State of Georgia
Department of Community Health

REQUEST FOR PROPOSALS

FOR

THE GEORGIA CARES PROGRAM FOR THE STATE'S MEDICAL ASSISTANCE AND PEACHCARE FOR KIDS PROGRAMS

REQUEST FOR PROPOSAL NUMBER
41900-001-0000000027

Request for Proposal posted: January 6, 2005
Proposals Due: April 4, 2005, 4:00 P.M. EST

TABLE OF CONTENTS

A. SCOPE OF SERVICES AND REQUIREMENTS

1.0 PROJECT SUMMARY

The Georgia Department of Administrative Services (DOAS) and the Georgia Department of Community Health (DCH) through this Request For Proposals (RFP) seek to obtain the services of qualified care management organizations (CMOs) to provide health care services in the Georgia Cares Program (GCS), a full-risk, capitated care management system.

For the purposes of coordination and planning, DCH has divided the State, by county, into six (6) Service Regions: Atlanta, Central, East, North, Southeast, and Southwest. Offerors may propose in as many or few Service Regions as desired. There will be two (2) awards made in each of the Central, East, North, Southeast, and Southwest Services Regions. In the Atlanta Service Region there will be between three (3) and five (5) awards made. In order to be considered for the Atlanta Service Region the Offeror must be awarded a Contract in at least one (1) other Service Region.

The following populations will be mandatorily enrolled in GCS: Low Income Families, Transitional Medicaid, Pregnant Women (Presumptive), Pregnant Women (Right from the Start Medicaid - RSM), Children (Right from the Start Medicaid - RSM), Children (newborn), PeachCare for Kids (pending legislative approval) and Women eligible for Medicaid due to Breast and Cervical Cancer.

Appendix G—The Project Specific Background—contains a listing of the counties in each Service Region, definitions of eligible populations, and additional information about DCH and GCS.

1.1 PROPOSAL SUBMISSION

Proposals must be <u>received</u> no later than 4:00 P.M. Eastern Standard Time on April 4, 2005. Proposals must be sent to:

Department of Administrative Services
RFP # 41900-001-0000000027
State Purchasing Office
200 Piedmont Avenue, SE
Suite 1308 (Bid Room), West Tower
Atlanta, GA 30334-9010
Attn: Ms. Pat W. Dockery

2.0 SCHEDULE

This request for proposals will be governed by the following schedule:

Post RFP to Georgia Procurement Registry	January 6, 2005
Technical Proposal Assistance Session*	January 25, 2005
Cost Proposal Assistance Session*	January 26, 2005
Deadline for written questions by 5:00 PM	February 2, 2005
Post Answers to Written Questions on Registry	February 23, 2005
Offerors' Conference*	February 28, 2005
Proposals Due	**April 4, 2005 4:00 PM EST**
Notice of Intent to Award	May 31, 2005
Best and Final Offers Due	June 16, 2005
Operations Begin in the Atlanta and Central Service Regions	January 1, 2006
Operations Begin in the East and North Service Regions	July 1, 2006
Operations Begin in the Southeast and Southwest Service Regions	December 1, 2007

*****Information about the time, site, and directions to the site for the Cost Proposal Assistance Session, the Technical Proposal Assistance Sessio, and the Offerors' Conference will be posted on the Georgia Procurement Registry Web site (www.procurements.state.ga.us) at a later date.

Proposals received after April 4, 2005 4:00 PM EST will not be considered. Faxed or e-mailed proposals will not be accepted.

Offerors are encouraged to check the Georgia Procurement Registry Web site frequently (www.procurement.state.ga.us, the same location as the RFP) for any POSSIBLE changes to the RFP document.

3.0 CONTRACT TERM

The Contract term will be from July 1, 2005 through June 30, 2006. The State shall have six (6) options for renewal. Each renewal will be for a one (1) year period from July 1 to June 30 (State Fiscal Year). Renewal is contingent upon successful Offeror's performance and availability of funds. Contract Award will consist of the issuance of a Notice of Award document and renewals will be accomplished through the issuance of Renewal Letters or Notice of Award Amendments.

4.0 PROJECT SCOPE OF WORK

The Offeror must be able to meet the following mandatory requirements. Inability to meet these requirements will result in no further evaluation of proposals.

Administrative Mandatory Requirements

_____A. The proposal must be divided into two (2) separately sealed packages – an original Technical proposal and copies and an original Cost proposal and copies.

_____B. The Offeror must have an approved Georgia Certificate of Authority from the Department of Insurance in all counties in the Service Regions in which the Offeror is bidding by April 4, 2005. A provisional certificate will suffice but the Offeror must have a final Certificate at least thirty (30) Calendar Days prior to implementation.

Technical Mandatory Requirements

_____C. The Offeror must have a minimum of three (3) years experience operating a full-risk Medicaid managed care program.

_____D. The Offeror must be willing and able to provide Covered Services to all assigned Members, whether chosen or Auto-Assigned, on the day GCS is operationalized in the Service Region.

_____E The Offeror must have achieved National Committee for Quality Assurance (NCQA) or URAC accreditation in at least one (1) state by the date of proposal submission. The Offeror must achieve NCQA or URAC accreditation in the State of Georgia by the end of the third (3rd) year of this Contract.

_____F. The Offeror must not use, or propose to use, any offshore programming or call center services in fulfilling the requirements outlined in this RFP and in the attached Model Contract.

The Offeror shall complete the actions, tasks, obligations, and responsibilities described below.

4.1 ENROLLMENT

4.1.1 Enrollment Procedures

4.1.1.1 DCH or its Agent is responsible for Enrollment, including Auto-Assignment of a CMO plan; Disenrollment; education; and outreach activities. The Offeror 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 recipients ineligible for Enrollment in GCS are not be enrolled in GCS. However, to ensure that such recipients are not enrolled in GCS, the Offeror shall assist DCH or its Agent in the identification of recipients that are ineligible for Enrollment in GCS, as discussed in Appendix G, should such recipients inadvertently become enrolled in GCS.

4.1.1.3 The Offeror shall accept all individuals without restrictions. The Offeror shall not discriminate against individuals on the basis of religion, gender, race, color, or national origin, and will not use any policy or 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.

4.1.2 Selection of a Primary Care Provider (PCP)

4.1.2.1 At the time of plan selection, Members, with counseling and assistance from DCH or its Agent, will choose an in-network PCP. If a Member fails to select a PCP, or if the Member has been Auto-Assigned to the CMO plan, the Offeror shall Auto-Assign Members to a PCP based on the following algorithm:

4.1.2.1.1 Assignment shall be made to a Provider with whom, based on FFS Claims history, the Member has a Historical Provider Relationship;

4.1.2.1.2 If there is no Historical Provider Relationship the Member shall be Auto-Assigned to a Provider who is the assigned PCP for an immediate family member enrolled in the CMO plan;

4.1.2.1.3 If other immediate family members do not have an assigned PCP, Auto-Assignment shall be made to a Provider with whom a family member has a Historical Provider Relationship; and

4.1.2.1.4 If there is no Member or immediate family historical usage Members shall be Auto-Assigned to a PCP, using an algorithm developed by the Offeror, based on the age and sex of the Member, and geographic proximity.

4.1.2.2 PCP assignment shall be effective immediately. The Offeror shall notify the Member via surface mail of their Auto-Assigned PCP within ten (10) Calendar Days of Auto-Assignment.

4.1.2.3 The Offeror shall submit its PCP Auto-Assignment Policies and Procedures to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.1.3 Newborn Enrollment

4.1.3.1 The Offeror shall contact Members who are expectant mothers sixty (60) Calendar Days prior to the expected date of delivery to encourage the mother to choose a CMO plan and a PCP for her newborn.

4.1.3.2 Within twenty-four (24) hours of receipt of notification of the birth of the newborn, the Offeror shall ensure the submission of a newborn notification form to DCH or its agent. If the mother has made a CMO plan and PCP selection, this information shall be included in the newborn notification form.

4.1.3.3 In the event the mother has not chosen a CMO plan for her newborn prior to delivery, the Offeror shall ensure the submission of a newborn notification form, within twenty-four (24) hours, to DCH or its Agent without that information. DCH or its Agent shall Auto-Assign the newborn to the mother's plan and notify the Offeror and the mother of the Auto-Assignment. Using the algorithm described in Section 4.1.2.1, the Offeror shall Auto-Assign the newborn to a PCP. Within seven (7) Calendar Days of receiving from DCH or its Agent the notice of CMO plan Auto-Assignment, the Offeror shall notify the mother of the Auto-Assignment of the newborn and provide notice of the opportunity to change CMO plans or PCPs without cause during the next ninety (90) Calendar Days.

4.1.4 Reporting Requirements

4.1.4.1 The Offeror shall submit to DCH weekly Member Information Reports as described in Section 4.18.2.1.

4.1.4.2 The Offeror shall submit to DCH monthly Eligibility and Enrollment Reconciliation Reports as described in Section 4.18.3.1.

4.2 DISENROLLMENT

4.2.1 Disenrollment Initiated by the Member

4.2.1.1 A Member may request Disenrollment from a CMO plan without cause during the ninety (90) Calendar Days following the date of the Member's initial enrollment with the CMO plan 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.

4.2.1.2 A Member may request Disenrollment from a CMO plan for cause at any time. The following constitute cause for Disenrollment by the Member:

4.2.1.2.1 The Member moves out of the CMO plan's Service Region;

4.2.1.2.2 The CMO plan 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 at the same time and not all related services are available within the network. The Member's Provider or another Provider have determined that receiving service separately would subject the Member to unnecessary risk;

4.2.1.2.4 The Member requests to be assigned to the same CMO plan as family members; and

4.2.1.2.5 The Member's Medicaid eligibility category changes to a category ineligible for GCS, and/or the Member otherwise becomes ineligible to participate in GCS.

4.2.1.2.6 Other reasons, per 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.

4.2.1.3 The Offeror shall provide assistance to Members seeking to disenroll. This assistance shall consist of providing the 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 Offeror

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

4.2.2.2 The Offeror 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 4.2.3.1.

4.2.2.3 Prior to requesting Disenrollment of a Member for reasons described in Sections 4.2.3.1.1, 4.2.3.1.2, and 4.2.3.1.3 the Offeror 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 Offeror shall provide at least one (1) written warning to the Member, certified return receipt requested, regarding implications of his or her actions. This notice shall be delivered within ten (10) Business Days of the Member's action.

4.2.2.4 If the Member has demonstrated abusive or threatening behavior as defined by DCH, only one (1) written attempt to resolve the difficulty is required.

4.2.2.5 The Offeror shall cite to DCH or its Agent at least one (1) acceptable reason for Disenrollment outlined in Section 4.2.3 before requesting Disenrollment of the Member.

4.2.2.6 The Offeror shall submit Disenrollment requests to DCH or its Agent and the Offeror 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 Acceptable Reasons for Disenrollment Requests by Offeror

4.2.3.1 The Offeror may request Disenrollment if:

4.2.3.1.1 The Member's continued Enrollment in the CMO plan seriously impairs the Offeror's ability to furnish services to either this particular Member or other Members;

4.2.3.1.2 The Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness;

4.2.3.1.3 The Member's Utilization of services is fraudulent or abusive;

4.2.3.1.4 The Member has moved out of the Service Region;

4.2.3.1.5 The Member is placed in a long-term care nursing facility, State institution, or intermediate care facility for the mentally retarded (ICFMR);

4.2.3.1.6 The Member's Medicaid eligibility category changes to a category ineligible for GCS, and/or the Member otherwise becomes ineligible to participate in GCS; or

4.2.3.1.7 The Member has other condition as so defined by DCH.

4.2.4 Unacceptable Reasons for Disenrollment Requests by Offeror

4.2.4.1 The Offeror shall not request Disenrollment of a Member for discriminating reasons, including:

4.2.4.1.1 Adverse changes in a Member's health status;

4.2.4.1.2 Missed appointments;

4.2.4.1.3 Utilization of medical services;

4.2.4.1.4 Diminished mental capacity;

4.2.4.1.5 Pre-existing medical Condition; or

4.2.4.1.6 Uncooperative or disruptive behavior resulting from his or her special needs.

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

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

4.3 MEMBER SERVICES

4.3.1 General Provisions

4.3.1.1 The Offeror shall ensure that Members are aware of their rights and responsibilities, the role of PCPs, how to obtain care, what to do in an emergency or urgent medical situation, how to request a Grievance, Appeal, or Administrative Law Hearing and how to report suspected Fraud and Abuse. The Offeror shall convey this information via written materials and via telephone, internet, and face-to-face communications which allow the Members to submit questions and receive responses from the Offeror.

4.3.2 Requirements for Written Materials

4.3.2.1 The Offeror shall make all written materials available in alternative formats and in a manner that takes into consideration the Member's special needs, including those who are visually impaired or have limited reading proficiency. The Offeror shall notify all Members and Potential Members that information is available in alternative formats and how to access those formats.

4.3.2.2 The Offeror 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.

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 Offeror 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 (5^{th}) 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 Offeror 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 All written materials, including information for the Web site, must be submitted to DCH for approval before being distributed.

4.3.3 Member Handbook Requirements

4.3.3.1 The Offeror shall mail to all newly enrolled Members a Member Handbook within ten (10) Calendar Days of receiving the notice of enrollment from DCH or its Agent.

4.3.3.2 Pursuant to the requirements set forth in 42 CFR 438.10, 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 will be supplied by DCH).

4.3.3.2.3 Information about the role of the PCP;

4.3.3.2.4 Information about choosing a PCP;

4.3.3.2.5 Information about what to do when family size changes;

4.3.3.2.6 Appointment procedures;

4.3.3.2.7 Information on Benefits and services, including a description of all available GCS Benefits and services;

4.3.3.2.8 Information on how to access services, including Health Check services, non-emergency transportation (NET) services, and maternity and family planning services;

4.3.3.2.9 An explanation of any service limitations or exclusions from coverage;

4.3.3.2.10 A notice stating that the Offeror shall be liable only for those services authorized by the Offeror;

4.3.3.2.11 Information on where and how Members may access Benefits not available from or not covered by the Offeror;

4.3.3.2.12 The Medical Necessity definition used in determining whether services will be covered;

4.3.3.2.13 A description of all pre-certification, prior authorization or other requirements for treatments and services;

4.3.3.2.14 The policy on Referrals for specialty care and for other Covered Services not furnished by the Member's PCP;

4.3.3.2.15 Information on how to obtain services when the Member is out of the Service Region and for after-hours coverage;

4.3.3.2.16 Cost-sharing;

4.3.3.2.17 The geographic boundaries of the Service Regions;

4.3.3.2.18 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including an inclusion of the Offeror's toll-free telephone line and internet website;

4.3.3.2.19 A description of Utilization Review policies and procedures used by the Offeror;

4.3.3.2.20 A description of Member rights and responsibilities as described in Section 4.3.4;

4.3.3.2.21 The policies and procedures for Disenrollment;

4.3.3.2.22 Information on Advance Directives;

4.3.3.2.23 A statement that additional information, including information on the structure and operation of the CMO plan and physician incentive plans, shall be made available upon request;

4.3.3.2.24 Information on the extent to which, and how, after-hours and emergency coverage are provided, including the following:

i. What constitutes an Urgent and Emergency Medical Condition, Emergency Services, and Post-Stabilization Services;

ii. The fact that Prior Authorization is not required for Emergency Services;

iii. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent;

iv. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered herein; and

v. The fact that a Member has a right to use any hospital or other setting for Emergency Services;

4.3.3.2.25 Information on the Grievance Systems policies and procedures, as described in Section 4.14. This description must include the following:

i. The right to file a Grievance and Appeal with the Offeror;

ii. The requirements and timeframes for filing a Grievance or Appeal with the Offeror;

iii. The availability of assistance in filing a Grievance or Appeal with the Offeror;

iv. The toll-free numbers that the Member can use to file a Grievance or an Appeal with the Offeror by phone;

v. The right to a State Administrative Law Hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;

vi. Notice that if the 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

vii. Any Appeal rights that the State chooses to make available to Providers to challenge the failure of the Offeror to cover a service.

4.3.3.3 The Member Handbook shall be submitted to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.3.4 Member Rights

4.3.4.1 The Offeror 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:

4.3.4.1.1 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 record 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 Offeror'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 Offeror; not be held liable for Covered Services provided to the Member for which DCH or the Offeror 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 amount the Member would owe if the Offeror 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 K of the Model Contract.

4.3.5 Provider Directory

4.3.5.1 The Offeror shall mail via surface mail a Provider Directory to all new Members within ten (10) Calendar Days of receiving the notice of enrollment from DCH or the State's Agent.

4.3.5.2 The Provider Directory shall include names, locations, office hours, telephone numbers of, and non-English languages spoken by, current Contracted Providers. This includes, at a minimum, information on PCPs, specialists, dentists, pharmacists, FQHCs and RHCs, mental health and substance abuse Providers, and hospitals. The Provider Directory shall also identify Providers that are not accepting new patients.

4.3.5.3 The Offeror shall submit the Provider Directory to DCH for review and prior approval within sixty (60) Calendar Days of Contract Award.

4.3.5.4 The Offeror shall up-date and amend the Provider Directory on its Internet Web site immediately as changes occur, produce quarterly up-dates, and re-print the Provider Directory and distribute to all Members at least once per year.

4.3.6 Member Identification (ID) Card

4.3.6.1 The Offeror shall mail via surface mail a Member ID Card to all new Members according to the following timeframes:

4.3.6.1.1 Within ten (10) Calendar Days of receiving the notice of enrollment from DCH or the Agent for Members who have selected a CMO plan and a PCP;

4.3.6.1.2 Within ten (10) Calendar Days of PCP assignment or selection for Members that are Auto-Assigned to the CMO plan.

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 The name and telephone number(s) of the Offeror;

4.3.6.2.5 The Offeror's twenty-four (24) hour, seven (7) day a week toll-free Member services telephone number; and

4.3.6.2.6 Instructions for emergencies.

4.3.6.3 The Offeror shall reissue the Member ID Card within ten (10) 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 Offeror shall submit a front and back sample Member ID Card to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.3.7 Toll-free Telephone Hotline

4.3.7.1 The Offeror shall operate a toll-free Telephone Hotline to respond to Member questions, comments and inquiries.

4.3.7.2 The Offeror shall develop Telephone Hotline 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 Offeror shall submit these Telephone Hotline Policies and Procedures, including performance standards pursuant to Section 4.3.7.7, to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.3.7.4 The Telephone Hotline shall handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.

4.3.7.5 The Offeror's call center systems shall have the capability to track call management metrics identified in Attachment L of the Model Contract.

4.3.7.6 The Telephone Hotline shall be fully staffed between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The Telephone Hotline staff shall be trained to respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider network, and non-emergency transportation (NET).

4.3.7.7 The Offeror shall develop performance standards and monitor Telephone Hotline performance by recording calls and employing other monitoring activities. At a minimum, the standards shall require that ninety-nine percent (99%) of calls are answered by the fourth (4^{th}) 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%).

4.3.7.8 The Offeror 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 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. The Offeror shall ensure that the voice mailbox has adequate capacity to receive all messages. An Offeror's Representative shall return messages on the next Business Day.

4.3.8 Internet Presence/Web Site

4.3.8.1 The Offeror shall provide general and up-to-date information about the CMO plan's program, its Provider network, its customer services, and its Grievance and Appeals Systems on its Web site.

4.3.8.2 The Offeror shall maintain a Member portal that allows Members to access a searchable Provider Directory that shall be updated immediately upon changes to the Provider network.

4.3.8.3 The Web site must have the capability for Members to submit questions and comments to the Offeror and receive responses.

4.3.8.4 The Web site must comply with the marketing policies and procedures and with requirements for written materials described in this RFP and must be consistent with applicable State and federal laws.

4.3.8.5 In addition to the specific requirements outlined above, the Offeror'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 (www.ghp.georgia.gov).

4.3.8.6 The Offeror shall submit Web site screenshots to DCH for review and approval sixty (60) Calendar Days prior to implementation of GCS.

4.3.9 Cultural Competency

4.3.9.1 In accordance with 42 CFR 438.206, the Offeror shall have a comprehensive written Cultural Competency Plan describing how the Offeror will ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency. The Cultural Competency Plan must describe how the Providers, individuals and systems within the CMO plan 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.

4.3.9.2 The Offeror shall submit the Cultural Competency Plan to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.3.9.3 The Offeror's Cultural Competency Plan must be distributed via surface mail to the network of Providers. It may also be posted on the Offeror's Web site.

4.3.10 Translation Services

4.3.10.1 The Offeror is required to 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 Offeror is required to 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 translation services.

4.3.11 Reporting Requirements

4.3.11.1 The Offeror shall submit weekly Telephone and Internet Activity Reports to DCH as described in Section 4.18.2.2.

4.4 MARKETING

4.4.1 Prohibited Activities

4.4.1.1 The Offeror 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 that are designed to induce enrollment in the Offeror's plan, and that are not health related and/or worth more than $5.00 cash;

4.4.1.1.3 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 Offeror's plan in order to obtain Benefits or in order to not lose Benefits or that the Offeror's plan is endorsed by the federal or State government, or similar entity; and

4.4.1.1.4 Distributing materials that, according to DCH, mislead or falsely describe the Offeror'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 Offeror 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 Make telephone calls, mailings and home visits only to Members currently enrolled in the Offeror's plan, for the sole purpose of

educating them about services offered by or available through the Offeror;

4.4.2.1.3 Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the CMO plan's Provider network, provided that all CMO plans in which the Provider participates have an equal opportunity to be represented; and

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

4.4.2.2 If the Offeror performs an allowable activity, the Offeror shall conduct these activities in the entire Service Region as defined by this RFP.

4.4.2.3 All materials shall be in compliance with the information requirements in 42 CFR 438.10 and detailed in Section 4.3.2.

4.4.3 State Approval of Materials

4.4.3.1 The Offeror shall submit a detailed description of its Marketing Plan and copies of all Marketing Materials (written and oral) it or its Subcontractors plan to distribute to DCH for review and approval within sixty (60) Calendar Days of Contract Award. This requirement includes, but is not limited to posters, brochures, Internet Web sites, and any materials that contain statements regarding the benefit package and Provider network-related materials. Neither the Offeror nor its Subcontractors shall distribute any marketing materials without prior, written approval from DCH.

4.4.3.2 The Offeror shall submit any changes to previously approved marketing materials and receive approval from DCH of the changes before distribution.

4.4.4 Provider Marketing Materials

4.4.4.1 The Offeror shall collect from its Providers any Marketing Materials they intend to distribute and submit these to DCH for review and approval prior to distribution.

4.5 COVERED BENEFITS AND SERVICES

4.5.1 Included Services

4.5.1.1 The Offeror shall at a minimum provide Medically Necessary services and Benefits as outlined below, and pursuant to the Georgia State Medicaid

Plan, and the Georgia Medicaid Policies and Procedures Manual. 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 Offeror 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

SERVICE	COVERAGE LIMITATIONS
Ambulatory Surgical Services	
Audiology Services	Not covered for Members age 21 and older. Available under EPSDT as part of a written service plan.
Childbirth Education Services	
Dental Services	Preventive, diagnostic and treatment services provided to Members under age 21. Emergency Services only for Members age 21 and older.
Durable Medical Equipment	
Early and Periodic Screening, Diagnostic, and Treatment Services	
Emergency Transportation Services	
Emergency Services	
Family Planning Services and Supplies	
Federally Qualified Health Center Services	Ambulatory services such as dental services are subject to any limitations applicable to the specific ambulatory service.
Home Health Services	Not covered: social services, chore services, meals on wheels, audiology services.
Hospice Services	Available to Members certified as being terminally ill and having a medical prognosis of life expectancy of six (6) months or less.
Inpatient Hospital Services	
Laboratory and Radiological Services	Not covered: portable X-ray services; services provided in facilities not meeting the definition of an independent laboratory or X-ray facility; services or procedures referred to another testing facility; services

SERVICE	COVERAGE LIMITATIONS
	furnished by a State or public laboratory; services or procedures performed by a facility not certified to perform them.
Mental Health Services	Community Mental Health Rehabilitation services are only available as part of a written service plan.
Nurse Midwife Services	
Nurse Practitioner Services	
Nursing Facility Services	Not covered: Long-term nursing facility stays (over 30 Days)
Obstetrical Services	
Occupational Therapy Services	Not covered for Members age 21 and older. Available under EPSDT as part of a written service plan.
Optometric Services	Not covered for Members age 21 and older: routine refractive services and optical devices.
Orthotic and Prosthetic Services	Not covered for Members age 21 and older: orthopedic shoes and supportive devices for the feet which are not an integral part of a leg brace; hearing aids and accessories.
Oral Surgery	
Outpatient Hospital Services	
Pharmacy Services	Not covered: certain outpatient drugs pursuant to Section 1927(d) of the Social Security Act. Additionally, certain over the counter (OTC) drugs must be included, pursuant to the Georgia Policies and Procedures Manual.
Physical Therapy Services	Not covered for Members age 21 and older. Available under EPSDT as part of a written service plan.
Physician Services	
Podiatric Services	Not covered: services for flatfoot; subluxation; routine foot care, supportive devices; vitamin B-12 injections.
Pregnancy-Related Services	
Private Duty Nursing Services	
Rural Health Clinic Services	
Speech Therapy Services	Not covered for Members age 21 and older; available under EPSDT as part of a written service plan.
Substance Abuse Treatment	Substance abuse treatment, inpatient and

SERVICE	COVERAGE LIMITATIONS
Services (Inpatient)	rehabilitative, are covered as part of a written service plan.
Swing Bed Services	
Transplants	Not covered for Members aged 21 and older: heart, lung and heart/lung transplants.

4.5.2 Enhanced Services

4.5.2.1 In addition to the Covered Services provided above, the Offeror shall do the following:

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

4.5.2.1.2 Make health promotion materials available to Members;

4.5.2.1.3 Hold annual wellness clinics;

4.5.2.1.4 Participate in community-sponsored health fairs; and

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

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

4.5.3 Medical Necessity

4.5.3.1 Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:

4.5.3.1.1 Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible member's medical Condition;

4.5.3.1.2 Compatible with the standards of acceptable medical practice in the community;

4.5.3.1.3 Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;

4.5.3.1.4 Not provided solely for the convenience of the member or the convenience of the Health Care Provider or hospital; and

4.5.3.1.5 Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.

4.5.3.2 There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

4.5.4 Experimental, Investigational or Cosmetic Procedures

4.5.4.1 Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manual, in no instance shall the Offeror cover experimental, investigational or cosmetic procedures.

4.5.5 Moral or Religious Objections

4.5.5.1 The Offeror 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 Offeror 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 Offeror shall notify:

4.5.5.1.1 DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;

4.5.5.1.2 Members within ninety (90) Calendar Days after adopting the policy with respect to any service; and

4.5.5.1.3 Members and Potential Members before and during enrollment.

4.5.5.2. The Offeror acknowledges that such objection will be grounds for recalculation of rates paid to the Offeror.

4.6 SPECIAL COVERAGE PROVISIONS

4.6.1 Emergency Services

4.6.1.1 Emergency Services shall be available 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 adequate 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 Offeror shall provide payment for Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Offeror's network. These services shall not be subject to prior authorization requirements. The Offeror shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Offeror shall also pay for any screening examination services conducted to determine whether an Emergency Medical Condition exists.

4.6.1.4 The Offeror 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.

4.6.1.5 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 Offeror, who shall be responsible for coverage and payment. The Offeror, however, may establish arrangements with a hospital whereby the Offeror may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the Member, provided that such arrangement does not delay the provision of Emergency Services.

4.6.1.6 The Offeror 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. 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 Offeror 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.

4.6.1.7 The Offeror may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but, the Offeror 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, CMO plan representative, or DCH of the Member's screening and treatment within said timeframes.

4.6.1.8 When a representative of the Offeror instructs the Member to seek Emergency Services the Offeror 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.

4.6.1.9 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.

4.6.1.10 Once the Member's Condition is stabilized, the Offeror 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 Offeror shall be responsible for providing 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 Offeror shall be responsible for payment for Post-Stabilization Services that are Prior Authorized or Pre-Certified by an In-Network Provider or organization representative, regardless of whether they are provided within or outside the Offeror's network of Providers.

4.6.2.3 The Offeror is financially responsible for Post-Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Offeror'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 Offeror is financially responsible for Post-Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Offeror's Provider network, that are not prior authorized by a CMO plan Provider or organization representative but are administered to maintain, improve or resolve the Member's stabilized Condition if:

4.6.2.4.1 The Offeror does not respond to the Provider's request for pre-certification or prior authorization within one (1) hour;

4.6.2.4.2 The Offeror cannot be contacted; or

4.6.2.4.3 The Offeror's Representative and the attending physician cannot reach an agreement concerning the Member's care and a CMO plan physician is not available for consultation. In this situation the Offeror shall give the treating physician the opportunity to consult with an In-Network physician and the treating physician may continue with care of the Member until a CMO plan physician is reached or one of the criteria in Section 4.6.2.5 are met.

4.6.2.5 The Offeror'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 Network Provider assumes responsibility for the Member's care through transfer;

4.6.2.5.3 The Offeror'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 Offeror's network, the Offeror is prohibited from charging the Member more than he or she would be charged if he or she had obtained the services through an In-Network Provider.

4.6.3 Urgent Care Services

4.6.3.1 The Offeror shall provide Urgent Care services 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 Offeror shall provide access to family planning services within the network. In meeting this obligation, the Offeror 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 Offeror shall verify its efforts to contract with Title X Clinics by maintaining records of communication.

4.6.4.2 The Offeror shall inform Members of the availability of family planning services and must provide services to Members 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 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;

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 diseases; and

4.6.4.3.7 Infertility assessment.

4.6.4.4 The Offeror 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 federal regulations, the Offeror shall cover sterilizations, hysterectomies, and abortions 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 Clinic 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 a "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" form prior to the Hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

4.6.5.3 Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

4.6.5.3.1 If it is performed solely for the purpose of rendering a Member permanently incapable of reproducing;

4.6.5.3.2 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

4.6.5.3.3 If it is performed for the purpose of cancer prophylaxis.

4.6.5.4 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 Offeror 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.

4.6.5.5 The Offeror shall maintain documentation of all sterilizations, hysterectomies and abortions and provide documentation to DCH upon the request of DCH.

