STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS (OGB)

NOTICE OF INTENT TO CONTRACT (NIC)

FOR

MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE (MHSA) PROGRAM

Issued
September 21, 2010

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SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Introduction

The State of Louisiana, Office of Group Benefits (hereinafter called "OGB" or the "Program") gives notices of its intent to contract with a qualified firm/organization (hereinafter called "Proposer") to develop, implement, and administer an effective Managed Mental Health and Substance Abuse (MHSA) Program and solicits proposals from any qualified firm/organization to provide such services on the terms and conditions specified below.

B. Background

The State of Louisiana through OGB is authorized by statute to provide health and accident benefits and life insurance to state employees, retirees and their dependents. Plan member eligibility includes employees of state agencies, institutions of higher education, local school boards that elect to participate and certain political subdivisions. Eligibility does not include local government entities, parishes, or municipalities.

OGB provides self-insured health and accident benefit plans for approximately 148,000 covered contracts. The self-insured benefit plans available to plan participants, effective January 1, 2011 are: Preferred Provider Option (PPO) and Health Maintenance Organization (HMO). In addition, OGB provides services for all participants in the LaCHIP Affordable plan, an expansion of the children's health insurance program available to uninsured Louisiana children up to the age of 19 whose families have an annual income up to 250 percent of the Federal Poverty Level (FPL), for which OGB provides administrative services pursuant to an interagency agreement with the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing. The services pursuant to this NIC will include all of these benefit plans.

Since 1993, MHSA benefits have been carved out of the OGB's self-funded benefit plans and OGB has contracted with a managed behavioral care firm to provide a gatekeeper/managed care network and all related administrative services for MHSA on a capitated (PEPM) basis.

Basic and supplemental life insurance is provided through Prudential Insurance Company. The OGB also administers an IRS qualified cafeteria plan offering optional benefits such as dental, eye care, cancer and catastrophic illness coverage, long term disability, and child care flexible spending accounts.

C. OGB Information Technology

Desktop: Dell 450 Workstations running Windows XP
LAN: 10/100/1000 Ethernet using Cisco switches

Servers: Windows servers, AIX UNIX servers, and LINUX servers
WAN: VPN Tunnel using Cisco routers, switches, and firewalls. In addition, Fujitsu scanners, and various laser printers are used

OGB computer applications include: Impact (claims adjudication, customer services, provider contracting and eligibility processes), Discoverer (Oracle report writer), MS Office, FileNet (Oracle based imaging and document management system). OGB uses Oracle databases as its standard.

OGB uses ONESIGN – Biologin and e-Trust, a single-sign-on and centralized security system.

D. Scope of Services

Contractor will provide a Managed Mental Health and Substance Abuse Program for OGB plan members that participate in its PPO, HMO and LaCHIP Affordable Plan plan of benefits.

Contractor will be responsible for providing and managing MHSA benefits through a network of providers and services to provide effective treatment and outcomes. In order for a plan member to receive full benefits, he or she must utilize the network for initial assessment and counseling as well as for ongoing MHSA treatment, both inpatient and outpatient. Contractor will provide all professional, technical, and administrative services in connection with the MHSA benefits, including, but not limited to, medical management, medical necessity reviews required under applicable laws and regulations, care management, claims adjudication and payment, customer services, and provider relations.

Option 1: Fully Insured (at risk)

Option 2: Self Insured (administrative services)

E. Standard Contract Provisions

It is expected that an initial 6-month contract , with the option to renew for two additional one-year terms will be awarded with the contract terms provided in Exhibit 1. Any deviation sought by a Proposer from these contract terms should be included in the Proposal. The provisions of the NIC and the winning proposal will be incorporated by reference into the contract. Any additional clauses or provisions, required by the Federal or State law or regulation in effect at the time of execution of the contract, will be included.

F. Miscellaneous

1. Member I.D. Cards: The MHSA firm will not be required to produce member I.D. cards. OGB utilizes a single member I.D. card for medical, prescription drug, utilization management services and MHSA benefits combined. The MHSA firm will be required to

provide the party responsible for card printing with the appropriate information to be included on the member I.D. card according to an OGB mandated deadline.

2. Insurance Requirement: The MHSA firm shall procure and maintain for the duration of any contract, as a result of this NIC, liability insurance with a combined single limit liability of not less than Ten Million ($10,000,000.00) Dollars.

3. The MHSA firm shall on request furnish OGB with certificate(s) of insurance affecting the required coverage. The certificate for each insurance policy is to be signed by a person authorized by that insurer to bind coverage on its behalf. OGB reserves the right to require complete, certified copies of all required insurance policies, at any time.

4. Performance Bond: The MHSA firm shall furnish a performance bond in the amount of $1,000,000 (One Million) dollars.

G. Fee Quotation

Option 1 - Fully Insured

MHSA Benefits

All-inclusive per employee/retiree/LACHIP monthly (PEPM) cost to provide MHSA benefits as described in the NIC on a capitated (at risk) basis. The cost must include the cost of the benefits, the payment of claims, all required utilization and management reports (including any special ad hoc reports requested by OGB), member services and communications, postage, etc. In short, the monthly cost must include all services required under the contract.

Option 2 – Self Insured

MHSA Benefits

All-inclusive per employee/retiree/LACHIP monthly (PEPM) premium to administer MHSA benefits as described in the NIC. The cost must include payment of claims, all required medical management, utilization and management reports (including any special ad hoc reports requested by OGB), member services and communications, postage, etc. In short, the monthly premium must include all services required under the contract. OGB will be "at risk" for all claims payments and will promptly reimburse MHSA firm for all claim payments.

The basis of your fees should be as follows:

1. Fees must be quoted on a single composite basis for all benefit plan types per contract for actives and retirees without Medicare, retirees with Medicare and LaCHIP. The term "covered contract" as used throughout this NIC is defined as any class of coverage in which a plan member is enrolled, whether employee only, employee and spouse, employee and children or family; therefore, a contract includes the employee or retiree and all dependents or LaCHIP enrollee.

2. Fees must include cost to develop, print and disseminate to all employees, retirees and providers communication materials necessary to effectively implement and manage the MHSA program for the OGB. This communication material shall be subject to OGB's advance approval.

3. Fees must include all services described in this NIC, including all necessary reports and any start-up fees. Furthermore, fees must take into account your expenses associated with attendance at meetings in Baton Rouge with OGB staff and actuarial consultant and with the OGB Policy and Planning Board or its committees, as requested. No pass-through of costs will be permitted.

4. The monthly cost may be quoted as a level per month fee for the entire three-year contract and may contain a flat, pre-determined dollar escalator for years two and three. In no event, will add-ons or changes be permitted during the term of the contract, except in the event of benefit modifications which would materially affect the contractor's responsibilities.

