

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p>Section S: Added Value to Louisiana Providers and CCN Members</p> <p>If you are awarded a contract, the response to this section will become part of your contract with DHH and DHH will confirm your compliance. The incentives and enhanced payments, for providers and expanded benefits to members proposed herein cannot be revised downward during the initial thirty-six (36) month term of the contract, as such programs were considered in the evaluation of the Proposal. Increases in payments or benefits during the term of the contract may be implemented.</p>	200		
S-1	A, B, and C	<p>S.1 The “value added” from Provider Incentive Payments and Enhanced Payments (above the Medicaid rate floor) will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor.</p>	100		

		<p>Pursuant to State Rules, the default payments between CCNs and providers are Louisiana Medicaid' rates and the CCN must contract at no less than Medicaid rate in effect on the date of service; for example the Medicaid physician fee schedule or Medicaid hospital per diem amounts or FQHC/RHC PPS amounts.</p> <p>Complete RFP Appendix OO to identify circumstances where you propose to vary from the floor reimbursement mechanism.</p> <ul style="list-style-type: none">• For increased provider payments to be considered in the evaluation, they must represent an increase in the minimum payment rates for all providers associated with the CCN's operating policies and not negotiated rates for a subset of the providers. As an example, if the CCN's physician payment policy is to pay Medicare rates, and possibly negotiate payments above that rate on a case-by-case basis, then the difference between the published Medicaid rate and the Medicare rate would be the quantifiable variance to be reported in this section; if the Medicaid rate was the base rate and anything above that rate subject to negotiation, then such amounts would not qualify for inclusion herein.• If you propose to contract with any providers using methodologies or rates that differ from the applicable Medicaid fee schedules, include such arrangements. By provider type, describe the proposed payment methodologies/rates and quantify the projected per member per month benefit.			
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		<ul style="list-style-type: none">• The quantified incentives and enhanced payments reported should only represent the value exceeding the minimum Medicaid payment equivalent. If any proposals are not explicitly above the Medicaid rates, include a detailed calculation documenting how the minimum Medicaid equivalent was considered in the determination of the incentive/enhanced amount. For example, if the CCN proposes to pay physicians at the Medicare fee schedule during calendar year 2012, the amount reported in the attached would be determined as the projected difference between payments at the Medicare fee schedule and the Medicaid fee schedule, documenting the projected value using the Medicaid fees. Further, if capitation or alternative payments are proposed, the equivalent value of Medicaid fee payments based on projected utilization would be removed in the determination of the enhanced value.• Do not include payments for services where Federal or State requirements are currently scheduled to increase payments at a future date. In such circumstances, maintenance of effort will be expected of the CCN. For example, some Medicaid primary care rates are projected to increase to Medicare n rates in January of 2013, and the variance between the two types of rates would not qualify as an enhanced/incentive payment after January 1, 2013.• During the evaluation of the proposals,			
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		<p>preferences will be given to plans based upon the cumulative amount of quantified provider benefit associated with the following:</p> <ul style="list-style-type: none">○ higher payment rates than the required Medicaid default rate (fee for service or per diem or PPS or sub-capitated/other alternative rate);○ bonus payments above the required Medicaid default rate;○ pay for performance incentive payments above the required Medicaid default rate; and○ other payment arrangements above the required Medicaid "floor" rate. <ul style="list-style-type: none">● Payments for case management services may be included if paid to unrelated practitioners, e.g., physicians, clinics, etc.● For bonus pools or Pay For Performance (P4P) programs, describe the eligible categories of provider, the basis for paying the applicable bonus pools and the proposed terms and conditions in the template. You may attach additional information, as appropriate.● Indicate if any bonus pool is to be held in escrow, and if so who will be the escrow agent.● If any part of the proposed bonus pool is to be funded by withhold from subcontracted provider payments, confirm that the initial provider payment net of withhold would not be less than the Medicaid rate.			
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		<ul style="list-style-type: none">• The completed template and all additional documentation and calculations shall be accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.			
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Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
S-6	A, B, and C	<p>S.2 Provide a listing, description, and conditions under which you will offer additional health benefits: 1) not included in the Louisiana Medicaid State Plan or 2) beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members.</p> <ul style="list-style-type: none"> • For each expanded benefit proposed: <ul style="list-style-type: none"> ○ Define and describe the expanded benefit; ○ Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members; ○ Note any limitations or restrictions that apply to the expanded benefit ○ Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable. ○ Propose how and when Providers and Members will be notified about the availability of such expanded benefits; ○ Describe how a Member may obtain or access the Value-added 	100		

		<p>Service;</p> <ul style="list-style-type: none">• Include a statement that you will provide the expanded benefits for the entire thirty six (36) month term of the initial contract.• Describe if, and how, you will identify the expanded benefit in administrative data (encounter Data). <p>Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 75,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.</p>			
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Question S.1

Provider Incentive Payments and Enhanced Payments

Section S: Added Value to Louisiana Providers and CCN Members

S.1 The “value added” from Provider Incentive Payments and Enhanced Payments (above the Medicaid rate floor) will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor.