4.6.6 Pharmacy

4.6.6.1 The Offeror shall provide pharmacy services either directly or through a Pharmacy Benefits Manager (PBM). The Offeror or its PBM may establish a drug formulary if the following minimum requirements are met:

4.6.6.1.1 Drugs from each specific therapeutic drug class are included and are sufficient in amount, duration, and scope to meet Members' medical needs;

4.6.6.1.2 The only excluded drug categories are those permitted under section 1927(d) of the Social Security Act;

4.6.6.1.3 A Pharmacy & Therapeutics Committee makes the formulary decisions; and

4.6.6.1.4 Over-the-counter medications specified in the Georgia State Medicaid Plan are included in the formulary.

4.6.6.2 The Offeror shall provide the formulary to DCH upon the request of DCH.

4.6.7 Immunizations

4.6.7.1 The Offeror shall provide all Members under twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

4.6.7.2 The Offeror shall ensure that all Providers use vaccines available free under the Vaccine for Children (VFC) program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with Well-Child/Health Check care.

4.6.7.3 The Offeror shall report all immunizations to the Georgia Registry of Immunization Transactions and Services (GRITS) in a format to be determined by DCH.

4.6.8 Transportation

4.6.8.1 The Offeror 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 Offeror is not responsible for providing non-emergency transportation (NET) but the Offeror shall coordinate with the NET vendors for services required by Members.

4.6.9 Perinatal Services

4.6.9.1 The Offeror shall ensure that appropriate perinatal care is provided to women and newborn Members. The Offeror 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 Offeror 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 one (1) year of age;

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;

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 Offeror 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 preventive pediatric visits and Health Check screens, the Offeror shall offer or arrange for parenting skills education to expectant and new parents, at no cost to the Member.

4.6.10.2 The Offeror agrees to 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. The classes shall be offered at times convenient to the population served, and in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members.

4.6.11 Mental Health and Substance Abuse

4.6.11.1 The Offeror 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 Offeror shall assure timely delivery of mental health and substance abuse services and coordination with other acute care services.

4.6.11.2 Mental Health and Substance Abuse Policies and Procedures shall be submitted to DCH for approval within sixty (60) Calendar Days of Contract Award.

4.6.11.3 The Offeror shall permit Members to self-refer to an In-Network Provider for an initial mental health or substance abuse visit but prior authorization may be required for subsequent visits.

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 Offeror 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 Offeror 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 Offeror'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 Offeror's information must inform Member`s that complaints may be filed with the State's Survey and Certification Agency.

4.6.12.4 The Offeror 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 Offeror 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 Foster Care Forensic Exam

4.6.13.1 The Offeror shall provide a forensic examination to a Member that is less than eighteen (18) years of age that is placed outside the home in State custody. Such exam shall be in accordance with State law and regulations.

4.6.14 Laboratory Services

4.6.14.1 The Offeror shall require all network laboratories to automatically report the Glomerular Filtration Rate (GFR) on any serum creatinine tests ordered by In-Network Providers.

4.6.15 Member Cost-Sharing

4.6.15.1 The Offeror shall ensure that Providers collect Member co-payments as specified in Attachment K of the Model Contract.

4.7 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM: HEALTH CHECK

4.7.1 General Provisions

4.7.1.1 The Offeror shall provide EPSDT services (called Health Check services) to Medicaid children less than twenty-one (21) years of age and PeachCare for Kids children less than age nineteen (19) years of age (hereafter referred to as Health Check eligible children), in compliance with all requirements found below.

4.7.1.2 The Offeror 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 et seq. that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The Offeror shall comply with all Health Check requirements pursuant to the Georgia Medicaid Policies and Procedures Manual.

4.7.1.3 The Offeror shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the Health Check periodicity schedules. 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 GCS population, as well as other unique characteristics of this population. The plan shall include procedures for follow-up of missed appointments, including missed Referral appointments for problems identified through Health Check screens and exams. The plan shall also include procedures for referral, tracking and follow up for annual dental examinations and visits. The Offeror shall submit its EPSDT Plan to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.7.2 Outreach and Informing

4.7.2.1 The Offeror's Health Check 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 Offeror shall inform its newly enrolled families with Health Check eligible children about the Health Check program within sixty (60) Calendar Days of enrollment with the 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 Offeror shall provide written notification to its families with Health Check eligible children when appropriate periodic assessments or needed services are due. The Offeror shall coordinate appointments for care. The Offeror shall follow up with families with Health Check eligible children that have failed to access Health Check screens and services after one hundred and twenty (120) Calendar Days of enrollment in the CMO plan.

4.7.2.4 The Offeror shall provide to each PCP, on a monthly basis, a list of the PCP's Health Check eligible children that have not had an encounter during the initial one hundred and twenty (120) Calendar Days of CMO plan enrollment, and/or are not in compliance with the Health Check periodicity schedule. The Offeror and/or the PCP shall contact the Members' parents or guardians to schedule an appointment.

4.7.2.5 Informing may be oral (on the telephone, face-to-face, or films/tapes) or written and may be done by Offeror personnel or Health Care Providers. All outreach and informing shall be documented and shall be conducted in non-technical language at or below a fifth (5^{th}) grade reading level. The Offeror shall use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with Section 4.3.2.

4.7.2.6 The Offeror may provide nominal, non-cash incentives to Members to motivate compliance with periodicity schedules.

4.7.3 Screening

4.7.3.1 The Offeror is responsible for periodic screens in accordance with the State's periodicity schedule. Such screens must include all of the following:

4.7.3.1.1 A comprehensive health and developmental history;

4.7.3.1.2 Developmental assessment, including mental, emotional, and behavioral health development;

4.7.3.1.3 Measurements (including head circumference for infants);

4.7.3.1.4 An assessment of nutritional status;

4.7.3.1.5 A comprehensive unclothed physical exam;

4.7.3.1.6 Immunizations according to the Advisory Committee of Immunization Practices (ACIP);

4.7.3.1.7 Certain laboratory tests (including the federally required blood lead screening);

4.7.3.1.8 Anticipatory guidance and health education;

4.7.3.1.9 Vision screening;

4.7.3.1.10 Tuberculosis and lead risk screening;

4.7.3.1.11 Hearing screening; and

4.7.3.1.12 Dental and oral health assessment.

4.7.3.2 Lead screening is a required component of a Health Check screen and the Offeror shall implement a screening program for the presence of lead toxicity. The screening program shall consist of two (2) parts: verbal risk assessment (from thirty-six (36) to seventy-two (72) months of age), and blood lead screening. Regardless of risk, the Offeror shall provide for a blood lead screening test for all Health Check eligible children at twelve (12) and twenty-four (24) months of age. Children between twenty-four (24) 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.

4.7.3.3 The Offeror shall have a lead case management program for Health Check 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, and aggressive pursuit of non-compliance with follow-up tests and appointments.

4.7.3.4 The Offeror shall have procedures for Referral to and follow up with oral health professionals, including annual dental examinations and services by an oral health professional.

4.7.3.5 The Offeror 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, hearing and dental services.

4.7.3.6 The Offeror shall provide Referrals for further diagnostic and/or treatment services to correct or ameliorate defects, and physical and mental illnesses and Conditions discovered by the Health Check screens. Referral and follow up may be made to the Provider conducting the screening or to another Provider, as appropriate.

4.7.3.7 The Offeror shall provide an initial health and screening visit to all newly enrolled GCS Health Check eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth to all newborns.

4.7.3.8 Minimum Offeror compliance with the Health Check screening requirements, including blood lead screening and annual dental examinations and services, is an eighty percent (80%) screening rate, using the methodology prescribed by CMS to determine the screening rate.

4.7.4 Tracking

4.7.4.1 The Offeror shall establish a tracking system that provides information on compliance with Health Check requirements. This system shall track, at a minimum, the following areas:

4.7.4.1.1 Initial newborn Health Check visit occurring in the hospital;

4.7.4.1.2 Periodic and preventive/well child screens and visits as prescribed by the periodicity schedule;

4.7.4.1.3 Diagnostic and treatment services, including Referrals;

4.7.4.1.4 Immunizations, lead, tuberculosis and dental services; and

4.7.4.1.5 A reminder/notification system.

4.7.4.2 All information generated and maintained in the tracking system shall be consistent with Encounter Data requirements as specified elsewhere herein.

4.7.5 Diagnostic and Treatment Services

4.7.5.1 If a suspected problem is detected by a screening examination as described above, the child shall be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

4.7.5.2 Health Check requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a problem discovered during a Health Check screen. 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 Offeror shall provide Medically Necessary, Medicaid-covered diagnostic and treatment services, either directly or by Referral.

4.7.6 Reporting Requirements

4.7.6.1 The Offeror shall submit to DCH quarterly Health Check Reports as described in Section 4.18.4.1. The Offeror shall report Health Check visits in accordance with the appropriate codes specified in the appropriate Provider Handbooks.

4.8 PROVIDER NETWORK

4.8.1 General Provisions

4.8.1.1 The Offeror is solely responsible for providing a network of physicians, pharmacies, hospitals, and other health care Providers through whom it provides the items and services included in Covered Services.

4.8.1.2 The Offeror shall ensure that its network of Providers is adequate to assure access to all Covered Services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services.

4.8.1.3 The Offeror shall not include any Providers who have been excluded from participation by the Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Offeror is responsible for routinely checking the exclusions list and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this RFP.

4.8.1.4 The Offeror shall require that each Provider have a unique physician identifier number (UPIN). Effective May 23, 2007, in accordance with 45 CFR 160.103, the Offeror shall require that each Provider have a national provider identifier (NPI).

4.8.1.5 The Offeror shall have written Selection and Retention Policies and Procedures. These policies shall be submitted to DCH for review and approval within sixty (60) Calendar Days of Contract Award. In selecting and retaining Providers in its network the Offeror shall consider the following:

4.8.1.5.1 The anticipated GCS enrollment;

4.8.1.5.2 The expected Utilization of services, taking into consideration the characteristics and Health Care needs of its Members;

4.8.1.5.3 The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the Covered Services;

4.8.1.5.4 The numbers of network Providers who are not accepting new GCS patients; and

4.8.1.5.5 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.

4.8.1.6 If the Offeror declines to include individual Providers or groups of Providers in its network, the Offeror shall give the affected Providers written notice of the reason(s) for the decision.

4.8.1.7 These provisions shall not be construed to:

4.8.1.7.1 Require the Offeror to contract with Providers beyond the number necessary to meet the needs of its Members;

4.8.1.7.2 Preclude the Offeror from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

4.8.1.7.3 Preclude the Offeror from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

4.8.1.8 The Offeror shall ensure that all network Providers have knowingly and willfully agreed to participate in the Offeror's network. The Offeror shall be prohibited from acquiring established networks without contacting each individual Provider to ensure knowledge of the requirements of the Model Contract and the Provider's complete understanding and agreement to fulfill all terms of the Provider Contract, as outlined in 4.10. DCH reserves the right to confirm and validate, through both the collection of information and documentation from the Offeror and on-site visits to network Providers, the existence of a direct relationship between the Offero and the network Providers.

4.8.1.9 The Offeror shall submit Provider Letters of Intent or executed Provider Contracts to DCH within sixty (60) Calendar Days of Contract Award.

4.8.1.10 The Offeror shall submit a Provider Network Listing and Signature Pages ninety (90) Calendar Days prior to implementation of GCS.

4.8.2 Primary Care Providers (PCPs)

4.8.2.1 The Offeror shall offer its Members freedom of choice in selecting a PCP. The Offeror shall have written PCP Selection Policies and Procedures describing how Members select their PCP.

4.8.2.2 The Offeror shall submit these PCP Selection Policies and Procedures policies to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.8.2.3 PCP assignment policies shall be in accordance with Section 4.1.2.

4.8.2.4 Members may not change their PCP for a period of six (6) months, with the following exceptions:

4.8.2.4.1 Members shall be allowed to change PCPs without cause during the first ninety (90) Calendar Days following PCP selection;

4.8.2.4.2 Members shall be allowed to change PCPs with cause at anytime. The following constitute cause for change:

i. The PCP no longer meets the geographic access standards as defined in Section 4.8.12;

ii. The PCP does not, because of moral or religious objections, provide the Covered Service(s) the Member seeks; and

iii. The Member requests to be assigned to the same PCP as other family members.

4.8.2.4.3 Members shall be allowed to change PCPs every six (6) months.

4.8.2.5 The PCP is responsible for supervising, coordinating, and providing all Primary Care to each assigned Member. In addition, the PCP is responsible for coordinating and/or initiating Referrals for specialty care (both in and out of network), maintaining continuity of each Member's Health Care and maintaining the Member's Medical Record, which includes documentation of all services provided by the PCP as well as any specialty services. The Offeror shall require that PCPs fulfill these responsibilities for all Members.

4.8.2.6 The Offeror shall include in its network as PCPs the following:

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

i. Family Practice;

ii. General Practice;

iii. Pediatrics; or

iv. Internal Medicine.

4.8.2.6.2 Nurse Practitioners Certified (NP-C) specializing in:

i. Family Practice; or

ii. Pediatrics.

4.8.2.7 NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who has hospital admitting privileges.

4.8.2.8 FQHCs and RHCs may be included as PCPs. The Offeror shall maintain an accurate list of all Providers rendering care at these facilities.

4.8.2.9 Primary Care Public Health Department Clinics and Primary Care Hospital Outpatient Clinics may be included as PCPs if they agree to the requirements of the PCP role, including the following conditions:

4.8.2.9.1 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. Any exceptions to this requirement will be considered on a case-by-case basis; and

4.8.2.9.2 Any Referrals for specialty care to other Providers of the same practice may be reviewed for appropriateness.

4.8.2.10 Physician's assistants (PAs) may participate as a PCP as a member of a physician's practice.

4.8.2.11 The Offeror may allow female Members to select a gynecologist or obstetrician-gynecologist (OB-GYN) as their Primary Care Provider.

4.8.2.12 The Offeror 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.

4.8.3 Women's Health Specialists

4.8.3.1 The Offeror 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 is in addition to the Member's designated source of Primary Care if that Provider is not a women's health specialist.

4.8.4 Significant Traditional Providers (STPs)

4.8.4.1 The Offeror shall include in its network all STPs in its Service Region for the first two (2) years of operation under the GCS Contract, provided that the STP:

4.8.4.1.1 Agrees to participate as an In-Network Provider and abide by the provisions of the Provider Contract as discussed in Section 4.10.

4.8.4.1.2 Agrees to accept the Offeror's Provider reimbursement rate for the Provider Type/Class; and

4.8.4.1.3 Meets the Offeror's credentialing requirements as established pursuant to Section 4.8.14.

4.8.4.2 Provider types/classes eligible for participation as a STP are:

4.8.4.2.1 PCPs (as defined in Section 4.8.2.6);

4.8.4.2.2 OB-GYNs;

4.8.4.2.3 Behavioral Health Providers;

4.8.4.2.4 Oral Health Providers;

4.8.4.2.5 Pharmacies; and

4.8.4.2.6 Hospitals.

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

4.8.5 Pharmacies

4.8.5.1 The Offeror shall maintain a comprehensive Provider network of pharmacies that ensures pharmacies are available and accessible to all Members.

4.8.6 Hospitals

4.8.6.1 The Offeror shall have a comprehensive Provider network of hospitals such that they are available and 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.

4.8.6.2 The Offeror shall include in its network Critical Access Hospitals (CAHs) that are located in its Service Region.

4.8.6.3 The Offeror 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.

4.8.7 Laboratories

4.8.7.1 The Offeror shall maintain a comprehensive Provider network of laboratories that ensures laboratories are accessible to all members. The Offeror 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.

4.8.8 Mental Health/Substance Abuse

4.8.8.1 The Offeror shall include in its network Community Service Boards (CSBs) that meet the Offeror's requirements and are located in its Service Region.

4.8.8.2 The Offeror shall maintain copies of all letters and other correspondence related to the inclusion of CSBs in its network. This documentation shall be provided to DCH upon request.

4.8.9 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

4.8.9.1 The Offeror shall include in its Provider network all FQHCs and RHCs in its Service Region.

4.8.9.2 The Offeror shall maintain copies of all letters and other correspondence related to its efforts to include FQHCs and RHCs in its network. This documentation shall be provided to DCH upon request.

4.8.10 Family Planning Clinics

4.8.10.1 The Offeror shall make a reasonable effort to subcontract with all family planning clinics, including those funded by Title X of the Public Health Services Act.

4.8.10.2 The Offeror 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.

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

4.8.11.1 The Offeror 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 Offeror to provide any services that are not Covered Services.

4.8.12 Geographic Access Requirements

4.8.12.1 In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Offeror shall meet the following geographic access standards for all Members:

	Urban	**Rural**
PCPs	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental 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

	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, seven (7) days a week within thirty (30) minutes or thirty (30) miles

4.8.12.2 All travel times are 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.

4.8.13 Waiting Maximums and Appointment Requirements

4.8.13.1 The Offeror 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 Offeror shall encourage its PCPs to offer After-Hours office care in the evenings and on week-ends.

4.8.13.2 Office wait times for appointments shall not exceed one (1) hour.

4.8.13.3 The Offeror shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

PCPs (routine visits)	21 Calendar Days
PCP (adult sick visit)	72 hours
PCP (pediatric sick visit)	24 hours
Specialist	30 Calendar Days
Dental Providers	30 Calendar Days
Non-emergency hospital stays	30 Calendar Days
Mental health Providers	14 Calendar Days
Urgent Care Providers	24 hours
Emergency Providers	immediately (24 hours a day, 7 days a week) and without prior authorization

4.8.13.4 The Offeror shall provide adequate capacity for initial visits for pregnant women within fourteen (14) Calendar Days and visits for Health Check eligible children within ninety (90) Calendar Days of enrollment into the CMO plan.

4.8.13.5 The Offeror shall take corrective action if there is a failure to comply with these waiting times.

4.8.14 Credentialing

4.8.14.1 The Offeror shall maintain written policies and procedures for the Credentialing and Re-Credentialing of network Providers, using standards

established by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or American Accreditation Healthcare Commission/URAC (AAHC/URAC). At a minimum the Offeror shall require that each Provider be credentialed in accordance with State law. The Offeror may impose more stringent Credentialing criteria than the State requires.

4.8.14.2 Such policies and procedures shall include: the verification of the existence and maintenance of credentials, licenses, certificates, and insurance coverage of each Provider from a primary source; a methodology and process for Re-Credentialing Providers; a description of the initial quality assessment of private practitioner offices and other patient care settings; and procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges.

4.8.14.3 Upon the request of DCH, The Offeror shall make available all licenses, insurance certificates, and other documents of network Providers.

4.8.13.4 The Offeror shall submit its Provider Credentialing and re-Credentialing Policies and Procedures to DCH within sixty (60) Calendar Days of Contract Award.

4.8.15 Mainstreaming

4.8.15.1 The Offeror shall ensure that all In-Network Providers accept Members for treatment, unless they have a full panel and are accepting no new GCS or commercial patients. The Offeror shall also ensure that In-Network Providers do not intentionally segregate members in any way from other persons receiving services.

4.8.15.2 The Offeror 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.

4.8.16 Coordination Requirements

4.8.16.1 The Offeror shall coordinate with all divisions within DCH, as well as with other State agencies, and with other CMO plans operating within the same Service Region.

4.8.16.2 The Offeror shall also coordinate with local education agencies in the Referral and provision of children's intervention services provided through the school to ensure Medical Necessity and prevent duplication of services.

4.8.16.3 The Offeror shall coordinate the services furnished to its Members with the service the Member receives outside the CMO plan, including services received through any other managed care entity.

4.8.16.4 The Offeror shall coordinate with all NET vendors.

4.8.16.5 DCH strongly encourages the Offeror to contract with Providers of essential community services who would normally contract with the State as well as other public agencies and with non-profit organizations that have maintained a historical base in the community.

4.8.16.6 The Offeror 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.

4.8.17 Network Changes

4.8.17.1 The Offeror 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:

4.8.17.1.1 A decrease in the total number of PCPs by more than five percent (5%);

4.8.17.1.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within sixty (60) miles;

4.8.17.1.3 A loss of a hospital in an area where another CMO plan hospital of equal service ability is not available within twenty-five (25) miles; or

4.8.17.1.4 Other adverse changes to the composition of the network which impair or deny the Members' adequate access to network Providers.

4.8.17.2 The Offeror shall have procedures to address changes in the health plan Provider network that negatively affect the ability of Members to access services, including access to a culturally diverse Provider network. Significant changes in network composition that negatively impact Member access to services may be grounds for Contract termination or State determined sanctions.

4.8.17.3 If a PCP ceases participation in the Offeror's Provider network, the Offeror shall send written notice to the Members who have chosen the Provider as their 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.

4.8.17.4 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 Offeror shall notify the Member in writing within ten (10) Calendar Days from the date the Offeror becomes aware of such unavailability.

4.8.17.5 These requirements to provide notice prior to the effective dates of 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 Offeror, or when a Provider fails Credentialing. Under these circumstances notice shall be issued immediately upon the Offeror becoming aware of the circumstances.

4.8.18 Out-of-Network Providers

4.8.18.1 If the Offeror's network is unable to provide Medically Necessary Covered Services to a particular Member, the Offeror shall adequately and timely cover these services Out-of-Network for the Member.

4.8.18.2 The Offeror shall coordinate with the Out-of-Network Providers regarding payment. The Offeror is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%), to Out-of-Network Providers to whom they have made at least three (3) documented attempts to include in their network.

4.8.18.3 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 Offeror is prohibited from charging the Member more than it would have if the services were furnished within the network.

4.8.19 Reporting Requirements

4.8.19.1 The Offeror shall submit to DCH Provider Network Adequacy and Capacity Reports, as described in Section 4.18.6.2.

4.8.19.2 The Offeror shall submit to DCH quarterly Timely Access Reports as described in Section 4.18.4.2.

4.9 PROVIDER SERVICES

4.9.1 General Provisions

4.9.1.1 The Offeror shall provide information to all Providers about the GCS program in order to operate in full compliance with the GCS Contract and all applicable federal and State regulations.

4.9.1.2 The Offeror shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.

4.9.1.3 The Offeror shall submit to DCH for review and prior approval all materials and information to be distributed and/or made available.

4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.

4.9.2 Provider Handbooks

4.9.2.1 The Offeror shall issue a Provider Handbook to all network Providers at the time the Provider Contract is signed. All Provider Handbooks and bulletins shall be in compliance with State and federal laws. The Provider Handbook shall serve as a source of information regarding GCS 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 Description of the GCS program;

4.9.2.1.2 Covered Services;

4.9.2.1.3 Emergency Service responsibilities;

4.9.2.1.4 Health Check/EPSDT program services and standards;

4.9.2.1.5 Policies and procedures of the Provider complaint system;

4.9.2.1.6 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;

4.9.2.1.7 Medical Necessity standards and practice guidelines;

4.9.2.1.8 Practice protocols, including guidelines pertaining to the treatment of chronic and complex Conditions;

4.9.2.1.9 PCP responsibilities;

4.9.2.1.10 Other Provider or Subcontractor responsibilities;

4.9.2.1.11 Prior Authorization, Pre-Certification, and Referral procedures;

4.9.2.1.12 Protocol for Encounter Data element reporting/records;

4.9.2.1.13 Medical Records standard;

4.9.2.1.14 Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;

4.9.2.1.15 Payment policies;

4.9.2.1.16 The Offeror's Cultural Competency Plan; and

4.9.2.1.17 Member rights and responsibilities.

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

4.9.2.3 The Offeror shall submit the Provider Handbook to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.9.3 Education and Training

4.9.3.1 The Offeror shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Offeror shall conduct initial training within thirty (30) Calendar Days of placing a newly contracted Provider on active status. The Offeror shall also conduct ongoing training as deemed necessary by the Offeror or DCH in order to ensure compliance with program standards and the Model Contract attached as Appendix E.

4.9.3.2 The Offeror shall submit the Provider Training Manual and Training Schedule to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.9.4 Provider Relations

4.9.4.1 The Offeror shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. The Offeror shall implement policies

addressing the compliance of Providers with the requirements of the GCS program, institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.

4.9.4.2 The Offeror shall provide for a Provider Relations Liaison to carry out the Provider relations functions. There shall be at least one (1) Provider Relations Liaison in each Service Region.

4.9.5 Toll-free Telephone Hotline

4.9.5.1 The Offeror shall operate a toll-free telephone hotline to respond to Provider questions, comments and inquiries.

4.9.5.2 The Offeror shall develop Telephone Hotline 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 Offeror shall submit these Telephone Hotline Policies and Procedures, including performance standards, to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.9.5.4 The Offeror's call center systems shall have the capability to track call management metrics identified in Attachment L of the Model Contract attached as Appendix E.

4.9.5.5 The Telephone Hotline shall be fully staffed between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The telephone hotline staff shall be trained to respond to Provider questions in all areas, including the Provider complaint system, Provider responsibilities, etc.

4.9.5.6 The Offeror shall develop performance standards and monitor telephone hotline performance by recording call and employing other monitoring activities. At a minimum, the standards shall require that ninety-nine percent (99%) of calls are answered by the fourth (4^{th}) 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%).

4.9.5.7 The Offeror shall ensure that after regular business hours the 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 requirement that the Offeror 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.

4.9.6 Internet Presence/Web Site

4.9.6.1 The Offeror shall dedicate a section of its Web site to Provider services and provide at a minimum, the capability for Providers to make inquiries and receive responses through the Web site, as is currently provided through DCH's Web site, (www.ghp.georgia.gov).

4.9.6.2 In addition to the specific requirements outlined above, the Offeror'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, (www.ghp.georgia.gov).

4.9.6.3 The Offeror shall submit Web site screenshots to DCH for review and approval sixty (60) Calendar Days prior to implementation of GCS.

4.9.7 Provider Complaint System

4.9.7.1 The Offeror shall establish a Provider Complaint system that permits a Provider to dispute the Offeror's policies, procedures, or any aspect of a Offeror's administrative functions, including Proposed Adverse Actions.

4.9.7.2 The Offeror shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.9.7.3 The Offeror 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 Offeror's Provider services to file a Provider complaint and which individual(s) have the authority to review a Provider complaint.

4.9.7.4 The Offeror shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers with the remittance advice of the processed Claim.

4.9.7.5 As a part of the Provider Complaint System, the Offeror shall:

4.9.7.5.1 Allow Providers forty-five (45) Calendar Days to file a verbal or written complaint;

4.9.7.5.2 Require that Providers exhaust the Offeror's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);

4.9.7.5.3 Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems;

4.9.7.5.4 Identify a staff person specifically designated to receive and process Provider Complaints;

4.9.7.5.5 Thoroughly investigate each Provider Complaint using applicable statutory, regulatory, and GCS Contractual provisions, collecting all pertinent facts from all parties and applying the Offeror's written policies and procedures; and

4.9.7.5.6 Ensure that CMO plan executives with the authority to require corrective action are involved in the Provider Complaint process.

4.9.7.6 The Offeror shall have a procedure for expedited review of a Provider complaint if the standard time frame could seriously jeopardize the Member's life, physical or mental health, or the Member's ability to regain maximum function. The expedited review shall be resolved no later than seventy-two (72) hours or as expeditiously as the Member's physical or mental health requires.

4.9.7.7 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Offeror shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers have fifteen (15) Business Days from the date the notice is mailed to request in writing an Administrative Law Hearing with the State.

4.9.7.8 The Offeror shall notify the Providers that a request for an Administrative Law Hearing must include the following information:

4.9.7.8.1 A clear expression by the Provider or Authorized Representative that he/she wishes to present his/her case to an administrative law judge;

4.9.7.8.2 Identification of the adverse Action being appealed and the issues that will be addressed at the hearing;

4.9.7.8.3 A specific statement of why the Provider believes the Offeror's adverse Action is wrong; and

4.9.7.8.4 A statement of the relief sought.

4.9.7.9 The Offeror shall include with the Notice of Adverse Action the following address where a request for an Administrative Law Hearing can be sent:

Department of Community Health
Legal Services Section
Division of Medical Assistance
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159

4.9.8 Reporting Requirements

4.9.8.1 The Offeror shall submit to DCH weekly Telephone Activity Reports as described in Section 4.18.2.2.

4.9.8.2 The Offeror shall submit to DCH quarterly Provider Complaints Reports as described in 4.18.4.3.

4.10 PROVIDER CONTRACTS AND PAYMENTS

4.10.1 Provider Contracts

4.10.1.1 The Offeror shall comply with all DCH procedures for contract review and approval submission. Memoranda of Agreement (MOA) shall not be permitted. Letters of Intent shall only be permitted in accordance with 4.8.1.9.

4.10.1.2 The Offeror shall submit to DCH for review and approval a model for each type of Provider Contract within sixty (60) Calendar Days of Contract Award.

4.10.1.3 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 the enrollment of Members into the CMO plan.