5. Fees must be guaranteed for the full term of the contract including any optional renewal.

6. Commissions or finders fees will <u>not</u> be payable under the contract.

H. Instructions on Proposal Format

Proposers should respond thoroughly, clearly and concisely to all of the points and questions set forth in the Notice of Intent to Contract (NIC). Answers should specifically address current capabilities separately from anticipated capabilities.

1. Submit an original (clearly marked "original") and (8) copies of a completed, numbered proposal placing each in a three-ring binder along with (2) electronic copies.

2. Use tabs to divide each section and each attachment. The tabs should extend beyond the right margin of the paper so that they can be read from the side and are not buried within the document.

3. Order of presentation:
   - ❑ Cover letter (Optional)
   - ❑ Tab 1 (See Section V) - Proposers Requirements
   - ❑ Tab 2 (See Section VI) – Questionnaire
   - ❑ Tab 3 (See Section VII) - Attachments to Proposal Response
   - ❑ Tab 4 (See Section VIII) - MHSA Firm Information and Mandatory Signature
   - ❑ Tab 5 (See Section IX) – Fee Quotation Form.

4. Answer questions <u>directly</u>. Where you cannot provide an answer, indicate not applicable or no response.

5. Do not answer a question by referring to the answer of a previous question; restate the answer or recopy the answer under the new question. If however, the question asks you to provide a copy of something; you may indicate where this copy can be found by an

attachment/exhibit number, letter or heading. You are to state the question, then answer the question. Do not number answers without providing the question.

I. Ownership, Public Release and Costs of Proposals.

1. All bids submitted in response to this NIC become the property of the OGB and will not be returned to the bidders.

2. After award of the Contract, all bids will be considered public record and will be available for public inspection during regular working hours.

   If a proposal contains trade secrets and/or privileged or confidential commercial or financial information which the Proposer (or his SubContractor) does not want used or disclosed for any purpose other than evaluation of the proposal. The use and disclosure of such data may be restricted, provided the Proposer marks the cover sheet of the proposal with the following legend, specifying the pages of the proposal which are to be restricted in accordance with the conditions of the legend:

   "*The data contained in Pages___ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions."*

   Further, to protect such data, each page containing such data shall be specifically identified and marked **"CONFIDENTIAL".**

   It should be noted, however, that data bearing the aforementioned legend shall be subject to release under the provision of the Louisiana Public Records Law, L.R.S. 44.1 et. seq. The State of Louisiana/OGB assumes no liability for disclosure or use of unmarked data and may use or disclose such data for any purpose. It should be noted that any resultant contract will become a matter of public record.

   OGB reserves the right to make any proposal, including proprietary information contained therein, available to the Office of the Governor, Division of Administration, Office of Contractual Review, or other state agencies or organizations for the purpose of assisting the OGB in its evaluation of the Proposal. OGB will require such individuals to protect the confidentiality of any specifically identified proprietary information or privileged business information obtained as a result of their participation.

   In addition, you are to provide a redacted version of your proposal, omitting those responses and attachments (or portions thereof) that you determine are within the scope of the exception to the Louisiana Public Records Law. In a separate document, you must provide the justification for each omission.

OGB will make the edited proposal available for inspection and/or copying upon the request of any individual pursuant to the Louisiana Public Records Law without notice to you.

SECTION II

MHSA PROGRAM REQUIREMENTS

A. Proposer Requirements

1. Your firm must have a minimum of five (5) years experience in providing MHSA services.

2. Your firm must currently provide MHSA services to at least two (2) groups each with a minimum size of 25,000 covered employees and/or retirees (not counting dependents) of which at least one of these groups is a single employer (corporate or government).

3. Your firm must be licensed as required by the Louisiana Commissioner of Insurance in order to provide the coverage requested in this NIC. You must provide evidence that your firm is so licensed or, if not currently licensed, a detailed description of the procedures, including a time line, you would follow in order to insure compliance.

4. Your firm must meet the following minimum network access standard as of the date your proposal is submitted:

   - 70% of plan members within 10 miles of one professional provider (urban)
   - 70% of plan members within 20 miles of one professional provider (suburban)
   - 70% of plan members within 45 miles of one professional provider (rural)
   - 70% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban)
   - 70% of plan members within 60 miles of one inpatient acute inpatient facility (rural)

5. Your firm must commit to the following minimum network access standard as of January 1, 2011 effective date:

   - 90% of plan members within 10 miles of two (2) professional providers (Urban)
   - 90% of plan members within 20 miles of two (2) professional provider (Suburban)
   - 90% of plan members within 45 miles of two (2)professional providers (rural)
   - 90% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban)
   - 90% of plan members within 60 miles of one inpatient acute inpatient facility (rural)

6. Your firm must have the capability to transmit and receive electronic claims in the HIPAA Standard formats (837P and 837I).

B. MHSA Benefit Structure

Plan Provisions	Proposed PPO Plan Design Changes	Proposed HMO Plan Design Changes
Behavioral Health Services (Carve-out Plan)		
Maximum OOP Maximum (behavioral health services only)	Integrate out-of-pocket maximum with medical plan	Integrate out-of-pocket maximum with medical plan
In-Patient – In-Network	90%	100% after $100/day copay; maximum $300 per admission
In-Patient – Out-of-Network • **Reside In Louisiana** • **Resides outside Louisiana**	90%	Compliant
Outpatient – In-network – Office Visits	90%	$15 copay*
Outpatient – In-network – all other outpatient svcs.	90%	100%
Outpatient – Out-of-Network – Office Visits • **Reside In Louisiana** • **Resides outside Louisiana**	90%	Compliant
Outpatient – Out-of-Network – all other outpatient svcs. • **Reside In Louisiana** • **Resides outside Louisiana**	90%	Compliant
Emergency Care	90% after $150 deductible; waived if admitted	100% after $100 copay; waived if admitted
Prescription Drug	Compliant	Compliant

There are no pre-existing condition (PEC) exclusions or active at work limitations imposed on current plan members unless a plan member is in the process of satisfying a new employee or late applicant PEC limitation.

The MHSA firm will not be required to cover outpatient prescription drugs under the terms of this contract. The cost of outpatient prescription drugs related to the treatment of MHSA disorders are covered under a separate prescription drug carve-out program administered by OGB's contracted pharmacy benefits manager (PBM).

C. OGB Plan Documents

Copies of the OGB's plan documents for the PPO and HMO plan can be obtained from the OGB website, www.groupbenefits.org. The plan documents list numerous exclusions and limitations relative to treatment and expenses considered ineligible under the PPO and HMO plan. Although it is the intent of the OGB to maintain these exclusions in principle, there will be situations in which the MHSA firm will be required to provide treatment. Examples might include psychiatric treatment following a suicide attempt; even though intentionally self-inflicted injuries are excluded, psychiatric treatment, psychological counseling and family counseling which may be appropriate treatment for certain diagnoses.