Pursuant to State Rules, the default payments between CCNs and providers are Louisiana Medicaid’ rates and the CCN must contract at no less than Medicaid rate in effect on the date of service; for example the Medicaid physician fee schedule or Medicaid hospital per diem amounts or FQHC/RHC PPS amounts.

Complete RFP Appendix OO to identify circumstances where you propose to vary from the floor reimbursement mechanism.

- For increased provider payments to be considered in the evaluation, they must represent an increase in the minimum payment rates for all providers associated with the CCN’s operating policies and not negotiated rates for a subset of the providers. As an example, if the CCN’s physician payment policy is to pay Medicare rates, and possibly negotiate payments above that rate on a case-by-case basis, then the difference between the published Medicaid rate and the Medicare rate would be the quantifiable variance to be reported in this section; if the Medicaid rate was the base rate and anything above that rate subject to negotiation, then such amounts would not qualify for inclusion herein.
- If you propose to contract with any providers using methodologies or rates that differ from the applicable Medicaid fee schedules, include such arrangements. By provider type, describe the proposed payment methodologies/rates and quantify the projected per member per month benefit.
- The quantified incentives and enhanced payments reported should only represent the value exceeding the minimum Medicaid payment equivalent. If any proposals are not explicitly above the Medicaid rates, include a detailed calculation documenting how the minimum Medicaid equivalent was considered in the determination of the incentive/enhanced amount. For example, if the CCN proposes to pay physicians at the Medicare fee schedule during calendar year 2012, the amount reported in the attached would be determined as the projected difference between payments at the Medicare fee schedule and the Medicaid fee schedule, documenting the projected value using the Medicaid fees. Further, if capitation or alternative payments are proposed, the equivalent value of Medicaid fee payments based on projected utilization would be removed in the determination of the enhanced value.
- Do not include payments for services where Federal or State requirements are currently scheduled to increase payments at a future date. In such circumstances, maintenance of effort will be expected of the CCN. For example, some Medicaid primary care rates are projected to increase to Medicare rates in January of 2013, and the variance between the two types of rates would not qualify as an enhanced/incentive payment after January 1, 2013.
- During the evaluation of the proposals, preferences will be given to plans based upon the cumulative amount of quantified provider benefit associated with the following:
 - higher payment rates than the required Medicaid default rate (fee for service or per diem or PPS or sub-capitated/other alternative rate);
 - bonus payments above the required Medicaid default rate;

REDACTED

- pay for performance incentive payments above the required Medicaid default rate; and
 - other payment arrangements above the required Medicaid “floor” rate.
- Payments for case management services may be included if paid to unrelated practitioners, e.g., physicians, clinics, etc.
 - For bonus pools or Pay For Performance (P4P) programs, describe the eligible categories of provider, the basis for paying the applicable bonus pools and the proposed terms and conditions in the template. You may attach additional information, as appropriate.
 - Indicate if any bonus pool is to be held in escrow, and if so who will be the escrow agent.
 - If any part of the proposed bonus pool is to be funded by withhold from subcontracted provider payments, confirm that the initial provider payment net of withhold would not be less than the Medicaid rate.
 - The completed template and all additional documentation and calculations shall be accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.

PART II: TECHNICAL APPROACH
RESPONSE APPLICABLE FOR GSAs A, B, C
S. ADDED VALUE TO LOUISIANA PROVIDERS AND CCN MEMBERS
REDACTED



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RESPONSE APPLICABLE FOR GSAs A, B, C
S. ADDED VALUE TO LOUISIANA PROVIDERS AND CCN MEMBERS
REDACTED



Question S.2

Additional Offered Health Benefits

REDACTED

S.2 Provide a listing, description, and conditions under which you will offer additional health benefits: 1) not included in the Louisiana Medicaid State Plan or 2) beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members.

- For each expanded benefit proposed:
 - Define and describe the expanded benefit;
 - Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members;
 - Note any limitations or restrictions that apply to the expanded benefit
 - Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable.
 - Propose how and when Providers and Members will be notified about the availability of such expanded benefits;
 - Describe how a Member may obtain or access the Value-added
 - Service;
- Include a statement that you will provide the expanded benefits for the entire thirty six (36) month term of the initial contract.
- Describe if, and how, you will identify the expanded benefit in administrative data (encounter Data).

Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 75,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information

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RESPONSE APPLICABLE FOR GSAs A, B, C
S. ADDED VALUE TO LOUISIANA PROVIDERS AND CCN MEMBERS
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