4.10.1.4 Upon request, the Offeror shall provide DCH with free copies of all executed Provider Contracts.

4.10.1.5 In addition to addressing the CMO plan licensure requirements, the Offeror's Provider Contracts shall:

4.10.1.5.1 Prohibit the Provider from seeking payment from the Member for any Covered Services provided to the Member within the terms of the GCS Contract and require the Provider to look solely to the Offeror for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Georgia State Medicaid Plan, the Georgia State Medicaid Policies and Procedures Manual, and the Model Contract;

4.10.1.5.2 Require the Provider to cooperate with the Offeror's quality improvement and Utilization Review and management activities;

4.10.1.5.3 Include provisions for the immediate transfer to another PCP or Offeror if the Member's health or safety is in jeopardy;

4.10.1.5.4 Not prohibit a Provider from discussing treatment or non-treatment options with Members that may not reflect the Offeror's position or may not be covered by the Offeror;

4.10.1.5.5 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;

4.10.1.5.6 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;

4.10.1.5.7 Require Providers to meet appointment waiting time standards pursuant to Section 4.8.13;

4.10.1.5.8 Provide for continuity of treatment in the event a Provider's participation terminates during the course of a Member's treatment by that Provider;

4.10.1.5.9 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 on the basis of such license or certification. This provision should not be construed as an any willing provider law, as it does not prohibit Offerors from limiting Provider participation to the extent necessary to meet the needs of the Members. This provision also does not interfere with measures established by the Offeror that are designed to maintain Quality and control costs;

4.10.1.5.10 Prohibit discrimination against Providers serving high-risk populations or those that specialize in Conditions requiring costly treatments;

4.10.1.5.11 Specify that CMS and DCH 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 Model Contract;

4.10.1.5.12 Specify Covered Services and populations;

4.10.1.5.13 Require Provider submission of complete and timely Encounter Data, pursuant to Section 4.17 of this RFP;

4.10.1.5.14 Include the definition and standards for Medical Necessity, pursuant to the definition in Section 4.5.3 of this RFP;

4.10.1.5.15 Specify rates of payment. The Offeror ensures that Providers will accept such payment as payment in full for Covered Services provided to Members, as deemed Medically Necessary and appropriate under the Offeror's Quality Improvement and Utilization Management program, less any applicable Member cost sharing pursuant to this Contract;

4.10.1.5.16 Provide for timely payment to all Providers for Covered Services to Members. Pursuant to the Georgia Prompt Payment Requirements timely payment is defined as fifteen (15) Calendar Days for a Clean Claim;

4.10.1.5.17 Specify acceptable billing and coding requirements;

4.10.1.5.18 Require that Providers comply with the Offeror's Cultural Competency plan;

4.10.1.5.19 Require that any marketing materials developed and distributed by Providers be submitted to the Offeror to submit to DCH for approval;

4.10.1.5.20 Specify that in the case of newborns the Offeror shall be responsible for any payment owed to Providers for services rendered prior to the newborn's enrollment with the Offeror;

4.10.1.5.21 Specify that the Offeror shall not be responsible for any payments owed to Providers for services rendered prior to a Member's enrollment with the Offeror, even if the services fell within the established period of retroactive eligibility;

4.10.1.5.22 Comply with 42 CFR 434 and 42 CFR 438.6;

4.10.1.5.23 Require Providers to collect Member co-payments as specified in Attachment K of the Model Contract;

4.10.1.5.24 Not employ or subcontract with individuals on the State or Federal Exclusions list;

4.10.1.5.25 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; and

4.10.1.5.26 Require Providers of transitioning Members to cooperate in all respects with Providers of other CMO plans to assure maximum health outcomes for Members.

4.10.2 Provider Termination

4.10.2.1 The Offeror shall comply with all State and federal laws regarding Provider termination. In its contracts with Providers, the Offeror 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 the Model Contract, DCH may request Provider termination immediately, or the Offeror 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 Offeror specifying such failure and requesting such Provider to abide by the terms and conditions hereof;

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 Offeror is created as a result of the Offeror's act of terminating or decision to terminate any Provider under the GCS Contract. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, the GCS Contract shall remain in full force and effect with respect to all other Providers;

4.10.2.2 The Offeror 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 Offeror's network. If the termination was "for cause" the Offeror shall provide to DCH the reasons for termination; and

4.10.2.3 The Offeror shall notify the Members pursuant to Section 4.8.17.3 and Section 4.8.17.4.

4.10.3 Provider Insurance

4.10.3.1 The Offeror shall require each Provider to maintain, throughout the term(s) of the Provider 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 Offeror 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, unless such coverage is unavailable in a specific region. Providers may be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve. DCH reserves the right to waive this requirement if necessary for business need.

4.10.3.2 In the event any such insurance is proposed to be reduced, terminated or canceled for any reason, the Offeror 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 Offeror 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.

4.10.3.3 The Offeror 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 the GCS Contract, even though asserted after the termination of the GCS Contract. DCH or DOI, at its discretion, may request that the Offeror 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 GCS Contract for any reason.

4.10.4 Provider Payment

4.10.4.1 With the exceptions noted below, the Offeror shall negotiate rates with Providers and such rates shall be specified in the Provider Contract. DCH prefers that Offerors pay Providers on a Fee for Service basis, however if the Offeror does enter into a capitated arrangement with Providers, the Offeror shall continue to require all Providers to submit detailed Encounter Data, including any Providers that may be paid a Capitation Payment.

4.10.4.2 When the Offeror negotiates a contract with a Critical Access Hospital (CAH), pursuant to Section 4.8.6 of this RFP, the Offeror shall pay the

CAH a payment rate based on allowable costs incurred by the CAH, in accordance with the Georgia Medicaid Policies and Procedures Manual.

4.10.4.3 When the Offeror 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 Offeror shall pay the FQHC/RHC rates that are comparable to rates paid to other similar Providers providing similar services.

4.10.5 Reporting Requirements

4.10.5.1 The Offeror shall submit a quarterly FQHC Report as described in Section 4.18.14.4.

4.11 UTILIZATION MANAGEMENT AND CARE COORDINATION RESPONSIBILITIES

4.11.1 Utilization Management

4.11.1.1 The Offeror 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, second opinions, discharge planning, and case management. Specifically, the Offeror shall have written Utilization Management Policies and Procedures that:

4.11.1.1.1 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.

4.11.1.1.2 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.

4.11.1.1.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.

4.11.1.1.4 Require that all Medical Necessity determinations are made in accordance with DCH's Medical Necessity definition as stated in Section 4.5.3.

4.11.1.2 The Offeror shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval within sixty (60) Calendar Days of Contract Award.

4.11.1.3 Network Providers may participate in Utilization Review activities in their own Service Region 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.

4.11.1.4 The Offeror shall have a Utilization Management Committee comprised of network Providers within each Service Region. The Utilization Management committee is accountable to the Medical Director and governing body of the Offeror. The Utilization Management Committee shall meet on a regular 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 The Offeror, and any delegated Utilization Review agent, shall not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

4.11.1.5.1 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

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

4.11.2 Prior Authorization and Pre-Certification

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

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

4.11.2.3 The Offeror 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 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 Offeror shall notify the Provider of Prior Authorization determinations in accordance with the following timeframes:

4.11.2.5.1 *Standard Service Authorizations*. Prior Authorization decisions for non-urgent services shall be made within fourteen (14) Calendar

Days of receipt of the request for services. An extension may be granted for an additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Offeror justifies to DCH a need for additional information and the extension is in the Member's interest.

4.11.2.5.2 *Expedited Service Authorizations*. In the event a Provider indicates, or the Offeror determines, that following the standard timeframe could seriously jeopardize the Member's life or health the Offeror shall make an expedited authorization determination and provide notice within twenty-four (24) hours. The Offeror may extend the twenty-four (24) hour time period for up to five (5) Business Days if the Member or the Provider requests an extension, or if the Offeror justifies to DCH a need for additional information and the extension is in the Member's interest.

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

4.11.2.6 The Offeror'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 Offeror 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 4.11.1.1, the Offeror 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 Offeror'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 Offeror 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 DCH strongly encourages the Offeror to develop electronic, web-based Referral processes and systems. In the event a Referral is made via the telephone, the Offeror shall ensure that Referral data, including the final decision, is maintained in a data file that can be accessed electronically by the Offeror, the Provider and DCH.

4.11.3.5 In conjunction with the other Utilization Management policies, the Offeror shall submit the Referral processes to DCH for review and approval.

4.11.4 Transition of Members

4.11.4.1 The Offeror shall allow for transitioning Members to receive services without a Referral, Prior Authorization or Pre-Certification from the current Provider in the following circumstances:

4.11.4.1.1 The Member has been diagnosed with a significant medical Condition within the last thirty (30) Calendar Days;

4.11.4.1.2 The Member needs an organ or tissue replacement;

4.11.4.1.3 The Member is receiving ongoing services such as chemotherapy and/or radiation; or

4.11.4.1.4 The Member has received Prior Authorization for services (from either another CMO plan or the State or its Agent), such as scheduled surgeries, or out-of-area specialty services.

4.11.4.2 When relinquishing Members, the Offeror shall cooperate with the receiving CMO plan regarding the course of on-going care with a specialist or other Provider.

4.11.5 Court-Ordered Evaluations and Services

4.11.5.1 In the event a Member requires evaluation services ordered by a State or federal court, the Offeror shall fully comply with all court orders while maintaining appropriate Utilization Management practices.

4.11.6 Second Opinions

4.11.6.1 The Offeror 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.

4.11.6.2 The second opinion must be provided by a qualified Health Care Professional within the network, or the Offeror shall arrange for the Member to obtain one outside the Provider network.

4.11.6.3 The second opinion shall be provided at no cost to the Member.

4.11.7 Care Coordination and Case Management

4.11.7.1 The Offeror shall be responsible for the Care Coordination/case management of all Members and shall make special effort to identify Members who have the greatest need for Care Coordination, including those who have catastrophic, or other high-cost or high-risk Conditions.

4.11.7.2 The Offeror's Care Coordination system shall emphasize prevention, continuity of care, and coordination of care. The system will advocate for, and link Members to, services as necessary across Providers and settings. Care Coordination functions include:

4.11.7.2.1 Early identification of Members who have or may have special needs;

4.11.7.2.2 Assessment of a Member's risk factors;

4.11.7.2.3 Development of a plan of care;

4.11.7.2.4 Referrals and assistance to ensure timely access to Providers;

4.11.7.2.5 Coordination of care actively linking the Member to Providers, medical services, residential, social and other support services where needed;

4.11.7.2.6 Monitoring;

4.11.7.2.7 Continuity of care; and

4.11.7.2.8 Follow-up and documentation.

4.11.7.3 The Offeror shall develop and implement a Care Coordination and case management system to ensure:

4.11.7.3.1 Timely access and delivery of Health Care and services required by Members;

4.11.7.3.2 Continuity of Members' care; and

4.11.7.3.3 Coordination and integration of Members' care.

4.11.7.4 These policies shall include, at a minimum, the following elements:

4.11.7.4.1 The provision of an individual needs assessment and diagnostic assessment; the development of an individual 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. These procedures must be designed to accommodate the specific cultural and linguistic needs of the Offeror's Members;

4.11.7.4.2 A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning;

4.11.7.4.3 Procedures and criteria for making Referrals to specialists and subspecialists;

4.11.7.4.4 Procedures and criteria for maintaining care plans and Referral Services when the Member changes PCPs; and

4.11.7.4.5 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 treatment plan.

4.11.7.5 The Offeror shall submit the Care Coordination and Case Management Policies and Procedures to DCH for review and approval within ninety (90) Calendar Days of Contract Award.

4.11.8 Disease Management

4.11.8.1 At a time to be determined by DCH, the Offeror shall develop disease management programs for individuals with Chronic Conditions.

4.11.8.2 The Offeror shall have disease management programs for Members with diabetes and asthma.

4.11.8.3 In addition, the Offeror shall develop programs for at least two (2) additional Conditions to be chosen from the following list:

4.11.8.3.1 Perinatal case management;

4.11.8.3.2 Obesity;

4.11.8.3.3 Hypertension;

4.11.8.3.4 Sickle cell disease; or

4.11.8.3.5 HIV/AIDS.

4.11.9 Discharge Planning

4.11.9.1 The Offeror 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.

4.11.10 Reporting Requirements

4.11.10.1 The Offeror shall submit Utilization Management Reports to DCH as described in Section 4.18.4.5.

4.11.10.2 The Offeror shall submit monthly Prior Authorization and Pre-Certification Reports to DCH as described in Section 4.18.3.2.

4.12 QUALITY IMPROVEMENT

4.12.1 General Provisions

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

4.12.1.3 The Offeror 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.

4.12.2 Quality Assessment Performance Improvement (QAPI) Program

4.12.2.1 The Offeror shall have in place an ongoing QAPI program consistent with 42 CFR 438.240.

4.12.2.2 The Offeror's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include:

4.12.2.2.1 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;

4.12.2.2.2 Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy;

4.12.2.2.3 A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data;

4.12.2.2.4 Designated staff with expertise in Quality assessment, Utilization Management and continuous Quality improvement;

4.12.2.2.5 Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to Providers and Members;

4.12.2.2.6 A methodology and process for conducting and maintaining Provider profiling;

4.12.2.2.7 Quarterly Reports to the Offeror's multi-disciplinary Quality oversight committee and DCH on results, conclusions, recommendations and implemented system changes;

4.12.2.2.8 Annual performance improvement projects (PIPs) that focus on clinical and non-clinical areas; and

4.12.2.2.9 Annual Reports on performance improvement projects and a process for evaluation of the impact and assessment of the Offeror's QAPI program.

4.12.2.3 The Offeror's QAPI Program Plan must be submitted to DCH for review and approval within ninety (90) Calendar Days of Contract Award.

4.12.2.4 The Offeror 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.

4.12.2.5 Upon the request of DCH the Offeror shall provide any information and documents related to the implementation of the QAPI program.

4.12.3 Performance Improvement Projects

4.12.3.1 As part of its QAPI program the Offeror shall conduct clinical and non-clinical performance improvement projects in accordance with DCH and federal protocols. In designing its performance improvement projects the Offeror shall:

4.12.3.1.1 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);

4.12.3.1.2 Establish clear, defined and measurable goals and objectives that the Offeror shall achieve in each year of the project;

4.12.3.1.3 Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;

4.12.3.1.4 Implement interventions designed to achieve Quality improvements;

4.12.3.1.5 Evaluate the effectiveness of the interventions;

4.12.3.1.6 Establish standardized performance measures (such as HEDIS or another similarly standardized product);

4.12.3.1.7 Plan and initiate activities for increasing or sustaining improvement; and

4.12.3.1.8 Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.

4.12.3.2 Each performance improvement project must be completed in a time 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.

4.12.3.3 The Offeror shall perform the following required clinical performance improvement projects, ongoing for the duration of the GCS Contract period:

4.12.3.3.1 One (1) in the area of Health Check screens;

4.12.3.3.2 One (1) in the area of immunizations; and

4.12.3.3.3 One (1) in the area of blood lead screens.

4.12.3.3.4 One (1) in the area of detection of chronic kidney disease.

4.12.3.4 The Offeror shall perform one (1) optional clinical performance improvement project from the following areas:

4.12.3.4.1 Coordination/continuity of care;

4.12.3.4.2 Chronic care management;

4.12.3.4.3 High volume Conditions; or

4.12.3.4.4 High risk Conditions.

4.12.3.5 The Offeror shall perform the following required non-clinical performance improvement projects:

4.12.3.5.1 One (1) in the area of Member satisfaction; and

4.12.3.5.2 One (1) in the area of Provider satisfaction.

4.12.3.6 The Offeror shall perform one (1) optional non-clinical performance improvement project from the following areas:

4.12.3.6.1 Cultural competence;

4.12.3.6.2 Appeals/Grievance/Provider Complaints;

4.12.3.6.3 Access/service capacity; or

4.12.3.6.4 Appointment availability.

4.12.3.7 The Offeror shall submit its Proposed Performance Improvement Projects to DCH for review and prior approval within ninety (90) Calendar Days of Contract Award.

4.12.3.8 The Offeror shall meet the established goals and objectives, as determined by DCH, for its performance improvement projects. The Offeror shall submit to DCH any and all data necessary to enable DCH to measure the Offeror's performance under this Section.

4.12.4 Practice Guidelines

4.12.4.1 The Offeror shall adopt a minimum of three (3) evidence-based clinical practice guidelines, one of which shall be for chronic kidney disease. Such guidelines shall:

4.12.4.1.1 Be based on the health needs and opportunities for improvement identified as part of the QAPI program;

4.12.4.1.2 Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;

4.12.4.1.3 Consider the needs of the Members;

4.12.4.1.4 Be adopted in consultation with network Providers; and

4.12.4.1.5 Be reviewed and updated periodically as appropriate.

4.12.4.2 The Offeror shall submit the Practice Guidelines, which shall include a methodology for measuring and assessing compliance, to DCH for review and prior approval as part of the QAPI program plan within ninety (90) Calendar Days of Contract Award.

4.12.4.3 The Offeror shall disseminate the guidelines to all affected Providers and, upon request, to Members.

4.12.4.4 The Offeror 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.

4.12.4.5 In order to ensure consistent application of the guidelines the Offeror shall encourage 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 Offeror may use Provider incentive strategies to improve Provider compliance with guidelines.

4.12.5 Focused Studies

4.12.5.1 The Offeror shall also perform a minimum of two (2) focused studies each year, commencing with the second (2^{nd}) year of operations. One (1) study shall focus on preventive care services.

4.12.5.2 The Offeror shall submit to DCH for approval the areas in which it will conduct focused studies on the first (1^{st}) day of the fourth (4^{th}) quarter of the first (1^{st}) year of operations.

4.12.6 Patient Safety Plan

4.12.6.1 The Offeror shall have a structured Patient Safety Plan to address concerns or complaints regarding clinical care. This plan must include written policies and procedures for processing of Member complaints regarding the care they received. Such policies and procedures shall include:

4.12.6.1.1 A system of classifying complaints according to severity;

4.12.6.1.2 A review by the Medical Director and a mechanism for determining which incidents will be forwarded to Peer Review and Credentials Committees; and

4.12.6.1.3 A summary of incident(s) and final disposition(s) included in the Provider profile.

4.12.6.2 The Offeror shall submit the Patient Safety Plan to DCH for review and approval within ninety (90) Calendar Days of the Contract Award.

4.12.7 Performance Incentives

4.12.7.1 The Offeror may be eligible for Performance Incentives as described in Section 7.0 of the Model Contract. All Incentives must comply with the federal managed care Incentive Arrangement requirements pursuant to 42 CFR 438.6 and the State Medicaid Manual 2089.3.

4.12.8 External Quality Review

4.12.8.1 DCH will contract with an External Quality Review Organization (EQRO) to conduct annual, external, independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Offeror shall collaborate with DCH's 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 plan improvement. To facilitate this process the Offeror shall supply data, including but not limited to Claims data and Medical Records, to the EQRO.

4.12.9 Reporting Requirements

4.12.9.1 The Offeror's Quality Oversight Committee shall submit Quality Oversight Committee Reports to DCH as described in Section 4.18.4.6.

4.12.9.2 The Offeror shall submit Performance Improvement Project Reports as described in Section 4.18.5.1

4.12.9.3 The Offeror shall submit annual Focused Studies Reports to DCH as described in Section 4.18.5.2.

4.12.9.4 The Offeror shall submit annual Patient Safety Plan Reports to DCH as described in Section 4.18.5.3.

4.13 FRAUD AND ABUSE

4.13.1 Program Integrity

4.13.1.1 The Offeror shall have a written 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 and Abuse in the administration and delivery of services under the Contract.

4.13.1.2 The Offeror shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below, to DCH for approval within sixty (60) Calendar Days of Contract Award.

4.13.2 Compliance Plan

4.13.2.1 The Offeror'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 Offeror's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Offeror'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 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 Offeror's Fraud and Abuse compliance plan;

4.13.2.1.4 Policies to establish a compliance committee that periodically meets and reviews Fraud and Abuse compliance issues;

4.13.2.1.5 Policies to ensure that any individual who Reports CMO plan violations or suspected Fraud and Abuse will not be retaliated against;

4.13.2.1.6 Polices 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 and Abuse and other compliance responsibilities;

4.13.2.1.8 Procedures for the detection of Fraud and Abuse that includes, at a minimum, the following:

i. Claims edits;

ii. Post-processing review of Claims;

iii. Provider profiling and Credentialing;

iv. Quality Control; and

v. 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 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 and Abuse reports; and

4.13.2.1.13 Procedures for reporting suspected Fraud and Abuse cases to 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 Offeror 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 Section 4.13.1.2. The pharmacy lock-in program shall:

4.13.2.2.1 Allow Members to change pharmacies for good cause, as determined by the Offeror 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 cas`e 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 Offeror's Compliance Officer report on the program on a quarterly basis to DCH.

4.13.3 Coordination with DCH and Other Agencies

4.13.3.1 The Offeror shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud and Abuse cases, including permitting access to the Offeror'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 Offeror'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 Offeror 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.

4.13.4 Reporting Requirements

4.13.4.1 The Offeror shall submit a Fraud and Abuse Report, as described in Section 4.18.4.7 to DCH on a quarterly basis. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2.

4.14 INTERNAL GRIEVANCE SYSTEM

4.14.1 General Requirements

4.14.1.1 The Offeror's Grievance System shall include a Grievance process, an Appeal process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Offeror's Grievance System is an internal process that shall be exhausted by the Member prior to access to an Administrative Law Hearing.

4.14.1.2 The Offeror shall develop written Grievance System Policies and Procedures that detail the operation of the Grievance System. The Offeror's policies and procedures shall be available in the Member's primary language. The Grievance System Policies and Procedures shall be submitted to DCH for review and approval within sixty (60) Calendar Days of Contract Award.

4.14.1.3 The Offeror shall process each Grievance and Appeal using applicable State and federal statutory, regulatory, and GCS Contractual provisions, and the Offeror's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

4.14.1.4 The Offeror shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Appeals. 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 Offeror shall acknowledge receipt of each filed Grievance and Appeal in writing within ten (10) Business Days of receipt. The Offeror shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.

4.14.1.6 The Offeror shall ensure that the individuals who make decisions on Grievances and Appeals 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 Appeal; and

4.14.1.6.3 Any Grievance or Appeal that involves clinical issues.

4.14.1.7 The Offeror shall establish and maintain an expedited review process for Appeals when the Offeror determines (based on a request from the Member) or the Provider indicates (in making the request on the Member's behalf) that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. The Member or the Member's Authorized Representative may file an expedited Appeal either orally or in writing. The Offeror shall ensure that punitive action is not taken against either a Provider who requests an expedited resolution, or a Provider that supports a Member's Appeal.

4.14.2 Grievance Process

4.14.2.1 A Member or an Authorized Representative with the Member's consent may file a Grievance with the Offeror either orally or in writing. A Grievance is any dissatisfaction about any matter other than a Proposed Action.

4.14.2.2 The Offeror shall ensure that the individuals who make decisions on Grievances that involve clinical issues or denial of an expedited review of an Appeal are Health Care Professionals 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.

4.14.2.3 The Offeror shall provide written notice of the disposition of the Grievance as expeditiously as the Member's health Condition requires but shall not exceed ninety (90) Calendar Days of the filing date.

4.14.2.4 The Offeror may extend the timeframe for disposition of a Grievance for up to fourteen (14) Calendar Days if the Member requests the extension or the Offeror demonstrates (to the satisfaction of DCH, upon its request) that there is a need for additional information and how the delay is in the Member's interest. If the Offeror extends the timeframe, it must, for any extension not requested by the Member, give the Member written notice of the reason for the delay.

4.14.3 Proposed Action

4.14.3.1 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.

4.14.3.2 In the event of a Proposed Action, the Offeror shall notify the Member in writing. The Offeror 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 and be sent in accordance with the timeframes described in Section 4.14.3.4.

4.14.3.3 The notice of Proposed Action must contain the following:

4.14.2.1.1 The Action the Offeror has taken or intends to take;

4.14.2.1.2 The reasons for the Action;

4.14.2.1.3 The Member's right to file an Appeal through the Offeror's internal Grievance System as described in 4.14;

4.14.2.1.4 The Provider's right to file a Provider Complaint as described in Section 4.9.7;

4.14.2.1.5 The requirement that a Member exhaust the Offeror's internal Grievance System and a Provider exhaust the Provider Complaint process prior to requesting a State Administrative Law Hearing;

4.14.2.1.6 The circumstances under which expedited review is available and how to request it; and

4.14.2.1.7 The Member's right to have Benefits continue pending resolution of the Appeal with the Offeror or with the State Administrative Law Hearing, how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

4.14.3.4 The Offeror shall mail the notice of Proposed Action within the following timeframes:

4.14.3.4.1 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:

i. The Offeror has factual information confirming the death of a Member.

ii. The Offeror 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.

iii. The Member's whereabouts are unknown and the post office returns Offeror mail directed to the Member indicating no forwarding address (refer to 42 CFR 431.231(d) for procedures if the Member's whereabouts become known).

iv. The Member's Provider prescribes a change in the level of medical care.

v. The date of action will occur in less than ten (10) Calendar Days in accordance with 42 CFR 482.12(a)(5)(ii).

vi. The Offeror may shorten the period of advance notice to five (5) Calendar Days before date of action if the Offeror has facts indicating that action should be taken because of probable Member Fraud and the facts have been verified, if possible, through secondary sources.

4.14.3.4.2 For denial of payment, at the time of any Proposed Action affecting the Claim.

4.14.3.4.3 For standard Service Authorization decisions that deny or limit services, within the timeframes required in Section 4.11.2.5.

4.14.3.4.4 If the Offeror extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.5, the Offeror shall give the Member written notice of the reasons for the decision to extend Grievance if he or she disagrees with that decision. The Offeror shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.

4.14.3.4.5 For authorization decisions not reached within the timeframes required in Section 4.11.2.5 for either standard or expedited Service Authorizations, 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 Appeal Process

4.14.4.1 An Appeal is the request for review of a "Proposed Action". The Member or the Member's Authorized Representative with the Member's written consent may file an Appeal either orally or in writing. Unless the Member or Provider requests expedited review, the Member or Authorized Representative must follow an oral filing with a written, signed, request for Appeal.

4.14.4.2 A Member or Authorized Representative may file an Appeal to the Offeror within thirty (30) Calendar Days from the date of the notice of Proposed Action.

4.14.4.3 Appeals shall be filed directly with the Offeror r, or its delegated representatives. The Offeror may delegate this authority to an Appeal committee, but the delegation must be in writing.

4.14.4.4 The Offeror shall ensure that the individuals who make decisions on Appeals 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:

4.14.4.4.1 An Appeal of a denial that is based on lack of Medical Necessity; or

4.14.4.4.2 An Appeal that involves clinical issues.

4.14.4.5 The Appeals process must provide the Member or Member's Authorized Representative a reasonable opportunity to present evidence and

allegations of fact or law, in person, as well as in writing. The Offeror shall inform the Member of the limited time available to provide this in case of expedited review.

4.14.4.6 The Appeals process must provide the Member and the Member's Authorized Representative opportunity, before and during the Appeals process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Appeals process.

4.14.4.7 The Appeals process must include as parties to the Appeal the Member and the Member's Authorized Representative or the legal representative of a deceased Member's estate.

4.14.4.8 The Offeror shall resolve each Appeal and provide written notice of the Appeal resolution, as expeditiously as the Member's health condition requires but shall not exceed forty-five (45) Calendar Days from the date the Offeror receives the Appeal. For expedited reviews of an Appeal and notice to affected parties, the Offeror has no longer than seventy-two (72) hours or as expeditiously as the Member's physical or mental health requires. If the Offeror denies a Member's request for expedited review, it must transfer the Appeal 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 Offeror shall also make reasonable efforts to provide oral notice for resolution of an expedited review of an Appeal.

4.14.4.9 The Offeror may extend the timeframe for standard or expedited resolution of the Appeal by up to fourteen (14) Calendar Days if the Member requests the extension or the Offeror 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 Offeror extends the timeframe, it must, for any extension not requested by the Member, give the Member written notice of the reason for the delay.

4.14.5 Notice of Adverse Action

4.14.5.1 If the Offeror upholds the Proposed Action in response to a Grievance or Appeal filed by the Member, the Offeror shall issue a Notice of Adverse Action within the timeframes as described in Section 4.14.3.8 and 4.14.3.9.

4.14.5.2 The Notice of Adverse Action shall meet the language and format requirements as specified in 4.3 and include the following:

4.14.5.2.1 The results and date of the Adverse Action;

4.14.5.2.2 The right to request a State Administrative Law Hearing within thirty (30) Calendar Days and how to do so;

4.14.5.2.3 The right to continue to receive Benefits pending a State Administrative Law Hearing;

4.14.5.2.4 How to request the continuation of Benefits; and

4.14.5.2.5 Information explaining that the Member may be liable for the cost of any continued Benefits if the Offeror's action is upheld in a State Administrative Law Hearing.

4.14.6 Administrative Law Hearing

4.14.6.1 The State will maintain an independent Administrative Law Hearing process as defined in the Georgia Administrative Procedure Act (O.C.G.A Title 50, Chapter 13) and as required by federal law, 42 CFR 200 et al. The Administrative Law Hearing process shall provide Members an opportunity for a hearing before an impartial Administrative Law Judge. The Offeror shall comply with decisions reached as a result of the Administrative Law Hearing process.

4.14.6.2 A Member or Authorized Representative may request in writing a State Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by the Offeror. The parties to the Administrative Law Hearing shall include the Offeror as well as the Member, Authorized Representative, or representative of a deceased Member's estate.

4.14.6.3 A Member may request a Continuation of Benefits as described in Section 4.14.7 while an Administrative Law Hearing is pending.

4.14.6.4 The Offeror shall make available any records and any witnesses at its own expense in conjunction with a request pursuant to an Administrative Law Hearing.

4.14.7 Continuation of Benefits while the Contractor Appeal and Administrative Law Hearing are Pending

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

4.14.7.1.1 Within ten (10) Calendar Days of the Offeror mailing the Notice of Adverse Action.

4.14.7.1.2 The intended effective date of the Offeror's Proposed Action.

4.14.7.2 The Offeror 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.

4.14.7.3 If, at the Member's request, the Offeror 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:

4.14.7.3.1 The Member withdraws the Appeal or request for the Administrative Law Hearing.

4.14.7.3.2 Ten (10) Calendar Day pass after the Offeror 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.

4.14.7.3.3 An Administrative Law Judge issues a hearing decision adverse to the Member.

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

4.14.7.4 If the final resolution of Appeal is adverse to the Member, that is, upholds the Offeror Action, the Offeror 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.

4.14.7.5 If the Offeror or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Offeror shall authorize or provide this disputed services promptly, and as expeditiously as the Member's health condition requires.

4.14.7.6 If the Offeror 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 Offeror shall pay for those services.

4.14.8 Reporting Requirements

4.14.8.1 The Offeror shall log and track all Grievances, Proposed Actions, Appeals and Administrative Law Hearing requests.

4.14.8.2 The Offeror shall maintain records of Grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of the Grievance, date of the decision, and the disposition.

4.14.8.3 The Offeror shall maintain records of Appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of Appeal, date of decision, and the resolution.

4.14.8.4 DCH may publicly disclose summary information regarding the nature of Grievances and Appeals and related dispositions or resolutions in consumer information materials.