D. Diagnoses Covered Under MHSA Contract

The MHSA firm shall cover expenses in connection with conditions classified in the Diagnosis and Statistical Manual of Mental Disorders (most recent edition) of the American Psychiatric Association, subject to the exclusions set forth in the self-funded medical plan document. In addition, the following DSM IV-R codes are specifically excluded under the MHSA contract: 307.81 (tension headaches), 310.0 (frontal lobe syndrome) and 310.2 (post-concussion syndrome).

E. Incurred Claims and Extension of Coverage for Hospital Confined Patients

The MHSA firm shall administer all MHSA claims which are incurred during the length of its contract. No additional fees may be charged to the OGB by the MHSA firm to administer the run-out of any claims incurred while the contract was in effect but paid after the termination of the MHSA contract.

Any inpatient hospital admissions and associated professional fees in progress on the effective date of the MHSA contract are the responsibility of the incumbent MHSA firm until date of discharge. The MHSA firm shall be liable for any inpatient hospital admissions and associated professional fees in progress on the termination date of its contract with the OGB, until the date that the patient is discharged from the hospital.

F. Initial Visit to Primary Care Physician or Other Non-MHSA Provider

The OGB self-funded medical plan reimburses the cost of one office visit to a primary care physician or other non-mental health provider related to the initial diagnosis of a MHSA disorder. Thereafter, the patient is to be referred to the MHSA plan and any subsequent visits to non-MHSA network providers are excluded under the OGB self-funded medical plan.

G. Coordination of Benefits (COB) with Other Plans

The MHSA firm will be required to coordinate benefits with other plans when OGB is secondary payor, as well as with Medicare for those retirees who are enrolled for the coverage. For Medicare retirees, benefits must be coordinated on a Medicare carve-out basis. Whatever benefits remain after Medicare has paid its benefits are subject to the plan's co-pay or coinsurance provisions. Full coordination of benefits applies to active employees and to retirees without Medicare and their dependents.

H. Administrative Requirements

1. File Transfer

Proposer must possess the capability to submit and transmit data via a secured file transfer process (FTP).

2. Plan Member Communication Materials

The MHSA firm shall submit copies of all plan member communication materials and promotional materials to the OGB. All such materials shall be approved in writing by OGB prior to their use in communicating the features of the MHSA plan to eligible enrollees. Liquidated damages of $5000 per occurrence may be assessed for failure to obtain OGB approval.

The cost of preparation and distribution of any plan member communication materials, including provider directories, must be included in the MHSA firm's quoted fees.

3. Grievance Procedures

If Option 1 is selected, the MHSA firm will be at full risk for providing MHSA coverage to plan members and the contractor's determination is final. If Option 2 is selected, the Contractor shall maintain appeal, grievance and review procedures in compliance with Louisiana law and provide same to OGB upon request. A plan member whose appeal, grievance or request for review is not satisfactorily resolved by Contractor's final determination may request further review through OGB's administrative review process. Effective July 1, 2011 all appeals procedures shall comply with the Patient Protection Affordable Cost Act.

4. Telephone Service Requirement

The MHSA firm must maintain a sufficient number of toll-free lines which may be accessed by plan members on a 24-hour basis for emergency crisis intervention to meet the requirements in the following paragraph. A sufficient number of toll-free lines must also be maintained to provide access during regular business hours (8:00 AM – 5:00 PM, Central Time) for routine assessment and referral for general questions.

Members/providers calls should be answered within 30 seconds by a person. The maximum period of time a call may be placed on hold may not exceed three (3) minutes. The average abandonment rate must be no greater than 3%. If the telephone access standards are not met, the MHSA will be required to add additional phone lines and personnel as necessary to meet the required standards. An electronic phone system capable of tracking call volume and abandonment rates is required.

Staff responding to incoming calls must have on-line computer terminals available for instant access to member eligibility.

5. Account Executive Requirement

The MHSA firm shall provide a designated, experienced Account Executive and at least one back-up staff member to handle the overall responsibility of the OGB program. The individual who serves as Account Executive must be experienced in working with large accounts (20,000 employees plus). Additionally, this representative must be responsible for assistance with program implementation and ongoing account support.

6. Meeting Requirement

The Account Executive for the MHSA firm shall be available for monthly management meetings with OGB staff and/or meetings of the OGB Policy and Planning Board or its committees, as requested. At these meetings, the MHSA firm should be prepared to discuss any aspect of its program. Discussions may include an in-depth review of management reports and any suggestions for program changes. The cost of all travel expense associated with attendance at these meetings are to be included in the fee quotation in Section IX of this NIC.

7. Data Elements

The MHSA contractor should maintain a minimum of data elements for each claim transaction as specified in Exhibit 4.

I. Reporting Requirements

1. Monthly Reports (Must be received within 30 days following the end of the month), Monthly reports must contain an Executive Summary.

a. Enrollment -- Number enrolled sorted by active, retiree, (Medicare and non-Medicare), dependent, LACHIP by age and sex. Average age of plan members to be included, sorted by active, retiree, dependents and LACHIP.

b. Authorization – Admission and units of service authorized by level of care and network status (participating vs. out of network) and reported separately for MH, SA and Total combined MH and SA; displayed by number and per 1000 members annualized.

c. Financial -- Provider charges and paid claims amounts for current month and cumulative year-to-date broken into categories by actives, retirees (Medicare and non-Medicare), dependents, LACHIP and level of care.

d. Claims Processing -- Number of claims received, paid, pended and denied by type of service; dollar amount of claims paid and denied; number and percent processed within 14 days and within 30 days. The number and amounts of payments for the LaCHIP claims must be reported separately.

e. Appeals and Denials by level of care and level of appeal Report should include break-out by clinical (medical necessity) and administrative denials reason type, providing data on number of denials, number/percent that are appealed at each level; resolution

of appeal and % resolved within timeframe standards.

f. Member and Provider Complaints

g. Telephone Service – To include number of calls received (by type and combined), average speed of answer, percent answered within 30 seconds, average hold time, number of calls placed on hold that exceeded three (3) minutes, average abandonment rate and number of calls actually abandoned.

