8.32		<= National Vital Statistics LBW rate published Dec of 2016		<= National Vital Statistics LBW rate published Dec of 2017		<= National Vital Statistics LBW rate published Dec or 2018	
10	Diabetes: Comprehensive Diabetes Care		HbA1c		HEDIS 2016		HEDIS 2017		HEDIS 2018

**Attachment U
Georgia Families
Value Based Purchasing Measures**

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	(18-75 years old) –The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing; HbA1c poor control (>9.0%); HbA1c control (<8.0%); HbA1c control (<7.0%) for a selected population; Eye exam (retinal) performed; Medical attention for nephropathy; and BP control (<140/90 Hg).		testing – 80.5; HbA1c >9 – 52.47; HbA1c <8 – 39.64; HbA1c <7 – 30.08; Eye exam – 57.81; Nephropathy – 74.51; BP control – 56.91		National 75 th percentile for HbA1c testing; 50 th percentile for all other rates		National 90 th percentile for HbA1c testing; 50 th percentile for > 9.0 and 75 th percentile for all other rates		National 90 th percentile for HbA1c testing; 25 th percentile for >9.0 and 75 th percentile for all other rates
11	Cardiovascular Conditions: Controlling High Blood Pressure (18-85) – The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.		48.36		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
12	Respiratory Conditions: Medication Management for People with Asthma – The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1) The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period; 2) The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	50% compliant - 5 – 11yo – 49.08; 50% compliant- 12 – 18 yo – 46.26 75% compliant - 5 – 11yo – 22.88; 75% compliant - 12 – 18 yo – 22.18		HEDIS 2016 National 75th percentile		HEDIS 2017 National 75th percentile		HEDIS 2018 National 90th percentile	
13	Experience with Care: CAHPS 5.0H Child Version – Shared Decision Making – This measure provides information on parents' experience with their child's Medicaid organization. A composite score is	Adult – 53.7% Child – 57.7%		Absolute 10% above baseline		Relative 10% above CY 2017 rate		Relative 10% above CY 2018 rate	