4.14.8.5 The Offeror shall submit quarterly Grievance System Reports to DCH as described in section 4.18.4.8.

4.15 ADMINISTRATION AND MANAGEMENT

4.15.1 General Provisions

4.15.1.1 The Offeror shall be responsible for the administration and management of all requirements of the GCS Contract. All costs related to the administration and management of the GCS Contract shall be the responsibility of the Offeror.

4.15.2 Place of Business and Hours of Operation

4.15.2.1 The Offeror shall maintain a central business office within the Service Region in which it is operating. If the Offeror is operating in more than one (1) Service Region, there must be one (1) central business office and an additional office in each Service Region. If an Offeror is operating in two (2) or more contiguous Service Regions, the Offeror may establish one (1) central business office for all Service Regions. This business office must be centrally located within the contiguous Service Regions and in a location accessible for foot and vehicle traffic. The Offeror may establish more than one (1) business office within a Service Region, but must designate one (1) of the offices as the central business office.

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. The Offeror shall ensure that the office(s) are adequately staffed to ensure that Members and Providers receive prompt and accurate responses to inquiries. Such offices shall be for the sole purpose of functions and duties related to the GCS program.

4.15.2.3 The Offeror shall ensure that all business offices, and all staff that perform functions and duties, related to the responsibilities outlined herein are located within the United States.

4.15.2.4 The Offeror shall provide live access, through its telephone hot-line and web-site, twenty-four (24) hours a day, seven (7) days per week to its Member Services program and other key functions that support Care Coordination and utilization.

4.15.3 Training

4.15.3.1 The Offeror shall conduct on-going training for all staff, in all departments, to ensure appropriate functioning in all areas and to ensure that staff is aware of all programmatic changes.

4.15.3.2 The Offeror shall submit a staff training plan to DCH for review and approval within ninety (90) days of Contract Award.

4.15.4 Data Certification

4.15.4.1 The Offeror 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, 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 Offeror's Chief Executive Officer, the Offeror's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to the Offeror's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows:

4.15.4.1.1 To the accuracy, completeness and truthfulness of the data.

4.15.4.1.2 To the accuracy, completeness and truthfulness of the documents specified by the State.

4.15.4.2 The Offeror shall submit the certification concurrently with the certified data.

4.15.5 Implementation Plan

4.15.5.1 The Offeror shall develop an Implementation Plan that details the procedures and activities that will be accomplished during the period between the awarding of this Contract and the start date of the GCS program. This Implementation Plan shall have established deadlines and timeframes for the implementation activities and shall include coordination and cooperation with DCH and its representatives during all phases.

4.15.5.2 The Offeror shall submit its Implementation Plan to DCH for DCH's review and approval within thirty (30) Calendar Days of Contract Award. Implementation shall not commence prior to DCH approval.

4.15.5.3 The Offeror will not receive any additional payment to cover start up or implementation costs.

4.16 CLAIMS MANAGEMENT

4.16.1 General Provisions

4.16.1.1 The Offeror 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 this Section and in compliance with all applicable State and federal laws, rules and regulations.

4.16.1.2 The Offeror shall maintain a Claims management system that can identify date of receipt (the date the Offeror 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 All Provider Claims that are clean and payable must be paid according to the following schedule.

4.16.1.3.1 Pharmacy Claims must be paid within twenty-one (21) Calendar Days of Claim receipt.

4.16.1.3.2 Physician and other non-institutional Claims must be paid within thirty (30) Calendar Days of Claim receipt.

4.16.1.3.3 Institutional Claims must be paid within forty-five (45) Calendar Days of Claim receipt.

4.16.1.4 At a minimum, the Offeror shall run one (1) Provider payment cycle per week, on the same day each week, as determined by the Offeror. The Offeror shall develop a payment schedule to be submitted to DCH for review and upon approval within sixty (60) days of Contract Award.

4.16.1.5 The Offeror shall support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of Claims payments.

4.16.1.6 The Offeror shall encourage that its Providers, as an alternative to the filing of paper-based Claims, 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 Section 4.17. As part of this Electronic Claims Management (ECM) function, the Offeror shall also provide on-line and phone-based capabilities to obtain Claims processing status information.

4.16.1.7 The Offeror shall generate Explanation of Benefits and Remittance Advices in accordance with State standards for formatting, content and timeliness.

4.16.1.8 The Offeror shall not pay any Claim submitted by a Provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for Fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The Offeror shall not pay any Claim submitted by a Provider that is on payment hold under the authority of DCH or its authorized Agent(s).

4.16.1.9 Not later than the fifteenth (15^{th}) Business Day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Offeror shall suspend the Claim and request in writing (notification via e-mail, the CMO plan Web site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. After receipt of the requested information from the Provider, the Offeror must process the Claim in accordance with the following schedule:

4.16.1.9.1 Pharmacy Claims must be paid within five (5) Calendar Days of receipt.

4.16.1.9.2 Physician and other Non-Institutional Claims must be paid within fifteen (15) Calendar Days of Claim receipt.

4.16.1.9.3 Institutional Claims must be paid within thirty (30) Calendar Days of Claim receipt.

4.16.1.10 Claims suspended for additional information must be closed (paid or denied) by the thirtieth (30^{th}) Calendar Day following the date the Claim is suspended if all requested information is not received prior to the expiration of the 30-day period. The Offeror shall send Providers written notice (notification via e-mail, the CMO plan Web Site/Provider Portal or an Explanation of Benefits satisfies this requirement) for each Claim that is denied, including the reason(s) for the denial, the date Offeror received

the Claim, and a reiteration of the outstanding information required from the Provider to adjudicate the Claim.

4.16.1.11 The Offeror shall process, and finalize, all appealed Claims to a paid or denied status within (30) Business Days of receipt of the Appealed Claim.

4.16.1.12 The Offeror shall finalize all Claims, including appealed Claims, within twenty-four (24) months of the date of service.

4.16.1.13 The Offeror may deny a Claim for failure to file timely if a Provider does not submit Claims to them within one hundred and twenty (120) Calendar Days of the date of service but must deny any Claim not initially submitted to the Offeror by the one hundred and eighty-first (181st) Calendar Day from the date of service, unless the Offeror or its vendors created the error. If a Provider files erroneously with another CMO plan or with the State, but produces documentation verifying that the initial filing of the Claim occurred within the one hundred and twenty (120) Calendar Day period, the Offeror shall process the Provider's Claim without denying for failure to timely file.

4.16.1.14 The Offeror shall inform all network Providers about the information required to submit a Clean Claim at least forty-five (45) Calendar Days prior to the Operational Start Date and as a provision within the Provider Contract. The Offeror shall make available to network Providers Claims coding and processing guidelines for the applicable Provider type. The Offeror shall notify Providers ninety (90) Calendar Days before implementing changes to Claims coding and processing guidelines.

4.16.1.15 The Offeror shall assume all costs associated with Claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Offeror or to the design of systems within the Offeror's Span of Control.

4.16.1.16 In addition to the specific Web site requirements outlined above, the Offeror's Web site shall be functionally equivalent to the Web site maintained by the State's Medicaid fiscal agent.

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 Reporting Requirements

4.16.3.1 The Offeror shall submit Claims Processing Reports to DCH as described in section 4.18.3.3.

4.17 INFORMATION MANAGEMENT AND SYSTEMS

4.17.1 General Provisions

4.17.1.1 The Offeror shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GCS program requirements, State and federal reporting requirements, all other RFP requirements and any other applicable State and federal laws, rules and regulations including HIPAA.

4.17.1.2 The Offeror's Systems shall possess capacity sufficient to handle the workload projected for the start of the program and will be scaleable and flexible so they can be adapted as needed, within negotiated timeframes, in response to program or enrollment changes.

4.17.1.3 The Offeror 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 RFP. Access to the DCH Portal shall be managed as described in section 4.17.5.

4.17.1.4 The Offeror shall participate in DCH's Systems Work Group. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its agents and every award-winning Offeror.

4.17.1.5 The Offeror 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 Offeror contacts; and

4.17.1.5.2 Capable of attaching and sending documents created using software products other than Offeror 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 Offeror will provide DCH with a systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Offeror'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 Offeror will insure that the version and/or release level of all of its System components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the System component.

4.17.2 Global System Architecture and Design Requirements

4.17.2.1 The Offeror 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 Offeror shall adhere to DCH and State-specific system and data architecture preferences as indicated in this Contract.

4.17.2.2 The Offeror's Systems shall:

4.17.2.2.1 Employ a relational data model in the architecture of its databases and relational database management system (RDBMS) to operate and maintain them;

4.17.2.2.2 Be SQL and ODBC compliant;

4.17.2.2.3 Adhere to Internet Engineering Task Force/Internet Engineering Standards Group standards for data communications, including TCP and IP for data transport;

4.17.2.2.4 Conform to standard code sets detailed in Attachment L of the Model Contract;

4.17.2.2.5 Conform to HIPAA standards for data and document management that are currently under development within one hundred twenty (120) Calendar Days of the standard's effective date or, if earlier, the date stipulated by CMS;

4.17.2.2.6 Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the Offeror and DCH; and

4.17.2.2.7 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 in the plan to implement the standards.

4.17.2.3 Where Web services are used in the engineering of applications, the Offeror'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.

4.17.2.4 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:

4.17.2.4.1 Contain a unique log-on ID (or batch update identifier), terminal ID, date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

4.17.2.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

4.17.2.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document shall also exist;

4.17.2.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs.

4.17.2.4.5 Facilitate auditing of individual Claim records as well as batch audits.

4.17.2.4.6 Be maintained for seven (7) years in either live and/or archival systems. The duration of the retention period may be extended at the discretion of and as indicated to the Offeror by the State as needed for ongoing audits or other purposes.

4.17.2.5 The Offeror shall house indexed images of documents used by Members and Providers to transact with the Offeror in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data. The Offeror shall follow all applicable requirements for the management of data in the management of documents.

4.17.2.6 The Offeror shall institute processes to insure 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.

4.17.2.7 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 L of the Model Contract.

4.17.2.8 The Offeror System(s) shall conform to HIPAA standards for information exchange that are currently under development within one hundred twenty (120) Calendar Days of the standard's effective date or, if earlier, the date stipulated by CMS.

4.17.2.9 The layout and other applicable characteristics of the pages of Offeror Web sites shall be compliant with Federal "section 508 standards" and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.

4.17.2.10 Offeror 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.

4.17.3 Data and Document Management Requirements by Major Information Type

4.17.3.1 In order to meet programmatic, reporting and management requirements, the Offeror'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 L of the Model Contract 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.

4.17.4 System and Data Integration Requirements

4.17.4.1 All of the Offeror's applications, operating software, middleware, and networking hardware and software shall be able to interface with the State's systems and will conform to standards and specifications set by the Georgia Technology Authority (GTA) and the agency that owns the system. These standards and specifications are detailed in Attachment L of the Model Contract.

4.17.4.2 The Offeror'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.

4.17.4.3 Each month the Offeror shall generate Encounter Data files 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 Offeror has a capitation arrangement for the most recent month for which all such transactions were completed. The Offeror will provide these files electronically to DCH and/or its designated agent in adherence to the procedure and format indicated in Attachment L of the Model Contract.

4.17.4.4 The Offeror's System(s) shall be capable of generating files in the prescribed formats for upload into state Systems used specifically for program integrity and compliance purposes.

4.17.4.5 The Offeror's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

4.17.5 System Access Management and Information Accessibility Requirements

4.17.5.1 The Offeror'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:

4.17.5.1.1 Restrict access to Information on a "need to know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;

4.17.5.1.2 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 Offeror; and

4.17.5.1.3 Restrict attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

4.17.5.2 The Offeror 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.

4.17.5.3 The Offeror shall have procedures to provide for prompt transfer of System Information upon request to other In-Network or Out-of-Network Providers for the medical management of the member in adherence to HIPAA and other applicable requirements.

4.17.5.4 All Information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of the GCS Contract are owned by DCH. The Offeror is expressly prohibited from sharing or publishing DCH information and reports without the prior written consent of DCH. In the event of a dispute regarding the sharing or publishing of information and reports, DCH's decision on this matter shall be final and not subject to change.

4.17.6 Systems Availability and Performance Requirements

4.17.6.1 The Offeror shall 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 Offeror. Unavailability caused by events outside of an Offeror's Span of Control is outside of the scope of this requirement.

4.17.6.2 The Offeror 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.

4.17.6.3 The Offeror shall ensure that the average response time that is controllable by the Offeror is no greater than the requirements set forth below, at least ninety percent (90%) of the available production time between 7:00 am and 7:00 pm, Monday through Friday for all applicable system functions except a) during periods of scheduled downtime, as scheduled, b) during periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Offeror'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:

4.17.6.3.1 Record Search Time – The response time shall be within five (5) seconds for ninety-five percent (95%) of the record searches as measured from a representative sample of DCH System Access Devices;

4.17.6.3.2 Record Retrieval Time – The response time will be within five (5) seconds for ninety-five percent (95%) of the records retrieved as measured from a representative sample of DCH System Access Devices;

4.17.6.3.3 Screen Edit Time – The response time will be within three (3) seconds for ninety-five percent (95%) of the time as measured from a representative sample of DCH System Access Devices.

4.17.6.3.4 New Screen/Page Time – The response time will be within three (3) seconds for ninety-five percent (95%) of the time as measured from a representative sample of DCH System Access Devices;

4.17.6.3.5 Confirmation of CMO Enrollment Response Time – The response time will be within five (5) seconds for ninety-five percent (95%) of the time as measured from a representative sample of user System Access Devices; and

4.17.6.3.6 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.

4.17.6.4 The Offeror 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 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.

4.17.6.5 Upon discovery of any problem within its Span of Control that may jeopardize System availability and performance as defined in this Section, the Offeror shall notify the applicable DCH staff in person, via phone, electronic mail and/or surface mail.

4.17.6.6 The Offeror shall deliver notification as soon as possible but no later than the close of business if the problem is identified during the business day and no later than 9:00 a.m. the following business day if the problem occurs after close of business.

4.17.6.7 Where the operational problem results in delays in report distribution or problems in on-line access during the business day, the Offeror shall notify the applicable DCH staff 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.

4.17.6.8 The Offeror shall provide to appropriate DCH staff 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 Offeror's Web site/DCH Portal.

4.17.6.9 Unscheduled System Unavailability of CCE and ECM functions, caused by the failure of systems and telecommunications technologies within the Offeror's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the official declaration of System Unavailability. Unscheduled System Unavailability to all other Offeror System functions caused by systems and telecommunications

technologies within the Offeror's Span of Control shall be resolved, and the restoration of services implemented, within four (4) hours of the official declaration of System Unavailability.

4.17.6.10 Cumulative System Unavailability caused by systems and telecommunications technologies within the Offeror's Span of Control shall not exceed one (1) hour during any continuous five (5) day period.

4.17.6.11 The Offeror shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Offeror's Span of Control.

4.17.6.12 Full written documentation that includes a Corrective Action Plan, that describes how the problem will be prevented from occurring again, shall be delivered within five (5) Business Days of the problem's occurrence.

4.17.6.13 Regardless of the architecture of its Systems, the Offeror 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, (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.

4.17.6.14 The Offeror 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 section.

4.17.6.15 In the event that the Offeror fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined herein, the Offeror shall be required to submit to the State a Corrective Action Plan that describes how the failure will be resolved. The Corrective Action Plan will be delivered within five (5) Business Days of the conclusion of the test.

4.17.7 System User and Technical Support Requirements

4.17.7.1 Beginning sixty (60) Calendar Days prior to the scheduled start of operations, the Offeror shall provide Systems Help Desk (SHD) services

to all DCH staff and the other agencies that may have direct access to Offeror systems.

4.17.7.2 The 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 Offeror shall staff the SHD on a State holiday, Saturday, or Sunday.

4.17.7.3 SHD staff shall answer user questions regarding Offeror System functions and capabilities; report recurring programmatic and operational problems to appropriate Offeror 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.

4.17.7.4 The Offeror shall submit to DCH for review and approval its SHD Standards. At a minimum, these standards shall require that between the hours of 7 a.m. and 7 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%).

4.17.7.5 Individuals who place calls to the SHD between the hours of 7 pm and 7 am EST shall be able to leave a message. The Offeror's SHD shall respond to messages by noon the following Business Day.

4.17.7.6 Recurring problems not specific to System Unavailability identified by the SHD shall be documented and reported to Offeror management within one (1) Business Day of recognition so that deficiencies are promptly corrected.

4.17.7.7 Additionally, the Offeror 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:

4.17.7.7.1 Assign a unique number to each recorded incident;

4.17.7.7.2 Create State defined extract files that contain summary information on all problems/issues received during a specified time frame;

4.17.7.7.3 Escalate problems based on their priority and the length of time they have been outstanding;

4.17.7.7.4 Perform key word searches that are not limited to certain fields and allow for searches on all fields in the database;

4.17.7.7.5 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;

4.17.7.7.6 List all problems assigned to a support person or group;

4.17.7.7.7 Perform searches for duplicate problems when a new problem is entered;

4.17.7.7.8 Allow for entry of at least five hundred (500) characters of free form text to describe problems and resolutions;

4.17.7.7.9 Generate Reports that identify categories of problems encountered, length of time for resolution, and any other State-defined criteria.

4.17.7.8 The Offeror's call center systems shall have the capability to track call management metrics identified in Attachment L of the Model Contract.

4.17.8 System Change Management Requirements

4.17.8.1 The Offeror 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.

4.17.8.2 The Offeror shall provide to DCH prior written notice of non-routine System changes excluding changes prompted by events described in Section 4.17.6 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 Offeror shall discuss the proposed change in the Systems Work Group.

4.17.8.3 The Offeror shall respond to State reports of System problems not resulting in System Unavailability according to the following timeframes:

4.17.8.3.1 Within five (5) Calendar Days of receipt the Offeror shall respond in writing to notices of System problems.

4.17.8.3.2 Within fifteen (15) Calendar Days, the correction will be made or a Requirements Analysis and Specifications document will be due.

4.17.8.3.3 The Offeror will correct the deficiency by an effective date to be determined by DCH.

4.17.8.3.4 Offeror systems will have a system-inherent mechanism for recording any change to a software module or subsystem.

4.17.8.4 The Offeror shall put in place procedures and measures for safeguarding the State from unauthorized modifications to Offeror Systems.

4.17.8.5 Unless otherwise agreed to in advance by DCH as part of the activities described in Section 4.17.8.3, scheduled System Unavailability to perform System maintenance, repair and/or upgrade activities shall take place between 11 p.m. on a Saturday and 6 a.m. on the following Sunday.

4.17.9 System Security and Information Confidentiality and Privacy Requirements

4.17.9.1 The Offeror shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Offeror 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.

4.17.9.2 The Offeror 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.

4.17.9.3 The Offeror 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.

4.17.9.4 The Offeror 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 Attachment L of the Model Contract.

4.17.9.5 The Offeror will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of an Offeror's Span of Control.

4.17.9.6 The Offeror shall ensure compliance with:

4.17.9.6.1 42 CFR Part 31 Subpart F (confidentiality of information concerning applicants and members of public medical assistance programs);

4.17.9.6.2 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and

4.17.9.6.3 Special confidentiality provisions related to people with HIV/AIDS and mental illness.

4.17.9.7 The Offeror shall provide its members with a privacy notice as required by HIPAA. The Offeror shall provide the State with a copy of its Privacy Notice for its filing.

4.17.10 Information Management Process and Information Systems Documentation Requirements

4.17.10.1 The Offeror shall ensure that written System Process and Procedure Manuals document and describe all manual and automated system procedures for its information management processes and information systems.

4.17.10.2 The Offeror 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.

4.17.10.3 The System User Manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.

4.17.10.4 When a System change is subject to State sign off, the Offeror shall draft revisions to the appropriate manuals prior to State sign off of the change.

4.17.10.5 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 GTA standard.

4.17.10.6 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.

4.17.11 Reporting Requirements

4.17.11.1 The Offeror shall submit a monthly Systems Availability and Performance Report to DCH as described in Section 4.18.3.4.

4.18 REPORTING REQUIREMENTS

4.18.1 General Procedures

4.18.1.1 The Offeror shall comply with all the reporting requirements established by this Contract. The Offeror shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH and at no cost to DCH. Changes to the format must be approved by DCH prior to implementation. The Offeror shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 21 of the Model Contract. The Offeror's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 23 of the Model Contract.

4.18.1.1.1 The Offeror shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, unless otherwise indicated.

i. Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12^{th}) month Members are enrolled in the CMO plan;

ii. Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceeding the due date; and

iii. Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month.

iv. Weekly Reports shall be submitted on the same day of each week, as determined by DCH.

4.18.1.2 The Offeror shall submit to DOI any and all reports required by DOI. While some of these reports have been specified in this RFP, this is not intended to be an exhaustive list of reports due to DOI, rather certain financial reports have been highlighted.

4.18.2 Weekly Reporting

4.18.2.1 Member Information Report

4.18.2.1.1 Pursuant to Section 4.1.4.1 the Offeror shall submit a Member Information Report. The report shall include information on the Members that change addresses or move outside the Service Region. The Offeror shall also report any information that may affect the Member's eligibility for GCS including, but not limited to, changes in income or employment, family size, or incarceration. The minimum data elements that will be required for this report are described in Attachment L of the Model Contract.

4.18.2.2 Telephone and Internet Activity Report

4.18.2.2.1 Pursuant to Sections 4.3.11.1 and 4.9.8.1 the Offeror shall submit a Member Telephone and Internet Activity Report and a Provider Telephone and Internet Activity Report. Each Telephone and Internet Activity Report shall include the following information:

i. Call volume;

ii. E-mail volume;

iii. Average call length;

iv. Average hold time;

v. Call abandonment rate; and

vi. Content of call or e-mail and resolution.

4.18.3 Monthly Reporting

4.18.3.1 Eligibility and Enrollment Reconciliation Report

4.18.3.1.1 Pursuant to Section 4.1.4.2 the Offeror shall submit an Eligibility and Enrollment Reconciliation Report that reconciles eligibility data to the Offeror's enrollment records. The written report shall verify that the Offeror has an enrollment record for all Members that are eligible for enrollment in the CMO plan.

4.18.3.2 Prior Authorization and Pre-Certification Report

4.18.3.2.1 Pursuant to Section 4.11.10.2 the Offeror shall submit Prior Authorization and Pre-Certification Reports that summarize all requests in the preceding month for Prior Authorization and Pre-Certification. The Report shall include, at a minimum, the following information:

i. Total number of requests for Prior Authorization and Pre-Certification requested by type of service;

ii. Total number of requests for Prior Authorization and Pre-Certification processed within fourteen (14) Calendar Days for standard Service Authorizations;

iii. Total number of requests for extension of the fourteen (14) Calendar Days for standard Service Authorizations;

iv. Total number of requests for Prior Authorization and Pre-Certification processed within twenty- four (24) hours for expedited Service Authorizations;

v. Total number of requests for the extension of the twenty-four (24) hours for expedited Service Authorizations;

vi. Total number of requests for authorization processed within thirty (30) Calendar Days for determination for services that have been delivered;

vii. Total number of requests approved by type of service; and

viii. Total number of requests denied by type of service.

4.18.3.3 Claims Processing Report

4.18.3.4.1 Pursuant to Section 4.16.3.1 the Offeror shall submit a Claims Processing Report that at a minimum contains the following:

i. Number and dollar value of Claims processed by Provider type and processing status (adjudicated and paid, adjudicated and not paid, suspended, appealed, denied);

ii. Aging of Claims: number, dollar value and status of Claims filed in most recent and prior months by Provider type and processing status; and

iii. Cumulative percentage for the current fiscal year of Clean Claim s processed and paid within thirty (30) calendar and ninety (90) Calendar Days of receipt.

4.18.3.4 System Availability and Performance Report

4.18.3.4.1 Pursuant to Section 4.17.11.1 the Offeror shall submit a System Availability and Performance Report that shall report the following information:

i. Record Search Time

ii. Record Retrieval Time

iii. Screen Edit Time

iv. New Screen/Page Time

v. Print Initiation Time

vi. Eligibility Verification System Response Time

4.18.4 Quarterly Reporting

4.18.4.1 EPSDT Report

4.18.4.1.1 Pursuant to Section 4.7.6.1 the Offeror shall submit an EPSDT Report for Medicaid Members and PeachCare for Kids Members that identifies at a minimum the following:

i. Number of Health Check eligible Members;

ii. Number of live births;

iii. Number of initial newborn visits within twenty-four (24) hours of birth;

iv. Number of Members who received all scheduled EPSDT screenings in accordance with the periodicity schedule;

v. Number of Members who received dental examinations services by an oral health professional;

vi. Number of Members that received an initial health visit and screening within 90 Calendar Days of enrollment;

vii. Number of diagnostic and treatment services, including Referrals; and

viii. Number and rate of blood lead screening.

4.18.4.1.2 Reports shall capture Medicaid Members and PeachCare for Kids Members separately.

4.18.4.1.3 DCH, at its sole discretion, may add additional data to the EPSDT Report if DCH determines that it is necessary for monitoring purposes.

4.18.4.2 Timely Access Report

4.18.4.2.1 Pursuant to Section 4.8.19.2 the Offeror shall submit Timely Access Reports that monitor the time lapsed between a Member's initial request for an office appointment and the date of the appointment. The report shall include:

i. Total number of appointment requests;

ii. Total number of requests that meet the waiting time standards;

iii. Total number of requests that exceed the waiting time standards; and

iv. Average waiting time for those requests that exceed the waiting time standards. Information for items iii and iv shall be provided for each provider type/class.

4.18.4.3 Provider Complaints Report

4.18.4.3.1 Pursuant to Section 4.9.8.2 the Offeror shall submit a Provider Complaints Report that includes, at a minimum, the following:

i. Number of complaints by type;

ii. Type of assistance provided; and

iii. Administrative disposition of the case.

4.18.4.4 FQHC Report

4.18.4.4.1 Pursuant to 4.10.5.1 the Offeror shall submit FQHC Payment Reports that that identify Offeror payments made to each FQHC and RHC for each Covered Services provided to Members.

4.18.4.5 Utilization Management Report

4.18.4.5.1 Pursuant to Section 4.11.10.1 the Offeror shall submit a Utilization Management Report on Utilization patterns and aggregate trend analysis. The Offeror shall also submit individual Provider profiles to DCH. These Reports should provide to DCH analysis and interpretation of Utilization patterns, including but not limited to, high volume services, high risk services, services driving cost increases, including prescription drug utilization; Fraud and Abuse trends; and Quality and disease management. The Offeror shall provide ad hoc Reports pursuant to the requests of DCH. The Offeror shall submit its proposed reporting mechanism, including focus of study, data sources, etc. to DCH for approval.

4.18.4.6 Quality Oversight Committee Report

4.18.4.6.1 Pursuant to Section 4.12.9.1 the Offeror shall submit a Quality Oversight Committee Report that shall include a summary of results, conclusions, recommendations and implemented system changes for the QAPI program.

4.18.4.7 Fraud and Abuse Report

4.18.4.7.1 Pursuant to Section 4.13.4.1 the Offeror shall submit a Fraud and Abuse Report which shall include, at a minimum, the following:

i. Source of complaint;

ii. Alleged persons or entities involved;

iii. Nature of complaint;

iv. Approximate dollars involved;

v. Date of the complaint;

vi. Disciplinary action imposed;

vii. Administrative disposition of the case;

viii. Investigative activities, corrective actions, prevention efforts, and results; and

ix. Trending and analysis as it applies to: Utilization Management; Claims management; post-processing review of Claims; and Provider profiling.

4.18.4.8 Grievance System Report

4.18.4.8.1 Pursuant to Section 4.14.8.5 the Offeror shall submit a summary of Grievance, Appeals and Administrative Law Hearing requests. The report shall, at a minimum, include the following:

i. Number of complaints by type;

ii. Type of assistance provided; and

iii. Administrative disposition of the case.

4.18.4.9 Cost Avoidance Report

4.18.4.9.1 Pursuant to Section 4.19.6.1 the Offeror shall submit a Cost Avoidance Report that identifies all cost avoided claims for Members with third party coverage from private insurance carriers and other responsible third parties.

4.18.4.10 Medical Loss Ratio Report

4.18.4.10.1 Pursuant to Section 4.19.6.2 the Offeror shall submit a Medical Loss Ratio Report that shall include all monthly expenditures reported on a rolling basis by Provider groupings including, but not limited to:

i. Direct payment to Providers for covered medical services;

ii. Capitated payments to Providers; and

iii. Subcontractors for covered medical services.

4.18.4.11 Independent Audit and Income Statement

4.18.4.11.1 Pursuant to Section 4.19.6.5.8, the Offeror shall submit to DOI a quarterly independent audit and income statement. The quarterly audit shall be on the form prescribed by the NAIC and the income statement shall detail the Offeror's earned revenue and incurred expenses under the GCS Contract. Each quarter shall be uniquely restated until the Offeror has reported the quarter as fully complete.

4.18.5 Annual Reports

4.18.5.1 Performance Improvement Projects Reports

4.18.5.1.1 Pursuant to Section 4.12.9.2 the Offeror shall submit a Performance Improvement Projects Report that includes the study design, analysis, status and results on performance improvement projects. Status Reports on Performance Improvement Projects may be requested more frequently by DCH.

4.18.5.2 Focused Studies Report

4.18.5.2.1 Pursuant to Section 4.12.9.3 the Offeror shall, on the first (1^{st}) day of the fourth (4^{th}) quarter of the first (1^{st}) year of operations submit a Focus Studies Report that includes the study design, analysis and results for each of the two required focused studies. The Offeror shall submit annual Reports on the focused studies thereafter.

4.18.5.3 Patient Safety Reports

4.18.5.3.1 Pursuant to Section 4.12.9.4 the Offeror shall submit a Patient Safety Report that includes, at a minimum, the following:

i. A system of classifying complaints according to severity;

ii. Review by Medical Director and mechanism for determining which incidents will be forwarded to Peer Review and Credentials Committees; and

iii. Summary of incident(s) included in Provider Profile.

4.18.5.4 Systems Refresh Plan

4.18.5.4.1 Pursuant to 4.17.1.6 the Offeror shall submit to DCH a Systems Refresh Plan no later than the 30th of April each year.