2. Quarterly Reports (Must be received within 45 days following the end of the each quarter). Quarterly reports must contain an Executive Summary.

a. Roll-up of monthly reports and year to date

b. Cost and Utilization of Care:
   - total charges and total paid (incurred during qtr and YTD and paid though run date of report) claims by level of care and broken out for MH and SA;
   - penetration rate, PMPM expense, PEPM expense, utilizers per 1000;members per 1000 by level of care;
   - paid (incurred during qtr and YTD and paid though run date of report) admits per 1000 and days/visits per 1000 by level of care;
   - average cost (amount claims paid) per day/visit, per admission by level of care and total;
   - Charges and paid by level of care and member category (active, dependents, retirees (with Medicare, retirees without Medicare), LACHIP;
   - Top 15 diagnosis report with claims paid, unique member count, utilizer per 1000 for quarter and YTD; Report should detail top 15 for Inpatient (total days and average length of stay, average amount paid per day and per admission); top 15 for outpatient (ambulatory) and combined.
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c. Care Management:
   - High cost report – number of members accumulating > $10,000 in paid claims during period and > $25,000 YTD with number of patients, average paid per patient, total paid amount, percent of total paid claims, distribution by diagnosis and member category (active, dependents, retirees with Medicare, retirees without Medicare and LaCHIP Members).
   - Number screened for Intensive management programs (case management, disease management, etc); number admitted to intensive management programs
   - In-patient Follow-Up Program Metrics – number of discharges, number members with attempted calls, number members with calls completed; number and percent of discharged with ambulatory follow-up appointment within 7 days of discharge and 30 days of discharge.
   - Readmissions within 30 day, 90 days and 365 days; should include comparison across quarters/years
   - number of IP admission reviews, and number of concurrent reviews;

d. Network:
   - Claim charges and paid for participating versus non-participating providers by level of care and broken out for MH and SA
   - Total claim charges submitted, amount paid, member responsibility, disallowment amount and net paid
   - Number of providers and facilities in network by type (MD, Psychologist, Masters level, Intensive Outpatient, Partial Hospital, Acute Hospital, CD Rehab, Residential);
   - Number provider and facility terminations by type during report period;
   - Number of new and re-contracted contracted providers and facilities by type during report period.

e. Claims Quality Report – number of claims reviewed/audited, dollar amount of claims reviewed; percent financial payment accuracy and percent claims processing accuracy.

f. COB/Subrogation - Report by active, retiree with Medicare and retiree without Medicare, type of service, amount of claim and amount recovered;

g. Quality Report – Report of status and/or progress on performance standards and quality improvement projects

h. “ALERT" Report – Over-utilization or abuse by plan member or provider, fraud, etc. with number of cases identified and disposition, number of cases under review.

i. Fraud and Abuse Report

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3. Semi-Annual Reports (Must be received 30 days following the end of every 6 months) Semi-Annual Reports must contain an Executive Summary).

   a. Geo Access Report for rural and urban, displayed for inpatient facility, partial, hospital, outpatient provider and MD

4. Annual Reports (Must be received within 60 days following the end of the fiscal year) Annual reports must contain an Executive Summary. and cumulative monthly and quarterly reports.

   a. Financial – Charges billed and paid claims amounts for each metropolitan area for current month and cumulative year-to-date broken into categories by:
      - level of care, service type (MH, SA, Combined MHSA)
      - employee category (actives, dependents, retirees (Medicare and non-Medicare), LACHIP
      - age group.

   b. Claims -- Lag report showing month of service and month of payment.

   c. Clinical Trend Report-- List of 25 most common inpatient diagnoses, (charges and paid) and list of outpatient diagnosis with paid charges and paid (include cost/member, sorted by geographic location and in the aggregate.

d. Clinical Quality Metrics
   - Follow-up care for children prescribed ADHD medication (can be submitted for last calendar year ending within the contract year)
   - Follow-up after hospitalization for mental illness – 7 days, 30 days.
   - Antidepressant Medication Management (can be submitted for last calendar year ending within the contract year)
   - Results of selected performance improvement projects

e. Network:
   - List of 50 most utilized network providers in Louisiana by geographic region, by average number of visits
   - List of top 25 most utilized facilities by number of admissions, average length of stay, 30 and 90 day readmission rate and 30 day ambulatory follow-up rate.
   - In-network versus out-of network analysis for each level of care.

f. Geo Access for inpatient, outpatient and MD (based on performance standards)

g. Patient Satisfaction Survey Results

h. Provider Satisfaction Survey Results

i. Savings – Savings summary by COB, subrogation, other.

In general, periodic reports must contain sufficient data to allow the reader to quickly analyze current period utilization as compared to previous periods and comparative benchmarks. The reports should contain a one-page overview of the period's activity noting the following key elements for mental health care alone, substance abuse alone, and mental health/substance abuse combined:

Inpatient (by facility type and combined)

1. Number of admissions
2. Number of total beds in acute facility
3. Average length of stay in acute facility
4. Average cost/day
5. Average cost per inpatient case
6. Total inpatient claim cost
7. Number of readmits within 30 days, 90 days and 365 days
8. Percentage of readmits with 30 days, 90 days and 365 days
9. Number of treatments within 30 days, 90 days and 365 days
10. Percentage of readmits with 30 days, 90 days and 365 days

Outpatient (by service type and combined)

11. Total number of patients receiving outpatient sessions
12. Total number of outpatient sessions
13. Average number sessions/patients

14. Average cost/session
15. Average cost per outpatient episode/case
16. Number of outpatient visits/1000 plan participants

A sample report layout which would include this information plus a trend of activity might look like:

Key Elements	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			Year-to-Date		
	P	S	C	P	S	C	P	S	C	P	S	C	P	S	C
# of admissions															

P=psychiatric S=substance abuse C=combined

Included with your quarterly reports should be information as suggested by the following formats:

Utilization	Benchmark (using your firm's goal data)	Quarter beginning _____ and ending _____
Acute Inpatient Admissions		Combined Mental Health Substance Abuse
IP Average Length of Stay		Combined Mental Health Substance Abuse
IP Days/1000 lives		Combined Mental Health Substance Abuse
Residential Admissions		
Residential Average Length of Stay		
Residential Days/1000 lives		
Partial Hospital (PH) Admissions		
PH Average Length of Stay		
PH Days/1000 lives		
Intensive Outpatient (IOP) Admissions		
IOP Average Length of Stay		
IOP sessions/1000 lives		
Outpatient visits/patient		Combined Mental Health Substance Abuse
Outpatient visits/1000 lives		Combined Mental Health Substance Abuse

Paid Claims

Claim Type	Requested Amount	Allowed Amount	Provider Discount	COB	Copay	Deductible	Amount Paid
Inpatient							
CD Rehab							
Residential							
Partial Hospital							
Intensive Outpatient							
Outpatient							
Other							
Totals							

j. Other

1. Ad hoc reports other than those listed above may be required by OGB from time to time.

   In preparing your response, bear in mind that this section is intended to illustrate the types of reports that might be required on a periodic basis. You should consider this the minimum data that you will be required to collect and maintain. The final report formats will be determined based upon mutual discussion and agreement among OGB staff, its consulting firm and the successful proposer prior to contract implementation.

k. Performance Standards and Guarantees.

Each MHSA firm must agree to abide by the performance standards and guarantees specified on the following tables.

OGB reserves the right to reduce or waive any performance penalties if, in OGB's sole discretion, the failure of the MHSA firm to meet a performance standard was due to extraordinary circumstances.

See Tables on Pages 18 - 20.