**Attachment U
Georgia Families
Value Based Purchasing Measures**

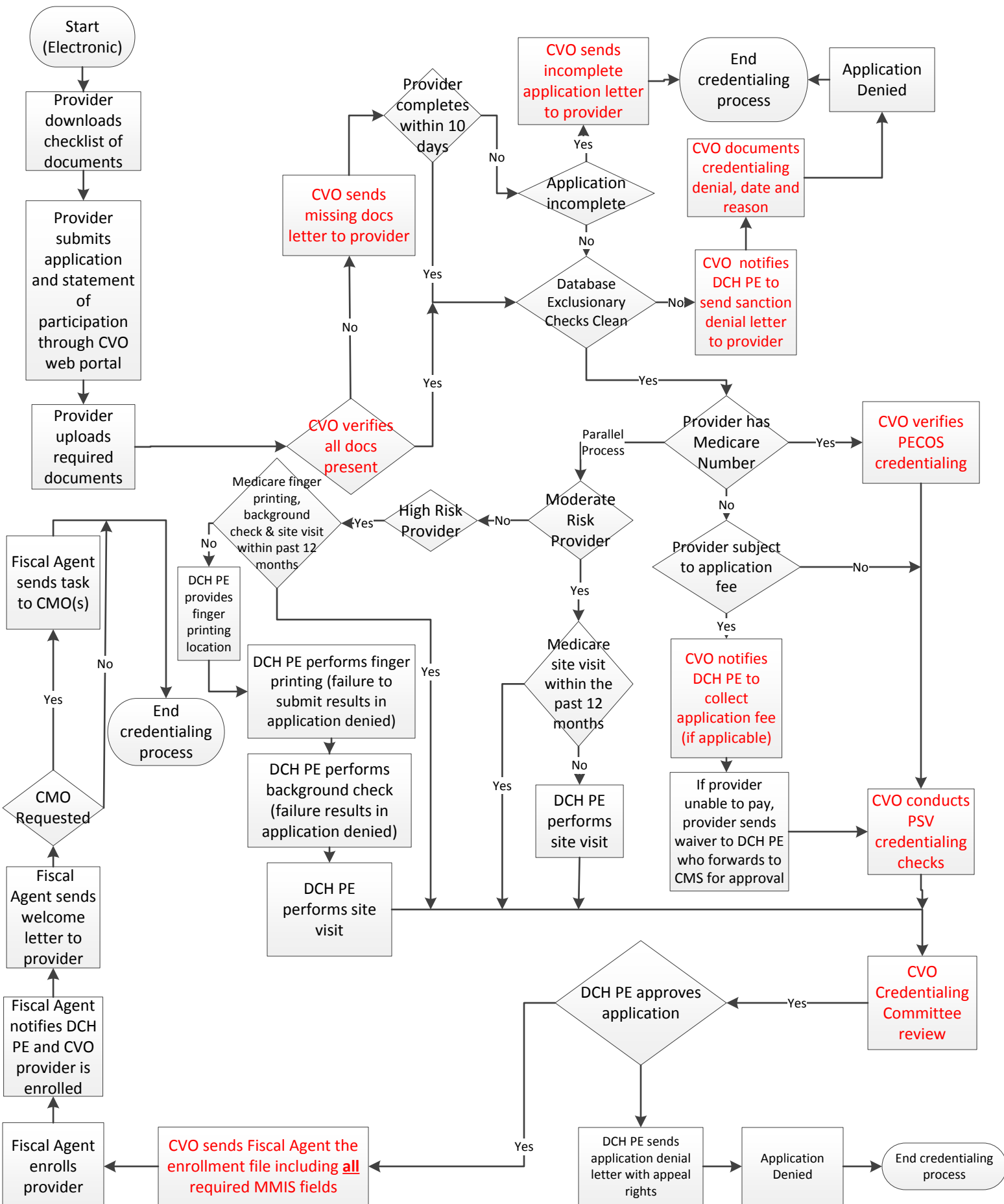
Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	calculated for the Shared Decision Making domain of member experience and responses of "Yes" and "A lot" are considered achievements for the Shared Decision Making composite.								
14.	Increase in the number of Patient Centered Medical Homes in the Contractor's Network – The percent increase of Providers enrolled in the Contractor's network that receive NCQA recognition.	Establish Baseline		Absolute 15% above baseline		Relative 15% above CY 2017 total		Relative 15% above CY 2018 total	

ATTACHMENT V

Georgia Department of Community Health

Traditional Managed Care Provider Credentialing Process

'Red' font indicates responsibilities of the CVO.



Note: This timeline represents a 30 Calendar Day window for the credentialing process for Traditional providers submitting Clean applications and enrolling with a CMO. This timeline does not include steps needed for providers to contract with CMO(s).

ATTACHMENT W PROVIDER CREDENTIALING TIMELINES

Georgia Department of Community Health

Provider Credentialing Timeline - Traditional Managed Care Providers

'Clean' Applications

Step No.	Credentialing Steps	Number of Calendar Days																																		
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30					
1	CVO verifies provider submitted all required docs, including statement of participation	1																																		
2	CVO conducts database exclusionary checks (fraud and abuse verification)			3 Days																																
3	CVO conducts PECOS Credentialing verification					5 Days																														
4	CVO conducts PSV Credentialing verification					5 Days																														
5	DCH PE conducts finger printing if needed (High-Risk Providers only)					10 Days																														
6	DCH PE conducts background check if needed (High-Risk Providers only)					10 Days																														
7	DCH PE conducts site visit, if needed (High and Moderate Risk Providers)					10 Days																														
8	CVO Credentialing Committee Review																																			
9	DCH PE approves application																																			
10	CVO sends enrollment file to Fiscal Agent																																			
11	Fiscal Agent enrolls providers and notifies DCH PE and CVO provider is enrolled																																			
12	Fiscal Agent sends welcome letter to Provider and notifies CMO if requested by provider (Managed Care Only)																																			

Note: This timeline represents a 30 Calendar Day window for the Credentialing process for Traditional providers submitting clean applications and enrolling with one or more CMO(s). This timeline does not include steps needed for Providers to contract with CMO(s).