4.18.5.5 Independent Audit and Income Statement

4.18.5.5.1 Pursuant to Section 4.19.6.5.8, the Offeror shall submit to DOI an annual independent audit that includes an audited and un-audited report for the GCS book of business in accordance with the format prescribed by NAIC. The annual report must include actuarial certification of incurred, but not reported, claims. The Offeror shall also submit an annual income statement detailing earned revenue and incurred expenses as a result of this Contract.

4.18.5.6 "SAS 70" Report

4.18.5.6.1 Pursuant to Section 4.19.6.4, the Offeror shall submit to DCH an annual SAS 70 Report conducted by an independent auditing firm.

4.18.5.7 Disclosure of Information on Annual Business Transactions

4.18.5.7.1 Pursuant to Section 4.19.6.5, the Offeror shall submit to DCH, in a format specified by DCH, an annual Disclosure of Information on Annual Business Transactions.

4.18.6 Ad Hoc Reports

4.18.6.1 State Quality Monitoring Reports

4.18.6.1.1 Pursuant to Appendix G the Offeror shall report, upon request by DCH, information to support the State's Quality Monitoring Functions in accordance with 42 CFR 438.204. These Reports shall include information on:

i. The availability of services;

ii. The adequacy of the Offeror's capacity and services;

iii. The Offeror's coordination and continuity of care for Members;

iv. The coverage and authorization of services;

v. The Offeror's policies and procedures for selection and retention of Providers;

vi. The Offeror's compliance with Member information requirements in accordance with 42CFR 438.10;

vii. The Offeror's compliance with 45 CFR relative to Member's confidentiality;

viii. The Offeror's compliance with Member enrollment and Disenrollment requirements and limitations;

ix. The Offeror's Grievance System;

x. The Offeror's oversight of all subcontractual relationships and delegations therein;

xi. The Offeror's adoption of practice guidelines, including the dissemination of the guidelines to Providers and Provider's application of them;

xii. The Offeror's quality assessment and performance improvement program; and

xiii. The Offeror's health information systems.

4.18.6.2 Provider Network Adequacy and Capacity Report

4.18.6.2.1 Pursuant to Section 4.8.19.1 the Offeror shall submit a Provider Network Adequacy and Capacity Report that demonstrates that the Offeror offers an appropriate range of preventive, Primary Care and specialty services that is adequate for the anticipated number of Members for the service area and that its network of Providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the service area.

4.18.6.2.2 This Provider Network Adequacy and Capacity Report shall list all Providers enrolled in the Offeror's Provider network, including but not limited to, physicians, hospitals, FQHC/RHCs, home health agencies, pharmacies, Durable Medical Equipment vendors, behavioral health specialists, ambulance vendors, and dentists. Each Provider shall be identified by a unique identifying Provider number as specified in Section 4.8.1.4. This unique identifier shall appear on all Encounter Data transmittals. In addition to the listing, the Provider Network Adequacy and Capacity Report shall identify:

i. Provider additions and deletions from the preceding month;

ii. All OB/GYN Providers participating in the Offeror's network, and those with open panels; and

iii. List of Primary Care Providers with open panels.

4.18.6.2.3 The Reports shall be submitted to DCH at the following times:

i. Sixty (60) Days after Contract Award and quarterly thereafter;

ii. Upon DCH request;

iii. Upon enrollment of a new population in the Offeror's plan; and

iv. Any time there has been a significant change in the Offeror's operations that would affect adequate capacity and services. A significant change is defined as any of the following:

- A decrease in the total number of PCPs by more than five percent (5%);
- A loss of Providers in a specific specialty where another Provider in that specialty is not available within sixty (60) miles; or
- A loss of a hospital in an area where another CMO plan hospital of equal service ability is not available within twenty-five (25) miles; or
- Other adverse changes to the composition of the network which impair or deny the Members' adequate access to CMO plan Providers.

4.18.6.3 Third Party Liability and Coordination of Benefits Report

4.18.6.3.1 Pursuant to Section 4.19.6.3 the Offeror shall submit a Third Party Liability and Coordination of Benefits Report that includes any Third Party Resources available to a Member discovered by the Offeror, in addition to those provided to the Offeror by DCH pursuant to Appendix G, within ten (10) Business Days of verification of such information. The Offeror shall report any known changes to such resources in the same manner.

4.19 FINANCIAL MANAGEMENT

4.19.1 General Provisions

4.19.1.1 The Offeror shall be responsible for the sound financial management of the CMO plan.

4.19.2 Solvency and Reserves Standards

4.19.2.1 The Offeror shall establish and maintain such net worth, working capital and financial reserves as required pursuant to State law.

4.19.2.2 The Offeror shall provide assurances to the State that its provision against the risk of insolvency is adequate such that its Members shall not be liable for its debts in the event of insolvency.

4.19.2.3 As part of its accounting and budgeting function, the Offeror shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. As part of its reserving process the Offeror shall conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

4.19.3 Reinsurance

4.19.3.1 DCH will not administer a Reinsurance program funded from capitation payment Withholding.

4.19.3.2 In addition to basic financial measures required by State law and discussed in 4.19.2, the Offeror shall meet financial viabiligy standards. The Offeror shall maintain net equity (asses minus liability) equal to at least one (1) month's capitation payments under this Contract. In addition, the Offeror shall maintain a current ration (current assets/current liabilities) of greater than or equal to 1.0.

4.19.3.3 In the event the Offeror does not meet the minimum financial viability standards outlined in 4.19.3.2, the Offeror shall obtain Reinsurance that meets all DOI requirements. While commercial Reinsurance is not required, DCH recommends that Offerors obtain commercial Reinsurance rather than self-insuring.

4.19.4 Third Party Liability and Coordination of Benefits

4.19.4.1 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.

4.19.4.2 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Offeror as its agent to identify and cost avoid Claims for all CMO plan Members, including PeachCare for Kids members.

4.19.4.3 The Offeror shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO plan Members. To the extent permitted by State and federal law, the Offeror shall use Cost Avoidance processes to ensure that primary payments from the liable third party are identified, as specified below.

4.19.4.4 If the Offeror is unsuccessful in obtaining necessary cooperation from a Member to identify potential Third Party Resources after sixty (60) Calendar Days of such efforts, the Offeror may inform DCH, in a format to be determined by DCH, that efforts have been unsuccessful.

4.19.4.5 Cost Avoidance

4.19.4.5.1 The Offeror 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 Offeror is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below. However, if a third party health insurance carrier requires the Member to pay any cost-sharing amounts (e.g., copayment, coinsurance, deductible), the Offeror shall pay the cost sharing amounts. The Offeror's liability for such cost sharing amounts shall not exceed the amount the Offeror would have paid under the Offeror's payment schedule for the service.

4.19.4.5.2 Further, the Offeror 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.

4.19.4.5.3 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 Offeror shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Offeror shall then coordinate with DCH or it agent to enable DCH to recover payment from the potentially liable third party.

4.19.4.5.4 If the Offeror determines that third party liability exists for part or all of the services rendered, the Offeror shall:

i. Notify Providers and supply third party liability data to a Provider whose Claim is denied for payment due to third party liability; and,

ii. Pay the Provider only the amount, if any, by which the Provider's allowable Claim exceeds the amount of third party liability.

4.19.4.6 Compliance

4.19.4.6.1 DCH may determine whether the Offeror is in compliance with this Section by inspecting source documents for timeliness of billing and accounting for third party payments.

4.19.5 Physician Incentive Plan

4.19.5.1 The Offeror may establish physician incentive plans pursuant to federal and State regulations, including 42 CFR 422.208 and 422.210, and 42 CFR 438.6.

4.19.5.2 The Offeror shall disclose any and all such arrangements to DCH, and upon request, to Members. Such disclosure shall include:

4.19.5.2.1 Whether services not furnished by the physician or group are covered by the incentive plan;

4.19.5.2.2 The type of Incentive Arrangement;

4.19.5.2.3 The percent of Withhold or bonus; and,

4.19.5.2.4 The panel size and if patients are pooled, the method used.

4.19.5.3 Upon request, the Offeror shall report adequate information specified by the regulations to DCH in order that DCH will adequately monitor the CMO plan.

4.19.5.4 If the Offeror's physician incentive plan includes services not furnished by the physician/group, the Offeror 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.

4.19.5.5 Such physician incentive plans may not provide for payment, either directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

4.19.6 Reporting Requirements

4.19.6.1 The Offeror shall submit to DCH quarterly Cost Avoidance Reports as described in Section 4.18.4.9.

4.19.6.2 The Offeror shall submit to DCH quarterly Medical Loss Ratio Reports that detail direct medical expenditures for Members and premiums paid by the Offeror, as described in Section 4.18.4.10.

4.19.6.3 The Offeror 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 Section 4.18.6.3. The Offeror shall report any known changes to such resources in the same manner.

4.19.6.4 The Offeror, at its sole expense, shall submit by July 31 (or a later date if approved by DCH) of each year a "Report on Controls Placed in Operation and Tests of Operating Effectiveness", meeting all standards and requirements of the AICPA's SAS 70, for the Offeror's operations performed for DCH under the GCS Contract.

4.19.6.4.1 Each such "SAS 70 report" shall apply to the full twelve (12) months of the State's preceding fiscal year. The audit shall be conducted by an independent auditing firm, which has prior SAS 70 audit experience. An independent auditing firm means an organization other than the CPA firm engaged as the Offeror's corporate auditor. 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 Offeror's operation, 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 Offeror's operations and records for monitoring and/or stewardship purposes.

4.19.6.4.2 The independent auditing firm shall simultaneously deliver identical reports of its findings and recommendations to the Offeror and DCH within one (1) month 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 "Statements on Auditing Standards" (SAS). In particular, both the "Statements on Auditing Standards Number 70-Reports on the Processing of Transactions by Service Organizations" and the AICPA Audit Guide, "Audit Guide of Service-Center-Produced Records" are to be used.

4.19.6.4.3 The Offeror shall respond to the audit findings and recommendations within thirty (30) days of receipt of the audit and shall submit an acceptable proposed corrective action to DCH. The Offeror shall implement the corrective action plan within forty (40) Calendar Days of its approval by DCH.

4.19.6.5 The Offeror shall submit to DCH a "Disclosure of Information on Annual Business Transactions." This report must include:

4.19.6.5.1 Definition of a Party in Interest – As defined in section 1318(b) of the Public Health Service Act, a Party in Interest is:

i. Any director, officer, partner, or employee responsible for management or administration of an HMO and HIO; 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;

ii. Any organization in which a person described 4.19.6.5.1.i is 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;

iii. Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or

iv. Any spouse, child, or parent of an individual described in 4.19.6.5.1.ii.

4.19.6.5.2 Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

i. Any sale, exchange or lease of any property between the HMO and a party in interest;

ii. Any lending of money or other extension of credit between the HMO and a party in interest; and

iii. Any furnishing for consideration of goods, services (including management services) or facilities between the

HMO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

4.19.6.5.3 The information which must be disclosed in the transaction listed in Section 4.19.6.5.2 between an HMO and a party in interest includes:

i. The name of the party in interest for each transaction;

ii. A description of each transaction and the quantity or units involved;

iii. The accrued dollar value of each transaction during the fiscal year; and

iv. Justification of the reasonableness of each transaction.

4.19.6.5.4 The Offeror shall submit all necessary reports, documentation, and statements to DOI as required by State law. This includes, but is not limited to the following:

i. An annual report on the form prescribed by the NAIC's Quarterly and Annual Statement Instructions for health maintenance organizations pursuant to State Law and regulations. This annual report must include actuarial certification of incurred, but not reported, claims.

ii. An annual income statement detailing the Offeror's earned revenue and incurred expenses as a result of this Contract.

iii. A quarterly report on the form prescribed by the NAIC's Quarterly and Annual Statement Instructions for health maintenance organizations pursuant to State Law and regulations.

iv. A quarterly income statement detailing the Offeror's earned revenue and incurred expenses as a result of this Contract.

4.20 OFFEROR STAFFING

4.20.1 Staffing Assignments and Credentials

4.20.1.1 The Offeror warrants and represents that all persons, including independent contractors and consultants assigned by it to perform the GCS Contract, shall be employees or formal agents of the Offeror and shall

have the credentials necessary (i.e., licensed, and bonded, as required) to perform the work required herein. The Offeror shall include a similar provision in any contract with any Subcontractor selected to perform work hereunder. The Offeror also agrees that DCH may approve or disapprove the Offeror's Subcontractors or its staff assigned to the GCS Contract prior to the proposed staff assignment. DCH's decision on this matter shall not be subject to Appeal.

4.20.1.2 In addition, the Offeror warrants that all persons assigned by it to perform work under the GCS Contract shall be employees or authorized Subcontractors of the Offeror and shall be fully qualified, as required in the RFP and specified in the Offeror's proposal, to perform the services required herein. Personnel commitments made in the Offeror's proposal shall not be changed unless approved by DCH in writing. Staffing will include the named individuals at the levels of effort proposed.

4.20.1.3 The Offeror shall provide and maintain sufficient qualified personnel and staffing to enable the Deliverables to be provided in accordance with the RFP, the Offeror's proposal and this Contract. The Offeror shall submit to DCH, within ninety (90) days of Contract award, a detailed staffing plan, including the employees and management for all CMO functions.

4.20.1.4 At a minimum, the Offeror shall provide the following staff:

4.20.1.4.1 An Executive Administrator who is a full-time administrator with clear authority over the general administration and implementation of the requirements detailed in the GCS Contract.

4.20.1.4.2 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 plan, 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.

4.20.1.4.3 A Quality Improvement/Utilization Director.

4.20.1.4.4 A Chief Financial Officer who oversees all budget and accounting systems.

4.20.1.4.5 An Information Management and Systems Director and a complement of technical analysts and business analysts as needed to maintain the operations of Offeror Systems and to address System issues in accordance with all the terms of this contract.

4.20.1.4.6 A Pharmacist who is licensed in the State of Georgia;

4.20.1.4.7 A Dental Consultant who is a licensed dentist in the State of Georgia.

4.20.1.4.8 A Mental Health Coordinator who is a licensed mental health professional in the State of Georgia.

4.20.1.4.9 A Member Services Director.

4.20.1.4.10 Provider Services Director.

4.20.1.4.11 Provider Relations Liaison.

4.20.1.4.12 Grievance/Complaint Coordinator.

4.20.1.4.13 Compliance Officer.

4.20.1.4.14 Prior Authorization/Pre-Certification Coordinator who is a physician, registered nurse, or physician's assistant licensed in the State of Georgia.

4.20.1.4.15 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.

4.20.1.5 The Offeror shall conduct on-going training of staff in all departments to ensure appropriate functioning in all areas.

4.20.1.6 The Offeror shall comply with all staffing/personnel obligations set out in the RFP and the GCS Contract, including but not limited to those pertaining to security, health, and safety issues.

4.20.2 Staffing Changes

4.20.2.1 The Offeror shall notify DCH in the event of any changes to key staff, including the Executive Administrator, Medical Director, Quality Improvement/Utilization Director, Management Information Systems Director, and Chief Financial Officer. The Offeror shall replace any of the key staff with a person of equivalent experience, knowledge and talent.

4.20.2.2 DCH also may require the removal or reassignment of any Offeror 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 Offeror may terminate any of its employees designated to perform work or services under the GCS Contract, as permitted by applicable law. In the event of a Offeror employee termination, the Offeror shall provide

DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee.

4.20.3 Offeror's Failure to Comply

4.20.3.1 Should the Offeror 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 Model Contract; or 4) fail in the performance of any term or condition contained in 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 Offeror:

4.20.3.1.1 Withhold any monies then or next due to the Offeror;

4.20.3.1.2 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 Offeror; or

4.20.3.1.3 Withhold monies in the amount of any damage caused by any deficiency or delay in the services.

4.21 OFFICE SPACE AND SUPPORT

DCH will not provide office space, equipment, supplies or telephone or IT services for the successful Offeror's assigned staff except in special circumstances as determined by DCH.

4.22 RIGHTS IN DATA AND WORKS

The State will be the owner of all rights, title and interest in all materials or documentation or both that are created by Offerors in connection with the performance of this RFP. The specific terms of the ownership and access rights will be defined more precisely in the negotiated agreement.

4.23 COST

Each Offeror MUST present a Cost Proposal for the work to be performed. The Offeror's Cost Proposal should include all costs. Use the Cost Proposal worksheet at Appendix C – the Capitation Rate Calculation Sheet (CRCS). A separate CRCS must be completed for every rate category in each Service Region in which the Offeror bids. The CRCS must be completed in full. Your proposal must include the assumptions used for utilization, unit cost, administrative cost, reinsurance cost (if any), and anticipated profit level. All costs must be reflected in the proposed rates. No other costs will be considered.

To maintain a competitive and viable market, DCH is limiting the maximum number of Members in any one CMO plan. In the Atlanta Service Region, DCH will limit enrollment in a single plan to no more than forty percent (40%) to fifty percent (50%) of total GCS eligible lives in the Service Region. Members will not be Auto-Assigned to, nor may they choose, that CMO plan unless an immediate family member is enrolled in the CMO plan or a Historical Provider Relationship exists with a Provider that does not participate in any other CMO plan in the Atlanta Service Region. The exact percentage will be determined by DCH based upon the number of participating CMO plans in the Atlanta Service Region. In the five (5) Service Regions other than Atlanta, DCH will limit enrollment in a single plan to no more than sixty-five percent (65%) of total GCS eligible lives in the Service Region. Members will not be Auto-Assigned to that CMO plan unless an immediate family member is enrolled in the CMO plan or a Historical Provider Relationship exists with a Provider that does not participate in any other CMO plan in the Service Region. Enrollment limits will be figured once per quarter at the beginning of each quarter. Please develop your proposed rates with this limit in mind.

Initial rates will be in effect until July, 2006. At the end of this initial period, DCH will conduct an annual actuarial review of the overall appropriateness of the capitation rates. Such review may or may not result in prospective changes to the contracted capitation rates.

The Offeror must submit a certification signed by an actuary who is a member in good standing of the American Academy of Actuaries stating that the rates bid by the Offeror were determined to be actuarially sound for the contract term. Proposals failing to submit this certification will be considered non-responsive.

By executing the Contract, the Offeror acknowledges the Contract is a risk-based Contract and accepts the final capitation rates, including any modification agreed to during Best and Final Offers (BFO), for the relevant Contract period subject to adjustment as allowed for in the Contract.

5.0 PROCESS FOR SUBMITTING PROPOSALS

Offerors must submit separate proposals for each Service Region on which they are bidding. Thus, if an Offeror is bidding on the Atlanta, Central and Northern Service Regions three (3) proposals, each with the required number of copies, must be submitted.

All proposals must be submitted according to the instructions described below. Where specified, page limits must be adhered to. Required Attachments shall not be counted towards the page limits on the narrative. Except where specifically requested, do not attach policies and procedures manuals and guides; rather summarize these policies. DCH reserves the right not to review information provided in excess of the page limits. Offerors need not feel compelled to submit unnecessary text in order to reach the page limits.

All proposals shall be submitted on 8 ½ by 11 inch paper, with text no smaller than 11-point font, single–spaced. All pages must have 1 inch margins. All responses must be ordered as in the RFP. Attachments may be placed in a separate section, if such attachments are not included in the page limits in the RFP.

All populations listed in Appendix G will be mandatorily enrolled except that legislation is required to mandatorily enroll PeachCare for Kids in GCS. Therefore, all proposals must, where applicable and necessary, respond to the questions below with PeachCare for Kids mandatorily enrolled and with PeachCare for kids voluntarily enrolled.

5.1 CONTENT OF TECHNICAL PROPOSALS

The Technical Proposal must be submitted using the format as indicated in Appendix B. Address your response in detail for the following requirements.

5.1.1 Company Overview & Background and Experience (no page limit)

Please provide the following information about your company:

- Legal name, trade name, or any other name under which you do business or have done business in the past;
- Address, telephone, and e-mail of your headquarters office;
- A copy of your current Georgia Certificate of Authority (either provisional or final);
- The type of ownership (proprietary, partnership, corporation);
- The type of incorporation (for profit, not-for-profit, or non-profit) and whether your company is publicly or privately owned;
- The name and address of any sponsoring corporation or others who provide financial support to your company and the type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support;
- The name and address of any Health Care Professional that has at least a five percent (5%) financial interest in your company and the type of financial interest;

- The names and addresses of officers and directors;
- The state in which you are incorporated and the state(s) in which you are licensed to do business as a Health Maintenance Organization (HMO);
- Your federal taxpayer identification number;
- Whether you have had a contract terminated or not renewed for nonperformance or poor performance within the past five (5) years. In this instance please describe the issues, the parties involved, and provide the address and telephone number of the principal terminating party. Please describe any corrective action taken to prevent any future occurrence of the problem leading to the termination;
- A description of other current publicly-funded managed care contracts, including: the client's name and address; contract size (average monthly covered lives and annual revenues); whether payments under the contract are capitated or non-capitated; contract start date and duration, whether work was performed as a prime contractor or subcontractor; and a description of the scope of services you provided (inpatient, outpatient, prescription drugs etc.), including the covered population(s) and number of lives; and a medical loss ratio;
- Specific client references (minimum of three, maximum of five), with at least one for a state Medicaid program or other large similar government or large private industry project);
- Any debarment or suspension, regulatory action, sanctions, and/or fines imposed by any federal or state regulatory entity within the last three (3) years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Indicate which of these actions or fines, if any, were related to Medicaid or SCHIP programs. DCH may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Offeror; and
- Previous work experience with DCH and/or other entities of the State of Georgia. ***Please be advised that, in the evaluation phase of this procurement, DCH will consider the performance history from Offerors who previously have or are currently doing business with DCH or any other agency in the State of Georgia, or previously have or are currently doing business with other states.***

5.1.2 Planned Approach to Project

Provide a detailed proposal describing your overall approach to, and specific experience in, accomplishing the required services as stated in 4.0 of this RFP. You must address the specific questions and areas outlined below.

5.1.2.1 Enrollment (2 pages)

Please provide the following narrative in your proposal for fulfilling the Enrollment requirements as described in 4.1.

Discuss your approach to fulfilling the Enrollment procedure requirements as described in 4.1.1, including how you will ensure that you will coordinate with DCH and its Agent.

Discuss your approach for conducting PCP Auto-Assignment as described in 4.1.2, including how you will ensure that Members are notified within ten (10) Calendar Days of the assignment.

Detail your approach to meeting the newborn enrollment requirements as described in 4.1.3, including how you will:

- Encourage Members who are expectant mothers to select a CMO and PCP for their newborns; and
- Ensure that a newborn notification form is submitted, either by you or the hospital, to DCH or its Agent within twenty-four (24) hours of the birth of the newborn.

DCH is responsible for making all eligibility determinations and will not intentionally enroll individuals excluded from GCS, for example any Georgia Pediatric Program (GAPP) or Multi-Agency Team for Children (MATCH) individuals. In the event such individuals are enrolled in GCS, please describe steps you will take to identify them and how you will facilitate their transition out of GCS and into the Medicaid Fee for Service (FFS) delivery system in a way that will minimize disruption to their care.

5.1.2.2 Disenrollment (1-2 pages)

Please provide the following narrative in your proposal for fulfilling the Disenrollment requirements as described in 4.2.

Describe the assistance you will provide to Members seeking to disenroll as described in 4.2.1.

Describe the types of interventions you will use prior to seeking to disenroll a Member as described in 4.2.2. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a Member.

As described in 4.2.4, discuss the steps you will take to assign a Member to a different Provider in the event a PCP requests the Member be assigned elsewhere.

5.1.2.3 Member Services (8-10 pages)

Please provide the following narrative and attachments in your proposal to explain how you will fulfill the Member Services requirements as described in 4.3.

Discuss your process for fulfilling the requirement, as described in 4.3.1, that Members are knowledgeable about the GCS program.

Describe how you will ensure that all written materials meet the language requirements detailed in 4.3.2 and which reference material you anticipate you will use to meet the fifth (5^{th}) grade reading level requirement.

Describe how you will fulfill the Provider Directory requirements described in 4.3.5 that:

- All newly enrolled Members receive the most recent and up-to-date Provider Directory and any relevant quarterly up-dates within ten (10) Calendar Days of the Offeror receiving the notice of enrollment from the State;
- All other Members receive the quarterly up-dates within ten (10) Calendar Days of publication of the up-dates, which shall occur on January 1, April 1, July 1, and October 1.

Describe how you will ensure that a Member receives a new Member ID Card whenever there has been a change in any of the information appearing on the Member ID Card, as required in 4.3.6.

The Member Telephone Hotline requirements are detailed in 4.3.7. Describe how you will fulfill these requirements, including:

- How you will route calls among hotline staff to ensure timely and accurate response to Member inquiries;
- What your after-hours procedures are;
- How you will ensure that the telephone hotline can handle calls from non-English speaking callers and from Members who are hearing impaired, including the number of hotline staff that are fluent in one of the State-identified prevalent non-English languages; and
- How you will monitor compliance with the performance standards and what you will do in the event the minimums are not being met.

The internet presence and Web site requirements are detailed in 4.3.8. Describe how you will fulfill these requirements, including:

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

HHS has created standards for culturally and linguistically appropriate services (CLAS). In meeting the requirements in 4.3.9 provide the following:

- An explanation of how your organization has incorporated CLAS into its practice;
- If you are not using CLAS, an explanation of the mechanism you are utilizing to ensure a culturally competent environment;
- An identification and detailed explanation of any mandates, guidelines and/or strategies currently being applied to your practice;
- An explanation of your culture competence policies and procedures as they relate to:
  - Support staff recruitment;
  - Performance measures;
  - Professional development;
  - Fiscal planning;

    - Translation of educational materials and methods for meeting the literacy needs of Members;
    - Evaluation of the quality and appropriateness of interpretation and translation services provided; and
    - Community outreach with individuals with limited English proficiency;
- An explanation of the mechanism in place to monitor the application of the standards; and
- The impact CLAS has on your staff, Members and operations.

Describe how you will notify all Members of the availability of oral translation services as described in 4.3.10.

Describe the procedures a Member Services representative will follow to address the following situations:

- A Member has received a bill for payment of Covered Services from a Network Provider;
- A Member is unable to reach her PCP after normal business hours; and
- A Member becomes ill while traveling outside of the Service Region.

Required Attachments

- The proposed Member Handbook or a Member Handbook you are using in another Medicaid managed care program;
- The proposed Cultural Competency Plan described in 4.3.9; and
- A sample Member ID Card.

5.1.2.4 Marketing (2-3 pages unless more are required to address sanctions or corrective actions)

Please provide the following narrative in your proposal to explain how you will fulfill the Marketing requirements as described in 4.4.

Describe the marketing activities in which you will engage as it relates to the GCS program.

Describe how you will monitor your Network Providers' marketing activities as described in 4.4.4.

If you have ever been sanctioned or placed under corrective action by CMS or another state for prohibited Marketing practices related to managed care products, describe the basis for each sanction or corrective action and your current status with CMS or the affected state.

Required Attachments

The proposed marketing plan.

5.1.2.5 Covered Benefits and Services (6-7 pages)

Please provide the following narrative in your proposal to explain how you will fulfill the Covered Benefits and Services requirements as described in 4.5.

Discuss your experience providing, on a capitated basis, the Covered Services described in 4.5.1. This description should indicate:

- The extent to which you have experience providing these Covered Services for a population comparable to the GCS population;
- Which Covered Services you do not have experience providing to a comparable population; and
- Your proposal for providing these Covered Services, including whether or not you plan to use a subcontractor to provide any Covered Services and, if so, how you will monitor and provide oversight of all subcontractors.

Describe how you will fulfill the requirement to provide, as described in 4.5.2, enhanced services to Members that emphasize health promotion and education.

Describe how you will encourage Members to be responsible for their own health and well-being and to prudently use the health care system in a manner that promotes good health.

Describe any health care service(s), in addition to the required Covered Services and enhanced services in 4.5.1 and 4.5.2, which you plan to provide to Members and how these services will be provided.

In accordance with 42 CFR 438.102 you may file an objection to provide, reimburse for, or provide coverage of, counseling or referral service for a Covered Service based on moral or religious grounds, as described in 4.5.5. Please indicate objections, if any, to providing a Covered Service based on moral or religious grounds and identify the specific service(s) to which you object and describe the grounds for your objection(s). Please note that your submitted CRCS(s) should reflect the objections.

5.1.2.6 Special Coverage Provisions (7-8 pages with 3-4 pages specifically addressing the delivery of mental health and substance abuse services)

Please provide the following narrative in your proposal to explain how you will fulfill the Special Coverage Provisions requirements as described in 4.6.

Describe how you will ensure that there is sufficient access to family planning services as described in 4.6.4 and specify the efforts you will make to include Title X clinics in your network.

Detail how you will develop and monitor a prescription drug formulary as described in 4.6.6. Specify whether you will subcontract with a Pharmacy Benefits Manager (PBM) and if so, the nature of the functions to be performed.

As described in 4.6.7, discuss how you will ensure that all Providers use vaccines available free under the Vaccines for Children (VFC) program or under the Vaccine Replacement Program.

DCH has contracts with several non-emergency transportation (NET) brokers on a regional basis. Describe how you will fulfill the requirement described in 4.6.8 that you collaborate with these vendors to provide services to Members.

Describe your perinatal services policies including your health promotion and education programs for all women of reproductive age women and your childbirth education classes for pregnant women as described in 4.6.9. Specifically address how you will target women in non-traditional settings, such as at schools and how you will identify women with greater need of such services. Also provide a synopsis of your parenting education classes as described in 4.6.10.

Describe your planned approach to delivering mental health and substance abuse services to Members as described in 4.6.11. Specify whether you will sub-contract with a behavioral health organization (BHO) and describe your approach to coordinating mental health and substance abuse services with services delivered by a Member's PCP. In addition, describe or propose any innovative programs or integrated medical/mental health and substance abuse delivery models. Specifically address how you will provide services to each of the following populations:

- Pregnant and parenting substance abusers;
- Children and adolescents; and
- Limited English speakers and minorities.

As discussed in 4.6.12 detail your methods for educating Members about Advance Directives.

Describe how you will monitor Providers' collection of applicable Member co-payments as required in 4.6.13.

5.1.2.7 EPSDT (2-3 pages)

Please provide the following narrative in your proposal to explain how you will fulfill the EPSDT requirements as described in 4.7.