PERFORMANCE STANDARD TOPIC	DESCRIPTION OF STANDARD	STANDARD EVIDENCED BY	TARGET	PENALTY (Fees At Risk)
Appointment Access	Appointment available for elective requests within 72 hours.	Report to OGB based on audit of valid sample of cases using methodology approved by OGB.	≥ 90 %	1.5%
	Urgent/emergency requests receive immediate telephone contact by an appropriate counselor and appointment available within 24 hours.	Audit of valid sample of cases using methodology approved by OGB.	≥ 95%	1.5%
Customer Service	Telephones answered 24 hours a day/7 days a week with average speed of answer of 30 seconds	Call system reports submitted to OGB calculated from time member selects a prompt to the time answered by a live voice. Includes intake and member service lines	≤ 30 seconds	1.0%
	Less than 3% abandonment rate for all intake and member service calls.	Call system reports submitted to OGB showing percent of calls that are placed in queue but not answered before caller hangs up. Includes intake and member service lines	≤ 3%	0.5%
Network	Maintain network with adequate providers to meet the following standards: 90% of plan members within 10 miles of two professional providers (Urban/Suburban) 90% of plan members within 45 miles of two professional providers (rural) 90% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban) 90% of plan members within 60 miles of one inpatient acute care facility provider (rural)	Geographic network accessibility reports produced by MHSA firm and submitted to OGB. Urban and rural standards must be met for both OP and IP standards to meet performance standard.	 ≥ 90% ≥ 90% ≥ 90% ≥ 90%	3.0%

PERFORMANCE STANDARD TOPIC	DESCRIPTION OF STANDARD	STANDARD EVIDENCED BY	TARGET	PENALTY (Fees At Risk)
Satisfaction Surveys	Member Satisfaction Survey Scores	Report to OGB. Member satisfaction survey administered at least annually with survey tool, methodology and sampling approved by OGB. Scores calculated by adding positive rating.	≥ 90%	1.5%
	Provider Satisfaction Survey Scores	Report to OGB. Provider satisfaction survey administered at least annually with survey tool, methodology and sampling approved by OGB. Scores calculated by adding positive rating.	≥ 85%	1.5%
Complaints	Complaints acknowledged within one business day following receipt of complaint.	Report to OGB, tracking time complaint is received verbally or in writing to time of acknowledgement, documented in writing to client.	≥ 95%	0.5%
	Complaints researched and resolved within 30 calendar days	Report to OGB, tacking time complaint is received verbally or in writing to time of resolution with client, documented in writing to client.	≥ 95%	1.5%
	Appeals resolved within time frame per MNRO standards	Report to OGB from Appeal log tracking receipt date, acknowledgement date, and resolution date for each level of appeal	100%	1.5%
Reporting Requirements	As specified in Section I(Y)	Receipt date of reports.	≥ 99%	1.5%
Claims Processing Accuracy	Percent of claims paid within 30 days	Monthly reports to OGB showing percentage of clean claims processed within 30 calendar days from receipt of claim (Subject to independent third party audit at discretion of OGB)	≥ 99%	1.5%
	Financial Payment (dollar) accuracy	Monthly report to OGB showing percentage of audited claims dollars paid accurately. (Subject to independent third party audit at discretion of OGB)	≥ 99%	1.0%

PERFORMANCE STANDARD TOPIC	DESCRIPTION OF STANDARD	STANDARD EVIDENCED BY	TARGET	PENALTY (Fees At Risk)
	Claim processing accuracy	Monthly report to OGB showing percentage of audited claims processed accurately (Subject to independent third party audit at discretion of OGB)	≥ 97%	1.0%
Clinical Standards	Ambulatory follow-up after acute hospitalization within 30 days after discharge	Ambulatory follow-up within 7 days of discharge from 24 hour acute facility using HEDIS specifications or modified HEDIS specification as approved by OGB	≥ 80%	1.5%
	Medical integration for members identified with major depressive, bipolar and psychotic disorders.	Percent of members identified with major depressive disorder, bipolar disorder, or psychotic disorders with annual medical visit with a primary care provider during the reporting year, using reporting specifications to be agreed upon during contract implementation	10% annual improvement from baseline	1.5%
	Readmission Rate with 30 days	Reported to OGB as measured through reporting based on discharge within the measurement period with readmission to an inpatient level of care within 30 days	≤ 8%	3.0%

SECTION III

SCHEDULE OF EVENTS

A. Time Line

Public notice by advertising in the official journal of the State	September 21, 2010
NIC mailed or available to prospective Proposers Posted to OGB Website; Posted to LAPAC	September 21, 2010
Deadline to notify OGB of interest to submit a Proposal **(MANDATORY)**	September 30, 2010
Deadline to receive written questions	September 30, 2010
Electronic data sent to interested proposers	October 4, 2010
Issue answers to written questions	October 5, 2010
Proposer's Conference – Attendance in Person **(MANDATORY)**	October 12, 2010
Proposals due	October 22, 2010
Finalist's interviews/site visits	TBD
Probable selection and notification of award	TBD
Contract effective date	January 1, 2011

NOTE: The OGB reserves the right to deviate from this schedule.

B. Mandatory – Notification to OGB of Interest to Submit a Proposal

All interested Proposers shall notify OGB of its interest in submitting a proposal on or before date listed in the Schedule of Events. Notification should be sent to:

Tommy D. Teague
Chief Executive Officer
Office of Group Benefits

Delivery:
7389 Florida Blvd., Ste 400
Baton Rouge, LA 70806

Mail:
Post Office Box 44036
Baton Rouge, LA 70804

Fax: (225) 922-0282

E-Mail: patty.rahl@la.gov

NOTE: Proposals will only be accepted from Proposers that have met this requirement of notification to OGB of their interest to submit a proposal.

C. Written Questions

Written questions regarding the NIC are to be submitted to and received on or before 4:00 p.m. Central Standard Time (CST) on the date listed in the Schedule of Events. Written questions should be directed to the address listed in subsection B of Section III.

D. Mandatory – Proposers Conference (In Person)

The Proposer's Conference will be held in the conference room at 10:00 a.m. Central Standard Time (CST) on the date listed in the Schedule of Events at the following location:

Office of Group Benefits
7389 Florida Blvd., Ste. 400
Baton Rouge, LA 70806

A representative of your organization must participate in person at the Mandatory Proposers Conference. OGB staff will be available to discuss the proposal specifications with you and answer any questions you may have in regards to submitted questions. If participation will be by telephone Proposer shall advise OGB of such when notifying OGB of their interest to submit a proposal.

Proposals will only be accepted from Proposers that have met this mandatory requirement. Attendance by a subcontractor is welcome, but will not be an acceptable substitute for a representative of the primary proposing firm/organization.

E. Proposal Due Date

The original proposal must be signed by an authorized representative of your firm/organization and delivered, together with eight (8) numbered copies, between the hours of 8:00 a.m. and 4:00 p.m. Central Standard Time (CST) on or before the date listed in the Schedule of Events at the address listed in subsection B of Section III.

SECTION IV

PROPOSAL EVALUATION

A. Proposal Evaluation

Proposals will be evaluated by a Selection Committee. Each proposal will be evaluated to insure all requirements and criteria set forth in the NIC have been met. Failure to meet all of the Proposer Requirements will result in rejection of the proposal.

After initial review and evaluation, the Selection Committee may invite those Proposers whose proposals are deemed reasonably susceptible of being selected for award for interviews and discussions at the OGB's offices in Baton Rouge, Louisiana, or the Committee may make site visits to the Proposers' offices and conduct interviews and discussions on site. The interviews and/or site visits will allow the Committee to substantiate and clarify representations contained in the Proposers written proposals, evaluate the capabilities of each Proposer and discuss each Proposers' understanding of the OGB's needs. The results of the interviews and/or site visits, if held, will be incorporated into the final scoring for the top scored proposals.

Following interviews and discussions, scoring will be finalized in accordance with the evaluation criteria below. The proposal receiving the highest total score will be recommended for contract award.

B. Evaluation Criteria

After determining that a proposal satisfies the Proposer Requirements stated in the NIC, an assessment of the relative benefits and deficiencies of each proposal, including information obtained from references, interviews and discussions and/or site visits, if held, shall be made using the following criteria:

Category	Maximum Points	Major Areas to be Addressed
1. Financial	500	Cost of Services
2. Network and Member Access	200	Plan Member Disruption/Continuity of Care, Providers by Discipline and Other Access Criteria (Office Hours, Average Wait Times for Appointments, provider issues, provider rate schedule)
3. Clinical Quality	150	Care management program, and clinical quality management program and results.

4. Administrative Member Services	100	Service capabilities, Claim paying Services and Guarantees (Non-Financial), Responsiveness to OGB issues
5. Organizational	50	Experience, References and Stability Financial Solvency
Maximum Points	1,000	

C. Cost Evaluation

Option 1 – Fully-Insured

The Proposer that provides the lowest fee per employee per month will be awarded the full points for cost of services.

All expenses (personnel compensation, travel, office supplies, copies, communications and etc.) should be included in the proposed rate. In addition, any projected increases for delivery of services for the entire contract period should be anticipated and included in the proposed rate.

Option 2 – Self-Insured

Points will be based on expected claims cost **(actuarially determined)** and administrative services fee averaged over a maximum three year term. The cost proposal determined to be most beneficial to the state will be awarded the full points for cost of services.

Each proposer will receive a CD containing claims actually incurred by OGB members. The claims on this CD must be readjudicated by each proposer utilizing the OGB MHSA Plan of Benefits detailed in Section II, Item B. The re-priced claims file must indicate if the claim was for inpatient hospital, outpatient hospital, or physician services, and further if the claim was for an in-network or out-of-network provider. If a claims was not re-priced, include a field in your file that indicates the reason for the claim not being re-priced. These readjudicated claims must be submitted with your proposal.

All expenses (personnel compensation, travel, office supplies, copies, communications and etc.) should be included in the proposed rate. In addition, any projected increases for delivery of services for the entire contract period should be anticipated and included in the proposed rate.

NOTE: OGB reserves the right to award a contract for Option 1 or Option 2.

Evaluation of Cost:

The total contract charge shall be quoted on the Fee Proposal Form of this NIC.

A maximum of 500 points shall be given to the proposal with the lowest total cost.

Points for the other proposals shall be awarded using the following formula for each category:

$$\frac{(X)}{N} \quad X \quad 500 \quad = Z$$

Where:

X = lowest computed cost for any proposal
N = actual computed cost awarded to the proposal
Z = awarded points

This formula will be used for all options.

SECTION V

PROPOSERS REQUIREMENTS

Requirements Checklist

Instructions for Completion of the Proposers Requirements Checklist:

Please proof your answers before submitting your response to ensure completeness.

The MHSA firm will be held accountable for the accuracy/validity of all answers. You may also be asked to substantiate any response during the interview, on-site visit or through a formal audit process.

Please note that your proposal will become part of the contract between OGB and the MHSA firm, if and when the proposal is accepted and accompanied by a separate formal written contract document.

Name of MHSA firm:

Minimum Requirements Checklist	Indicate "Yes" or "No"
1. Does your firm have a minimum of five (5) years experience in providing MHSA services?	
2. Are you currently providing MHSA services to at least two (2) groups with a minimum size of 25,000 covered employees and/or retirees (not counting dependents) of which at least one of these groups is a single employer (corporate or government)?	
3. Is your firm licensed as required by the Louisiana Commissioner of Insurance in order to provide the coverage requested in this NIC? Please attach your response to this Section evidence that your firm is so licensed or, if not currently licensed, a detailed description of the procedures, including a time line, you would follow in order to insure compliance by January 1, 2011?	
4. Do you meet the following minimum network access standard as of the date your proposal is submitted? 70% of plan members within 10 miles of one professional providers (Urban) 70% of plan members within 20 miles of one professional provider (Suburban)	

Minimum Requirements Checklist	Indicate "Yes" or "No"
70% of plan members within 45 miles of one professional providers (rural) 70% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban) 70% of plan members within 60 miles of one inpatient acute inpatient facility (rural)	
5. Are you willing to commit to the following minimum network access standard as of January 1, 2011 effective date? 90% of plan members within 10 miles of two (2) professional providers (urban) 90% of plan members within 20 miles of two (2) professional provider (suburban) 90% of plan members within 45 miles of two (2) professional providers (rural) 90% of plan members within 30 miles of one inpatient acute care facility provider (urban/suburban) 90% of plan members within 60 miles of one inpatient acute inpatient facility (rural)	

SECTION VI

QUESTIONNAIRE

A. General Information

1. Provide a brief history of and an organizational table for your company. Include any name changes, mergers and reorganizations. Include the names and titles of all senior officers.

2. Name all organizations which have a financial interest in your company. Describe their relationship to your company in terms of percentage of stock held or amount of venture capital invested.

3. List the names, addresses and professional affiliations of members of your Board of Directors.

4. a. Provide the names and resumes for each of your staff who will provide services to OGB and their function with respect to this contract.

   b. Provide a team organization chart, indicating the senior officer in charge of the team and the specific liaison(s) with OGB.

5. If you are the successful proposer, what percentage of your business would this contract represent in terms of:

   a. Membership _____% (number of employees)

   b. Dollar volume _____% (% of total revenue)

   c. Claims paid _____% (% of number of claims)

6. What is the total dollar volume of MHSA business written by your company during the most recent fiscal year?

7. What was the total volume, in terms of numbers of claims and benefits paid by your company during the most recent fiscal year?

8. Please list the locations of your

   a. Main office
   b. Claims office
   c. Service office(s)
   d. Service locations for after hours

9. Do you have an office in Louisiana? If so, note location and describe its function.

10. For how many years has your company been providing capitated full-risk MHSA network services?

11. Please list any accreditations (e.g. URAC, NCQA, etc) your company has for the proposed service center that will serve OGB employees.