Describe your outreach and informing process. In particular, address how you will inform all newly enrolled families with Health Check eligible children about the program and how you will monitor needed assessment and services as described in 4.7.2. In addition, detail how you will ensure that all Health Check eligible children receive services according to the periodicity schedule and how you will coordinate with PCPs to ensure that Members' parents or guardians schedule appointments when Members are out of compliance with the Health Check periodicity schedule.

Explain if, and how, you will provide any non-cash incentives to Members or their parents or guardians to motivate compliance with periodicity schedules.

Provide a description of your required lead case management program as described in 4.7.3.

Describe the tracking system you will implement to comply with the requirements described in 4.7.4.

Describe the procedures you will follow to address the following situations:

- A parent who is not adhering to periodicity schedules; and
- A parent who is not following up with the children's referrals for diagnostic treatments services.

5.1.2.8 Provider Network (8-10 pages)

Please provide the following narrative in your proposal to explain how you will fulfill the Provider Network requirements as described in 4.8.

Indicate which, if any, Covered Services are not available from a qualified Provider in your proposed Network in each Service Region and how you propose to provide these Covered Services. Briefly describe how deficiencies will be addressed when the Provider Network is unable to provide a Member with appropriate access due to the lack of a qualified, In-Network Provider within the travel distance of the Member's residence. In particular, describe how you will address deficiencies in the following areas:

- Lack of an age-appropriate PCP with an open-panel within the required travel distance of a Member's residence;
- For females, lack of an OB/GYN with an open panel within the required travel distance of a Member's residence;
- Lack of a cardiologist within the required travel distance of the Member's residence; and
- Lack of dental services within the required travel distance of the Member's residence.

Describe the steps you will take to ensure that your Provider Network is ethnically diverse and similar to the demographic profile of your Members.

Describe steps you have taken in the past when you have identified:

- A deficiency in compliance with travel time and distance access standards; or
- A Provider that is not meeting with state appointment access standards.

Explain your procedures for ensuring that PCPs fulfill their responsibilities for supervising and coordinating all care for their assigned Members as described in 4.8.2. Describe your criteria for permitting Members with chronic conditions to select a specialist as his or her PCP.

As described in 4.8.4, you are required to contract with all Significant Traditional Providers (STPs) who meet your credentialing standards and accept your payment rates. Explain how you would address the situation in which a STP does not meet your credentialing requirements but is needed in your Network in order to meet the geographic access standards described in 4.8.12.

Describe the steps you will take to include community service boards (CSBs) and family planning clinics, including Title X Clinics, in your Network as required in 4.8.8 and 4.8.10.

Describe how you will ensure that all maximum travel times and waiting times for appointments are met, as required in 4.8.12 and 4.8.13.

As required by 4.8.14, describe your minimum credentialing and/or licensing requirements and procedures for Providers, by type, and demonstrate how you will ensure that minimum credentialing requirements are met by any Provider rendering services.

Describe your re-credentialing procedures and timing and explain how you will capture and assess:

- Member Grievances and Appeals;
- Results from quality reviews and Provider profiling
- Utilization Management Information; and
- Information from licensing and accreditation agencies.

Describe the percentage of providers in another state in which you are operating who have been re-credentialed by type. Also describe if, and how, you will help a STP meet your credentialing requirements who does not yet do so but has expressed an interest in doing so.

Describe how you will ensure that your Providers are not intentionally segregating Members from other persons receiving services from them.

Describe how you will coordinate services for those Members receiving services from other entities as required in 4.8.16. Provide examples of ways you have coordinated care in other states in which you have operated.

Provide a brief summary of your policies and procedures for addressing network changes.

Required Attachments

- Complete listings of proposed Network Providers for each Service Region. Include in this list the Provider type, name, address, and Medicaid number. Provide a list of:
  - Acute care hospitals;
  - Hospitals providing trauma care, by trauma level;
  - Hospitals designated as transplant centers;
  - Hospitals designated as children's hospitals;
  - Other hospitals with specialized pediatric services;
  - Psychiatric hospitals;
  - Mental health and substance abuse Providers, including clinics and other facilities;
  - All PCPS;
  - Pharmacies;
  - Laboratories; and
  - Specialists by type;

- A copy of Appendix J of this RFP on which you have marked those STPs with whom you have Provider Letters of Intent;
- Provider Letters of Intent; and
- Tables to demonstrate that you will fulfill the geographic access requirements as described in 4.8.11. These tables should be created using GeoAcess or a comparable software program.

5.1.2.9 Provider Services (3-4 pages)

Please provide the following narrative in your proposal to explain how you will fulfill the Provider Services requirements as described in 4.9.

Provide a description of your proposed education and training activities for Providers and office staff as described in 4.9.3.

The Provider Telephone Hotline requirements are detailed in 4.9.5. Describe how you will fulfill these requirements, including:

- How you will route calls among hotline staff to ensure timely and accurate response to Provider inquiries;
- What your after-hours procedures are, specifically related to verifying enrollment for Members; and
- How you will monitor compliance with the performance standards and what you will do in the event the minimums are not being met.

The Web site requirements are detailed in 4.9.6. Describe how you will fulfill these requirements, including:

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

Discuss how you will fulfill the Provider Complaint System requirements as described in 4.9.7.

5.1.2.10 Provider Contracts and Payments (3 pages)

Please include the following narrative in your proposal for meeting the Provider Contracts and Payments requirements as described in 4.10.

Discuss your approach for fulfilling the Provider Contract requirements described in 4.10.1.5.

Discuss your plan for fulfilling the Provider Termination requirements described in 4.10.2 and discuss how you plan to ensure that DCH and your Members are notified as described in 4.10.2.2 and 4.10.2.3.

Discuss your plan for fulfilling the Provider Insurance requirements described in 4.10.3.

Discuss your plan for fulfilling the Provider Payment requirements in 4.10.4, including how you will issue IRS Form 1099s to Providers in accordance with Federal regulations and/or guidelines.

Required Attachments

A Sample Provider Contract.

5.1.2.11 Utilization Management and Care Coordination Responsibilities (7-8 pages)

Include the following in your proposal for meeting the Utilization Management (UM) and Care Coordination requirements as described in 4.11.

In fulfilling the requirements in 4.11.1 provide the following:

- Description of the UM guidelines you plan to employ, including whether and how the standards comply with the standards in 4.11.1;
- Description of the process by which the UM guidelines were developed and when they were developed or last revised;
- Description of how the UM guidelines will generally be applied to authorize or retrospectively review services for the spectrum of Covered Service;
- Description of how you will use your UM activities to reduce ER use for non-emergency services; and
- Discussion of any special issues in applying UM guidelines for mental health and substance abuse services and for disease management services.

In fulfilling the requirements in 4.11.2 and 4.11.3 provide the following:

- A description of how you will assure that prior authorization requests are responded to within the required timeframes; and
- A description of your proposed prior authorization process, including how prior authorization will be applied for members requiring out-of-network services or services for conditions that threaten the member's life or health.

Describe your proposed continuity of care transition plan for serving new members, including how you will ensure that service authorizations issued prior to enrollment in your CMO plan will be honored and how you will transition Members whose current PCP, OB/GYN or specialty care providers, including mental health substance abuse providers, are not participating in your Network.

In fulfilling the requirements in 4.11.7 provide the following:

- A description of your proposed method of providing care coordination and case management, including how you will identify members who have the greatest need,

and the procedures and timelines for conducting needs assessments and developing treatment plans;

- A description of your prior experience providing care coordination and case management to members with catastrophic or other high risk or high cost conditions.
- Description of any measurable results in terms of clinical outcomes and program savings that have resulted from your prior care coordination and case management activities; and
- A brief description of the analyses used to identify such outcomes and savings.

In fulfilling the requirements in 4.11.8 provide the following:

- A description of your prior experience implementing a disease management program;
- A description of any measurable results in terms of clinical outcomes and program savings that have resulted from your disease management activities; and
- Identification of the process by which you propose to provide disease management, including the diseases you propose to address, how Members requiring disease management services will be identified, the outreach approach, and disease management program components for Members of different risk levels.

5.1.2.12 Quality Improvement (8-10 pages)

Include the following narrative in your proposal for meeting the Quality Improvement requirements as described in 4.12.

In fulfilling the requirements in 4.12.2 and 4.12.3 provide the following:

- Descriptions of data-driven clinical performance improvement projects you have initiated within the past twenty-four (24) months that have yielded improvement in clinical care for a managed care population comparable to the GCS population;
- Documentation of two (2) statistically significant improvements generated by your clinical performance improvement projects;
- Description of two (2) new or ongoing clinical performance improvement projects you propose to pursue in the first (1^{st}) year of the Contract. Document why each topic warrants quality improvement investigation, and describe your measurable goals for the projects;
- Discussion of the steps, if any, you propose to take to improve delivery of preventative services and immunization for children;
- Discussion of any non-clinical performance improvement projects you have undertaken and analysis of their impact;
- Description of how you will conduct the required clinical performance improvement projects;
- Efforts you have made to assess Member satisfaction during the past year for a managed care population comparable to the GCS population;
- Efforts you have made to assess Provider satisfaction during the past year;

- Identification of HMO-level statistical clinical indicator measures (such as HEDIS or another similarly standardized product) which you will generate to identify HMO program-level opportunities for clinical quality improvement;
- Examples of statistical clinical indicator measures generated during 2003-2004 for a managed care population comparable to the GCS population; and
- A description of how you will, or propose to, conduct Provider profiling of the quality of care delivered by network PCPs and any other acute care providers (e.g., high volume specialists, and hospitals), including the methodology for determining which and how many Providers will be profiled. Also include a description of the rationale for selecting the performance measures presented in the sample profile reports, and the proposed frequency with which you will distribute quality provider profile reports to Network Providers and identify which Providers will receive such reports.

Describe how you will actively work with Network Providers to ensure accountability and improvement in the quality of care provided by the Providers. The description should include:

- The explicit steps you will take to follow-up with each profiled Provider, including a description of how you will motivate and facilitate improvement in the performance of each profiled provider;
- The process and timeline you propose for periodically assessing Provider progress on implementation of strategies to attain improvement goals;
- How you will reward Providers who demonstrate continued excellence and/or significant performance improvement over time, through non-financial or financial means;
- How you will share best practice methods or programs with Providers;
- How you will take action with Providers who demonstrate continued unacceptable performance and performance that does not improve over time; and
- The steps you will take with Providers who are not meeting contractual access standards.

In fulfilling the requirements in 4.12.4 regarding practice guidelines provide the following descriptions:

- Two (2) clinical practice guidelines that are relevant to the GCS population and that you believe are currently not being adhered to at a satisfactory level;
- The steps that you will take to increase compliance with the clinical practice guidelines noted above; and
- Your process for developing, updating, and disseminating clinical practice guidelines to Network Providers.

As described in 4.12.5 two (2) focused studies will be required starting in the second (2^{nd}) year of operations. Describe any focused studies you have conducted during the previous year and the impact they have had on your quality of care.

Required Attachments

- If applicable, provide a copy of your 2004 Quality Assessment and Performance Improvement (QAPI) Program. If you did not operate a Medicaid or SCHIP managed care plan in 2004, provide a copy of your most recent QAPI plan for a population comparable to the GCS population; and
- Sample Provider profile reports you use or propose to use (identify which).

5.1.2.13 Fraud and Abuse (2-3 pages)

Please provide the following narrative in your proposal for meeting the Fraud and Abuse requirements as described in 4.13.

Discuss your approach for meeting the program integrity program requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services under the Contract as described in 4.13.1 and 4.13.2.

Discuss your approach for meeting the pharmacy lock-in program as described in 4.13.2.2.

Discuss your approach for meeting the coordination with DCH and other agencies requirements as described in 4.13.3.

5.1.2.14 Internal Grievance System (2-3 pages)

Please provide the following narrative and attachments in your proposal for meeting the Internal Grievance System requirements as described in 4.14.

Discuss your approach for meeting the general requirements as described in 4.14.1 and describe your plan to:

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

Discuss your approach for meeting the Grievance Process requirements as described in 4.14.2 and describe your plan to ensure that disposition of the Grievance will be issued within ninety (90) Calendar Days.

Discuss your approach for meeting the Appeal Process requirements as described in 4.14.4 and describe your plan to:

- Ensure that the disposition of the Appeal will not exceed forty-five (45) Calendar Days;
- Ensure that the disposition will not exceed seventy-two (72) hours for expedited Appeals; and
- Ensure that the timeframe will be extended by fourteen (14) Calendar Days if the Member requests an extension and the extension is in the Member's best interest.

Discuss your approach for meeting the Administrative Law Hearing requirements as described in 4.14.6.

Discuss your approach for meeting the Continuation of Benefits requirements as described in 4.14.7 and include your plan to:

- Ensure that benefits are provided to eligible Members that request continuation in accordance with the timeframes specified;
- Recover costs from the Member if the final disposition is adverse to the Member and the services were provided at the Member's request as described in 4.14.7.

Required Attachments

A sample Notice of Adverse Action.

5.1.2.15 Administration and Management (5-6 pages)

Please provide the following narrative and attachments in your proposal for meeting the Administration and Management requirements as described in 4.15.

Discuss your approach for meeting the place of business and hours of operation requirements as described in 4.15.2.

Discuss your approach for meeting the training requirements as described in 4.15.3.

Discuss your approach for meeting the data certification requirements as described in 4.15.4.

Discuss your approach for meeting the implementation requirements as described in 4.15.5 and include:

- A detailed description of the Offeror's project management methodology. The methodology must address, at a minimum, the following:
    - Issue identification, assessment, alternatives analysis and resolution;
    - Resource allocation and deployment;
    - Reporting of status and other regular communications with DCH, including a description of the Offeror's proposed method for ensuring adequate and timely reporting of information to DCH project personnel and executive management; and
    - Automated tools, including use of specific software applications.

- A work plan for the implementation of GCS. At a minimum the work plan will include the following:
    - Tasks associated with the Offeror's establishment of a "project office" or similar organization by which the Offeror will manage of the implementation of GCS;
    - An itemization of activities that the Offeror will undertake during the period between the awarding of this procurement and the start date of the GCS program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP;
        - An estimate of person-hours associated with each activity in the Work Plan;
        - Identification of interdependencies between activities in the Work Plan; and
        - Identification of Offeror expectations regarding participation by DCH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DCH will be responsible.

- A Risk Management Plan that at a minimum addresses the following contingency scenarios that could be encountered during implementation of the program:
    - Delays in building the appropriate Provider Network as stipulated in 4.8;
    - Delays in building and/or configuring and testing the information systems within the Offeror's Span of Control required to implement the GCS program;
    - Delays in hiring and training of the staff required to operate program functions;
    - Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;
    - Delays in enrollment processing during the implementation of GCS;
    - Delays in the publication of marketing and related materials and/or the delivery of these materials to DCH and/or its agents

- For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:
    - Risk identification and mitigation strategies;
    - Risk management implementation plans; and
    - Proposed or recommended monitoring and tracking tools.

Required Attachments

- A Work Plan, generated in Microsoft Project or similar software product, that includes the aforementioned implementation activities along with the timeframes, person-hours and dependencies associated with these activities;
- A roster of the members of the proposed implementation team including the group that will be responsible for initial Provider recruitment; and
- A resume of the Implementation Manager, the primary person responsible for coordinating implementation activities and for allocating implementation team resources

5.1.3.16 Claims Management (5-6 pages)

Please provide the following narrative and attachments in your proposal for meeting the Claims Management requirements as described in 4.16.

Describe your plan to support the automated clearinghouse that will allow providers to request and receive electronic funds transfer for claims payments as described in 4.16.1.5.

Describe your plan to encourage your network providers to utilize electronic claim filing as described in 4.16.1.6.

Discuss the processes that will ensure that claims submitted by providers who are excluded or suspended from the Medicare, Medicaid or S-CHIP programs for fraud, abuse or waste are not paid as required in 4.16.1.8.

Describe the methodology you will use to determine accounts payable associated with claims incurred but not paid.

Required Attachments

- A recent copy of a claims payment performance report for your largest Medicaid program customer;
- A recent copy of a claims report for incurred but not paid claims for your largest Medicaid program customer;
- A sample copy of an explanation of benefits (EOB); and
- A summary of the denial rates by EOB code.

5.1.3.17 Information Management and Systems (45 pages including tables and diagrams)

Please respond to the following as part of your proposal for meeting the Information Management and Systems requirements as described in 4.17:

(1) Provide a detailed profile, preferably in tabular form, of the information systems, including Web sites and Web accessible Systems, within your Span of Control that will be used to perform the following information management and systems functions (refer as needed to Model Contract Attachment L1 for more detail on data and document management requirements by major information type):

- Maintenance of Member enrollment and other Information, both current and historical;
- Maintenance of Claims Information (and/or equivalent Encounter Information for Providers with whom the Offeror has a capitated arrangement), both current and historical;
- Maintenance of authorization and care coordination Information, both current and historical;
- Maintenance of Provider Network and other Information;

- Maintenance of EPSDT-specific Information;
- Maintenance of Information related to Member health status and outcomes;
- Maintenance of Offeror financial data;
- Maintenance of Information related to interactions with Members and Providers, including Grievances, Appeals and Complaints;
- Maintenance of internal operations data, e.g. call center statistics, System availability and performance, information security incidents, system problems and changes;
- Maintenance of Information related to reported incidents that may have compromised patient safety;
- Maintenance of data collected via client satisfaction surveys;
- Maintenance of Information related to program integrity and compliance activities;
- Generation of the reports stipulated in 4.18;
- Processing of Claims including electronic submission and, where applicable, automated and/or rules-based adjudication; and
- Processing of other interactions and transactions between the Offeror and its Enrollees and between the Offeror and Providers including but not limited to: Provider applications for network participation; Member and/or Provider inquiries, suggestions, Complaints, Grievances and Appeals; etc.

In the Systems profile, please indicate whether these systems will be:

- Used solely for the administration and management of GCS activities, or
- Multi-client Systems, where information and transactions related to the GCS program will be captured and/or processed along with Information and transactions of other clients of the Offeror and/or its subcontractors.

Additionally, as part of your Systems profile indicate:

- Name and version/release level of each application (e.g. Microsoft Word 2003)
- Operating hardware vendor and model/series ID (e.g. SUN Microsystems Sunfire 4800 Series);
- Operating system vendor and ID along with version/release level (e.g. SUN Microsystems Solaris version 8); and
- Whether operation of the application and/or operating hardware is being outsourced to a third party; if so, indicate the third party to which the operation is or will be outsourced and the location of this operation.

Finally, describe the effort and technology that will be required for the applicable Systems to be Web accessible as required in 4.3.8, 4.9.6 and 4.17.1.3.

(2) Describe how you will meet the Global Systems Architecture and Design requirements specified in 4.17.2; in your description specifically address:

- How your Systems will employ a relational data model as described in 4.17.2.2.1;
- How your systems will be SQL and ODBC compliant as described in 4.17.2.2.2;
- Compliance with IETF/IESG standards as described in 4.17.2.2.3;

- How your Systems will adhere to the standard code sets identified in 4.17.2.2.4;
- How your Systems will conform to HIPAA standards as described in 4.17.2.2.5;
- How your Systems will maintain information integrity as described in 4.17.2.2.6;
- How you will partner with the State to develop future code sets not specific to HIPAA as described in 4.17.2.2.7; and
- How the Systems and telecommunications infrastructure within your Span of Control will, where applicable, conform to Georgia Technology Authority (GTA) standards as described in 4.17.1.3

(3) Describe your plan to incorporate audit trails to allow Information on data files and documents to be traced through the processing stages to the point where the Information is finally recorded as described in 4.17.2.4.

(4) Describe how, as required in 4.17.2.4.6, you intend to retain data and documents stored and maintained in your Systems for no less than seven (7) years in either live and/or archival systems, and how you will accommodate State requests to extend the retention period as needed for ongoing audits or other purposes.

(5) Describe your plan to store and codify documents used by Members and Providers to interact and/or transact with you so as to maintain the logical relationships between certain documents and certain data as described in 4.17.2.5. Additionally, explain how you will enable data and documents related to the same entity (i.e. Member, Provider, Claim) to be accessible via a singular process and/or System.

(6) Describe the processes and tools you will employ to ensure the validity and completeness of the data you submit to DCH as described in 4.17.2.6.

(7) Describe how you will adopt HIPAA-standard protocols for information exchange indicated in Attachment L3 of the Model Contract and cite at least three (3) currently-live instances where you have implemented these protocols.

(8) Explain, preferably in tabular form, how you will meet the Data and Document Management Requirements by Major Information Type specified in 4.17.3 (refer to Model Contract Attachment L1 as needed).

(9) Describe how you will meet the System and Data Integration Requirements specified in 4.17.4; at a minimum please address the following:

- How your Systems would be able to interface bi-directionally and/or exchange data with the State's MMIS (refer to Model Contract Attachment L5 as needed);
- How your Systems will provide Encounter data to DCH and/or its agent(s);
- Cite at least three (3) currently-live instances where you have successfully provided Encounter Information to another state's MMIS, DSS or other third party in accordance with the state's standards and specifications, with at least two of these instances involving the provision of Encounter Information from providers with whom you have capitation arrangements;

- How your Systems would be able to generate files as needed for upload into state Systems used specifically for program integrity and compliance purposes; and
- How your systems will standardize mailing addresses in accordance with US Postal Service conventions.

(10) Describe your plan to meet System Access Management and Information Accessibility Requirements described in 4.17.5. At a minimum the plan should address:

- How you will employ a function that manages access to Information contained in Offeror Systems while restricting access based on various hierarchical levels of System functionality and Information and blocking System access after repeated failed access attempts as described in 4.17.5.1; and
- How you will provide for prompt transfer of System Information upon request to other In-Network or Out-of-Network Providers as described in 4.17.5.3.

(11) Describe your plan to meet the Systems Availability and Performance Requirements described in 4.17.6; at a minimum the plan will address:

- How you will measure System availability and performance within your Span of Control, including what processes and tools would be used for this purpose;
- Per 4.17.6.1, how you will ensure that certain System functions will be available twenty-four (24) hours a day, seven (7) days a week or, alternatively, what the availability standard is that you expect to achieve;
- How you will ensure that response times within your Span of Control meet the performance standards described in 4.17.6.3 and what corrective actions you will take at times when these are not being met;
- How you will develop an automated method of monitoring the CCE and ECM functions as described in 4.17.6.4;
- Your business continuity/disaster recovery (BC-DR) plan, including how will use options such as cold sites, hot sites, backup data centers, data storage vaults and telecommunications network redundancy to ensure business continuity and the ability to expeditiously recover from a disaster;
- How you will test your BC-DR plan as described in 4.17.6.13 and 4.17.6.14. If a third party will be involved in the testing of the BC-DR plan, please identify the third party; and
- How you will, as needed update your BC-DR plan. If a third party will be involved in the updating of the BC-DR plan, please identify the third party.

(12) Describe your plan to meet the System User and Technical Support Requirements described in 4.17.7 and discuss:

- How you will provide access to your Systems Help Desk services to DCH staff and other assigned agencies as described in 4.17.7.1;
- How you will ensure that you will meet the performance standards specified in 4.17.7.5; and

- How you will implement an IT service management system that provides an automated method to record, track, and report questions and problems reported to the Systems Help Desk as described in 4.17.7.6.

(13) Describe your plan to meet the System Change Management Requirements as described in 4.17.8 and discuss:

- How you will comply with the notification requirements and performance standards described in 4.17.8.2 and 4.17.8.3;
- How you will ensure that the State is safeguarded from unauthorized modifications to your Systems;
- How you will accommodate State requests to reject application of a proposed system change to a Offeror's system if the State concludes that it is not in its best interest for the change to be promoted;
- How you will build and operate test regions that emulate the functionality of live, production Systems and hold a representative sample of System Information such that accurate System performance modeling and testing can be performed in these regions; and
- How you will provide the State with access to the test regions of your Systems as needed to perform tests of a System change prior to its promotion.

(14) Describe your plan to meet the System Security and Information Confidentiality and Privacy Requirements as described in 4.17.9 and discuss:

- How you will provide for the physical safeguarding of data processing facilities as described in 4.17.9.1 through 4.17.9.3;
- How the Offeror will put in place procedures and measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a Offeror edge router's Span of Control, as outlined in 4.17.9.4; and
- How you will ensure compliance with the confidentiality requirements as described in 4.17.9.6;
- The security tools and procedures that you will build into all Web portals (Member, Provider, DCH System user),how you will ensure that these are in accordance with GTA standards and guidelines and how you expect these to prevent unauthorized access to Systems and/or Information and/or System availability and performance problems; and
- How you will provide DCH and/or its agent(s) with Information on proactively identified and/or reported security incidents including attempted "hacks" into Systems within your Span of Control.

(15) Describe your plan to meet the Information Management Process and Information Systems Documentation Requirements as described in 4.17.10. At a minimum, the plan will address:

- The periodicity of "background" document reviews, i.e. reviews that are not tied to a specific event that triggers a document change;

- How each type of document will be updated after an event that triggers a change in the document;
- How each type of document will be made available to DCH; and
- How DCH will be notified of a change in these documents.

(16) Summarize, preferably in tabular form, how your Systems will provide functionality which at a minimum is equivalent to the functionality provided at present via the Georgia Health Partnership (GHP) Web portal. Where the equivalent functionality will not be available on the Operational Start Date, please indicate when you plan for the functionality to be available, expressed as a date following the Operational Start Date, and what effort and technology will be required for the functionality to be available on that date. For reference, the GHP portal can be accessed at http://www.ghp.georgia.gov.

(17) Provide a Systems refresh plan, as noted in 4.17.1.6, which describes how you propose to systematically assess the need to modify, upgrade and/or replace System application software, System operating hardware and software, telecommunications capabilities, information management policies and procedures, and Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. Indicate in your Systems refresh plan how you will ensure that you will not operate System components (application software, operating hardware, operating software) which are not formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the System component.

(18) Describe the methodologies you currently follow for: Identifying, developing and finalizing System requirements;
- Managing the life cycle of application development within your enterprise and that of your Systems contractors; and
- Conducting technical and usability testing of Systems before their implementation.

(19) Provide, preferably in tabular form, a profile of your Information Management and Systems (IM&S) organization – i.e. in-house or outsourced operation within your Span of Control - that includes an organizational chart and a roster by job type/class of: number of in-house or outsourced IM&S staff, average years of experience in the IM&S field, and average number of years working in the IM&S organization.

Required Attachments

- Diagrams that illustrate (a) point-to-point interfaces, (b) Information flows and (c) the networking arrangement (AKA “network diagram”) associated with the information systems profiled in (1). These diagrams should provide insight into how your Systems will be organized and interact with DCH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the GCS program.

- Samples of System design and management manuals, System user manuals and System user quick reference guides.

5.1.2.18 Reporting Requirements (2 pages)

Describe, and if applicable or beneficial illustrate, the processes by which reports will be generated and accessed, in accordance with the reporting requirements specified in 4.18.

5.1.2.19 Financial Management (4 pages)

Include the following narrative in your proposal for meeting the Financial Management requirements as described in 4.19.

Describe and document how you will establish and maintain financial viability standards for net worth, working capital and financial reserves, as required pursuant to State law.

Describe how you will ensure that Members and Providers shall not be liable for your debt in the event of insolvency.

Describe the processes you will follow to estimate and track liability associated with claims incurred but not reported, and explain how these processes are actuarially sound.

Describe and document how you will obtain Reinsurance that meets all DOI requirements.

Describe how you will meet the Third Party Liability and Coordination of Benefits requirements, at a minimum specifically address:

- The procedures to be implemented to identify the legal liability of third parties and recover costs; and
- The procedures to be implemented to meet cost avoidance requirements.

Describe your plan to meet Physician Incentive Plan requirements.

5.1.3 Proposed Organization and Staffing for the Project

Submit an organizational chart (Chart A) showing the structure and lines of responsibility and authority in your company.

Submit an organizational chart (Chart B) showing the Georgia organizational structure, including staffing and functions performed at the local level. Specifically show how you will organize, if you are operating in more than one (1) Service Region. If Chart B represents the entire organizational structure label the chart with both A and B.

If you are planning on using subcontractors for any major functions describe how they will be managed and monitored within your organizational structure.

Provide a brief narrative to explain the organizational charts submitted.

In order to demonstrate how you will fulfill the staffing requirements described in 4.20, for the positions listed below, provide a job description and qualifications, and a resume of the individual expected to hold the position (if known). If you are bidding on more than one (1) Service Region indicate whether the same person will serve in multiple Service Regions or which, if any, positions you will fill with different individuals in each Service Region.

- Executive Administrator;
- Medical Director;
- Quality Improvement/Utilization Director;
- Chief Financial Officer;
- Information Management and Systems Director;
- Mental Health Coordinator;
- Member Services Director;
- Compliance Officer; and
- Provider Services Director.

Provide information on staffing levels, job descriptions, and qualifications for staff in the following divisions:

- Member Services;
- Provider Services;
- Information Management and Systems;
- Quality Improvement;
- Provider Complaint and Member Grievances Systems; and
- Utilization Management.

Describe how you will fulfill the requirement set forth in 4.20 that staff are trained to ensure appropriate functioning in all areas. Specifically, describe your training curricula for:

- Member and Provider Services staff, including cultural competency curricula;
- Provider Relations staff;
- Staff responsible for prior authorization approvals;
- Information systems staff; and
- Provider Complaint and Member Grievance System staff.

5.2 PREPARATION OF PROPOSAL

Each proposal shall be prepared simply and economically, avoiding the use of elaborate promotional material beyond those necessary to provide a complete, accurate and reliable presentation.

All requested attachments shall be clearly labeled.

Offerors shall submit a separate proposal with the number of copies as required in 5.4 for each Service Region on which they are bidding.

5.3 PACKAGING OF PROPOSAL

The proposal may be submitted in one (1) shipping package. The outer shipping package must be plainly marked as:

Name of Company
Company Point of Contact
Telephone Number and E-mail Address
RFP # 41900-001-0000000027
April 4, 2005, 4:00 PM EST
Attn: Ms. Pat Dockery

Inside the package, the proposals must be divided into two sealed packages – a Technical Proposal and a Cost Proposal.