12. Within the last 3 years has your organization, any affiliate of the company, any senior officers or board members been a party to a lawsuit or governmental investigation? If so, provide a brief description of each incident. What was disposition?

13. List any ownership interest your company has in any MHSA facility or provider. Describe the relationship and attach the organizations' audited financial statements for the most recent two fiscal years. Please include all financial statements and any notes that relate to those statements.

14. Do you now subcontract with any other organization(s) for services (such as claims processing, utilization review, data processing or any other professional services)? If so, provide a description of your subcontracting arrangements.

15. If your firm is the successful proposer, will the services required under this contract require you to enter into new or substantially modified subcontracting arrangements? If so, describe the reasons and a description of the new or modified arrangements.

16. Please explain the measures you take to protect patient and organizational confidentiality. Specifically, what measures do you take to protect your current clients' confidentiality?

17. Describe the internal quality control audits performed by your firm by type and frequency during a given year.

18. Pursuant to Section II of this NIC, is your firm currently licensed as required by the Louisiana Commissioner of Insurance? If not, provide a detailed description, including a time line that you would follow to ensure that your firm is properly licensed before the effective date of the contract with the OGB.

19. Disclose any financial or claims paying ability ratings issued to your firm by any of the following rating agencies: A.M. Best, Moody's, Standard & Poor's and Duff and Phelps. Provide the same information on ratings issued to your parent company, if any.

20. Identify the full name of the insurance company underwriting the proposed MHSA benefits and disclose any financial or claims paying ability ratings issued to the carrier by the following agencies: A.M. Best, Moody's, Standard & Poor's and Duff and Phelps.

21. Do you agree to provide liability coverage, including malpractice and insolvency protection, with a combined single liability of not less than $10 million?

22. Do you agree to a performance bond in an amount equal to three (3) months' aggregate per-contract cost based on enrollment as of January 1, 2011, to insure performance under the contract?

23. Do you agree to provide MHSA services, as specified in this NIC, recognizing the unique benefit plan designs of OGB?

24. Do you agree to assume liability for all MHSA services rendered from January 1, 2011 through the date of termination of the contract, with the exception of inpatient admissions in progress on January 1, 2011, which are the responsibility of the incumbent MHSA firm until date of discharge, thereafter, such patients will be covered by your contract?

25. Do you agree to assume liability for inpatient admissions in progress on termination date of the new contract until date of discharge?

26. Do you agree to the Performance Standard and Guarantees? (See Section II)

27. For each of the past two fiscal years, please provide the following information by class of employee, e.g. physicians, RNs, LPNs, member services staff, provider relations staff, claims processing staff, etc. a. number of staff, b. employee turnover, average tenure with company.

B. Communications

1. How do you propose to educate plan members and their dependents about the plan and your services? Describe the approach you would use for initial and ongoing communication.

2. a. What communications materials do you propose to provide to plan members and OGB staff and how often?

   b. Keeping in mind that OGB will have final approval, please provide samples of initial and ongoing communication materials you would suggest.

3. You must agree to make appropriate members of your organization available to meet with OGB staff, employee groups, etc. as needed and agree to attend meetings of the OGB Policy and Planning Board and its committees, as requested.

4. What website capability is available to members? Please provide information necessary to access a demonstration website (i.e. URL, logon ID, password)

C. Intake and Member Services

1. For the following services, list the days and hours of accessibility as well as staffing

information, i.e. who answers the phone and their qualifications.

a. Intake and Referral/crisis line

b. Provider relations

c. Member service

d. Utilization review

2. Do you use an automated attendant to route callers? If yes, how many choices is the caller offered (i.e. buttons to press) before speaking with a live staff member? Can you customize the auto-attendant message for OGB?

3. How do you handle after-hours and weekend emergency calls? Who handles the calls and what are their qualifications?

4. Describe the screening and referral process starting from the moment the patient contacts you. Provide a flow chart.

5. For a typical, non-emergency assessment/referral call, what information is taken over the toll-free line and by whom?

6. When calls to member service require transfer to a licensee clinician, do you transfer callers to voicemail or to the clinical queue – If to the clinical queue, what is the average wait time in queue to access a licensed clinician?

7. a. Provide a description of your telephone system and a sample of your standard call report.

   b. How do you track the number of calls received, speed of answer, hold time (time in queue) abandoned calls, etc.?

8. Please provide actual average performance results based on your book of business for the most recent 12 month period of time (include intake and member service calls).

	ACTUAL	GOAL
a. Percent Abandoned calls	%	%
b. Average speed of answer	Seconds	Seconds
c. After-hours average speed of answer	Seconds	Seconds
d. Average percent of calls answered within 30 seconds	%	%
e. Average time in queue for transfer from	Seconds	Seconds

	ACTUAL	GOAL
member service to any other department		
f. Percent calls receiving busy signal	%	%
g. Percent abandonment rate	%	%

9. Initial calls from plan members can be expected to be answered within how many seconds or rings?

10. a. Indicate your standard business hours and days:
DAYS:
HOURS:

b. Indicate your "after" hours and days:
DAYS:
HOURS:

11. Provide the average time from a call being answered to a referral being given for both emergency and non-emergency assessment calls.

12. You must agree to maintain a sufficient number of toll-free lines which may be accessed by plan members on a 24-hour basis for emergency crisis intervention. A sufficient number of toll-free lines must be maintained to provide access during regular business hours for routine assessment and referral and for general questions. Describe how you plan to accomplish this for OGB.

13. Describe how you would handle urgent, emergent and calls requiring crisis intervention such as a threat of suicide or violence.

a. How call will be triaged to an appropriate clinician and then to an appropriate network resource?
b. List of risk screening questions that staff is required to ask?
c. Follow-up to assure member reaches and is seen by network resources to resolve crisis and appropriate intervention.
d. Indicate the qualifications of the person managing this call.

14. What are your current average waiting times and what are your goals for participants to secure appointments for the following types of conditions:

	Current	Goal
a. Emergency b. Urgent c. Routine	_____ _____ _____	_____ _____ _____

15. Describe any automated patient registration and referral technologies that your organization has available for members which will enhance access to services.

16. Discuss your method of measuring patient satisfaction including scoring, sampling, administration and follow-up for improvement. You must evaluate satisfaction for a statistically valid sample of members receiving treatment each year. Provide the complete results of your most recent patient survey and the time frame covered. Include a copy of the questionnaire/survey.

17. Discuss the process you follow to address complaints from participants dissatisfied with member services. Include a definition of "complaint" and "grievance" and how you train staff on documenting and resolving complaints and grievances. In addition,

    a. Provide the number of complaints/yr for the last 3 years.
    b. Have you categorized the nature of complaints received? And if so, what are the three largest categories and what percentage of the total complaints are represented by each one of the top three.
    c. How many complaints in each of the last three years escalated to agencies outside of your organization?