5.4 NUMBER OF PROPOSAL COPIES

Please submit an original (marked) and five (5) hard copies, plus ten (10) CD-ROMs (in Microsoft Word or Adobe Acrobat PDF format) of your Technical proposal. The Technical Proposal MUST NOT include any cost figures.

Please submit an original (marked) and five (5) hard copies, plus ten (10) CD-ROMs of your Cost Proposal in a separate sealed package.

5.5 SUBMISSION OF PROPOSALS

Proposals must be submitted to:

Department of Administrative Services
RFP # 41900-001-0000000027
State Purchasing Office
200 Piedmont Avenue, SE
Suite 1308 (Bid Room), West Tower
Atlanta, GA 30334-9010
Attn: Ms. Pat Dockery

All proposals must be received by April 4, 2005 in the above office no later than 4:00 P.M. Eastern Standard Time. Proposals received after the above date and time will not be considered. Faxed or e-mailed proposals will not be accepted.

5.6 INQUIRIES & COMMUNICATION WITH AGENCY STAFF

Questions about this RFP must be directed in writing, via e-mail only, to:

Ms. Pat Dockery

Department of Administrative Services
State Purchasing Office
200 Piedmont Avenue, S.E.
Suite 1308, West Tower
Atlanta, GA 30334-9010
pwdocker@doas.ga.gov

Please submit your questions in the following format only:

COMPANY NAME	
Question	**Referenced RFP Section**
1.	
2.	

From the date that this RFP is issued until CMO plans are selected and the selection is announced, Offerors are not allowed to communicate for any reason with any State employee other than the contracting officer listed above regarding this procurement. The state reserves the right to reject any proposal for violation of this provision.

No questions other than written will be accepted, and no response other than written will be binding upon the state. All binding answers to Offerors' inquires will be included in a formal addendum to this RFP posted to the web site. Any question received after the deadline for questions **may or may not** be answered by the State. Any additional questions answered will also be posted to the website with the RFP document and Addenda documents. Offerors are reminded and encouraged to check this website daily for any changes to the RFP.

5.7 REJECTION OF PROPOSALS / CANCELLATION OF RFP

The State of Georgia reserves the right to reject any or all proposals, to waive any irregularity or informality in a proposal, and to accept or reject any item or combination of items, when to do so would be to the advantage of the state or its taxpayers. It is also within the right of the state to reject proposals that do not contain all elements and information requested in this document. The State of Georgia shall not be liable for any losses incurred by the Offerors throughout this process. The State reserves the right to cancel this RFP at any time.

6.0 EVALUATION CRITERIA

The evaluation of proposals received for each Service Region, by the specified due date in Section 2.0, will be conducted in the following four (4) phases:

A) Administrative Review

The proposals will be reviewed by the DOAS contracting officer for the following administrative requirements:

(a) Separately sealed technical proposal and a separately sealed cost proposal;
(b) Only technical information is included in the technical proposal; and
(c) All documents requiring a signature have been signed and submitted.

B) Mandatory Requirements Review

The proposals that pass the administrative review will be reviewed by the DOAS contracting officer for completeness to ensure that all mandatory requirements, identified in Appendix A and 4.0, are submitted and addressed satisfactorily.

C) Technical Review

Technical Weighting Distribution:

The proposals that pass the mandatory requirements review will be technically reviewed for quality and completeness by technical evaluation team members. These proposals can receive a maximum of 700 Technical points. The following listing provides you with the maximum points available for each factor in the evaluation:

Mandatory Items	Pass/Fail
Background/Experience (5.1.1)	300
Planned Approach to Requirements (5.1.2)	300
Organization and Staffing (5.1.3)	100
	700 Technical Points

For those proposals that receive 525 or more Technical points, their scores will be adjusted to maintain the balance between the technical and cost components. The proposal with the highest score will be adjusted up to 700 points. All other Technical proposals with 525 or more Technical points (75% of 700 points) will receive a prorated technical score calculated using the following formula: P/H x 700 = V

Where: P = Technical score of the proposal being adjusted
H = Original technical score of the highest ranking proposal
V = Assigned points for proposal being adjusted

Proposals that do not receive 525 Technical points will be considered non-qualifying and will not be evaluated further.

D) Cost Review

Scoring

The proposals that pass the technical review with 525 or more Technical points will have their cost proposals (Appendix C) reviewed. Proposals will be scored following a rank and range methodology applied to each rate cell. Three hundred (300) points have been assigned to cost, two-thirds (200 points) of those points will be awarded based on rank. One-third (100 points) will be awarded based on range.

Rank and Range

Rank points will be awarded based on how a particular proposal ranked in terms of the other proposals within that geographic region. Full rank points (200) are awarded to the proposal passing the technical evaluation that has the lowest weighted total cost in a given geographic region. For scoring purposes, total costs for each region will be calculated based upon the Offeror's submission multiplied by the most recent available enrollment data (which will be provided at the cost proposal assistance session). Bids below the bottom of the rate range will be brought up to the bottom of the range for the purpose of rank scoring.

The remaining proposals passing technical evaluation are awarded points according to the following schedule:

Lowest cost	200 points
2nd lowest cost	160 points
3rd lowest cost	120 points
4th lowest cost	80 points
5th lowest cost	40 points
All remaining	0 points

Note: this schedule is based on awarding 5 (five) contracts in a region and may be adjusted accordingly for different numbers of qualified bidders.

Range points will be awarded based on how a particular proposal compares against the established actuarially sound rate range for each rate cell within a geographic region. The range is divided into quartiles and points set accordingly. Bids falling into the first quartile (the lower end of the rate range) receive the maximum number of range points (100). The quartiles are scored as follows:

More than 5% below the bottom of the range	50 points
No more than 5% below the bottom of the range	75 points
1st quartile	100 points
2nd quartile	75 points
3rd quartile	50 points
4th quartile	25 points
Above the top of the range	0 points

Bid rates falling within five percent (5%) below the bottom of the actuarial rate range will be awarded 75 range points, equivalent to those rates falling into the 2nd quartile. Bid rates more than five percent (5%) below the bottom of the actuarially sound rate range will be awarded 50 range points. Bids above the top of the rate range will have no range points awarded.

These two scoring components are designed to cover the competitiveness of a bid as well as the reasonableness of a bid by being within the rate range. An overall cost proposal score for each bidder will be calculated by adding the rank points awarded above to the weighted average range points. The weighted average range points will be calculated from the various rate cells using weights developed from the 2002 fee for service per member per month costs (Provided the data book) multiplied by the most recent enrollment data (which will be provided at the cost proposal assistance session).

The combined rank and range points establish the Offeror's cost proposal score subject to any Best and Final Offer process.

Offerors shall submit separate cost proposals for each Service Region on which they are bidding. To address any changes in health care costs between the time of proposal submission and the implementation in the Phase 3 Service Regions planned for December 1, 2006, prior to implementation, DCH will ensure that those rates remain actuarially sound. At a minimum DCH will make any appropriate adjustments to those proposed rates to reflect any programmatic changes and to reflect changes in health care costs based upon the medical component of the Consumer Price Index.

Quality Assessment Fee

DCH is anticipating approval to implement a quality assessment fee in the amount of 5.5%. However, this fee is subject to approval and the exact amount may change in either an upward or downward direction. Should the quality assessment fee change, DCH may issue an amendment to this RFP informing Offers of the change.

Best and Final Offers

DOAS reserves the right to conduct BFO in connection with this RFP. During the BFO, no Offeror may increase its total cost for any category of aid or any geographic region. Individual age/gender rate cells may be changed up or down as long as the weighted average rate for a category of aid or region does not increase. To ensure a competitive initial bid, if a BFO is conducted the initial cost proposal and the BFO cost proposal together will be worth a maximum of 300 points split 50% each. If an Offeror elects not to submit a BFO, their initial cost proposal will be based on the original 300 point system. At DCH's discretion, Offerors with rates outside the rate ranges may be offered a rate within the rate range and no BFO held.

6.1 IDENTIFICATION OF APPARENT SUCCESSFUL OFFEROR

The resulting Cost Proposal scores will be combined with the Technical Proposal scores to identify the apparent successful firms. In all Service Regions but Atlanta the Apparent

Successful Offerors will have the two highest combined scores. In the Atlanta Service Region the Apparent Successful Offerors will those three (3), four (4), or five (5) Offerors with the highest combined scores.

7.0 STANDARD TERMS AND CONDITIONS

7.1 ADDENDA

The state reserves the right to amend this RFP prior to the proposal due date. All addenda and additional information will be posted to the Georgia Procurement Registry, http://www.procurement.state.ga.us. Offerors should check this web page daily for new information.

7.2 COST FOR PREPARING PROPOSAL

The cost for developing the proposal is the sole responsibility of the Offeror. All proposals submitted become the property of the State.

7.3 CONTRACT DISCUSSIONS

Prior to award, the apparent successful firm may be required to enter into discussions with the State to resolve any contractual differences. These discussions are to be finalized and all exceptions resolved within one (1) week from notification. If no resolution is reached, the proposal may be rejected and discussions with the second highest scoring firm will be initiated.

7.4 CONFIDENTIALITY REQUIREMENTS

The staff members assigned to this project may be required to sign a departmental non-disclosure statement. All proposals, related materials, exhibits, documents, and samples submitted are subject to the Georgia Open Records Act. The State cannot protect proprietary data submitted in proposals.

7.5 ADA GUIDELINES

The State of Georgia adheres to the guidelines set forth in the American Disabilities Act (ADA). Provisions will be made to make your use of the required services provided easier and more accessible. We ask that you please call the Contracting Officer at 404- 657-6000 or, e-mail: wnorswor@doas.ga.gov, in advance if you require special arrangements. The Georgia Relay Center at 1-800-255-0056 (TDD Only) or 1-800-255-0135 (Voice) will relay messages for the speech and hearing impaired, in strict confidence.

7.6 FINANCIAL INFORMATION

In order to protect the interests of the citizens and taxpayers of the State of Georgia, the State will only enter into contracts with financially stable and viable entities. To that end, please provide sufficient data to lead the State to the conclusion that your firm has the financial capability to perform. As detailed financial data is generally proprietary and bidders do not wish such information to be part of the public record under the Georgia Open Records Act

(G.O.R.A.), the Department reserves the right to perform additional due diligence in this area, at the sole discretion of the Department, prior to award of any contract.

7.7 PROPOSAL AUTHORIZATION

In accordance with the provisions of the Official Code of Georgia Annotated 50-5-67(a) DCH and DOAS have determined that the use of competitive sealed bidding will not be practical or advantageous to the state in completing the acquisition of the services and/or commodities described herein. Competitive sealed proposals shall be submitted in response to this request in the same manner as competitive sealed bids. All proposals submitted as a result of this request shall be made in accordance with the provisions of the Georgia Vendor Manual, these instructions, and specifications. Evaluation worksheets are not available during the solicitation process, but are available after award under the Georgia Open Records Act, as are all other solicitation documentation.

Appendix A:
AGREEMENT TO MANDATORY PROJECT REQUIREMENTS

All mandatory requirements listed in the RFP are presented below. Offeror should indicate their understanding of these mandatory requirements and their agreement to satisfy these mandatory requirements by placing the word "Yes" by each requirement. Failure to place "yes" by each mandatory requirement may cause the Department to reject the proposal.

This checklist is provided for the convenience of Offerors, but it is the Offeror's responsibility to review the entire RFP and ensure response is made to all requirements.

Offerors must meet all of the following mandatory requirements to be considered for evaluation under this RFP.

Administrative Mandatory Requirements

_____A. The proposal must be divided into two (2) separately sealed packages – an original Technical proposal and copies and an original Cost proposal and copies.

_____B. The Offeror must have an approved Georgia Certificate of Authority from the Department of Insurance in all counties in the Service Regions in which the Offeror is bidding by April 4, 2005. A provisional certificate will suffice but the Offeror must have a final Certificate at least thirty (30) Calendar Days prior to implementation.

Technical Mandatory Requirements

_____C. The Offeror must have a minimum of three (3) years experience operating a full-risk Medicaid managed care program.

_____D. The Offeror must be willing and able to provide Covered Services to all assigned Members, whether chosen or Auto-Assigned, on the day GCS is operationalized in the Service Region.

_____E. The Offeror must have achieved National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Committee (URAC) accreditation in at least one (1) state by the date of proposal submission. The Offeror must achieve NCQA or URAC accreditation in the State of Georgia by the end of the third (3rd) year of this Contract.

_____F. The Offeror must not use, or propose to use, any offshore programming or call center services in fulfilling the requirements outlined in this RFP and in the attached Model Contract.

Authorized Signature

Print Name

Date

Appendix B:
REQUIRED CONTENT OF PROPOSALS

This appendix will identify what information should be submitted within your proposal in response to this RFP and the order in which it should appear.

Please indicate that the required documents are included within the technical proposal and the location of those documents by placing the word "Yes" by each requirement and specifying the page or reference number where that document is located. Failure to place 'yes' by each requirement **may** cause DCH to reject the proposal.

This checklist is provided for the convenience of Offeror, but it is the Offeror's responsibility to review the entire RFP and ensure response is made to all requirements. Unless otherwise indicated, Offerors must meet all of the following requirements to be considered for evaluation under this RFP.

Yes/No	Page/Ref. No.	
_____	_____	**1. Cover Letter** The proposal should contain a cover letter and introduction. This shall include: the company name; address and the name, telephone number, and email address of the person or persons authorized to represent the company regarding all matters related to the proposal; and the Service Regions on which you are bidding. Attach your actuarial certification letter.
_____	_____	**2. Completed Appendix B** The proposal must contain a completed Appendix B form (Required Content of Proposal).
_____	_____	**3. Proposal Form Letter** The proposal must contain a signed proposal form (Appendix D).
_____	_____	**4. Agreement to Mandatory Project Specifications** The Offeror must indicate its agreement to all of the Mandatory Specifications for this project by completing Appendix A.
_____	_____	**5. Contract Attestation** The Contract that the State intends to use is identified as Appendix E and will be published separately. The Offeror shall state they have read the contract and agree to abide by it unless the State chooses to open negotiatons over specific contract provisions.

Yes/No	Page/Ref. No.	
_____	_____	**6. Small or Minority Business Form** The Offeror should indicate its classification as a small or minority business by completing Appendix F.
_____	_____	**7. Summary of Understanding of the Proposed Services** The Offeror should indicate their understanding of the requested services and describe how it proposes to provide those services to the Department of Community Health.
_____	_____	**8. Insurance, Payment Bonds and Irrevocable Letter of Credit** The Offeror must provide the following information: A description of the level of insurance coverage your firm carries. Please identify all the insurance carrier(s) supplying coverage. Offerors do not have to have the insurance, payment bonds and irrevocable letter of credit required in the Contract to propose on the RFP; however, you must have a statement from your insurance provider, surety or bank, on their letterhead, stating that if you are awarded the contract, they will insure, bond or hold letters for the type and amounts of coverage and payment required in the contract. If an Offeror does not have insurance and submits a letter from their provider, they will have ten (10) Calendar Days to obtain ALL required insurance and submit to the DOAS Contracting Officer.
_____	_____	**9. Statement of Work** Please address each item in 5.1.1, 5.1.2, and 5.1.3 focusing on your ability to perform this required service for the State.

Appendix C:
COST PROPOSAL

Forthcoming

Appendix D:
PROPOSAL FORM LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposals (RFP) for which prices have been set. The price or prices offered herein shall apply for the period of time stated in the RFP.

We further agree to strictly abide by all the terms and conditions contained in the Georgia Vendor Manual (http://www.doas.state.ga.us) as modified by any attached special terms and conditions, all of which are made a part hereof.

It is understood and agreed that this proposal constitutes an offer, which when accepted in writing by State Purchasing, Department of Administrative Services, State of Georgia and the Department of Community Health and subject to the terms and conditions of such acceptance, will constitute a valid and binding contract between the undersigned and the state of Georgia.

It is understood and agreed that we have read the state's specifications shown or referenced in the RFP and that this proposal is made in accordance with the provisions of such specifications. By our written signature on this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such state specifications. We further agree, if awarded a contract, to deliver goods and services that meet or exceed the specifications.

It is understood and agreed that this proposal shall be valid and held open for a period of one hundred eight (180) Calendar Days from proposal opening date.

PROPOSAL SIGNATURE AND CERTIFICATION

I certify that this proposal is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a proposal for the same materials, supplies, equipment, or services and is in all respects fair and without collusion or fraud. I understand collusive bidding is a violation of state and federal law and can result in fines, prison sentences, and civil damage awards. I agree to abide by all conditions of the proposal and certify that I am authorized to sign this proposal for the Offeror. I further certify 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.

I also certify that I have read the Model Contract (Appendix E) and agree to abide by all terms and conditions unless the State chooses to open negotiations over specific Contract provisions.

I also certify that I, and my Lobbyists, have complied with the Lobbyist Registration Requirements in accordance with the Georgia Vendor Manual.

Authorized Signature_____Date_____

Print/Type Name_____

Print/Type Company Name Here_____

Appendix E:
CONTRACT

STATE OF GEORGIA

(DEPARTMENT OF COMMUNITY HEALTH)

THE GEORGIA CARES PROGRAM FOR THE STATE'S MEDICAL ASSISTANCE AND PEACHCARE FOR KIDS PROGRAMS

CONTRACT NUMBER (41900-001-0000000027)

To Be Printed Under Separate Cover

Appendix F:
SMALL OR MINORITY BUSINESS FORM

Can your company be classified as a **SMALL BUSINESS** by the following definition?

- **Small Business –** defined as an independently owned and operated entity that has either fewer than one hundred (100) employees or less than one million dollars ($1,000,000) in gross receipts per year.
  (State Statute 50-5-121)

  - **___ YES** - If yes, please check the following reason(s) that apply:
    ___ Less than 100 employees or ____ Less than $1,000,000 in gross annual receipts.
  - **___ NO**

Minority Owned Business Enterprise

Can your company be classified as a **MINORITY OWNED BUSINESS** by the following definition?

- **Minority Owned Business –** means a business that is 51% owned or controlled by one or more minority persons.

Please indicate below if your firm is 51% owned or controlled by one or any combination of the minority groups listed.

African American	%	Asian American	%
Hispanic / Latino	%	Pacific Islander	%
Native American	%		

Ownership
American Citizen ____ YES ____ NO
Are any of your supplier's minority and/or small business enterprises? ____ Yes ____ No
If Yes, please indicate the percentage of minority companies represented. ___%

Company Name _____ Phone No. _____
Address _____ Fax No. _____
_____ E-Mail _____
City _____ State ____ Zip _____
Owner Name _____ Signature _____
Print or Type

If awarded a contract as a result of this solicitation, do you anticipate employing any small or minority subcontractors? ____ Yes ____ No If yes, can you identify them at this time?

Please mark as appropriate for your business: Small Business _____ Minority Business _____

Company Name _____ Phone No. _____

Address _____ Fax No. _____

_____ E-Mail_____

City _____ State _____ Zip _____

Appendix G:
PROJECT SPECIFIC BACKGROUND

The Georgia Department of Community Health (DCH) was created in 1999 by the Governor and the Georgia General Assembly. The Department is responsible for insuring nearly 2 million people, maximizing the State's health care purchasing power, planning coverage for uninsured Georgians, and coordinating health planning for State agencies. The Board of Community Health sets policy and direction for DCH.

DCH is organized in the following manner:

- **Commissioners Office** – provides strategic and operational guidance to all functions of the Department. Includes media relations as well as legislative and external affairs.

- **Financial Division** – led by the Chief Financial Officer, this division is responsible for guiding and implementing the financial responsibilities of the Department.

- **Medical Assistance Division** – directed by the State Medicaid Director, this division manages and enforces the policies and regulations of the state Medicaid program.

- **Information Technology Division** – managed by the Chief Information Officer, this division manages and directs the information technology needs and requirements for the Department. This responsibility includes oversight for the claims payment system.

- **Operations Division** – under the direction of the Chief Operating Officer, this division manages agency administrative responsibilities including procurement, human resources and contract administration.

- **Legal Division** – guided by the agency's General Counsel, this division provides the Commissioner and the Department's leadership with legal assistance and advice on all matters. This division also manages the fraud and abuse responsibilities of the Department as well as the State Certificate of Need Program.

- **Managed Care and Quality Division** – led by the Chief of Managed Care, this division is responsible for establishing and directing the managed care efforts of the Department. These efforts include the intent of the Department to move a large proportion of the current Medicaid program into a managed care environment. This division also administers the state employee health benefit plan.

There are also two (2) administratively attached agencies;

- Composite State Board of Medical Examiners - Licenses and regulates physicians, physician's assistants, resident physicians, respiratory care professionals, perfusionists, acupuncturists and auricular (ear) detoxification specialists.

- Georgia Board for Physician Workforce - Develops medical education programs to help ensure that communities have enough physicians.

Phase 1 of GCS, will commence January 1, 2006, when DCH (through DMA) will begin enrolling eligible Medicaid adults and children and PeachCare for Kids children (pending legislative approval) in the Atlanta and Central Service Regions. On July 1, 2006, during Phase 2, eligible Medicaid adults and children and PeachCare for Kids children will be enrolled in the East and North Service Regions and on December 1, 2006, during Phase 3, eligible Medicaid adults and children and PeachCare for Kids children will be in enrolled in GCS in the Southeast and Southwest Service Regions.

The GCS program is designed to:

- Improve the health care status of the Member population;

- Establish a "Provider Home" for Members through its use of assigned Primary Care Providers (PCP's);

- Establish a climate of contractual accountability among the state, the care management organizations and the health care providers;

- Slow the rate of expenditure growth in the Medicaid program; and

- Expand and strengthen a sense of Member responsibility that leads to more appropriate utilization of the health care system.

The following Medicaid eligibility categories will be required to enroll in GCS:

- *Low Income Families* – Adults and children who meet the standards of the old AFDC (Aid to Families with Dependent Children) program (296,703 individuals);

- *Transitional Medicaid* – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit (62,124 individuals);

- *Pregnant Women (Right from the Start Medicaid - RSM)* – Pregnant women with family income at or below two hundred percent (200%) of the federal poverty level who receive Medicaid through the RSM program and *Pregnant Women (Presumptive)* – Pregnant women with family income at or below two hundred percent (200%) of the federal poverty level who receive temporary Medicaid under the Presumptive Medicaid Eligibility Program (59,212 individuals);

- *Children (Right from the Start Medicaid - RSM)* – Children under 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 (427,908 individuals);

- *Children (newborn)* – A child born to a woman who is eligible for Medicaid on the day the child is born (81,004 individuals); and

- *Women Eligible Due to Breast and Cervical Cancer* – Women under 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 (2,063 individuals).

PeachCare for Kids--the State Children's Health Insurance Program in Georgia--children eighteen (18) years of age and younger who have family income that is less than two hundred thirty-five percent (235%) of the federal poverty level, are not eligible for Medicaid or any other health insurance program, and cannot be covered by DCH Health Benefit Plan will be mandatorily enrolled, pending legislative approval (201,066 individuals). In the event the Georgia Legislature does not pass legislation allowing for mandatory enrollment of PeachCare of Kids Members, these children will be permitted to voluntarily enroll in GCS.

The following medical assistance program beneficiaries will be excluded from enrollment in GCS:

- Those eligible for Medicare;
- Those that are Members of a federally recognized Indian Tribe;
- Those eligible for Supplemental Security Income;
- Children eighteen (18) years of age or younger who are in foster care or other out-of-home placement;
- Children eighteen (18) years of age or younger who are receiving foster care or adoption assistance under Title IV-E of the SSA;
- Children enrolled in the Children's Medical Services program administered by the Georgia Division of Public Health;
- Children enrolled in the Georgia Pediatric Program (GAPP);
- Children with sever emotional disturbance whose care is coordinated under the Multi-Agency Team for Children (MATCH) program; and
- Those enrolled under group health plans for whom DCH provides payment for premiums, deductibles, coinsurance and other cost sharing pursuant to section 1906 of the SSA.

For the purposes of coordination and planning, DCH has divided the State, by county, into six (6) Service Regions. Offerors may serve in as many or as few Services Regions as they bid on and are awarded, except that in order to be awarded a Contract in the Atlanta Service Regions the Offeror must also win a Contract in at least one (1) of the other five (5) Service Region.

The following tables list the counties in each Service Region as well as the average monthly enrollment numbers in 2004, by eligibility category.

Atlanta Service Region

Counties	Low Income Families	Transitional Medicaid	RSM Adult*	RSM Child	Newborn	Breast/ Cervical Cancer	PeachCare	Grand Total
Atlanta								
Barrow	1,297	301	376	2,413	487	15	1,879	6,768
Bartow	2,997	547	642	4,624	794	22	2,845	12,470
Butts	600	130	143	1,127	192	4	578	2,773
Carroll	4,090	991	847	4,948	1,090	23	2,424	14,413
Cherokee	1,563	346	581	4,598	1,089	36	3,712	11,925
Clayton	10,931	2,080	3,564	17,654	3,507	55	7,605	45,396
Cobb	9,897	2,286	2,466	20,746	4,610	72	12,202	52,278
Coweta	2,814	566	465	3,054	651	19	1,942	9,511
DeKalb	18,669	2,353	5,602	35,933	6,946	120	15,433	85,056
Douglas	3,001	634	584	4,348	788	14	2,850	12,217
Fayette	865	192	188	1,648	295	7	1,147	4,342
Forsyth	623	165	336	2,345	567	15	1,903	5,954
Fulton	40,684	5,281	5,282	34,418	7,808	117	10,967	104,557
Gwinnett	8,853	1,850	3,579	28,123	6,333	54	19,272	68,064
Henry	3,011	580	683	4,595	865	15	3,424	13,173
Newton	3,146	518	597	3,808	712	31	2,406	11,218
Paulding	1,139	235	565	3,839	654	14	3,004	9,450
Pickens	629	146	133	1,085	182	11	869	3,055
Rockdale	1,978	498	437	3,307	616	21	1,944	8,799
Spalding	3,537	658	490	3,183	708	13	1,253	9,841
Walton	1,778	288	370	3,095	489	19	2,035	8,074
Atlanta Total	**122,100**	**20,644**	**27,928**	**188,889**	**39,382**	**696**	**99,695**	**499,334**

Central Service Region

Counties	Low Income Families	Transitional Medicaid	RSM Adult*	RSM Child	Newborn	Breast/ Cervical Cancer	PeachCare	Grand Total
Central								
Baldwin	1,641	410	363	1,916	389	3	487	5,209
Bibb	10,431	2,100	1,164	9,024	1,509	39	2,615	26,882
Bleckley	480	139	72	599	80	3	212	1,585
Chattahoochee	226	75	29	253	31	5	65	685
Crawford	517	125	86	656	83	5	399	1,871
Crisp	1,595	442	172	1,653	255	9	546	4,671
Dodge	901	230	135	1,087	160	6	468	2,987
Dooly	583	149	94	874	135	5	295	2,134
Harris	504	143	88	703	114	5	489	2,046
Heard	505	154	71	588	110	3	387	1,818
Houston	4,046	1,114	687	4,639	860	17	2,091	13,454
Johnson	532	162	53	550	53	2	197	1,549
Jones	553	133	128	1,051	158	4	633	2,661
Lamar	453	82	146	971	159	1	398	2,209
Laurens	2,499	592	388	3,377	428	17	997	8,298
Macon	884	192	91	960	126	7	288	2,548
Marion	451	74	56	545	71	2	198	1,396
Meriwether	1,084	247	182	1,466	256	3	530	3,768
Monroe	585	103	136	1,063	187	2	559	2,635
Muscogee	10,170	2,260	1,478	9,696	1,797	42	2,863	28,305
Peach	1,163	211	178	1,501	214	8	515	3,790
Pike	454	95	76	595	98	4	390	1,711
Pulaski	351	104	48	543	59	1	188	1,294
Talbot	362	73	42	395	60	3	139	1,075
Taylor	567	145	47	494	70	2	229	1,553
Telfair	674	152	91	680	109	3	345	2,055
Treutlen	356	77	55	455	73	3	233	1,251
Troup	3,018	630	483	3,461	665	11	1,426	9,694
Twiggs	368	63	82	569	108	1	252	1,444
Upson	1,459	315	157	1,386	202	7	674	4,201
Wheeler	313	40	52	376	71	1	190	1,043
Wilcox	531	166	59	487	53	6	219	1,520
Wilkinson	566	95	69	616	79	2	229	1,656
Central Total	**48,822**	**11,090**	**7,056**	**53,229**	**8,822**	**231**	**19,744**	**148,995**

East Service Region

Counties	Low Income Families	Transitional Medicaid	RSM Adult*	RSM Child	Newborn	Breast/ Cervical Cancer	PeachCare	Grand Total
East								
Burke	1,692	346	219	2,016	328	6	591	5,197
Columbia	1,304	328	376	2,897	476	18	1,733	7,133
Emanuel	983	305	266	1,996	319	10	693	4,571
Glascock	86	22	16	118	22	1	80	345
Greene	639	132	108	1,082	145	4	345	2,456
Hancock	621	80	74	585	97	5	96	1,558
Jasper	471	107	88	680	120	3	415	1,884
Jefferson	1,055	253	148	1,413	188	3	542	3,602
Jenkins	618	180	71	652	71	4	253	1,850
Lincoln	259	51	46	480	48	1	247	1,133
McDuffie	1,230	322	277	1,998	247	6	614	4,694
Putnam	682	171	120	990	191	6	487	2,647
Richmond	12,394	2,603	1,601	12,137	1,974	41	3,047	33,796
Screven	901	212	89	950	107	7	357	2,623
Taliaferro	102	24	13	127	17	2	38	322
Warren	332	99	45	433	60	3	148	1,120
Washington	1,072	279	147	1,193	170	5	396	3,262
Wilkes	480	127	57	641	58	1	297	1,660
East Total	**24,920**	**5,640**	**3,761**	**30,387**	**4,640**	**125**	**10,378**	**79,851**

North Service Region

Counties	Low Income Families	Transitional Medicaid	RSM Adult*	RSM Child	Newborn	Breast/ Cervical Cancer	PeachCare	Grand Total
North								
Banks	306	66	113	854	133	7	582	2,060
Catoosa	1,281	250	311	2,177	409	16	979	5,422
Chattooga	990	261	178	1,126	214	3	478	3,249
Clarke	2,723	780	875	5,171	976	26	1,378	11,929
Dade	325	94	104	657	124	6	389	1,699
Dawson	266	63	88	713	122	5	576	1,832
Elbert	766	110	137	1,194	185	13	606	3,012
Fannin	386	130	164	1,124	217	17	1,034	3,072
Floyd	4,158	855	599	4,376	964	18	2,030	12,999
Franklin	641	122	138	1,144	184	11	756	2,996
Gilmer	416	119	195	1,642	253	14	942	3,579
Gordon	1,311	361	358	3,024	585	7	1,493	7,139
Habersham	452	134	307	1,808	409	10	1,246	4,366
Hall	3,665	739	1,333	9,574	2,248	27	4,692	22,279
Haralson	1,199	167	204	1,463	268	10	945	4,257
Hart	645	223	153	1,089	195	23	628	2,955
Jackson	1,301	261	361	2,237	474	13	1,470	6,117
Lumpkin	295	80	133	1,143	217	9	759	2,637
Madison	729	157	162	1,442	215	10	834	3,549
Morgan	574	163	96	790	109	5	536	2,273
Murray	1,042	152	300	2,476	451	9	1,243	5,673
Oconee	273	89	73	687	125	1	539	1,787
Oglethorpe	306	61	73	623	118	5	408	1,594
Polk	1,061	151	284	2,546	547	9	1,253	5,850
Rabun	180	49	106	755	137	5	674	1,907
Stephens	698	189	176	1,579	259	10	712	3,622
Towns	108	53	49	377	56	4	316	963
Union	330	127	108	845	126	8	707	2,250
Walker	2,069	427	401	2,960	513	22	1,185	7,576
White	555	162	152	1,060	211	11	796	2,947
Whitfield	1,759	345	952	6,497	1,462	19	3,317	14,350
North Total	**30,809**	**6,938**	**8,685**	**63,153**	**12,503**	**350**	**33,502**	**155,940**

Southeast Service Region

Counties	Low Income Families	Transitional Medicaid	RSM Adult*	RSM Child	Newborn	Breast/ Cervical Cancer	PeachCare	Grand Total
SouthEast								
Appling	579	134	213	1,327	235	16	681	3,184
Bacon	352	67	88	718	141	6	414	1,785
Brantley	707	187	154	1,130	209	12	690	3,088
Bryan	414	106	127	1,081	212	11	719	2,670
Bulloch	1,997	524	642	3,222	610	30	1,023	8,048
Camden	1,333	367	404	1,901	510	17	883	5,416
Candler	526	141	66	674	155	7	282	1,850
Charlton	485	77	97	754	98	7	337	1,854
Chatham	8,242	2,577	1,735	12,072	2,244	113	4,202	31,185
Effingham	1,000	248	294	1,866	366	15	1,222	5,011
Evans	609	139	89	799	177	4	317	2,133
Glynn	2,886	783	432	3,612	706	30	1,539	9,988
Jeff Davis	543	149	133	1,121	193	5	534	2,678
Liberty	2,326	648	370	2,760	378	24	826	7,332
Long	642	179	67	653	102	3	191	1,837
McIntosh	384	149	92	779	94	9	375	1,881
Montgomery	252	104	66	560	92	4	283	1,361
Pierce	605	208	137	1,159	177	15	708	3,009
Tattnall	654	182	126	1,367	234	16	473	3,051
Toombs	1,716	463	226	2,001	356	15	828	5,605
Ware	2,041	379	429	2,601	443	19	1,164	7,076
Wayne	1,312	254	192	1,736	266	20	803	4,582
SouthEast Total	**29,603**	**8,064**	**6,181**	**43,892**	**7,995**	**396**	**18,493**	**114,624**

Southwest Service Region

Counties	Low Income Families	Transitional Medicaid	RSM Adult*	RSM Child	Newborn	Breast/ Cervical Cancer	PeachCare	Grand Total
SouthWest								
Atkinson	422	117	61	890	144	3	280	1,917
Baker	240	40	21	258	49	1	111	719
Ben Hill	1,184	214	184	1,372	245	5	606	3,809
Berrien	716	172	167	1,166	169	8	588	2,985
Brooks	766	184	111	1,260	146	4	461	2,932
Calhoun	332	68	45	413	66	2	177	1,102
Clay	307	77	26	257	42	1	81	791
Clinch	500	92	68	522	91	3	235	1,512
Coffee	1,998	478	389	3,314	546	29	1,275	8,029
Colquitt	2,521	756	379	3,602	534	15	1,269	9,076
Cook	826	236	121	1,160	172	7	618	3,140
Decatur	1,990	433	170	2,182	222	5	859	5,861
Dougherty	8,032	1,729	788	6,282	1,051	32	1,811	19,724
Early	1,079	324	93	1,011	131	2	304	2,945
Echols	160	54	30	325	68	-	128	764
Grady	1,064	305	186	1,843	305	10	792	4,506
Irwin	416	106	81	638	95	3	316	1,654
Lanier	387	99	68	546	84	3	257	1,443
Lee	432	130	132	1,068	166	5	787	2,720
Lowndes	3,926	992	801	5,355	935	31	2,211	14,251
Miller	335	96	30	411	46	1	170	1,089
Mitchell	1,458	343	162	1,787	271	13	747	4,781
Quitman	188	36	14	186	27	2	47	500
Randolph	635	120	48	505	83	1	186	1,579
Schley	175	44	26	278	44	-	133	701
Seminole	605	177	62	708	108	5	240	1,905
Stewart	317	69	28	337	27	5	119	901
Sumter	2,865	579	319	2,006	378	14	703	6,864
Terrell	964	228	69	670	102	3	200	2,237
Thomas	1,943	475	319	2,862	432	26	1,268	7,327
Tift	1,887	523	330	2,755	484	16	1,141	7,136
Turner	423	90	97	943	134	3	348	2,039
Webster	140	23	18	151	17	2	70	421
Worth	1,216	340	158	1,294	247	4	716	3,976
SouthWest Total	**40,449**	**9,747**	**5,601**	**48,358**	**7,664**	**263**	**19,254**	**131,336**

DCH will be responsible for administering the GCS program. The agency will administer all contracts, monitor Offeror performance, and provide oversight in all aspects of the Offeror's operations. Specifically, DCH will perform the following activities:

LEGAL COMPLIANCE

DCH will comply with, and will monitor the Offeror's compliance with, all applicable State and federal laws and regulations.

ELIGIBILITY AND ENROLLMENT

The State of Georgia has the sole authority for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for enrollment in GCS. 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).

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 GCS. A Member shall have thirty (30) Calendar Days to select a CMO plan and a PCP. DCH or its Agent will issue a notice of enrollment to the CMO plan within two (2) Business Days of the Member's choice.

At the time of CMO plan selection the Member will also sign an acknowledgement of receipt of the Member Roles and Responsibilities document (to be provided by DCH).

If the Member does not choose a CMO plan within thirty (30) Calendar Days of enrollment, DCH or its Agent will Auto-Assign the individual to a CMO plan using the following algorithm:

> If an immediate family member(s) of the Member is already enrolled in one (1) CMO plan, the Member will be Auto-Assigned to that plan;
>
> 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 plan where the Provider is contracted;
>
> If the Member does not have a Historical Provider Relationship with a Provider in either CMO plan, or the Provider contracts with both plans, the Member will be Auto-Assigned to the CMO plan that has the lowest capitated rates in the Service Region.

Enrollment, whether chosen or Auto-Assigned, will be effective at 12:01 a.m. on the first (1^{st}) Calendar Day of the month following the Member selection or Auto-Assignment, for those Members assigned on or between the first (1^{st}) and twenty-fourth (24^{th}) Calendar Day of the month. For those Members assigned on or between the twenty-fifth (25^{th}) and thirty-first (31^{st}) Calendar Day of the month, Enrollment will be effective at 120:01 a.m. on the first (1^{st}) Calendar Day of the second (2^{nd}) month after assignment.

In the future, at a date to be determined by DCH, 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 on quality measures to be defined by DCH. This factor will be applied after determining that there are no Historical Provider Relationships, but prior to utilizing the lowest Capitation rates criteria.

In the Atlanta Service Region, DCH will limit enrollment in a single plan to no more than forty percent (40%) to fifty percent (50%) of total GCS eligible lives in the Service Region. Members will not be Auto-Assigned to, nor may they choose, that CMO plan unless an immediate family member is enrolled in the CMO plan or a Historical Provider Relationship exists with a Provider that does not participate in any other CMO plan in the Atlanta Service Region. The exact percentage will be determined by DCH based upon the number of participating CMO plans in the Atlanta Service Region.

In the five (5) Service Regions other than Atlanta, DCH will limit enrollment in a single plan to no more than sixty-five percent (65%) of total GCS eligible lives in the Service Region. Members will not be Auto-Assigned to that CMO plan unless an immediate family member is enrolled in the CMO plan or a Historical Provider Relationship exists with a Provider that does not participate in any other CMO plan in the Service Region.

DCH or its Agent will have five (5) Business Days to notify Members and the CMO plan of the Auto-Assignment. Notice to the Member will be made in writing and sent via surface mail. Notice to the CMO plan will be made via file transfer.

DCH or its Agent will be responsible for the consecutive enrollment period and re-enrollment functions.

Conditioned on continued eligibility, all Members will be enrolled in a CMO plan for a period of twelve (12) consecutive months. This consecutive enrollment period will commence on the first (1^{st}) day of enrollment or upon the date the notice is sent, whichever is later. If a Member disenrolls from one CMO plan and enrolls in a different CMO plan, consecutive enrollment period will begin on the effective date of enrollment in the second (2^{nd}) CMO plan.

DCH or its Agent will automatically enroll a Member into the CMO plan in which he or she was most recently enrolled if the Member has a temporary loss of eligibility, defined as less than ninety (90) Calendar Days. 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.

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 CMO plans. Members who do not make a choice will be deemed to have chosen to remain with their current CMO plan.

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 plan in which he or she was enrolled prior to the loss of eligibility. The Member will have ninety (90) Calendar Days to disenroll without cause as described in 4.2.1.

In accordance with current operations, the State will issue a Medicaid number to a newborn upon notification from the Offeror, the hospital or other authorized Medicaid Provider. In the event the mother has made a CMO plan and PCP selection for the newborn, the Offeror shall send a Member Identification Card to the mother within ten (10) Calendar Days.

If the mother has not made a plan selection, DCH or its Agent will notify the mother that the newborn has been Auto-Assigned to her CMO plan and that she has ninety (90) Calendar Days from the day a Medicaid number was assigned to her child to choose a different CMO plan.

DCH or its Agent will also notify the CMO plan of the newborn's Auto-Assignment. The notice will state that the newborn is retroactively enrolled, back to the time of birth, in the mother's CMO plan.

DISENROLLMENT

DCH or its Agent will process all CMO plan Disenrollments. This includes Disenrollments due to non-payment of the PeachCare for Kids premiums, loss of eligibility for GCS due to other reasons, and all Disenrollment requests Members or CMO plans submit via telephone, surface mail, internet, facsimile, and in person.

DCH or its Agent will make final determinations about granting Disenrollment requests and will notify the CMO plan via file transfer and the Member via surface mail of any Disenrollment decision within five (5) Calendar Days of making the final determination

Whether requested by the Member or the Offeror the following are the Disenrollment timeframes:

> If the Disenrollment request was date stamped received by DCH on or between the first (1st) and fifteenth (15th) 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
>
> If the Disenrollment request was date stamped received by DCH on or between the sixteenth (16th) and thirty-first (31st) 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.

If DCH or its Agent fails to make a determination, the date of Disenrollment will be deemed effective on the first (1st) day of the second (2nd) month.

When Disenrollment is necessary due to a change in eligibility category, or eligibility for GCS, the Member will be disenrolled effective the date of the Disenrollment request.

MEMBER SERVICES AND MARKETING

DCH will provide to the Offeror 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.

DCH will review and prior approve all marketing materials.

COVERED SERVICES & SPECIAL COVERAGE PROVISIONS

DCH will use submitted Encounter Data, and other data sources, to determine Offeror compliance with federal requirements that eligible members under the age of twenty-one (21) receive periodic screens and preventive/well child visits in accordance with the specified periodicity schedule. DCH will use the participant ratio as calculated using the CMS 416 methodology for measuring the Offeror's performance.

NETWORK

DCH will provide to the Offeror up-to-date changes to the State's list of excluded Providers, as well as any additional information that will affect the Offeror's Provider network.

DCH will process the Offeror's requests to waive network geographic access requirements in rural areas.

DCH will provide the State's Provider Credentialing policies to the Offeror upon award of the GCS Contract.

QUALITY MONITORING

DCH will have a written strategy for assessing and improving the quality of services provided by the Offeror. In accordance with 42 CFR 438.204 this strategy will, at a minimum, monitor:

The availability of services;

The adequacy of the Offeror's capacity and services;

The Offeror's coordination and continuity of care for Members;

The coverage and authorization of services;

The Offeror's policies and procedures for selection and retention of Providers;

The Offeror's compliance with Member information requirements in accordance with 42 CFR 438.10;

The Offeror's compliance with State and federal privacy laws and regulations relative to Member's confidentiality;

The Offeror's compliance with Member enrollment and Disenrollment requirements and limitations;

The Offeror's Grievance System;

The Offeror's oversight of all Subcontractor relationships and delegations;

The Offeror's adoption of practice guidelines, including the dissemination of the guidelines to Providers and Providers' application of them;

The Offeror's quality assessment and performance improvement program; and

The Offeror's health information systems.

COORDINATION WITH OFFEROR'S KEY STAFF

DCH will make diligent good faith efforts to facilitate effective and continuous communication and coordination with the Offeror in all areas of GCS program operations.

Specifically, DCH will designate individuals within the department who will serve as a liaison to the corresponding individual on the Offeror's staff, including:

A program integrity staff member;

A quality oversight staff member;

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;

An information systems coordinator; and

A vendor management staff member.

FORMAT STANDARDS

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

FINANCIAL MANAGEMENT

In order to facilitate the Offeror'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 Offeror pursuant to this RFP

DCH will monitor Offeror compliance with federal and State physician incentive plan rules and regulations.

INFORMATION SYSTEMS

DCH will supply the following information to the Offeror:

Application and database design and development requirements (standards) that are specific to the State of Georgia.

Networking and data communications requirements (standards) that are specific to the State of Georgia.

Specific information for integrity controls and audit trail requirements.

State web portal (www.georgia.gov) integration standards and design guidelines.

Specifications for data files to be transmitted by the Offeror to DCH and/or its agents.

Specifications for point-to-point, uni-directional or bi-directional interfaces between Offeror and DCH systems.

READINESS REVIEW

DCH will conduct a readiness review of each CMO plan that will include, at a minimum, one (1) on-site review. This review shall be conducted ninety (90) to one hundred twenty (120) Calendar Days prior to enrollment of Medicaid/PeachCare for Kids recipients in the CMO plan and at other times during the Contract period at DCH discretion. DCH will conduct the readiness review to provide assurances that the Offeror is able and prepared to perform all administrative functions and to provide high-quality services to Members.

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

Network Provider composition and access;

Staff;

Marketing materials;

Content of Provider agreements;

EPSDT plan;

Member services capability;

Comprehensiveness of quality and Utilization Management strategies;

Policies and procedures for the Grievance System and Complaint System;

Financial solvency;

Offeror litigation history, current litigation, audits and other government investigations both in Georgia and in other states; and

Information systems' Claims payment system performance and interfacing capabilities.

The readiness review may assess the Offeror's ability to meet any requirements set forth in the Model Contract and the documents referenced herein.

Members may not be enrolled in a CMO plan until DCH has determined that the Offeror is capable of meeting these standards. A Offeror's failure to pass the readiness review within one hundred twenty (120) Calendar Days of Contract Award may result in immediate Contract termination.

DCH will provide the Offeror with a summary of the findings as well as areas requiring remedial action.

Appendix H:
GLOSSARY

Whenever capitalized in this Contract, the following terms have the respective meaning set forth below, unless the context clearly requires otherwise.

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 Member practices that result in unnecessary cost to the Medicaid program.

Administrative Law Hearing: The appeal process administered by the State in accordance with O.C.G.A. Title 50, Chapter 13 and as required by federal law, 42 CFR 200 et al, available to Members and Providers after they exhaust the Contractor's Grievance System and Complaint Process.

Administrative Service(s): The Contractual obligations of the Contractor that include but may not be limited to Utilization Management, Credentialing Providers, network management, Quality improvement, marketing, enrollment, Member services, Claims payment, management information Systems, financial management, and reporting.

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 CMO to act within the time frames provided in 42 CFR 438.408(b).

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 that extend beyond the normal business hours of Monday-Friday 9-5:30 and also extend to Saturday hours.

Appeal: A Member request for a review by the Contractor of a Proposed Action through the Contractor's Internal Grievance System.

At Risk: Any service for which the Provider agrees to accept responsibility to provide, or arrange for, in exchange for the Capitation payment.

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 PCP.

Automatic Assignment (or Auto-Assignment): The enrollment of an eligible person, for whom enrollment is mandatory, in a CMO plan chosen by DCH or its agent/Enrollment Broker. Also the assignment of a new Member to a PCP chosen by the CMO Plan, pursuant to the provisions of this Contract.

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

Business Days: Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Holidays are excluded.

Calendar Days: All seven days of the week.

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

Capitation Payment: A payment, fixed in advance, that DCH makes to a Contractor for each Member covered under a Contract for the provision of medical services. This payment is made regardless of whether the Member receives Covered Services or Benefits during the period covered by the payment.

Capitation Rate: The fixed monthly amount that the Contractor is prepaid by DCH for each Member to ensure that Covered Services and Benefits under this Contract are provided.

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

Care Coordination: 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 is also referred to as care management.

Care Management Organization (CMO): An entity, that is organized for the purpose of providing Health Care and has a Health Maintenance Organization Certificate of Authority granted by the State of Georgia, which contracts with Providers and furnishes Health Care services on a prepaid, capitated basis to Members in a designated Service Region.

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

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.

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 normally considered routine.

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

Claims Administrator: The entity engaged by DCH to provide Administrative Service(s) to the CMO Plans in connection with processing and adjudicating risk-based payment, and recording health benefit encounter Claims for Members.

Clean Claim: A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines and 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 personal contact by the CMO Plan, with a potential Member, for the purposes of marketing.

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 CMO plans 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 plan. This is not to be construed as a guarantee of eligibility during the consecutive enrollment period.

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.

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 this Contract becomes effective.

Contractor: The Care Management Organization with a valid Certificate of Authority in Georgia that contracts hereunder with the State for the provision of comprehensive Health Care services to Members on a prepaid, capitated basis.

Contractor's Representative: The individual legally empowered to bind the Contractor, using his/her signature block, including his/her title. This individual will be considered the Contractor's Representative during the life of any Contract entered into with the State unless amended in writing.

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.

Corrective Action Plan: The detailed written plan required by DCH to correct or resolve a deficiency or event causing the assessment of a liquidated damage or sanction against the CMO.

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: The Contractor's determination as to the qualifications and ascribed privileges of a specific Provider to render specific Health Care services.

Critical Access Hospital (CAH): The facility located in the Primary Service Area that has been designated or is eligible for designation as a Critical Access Hospital by the State under the criteria for such hospitals as specifically set forth in 42 U.S.C.§ 1395i-4.

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.

Department of Community Health (DCH): The Agency in the State of Georgia responsible for oversight and administration of the Medicaid program, the PeachCare for Kids program, and the State Health Benefits Plan (SHBP).

Department of Insurance (DOI): The Agency in the State of Georgia responsible for licensing, overseeing, regulating, and certifying insuring entities.

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.

Disenrollment: The removal of a Member from participation in the Contractor's plan, but not necessarily from the Medicaid or PeachCare for Kids program.

Durable Medical Equipment (DME): Equipment, including assistive technology, which: a) can withstand repeated use; b) is used to service a health or functional purpose; c) is ordered by a qualified practitioner to address an illness, injury or disability; and d) is appropriate for use in the home, work place, or school.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program: A Title XIX mandated program that covers screening and Diagnostic Services to determine physical and mental deficiencies in Members less than 21 years of age, and Health Care, treatment, and other measures to correct or ameliorate any deficiencies and Chronic Conditions discovered.

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

Encounter: For the purposes of this Contract, a Health Care encounter is defined as a distinct set of services provided to a Medicaid or PeachCare for Kids Member enrolled with a Contractor on the dates that the services were delivered.

Encounter Data: Health Care Encounter Data include: (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, medical devices and equipment associated with the member receiving services during the Encounter; (ii) The identification of the member receiving and the Provider(s) delivering the Health Care services during the single Encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single Encounter.

Enrollee: See Member.

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 fee for service and such application is approved by DCH or its agent/Enrollment Broker.

Enrollment Broker: The entity engaged by DCH to assist in outreach, education and enrollment activities associated with the GCS program.

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

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 and to DCH.

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.

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

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

Fee-for-Service (FFS): A method of reimbursement based on payment for specific services rendered to a Member.

Incentive Arrangement: Any mechanism under which a Contractor may receive additional funds over and above the Capitation rates, for exceeding targets specified in the Contract.

Financial Relationship: A direct or indirect ownership or investment interest (including and option or nonvested interest) in any 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.

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.

Grievance: An expression of dissatisfaction about any matter other than a Proposed Adverse Action.

Grievance System: The overall system that includes Grievances and Appeals at the Contractor level and access to the State Fair Hearing process (the State's Administrative Law Review).

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.

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: The State of Georgia's Early and Periodic Screening, Diagnostic, and Treatment program pursuant to Title XIX of the Social Security Act.

Health Insurance Portability and Accountability Act (HIPAA): A law enacted in 1996 by the Congress of the United States. When referenced in the GCSContract it includes all related rules, regulations and procedures.

Historical Provider Relationship: A Provider who has been the main source of Medicaid or PeachCare for Kids services for the Member during the previous year.

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

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

Information: i. Structured Data: Data that adhere to specific properties and Validation criteria that are 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; ii. Document: Information that does not meet the definition of structured data includes 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: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Insolvent: Unable to meet or discharge financial liabilities.

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 Provider.

Mandatory Enrollment: The process whereby an individual eligible for Medicaid or PeachCare for Kids is required to enroll in a Contractor's plan, unless otherwise exempted or excluded, to receive covered Medicaid or PeachCare for Kids services.

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

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 Medicaid or PeachCare for Kids eligible individual.

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 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 SCHIP functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manual.

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

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 physician or 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: 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.

Medically Necessary Services: Those services that meet the definition found in Section 4.5.

Member: A Medicaid or PeachCare for Kids recipient who is currently enrolled in a CMO plan.

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

Non-Emergency Transportation (NET): A ride, or reimbursement for a ride, provided so that a Member 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/mentally retarded (ICF/MR).

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.

Offeror: An organization submitting a proposal to the RFP for the Georgia Cares Program for the State's Medical Assistance and PeachCare for Kids Programs.

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

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

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy services.

Physician Incentive Plan: Any compensation arrangement between a Contractor and a physician or physician group that may directly have the effect of reducing or limiting services furnished to Members.

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 Enrollee: See Potential Member.

Potential Member: A Medicaid or SCHIP recipient who is subject to mandatory enrollment in a care management program but is not yet the Member of a specific CMO plan.

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

Prevalent Non-English Language: A language other than English, spoken by a significant number or percentage of potential Members and Members in the State.

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 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 medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner 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, physician's assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these Contract provisions and licensure requirements.

Prior Authorization: (also known as "pre-authorization" or "prior approval"). Authorization granted in advance of the rendering of a service after appropriate medical review.

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).

Provider: Any physician, hospital, facility, or other Health Care Professional who is licensed or otherwise authorized to provide Health Care services in the State or jurisdiction in which they are furnished.

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, including a Proposed Action.

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.

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.

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 professional other than the Primary Care Provider and which are ordered and approved by the Primary Care Provider or the Contractor.

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 the Provider level.

(Claims) Reprocessing: 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.

Risk Contract: A Contract under which the Contractor assumes financial risk for the cost of the services covered under the Contract, and may incur a loss if the cost of providing services exceeds the payments made by DCH to the Contractor for services covered under the Contract.

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.

Scope of Services: Those specific Health Care services for which a Provider has been credentialed, by the plan, to provide to Members.

Service Authorization: A Member's request for the provision of a service.

Service Region: A geographic area comprised of those counties where the Contractor is responsible for providing adequate access to services and Providers.

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

Significant Traditional Providers: Those Providers that provided the top eighty percent (80%) of Medicaid encounters for the GCS-eligible population in the base year of 2004.

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 Systems and telecommunications capabilities outsourced by the CMO.

State: The State of Georgia.

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 SCHIP program is called PeachCare for Kids.

State Fair Hearing: See Administrative Law Hearing

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 to perform a specified part of the Contractor's obligations under this Contract.

Subcontractor Payments: Any amounts the Contractor pays a Provider or Subcontractor for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of Referral Services (such as Withhold amounts, bonuses based on Referral levels, and any other compensation to the physician or physician group to influence the use for Referral Services). Bonuses and other compensation that are not based on Referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of Physician Incentive Plans.

System Access Device: A device used to access 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, v. Multi-function communication and computing device, e.g. PDA.

System Unavailability: As measured within the Contractor's information systems Span of Control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the "Enter" or other function key.

System Function Response Time: Based on the specific sub function being performed,
Record Search Time-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
Record Retrieval Time-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.
Screen Edit Time-the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with the errors highlighted.
New Screen Page Time-the time elapsed from the time a new screen is requested until the data from that screen start to appear on the monitor.
Print Initiation Time- the elapsed time from the command to print a screen or report until it appears in the appropriate queue.
Confirmation of CMO Enrollment System 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.
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.

Systems: See Information Systems.

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.

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 recipient of medical assistance.

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 Contractor, 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.

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

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

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

1.5 ACRONYMS

AFDC – Aid to Families with Dependent Children

AICPA – American Institute of Certified Public Accountants

CAH – Critical Access Hospital

CDC – Centers for Disease Control

CFR – Code of Federal Regulations

CMO – Care Management Organization

CMS – Centers for Medicare & Medicaid Services

CNM – Certified Nurse Midwives

CSB – Community Service Boards

DME – Durable Medical Equipment

DOI – Department of Insurance

EB – Enrollment Broker

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

FFS – Fee-for-Service

FQHC – Federally Qualified Health Center

GCS – Georgia Cares Program

HHS – US Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountabilty Act

HMO – Health Management Organization

IBNR – Incurred-But-Not-Reported

LIM – Low-Income Medicaid

MMIS – Medicaid Management Information System

NAIC – National Association of Insurance Commissioners

NCQA – National Committee for Quality Assurance

NET – Non-Emergency Transportation

NP-C – Certified Nurse Practitioners

NPI – National Provider Identifier

PBM – Pharmacy Benefit Manager

PCP – Primary Care Provider

QAPI – Quality Assessment Performance Improvement

RHC – Rural Health Clinic

RSM – Right from the Start Medicaid

SCHIP – State Children's Health Insurance Program

SSA – Social Security Act

TANF – Temporary Assistance for Needy Families

TDD – Telecommunication Device for the Deaf

UM – Utilization Management

UPIN – Unique Physician Identifier Number

UR – Utilization Review

Appendix I:
APPLICABLE DOCUMENTS

The Offeror shall comply with the most recent versions and future revisions to all applicable Federal and State laws, court orders, regulations, policies, and subsequent amendments. The following Applicable Documents are incorporated into the Contract, as well as any pertinent amendments, by this reference.

Document Type	Title	Location
Federal Law	Title X of the Social Security Act, Grants to States for Aid to the Blind	http://www.ssa.gov/OP_Home/ssact/title10/1000.htm
Federal Law	Title XIX of the Social Security Act, Grants to States for Medical Assistance Programs	http://www.ssa.gov/OP_Home/ssact/title19/1900.htm
Federal Law	Title XXI of the Social Security Act, State Children's Health Insurance Program	http://www.ssa.gov/OP_Home/ssact/title21/2100.htm
Federal Regulations	42 CFR Part 433 et al, State Fiscal Administration	http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=4aefdc169e18d1ab42a01144afdb0bb8&rgn=div5&view=text&node=42:3.0.1.1.4&idno=42
Federal Regulations	42 CFR Part 438 et al, Managed Care Regulations	http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6d2776bba67311522d9058fa3d5543fe&rgn=div5&view=text&node=42:3.0.1.1.8&idno=42
Federal Regulations	42 CFR Part 441 et al, Services Requirements and Limits Applicable to Specific Services	http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6d2776bba67311522d9058fa3d5543fe&rgn=div5&view=text&node=42:3.0.1.1.10&idno=42
Federal Regulations	42 CFR Part 447 et al, Payments for Services	http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=6d2776bba67311522d9058fa3d5543fe&rgn=div5&view=text&node=42:3.0.1.1.12&idno=42
Federal Regulations	45 CFR Part 160 and 164, et al, HIPAA Regulations	http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=9886c6b4203b1682c8a3ba6e4a642cc6&c=ecfr&tpl=/ecfrbrowse/Title45/45cfrv1_02.tpl
State Policies and Procedures	Medicaid and PeachCare for Kids Provider Manuals	https://www.ghp.georgia.gov/wps/portal/.cmd/ActionDispatcher/_pagr/104/_pa.104/112/.st/X/.piid/927/.ciid/1134/.reqid/-1/PC_927_WPSLINKTYPE/internal#1134

Document Type	Title	Location
State Policies and Procedures	Georgia Vendor Guides	http://ssl.doas.state.ga.us/PRSapp/formLinks/vendor_guides.html
State Regulations	Rules of Office of State Administrative Hearings Chapter 616-1-2, Administrative Rules of Procedure	http://osah.georgia.gov/vgn/images/portal/cit_1210/13/48/29837250chap616_1_2.pdf
State Code	Un-Annotated Georgia Code, Title 33, Insurance	http://www.legis.state.ga.us/legis/GaCode/Title33.pdf
State Code	Un-Annotated Georgia Code, Title 50, State Government	http://www.legis.state.ga.us/legis/GaCode/Title50.pdf
State Policies and Procedures	GTA Policies and Standards	http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.html

Appendix J:

SIGNIFICANT TRADITIONAL PROVIDERS (STPS)

PUBLISHED UNDER SEPARATE COVER