18. Describe specifically your appeals process to which plan members and their dependents would have access in the event of a disputed claim or referral procedure. Indicate the maximum turnaround time at each stage of the process and provide a flow chart describing the appeals procedure. In addition,

    a. What was the percentage of denials/certifications for inpatient and outpatient care. Give these figures for the total population and then broken down by psychiatric, substance abuse and detox certifications.

D. Claims Administration/Data Reports (Total points for this section: 44; 0 for poor; 1 for average; 2 for excellent)

1. Describe your claims turnaround goal <u>vs.</u> actual turnaround time with respect to contracted providers, non-contracted providers and COB claims.
2. Describe your claim processing quality review procedures. What type of internal and external audits are done, how often and by whom?

3. Explain how you would propose to handle COB for OGB. What percentage of COB savings do you now realize on average? How do you achieve this?

4. Provide a description of your claims processing system, including hardware and software.
5. How would you design safeguards against an ineligible plan member attempting to or actually using the network? Would your procedure attempt to identify the ineligible member

at the point of interface with the referral counselor or would it be an after the fact benefits denial?

6. As a continuation of (5) above, describe your computer capability for data analysis and reporting, including model, capacity, redundancy, access protocols, ability to recognize duplicate claims, interface with UR firm decisions, etc.

7. List a representative sample of your explanation of benefit messages and furnish a sample of the EOB your company will be using. Also provide a representative sample of all claim-related form letters sent to participants including denial notices and describe how forms and letters will be customized for the purposes of OGB.

8. Please confirm your ability to accept and integrate into your system eligibility information furnished by OGB, both initially and for monthly updates. Are there any specific requirements that your system cannot accommodate?

9. Who owns the claim system and/or facility?

10. How much longitudinal data (in months) is maintained in your working data set? Archived? At any point in time, how much is accessible for analytical purposes?

11. If original claims fields are not preserved in detail, which are summarized and which are excluded?

12. Please confirm that your system is capable of processing paperless (electronic) and paper claims.

13. Please describe your procedures for processing and documenting adverse claims decisions (complete and partial). The successful proposer must retain this documentation during the term of this contract and for a period of time thereafter as determined by OGB.

14. Discuss the flexibility of your data structure. Can it be reorganized, expanded or otherwise modified to accommodate OGB's reporting requirements? If so, what is the time frame needed for such modification?

15. Is your computer system owned by your firm? If not, who owns the system?

16. Are system programmers comprised of in-house staff or contracted professionals? In either case, please discuss staffing adequacy.

17. What experience do you have exporting MHSA data to another vendor for the purpose of implementing integration initiatives? Describe the nature and size of the data sent and frequency of data feed.

18. What experience do you have for accepting medical, pharmacy, health risk assessment

or other patient data from other vendor partners for the purpose of implementing integration initiatives? Describe the nature and size of the data set and what you did with the data once received, including use by care managers in the management of care.

19. Describe your reporting system and its purpose, including report parameters.

20. Your system must provide the flexibility to accommodate OGB needs which may include, but may not be limited to reports showing utilization by provider, geographic area, type and duration of treatment, diagnosis, classification and age of the plan member, normative comparisons, etc. Please confirm your understanding of and ability to conform to this requirement.

21. Describe the time frame needed to produce any ad hoc reports over and above OGB-specific periodic reports. .

22. What is the average length of time from a network provider submitting its charges to date of payment by your firm?

E. Cases in Progress

1. There will be MHSA cases in progress at the time of implementation of the next MHSA contract. How would you handle existing inpatient and outpatient cases in progress during the transition? Specifically address the potential problems of non-matches of providers between your network and the incumbent MHSA firm's network.

F. Provider Network

1. Describe the process and specific criteria your firm uses to:

   a. Develop a network

   b. Select network providers, both facilities and professionals.
   Be certain to include the specific qualifications you require and credentialing criteria you apply in the selection of network hospitals, residential treatment centers, partial day facilities and half-way homes, as well as those for individual practitioners. In your response, discuss the extent to which your credentialing process is automated.

2. Address each of the following issues separately:

   a. Guidelines and software used for determining a cost-efficient provider

   b. Minimum requirements for practitioner and facility malpractice and liability insurance

   c. Methods for evaluating quality of care

d. Profiling or metrics reported to network providers and facilities to provide feedback on performance.

e. Any initiation, processing, or ongoing fees paid to you by providers in order to participate in the network.

f. Any Pay for Performance incentives in place.

3. Describe any difficulties you may have experienced in the past in identifying or developing network providers in various areas throughout Louisiana.

4. Do you interview the potential provider face-to-face?

5. Do you visit provider offices A) prior to credentialing or as part of re-credentialing? B) If yes, a) what percentage of network providers in Louisiana had a provider office visit, b) what are the criteria for deciding who will receive an office visit c) what are criteria reviewed when the office visit is made?

6. Do you require that physicians be Board Certified in psychiatry? What percentage of your physicians are Board Certified?

7. a. How are credentials verified?

   b. How often do you re-credential providers?

   b. What standards must be met for re-credentialing?

8. Describe how provider data is used for contract negotiation and renewal.

9. a. How many providers did you recruit during the past two years?

   b. What is the average length of time from receipt of application to join your network and official contract effective date as a network provider?

   c. What is the average length of time from receipt of application to join the network and official credentialing date as a network provider?

10. How many providers were involuntarily terminated during the past two years? Provide this information for both facilities and practitioners, indicate the percentage of network providers terminated and the reasons for termination.

11. How many providers resigned during the past two years? Provide this information for both facilities and practitioners, indicate the percentage of network providers who resigned and the reasons for resignation, if available.

12. Describe specifically your process for removing, penalizing, or warning/counseling providers who do not meet performance and/or quality standards.

13. Provide a description of the following financial and contractual provider arrangements for network providers:

    a. Hospital and other in- and out-patient facilities

    b. Physician and other practitioner arrangements, including:
        - Any Capitation arrangements
        - Fee schedules
        - Withholds, bonuses, incentives
        - Per case rates

14. a. What type of case(s) or specialized treatment conditions cannot be provided by any of the professional providers in your network?

    b. How can members access these services? Where?

15. Does your provider contract contain language which requires the provider to comply with Utilization management and quality management protocol/procedures?

16. For your existing provider network, describe the number and nature of any malpractice suits incurred during the past two years, including the following information:
    a. Number and nature
    b. Disposition of each and the amount of judgment
    c. Pending suits and anticipated outcome
    d. Preventive steps against future actions

17. Address any areas of Louisiana where you feel you should expand or add providers to your network. Discuss your approach and time frame for recruiting the number of providers where needed in order to insure that plan members in all areas of the State are afforded access to your network as of January 1, 2011, which meet the minimum access standards set forth in this NIC.

18. Provide your firm's benchmark guidelines relative to the ratio of each type of MHSA provider per 1,000 members and accessibility in terms of mileage and driving time.

19. Explain how you will handle the provision of services to plan members who are located out-of-state and out of the country.

20. Please describe your medical director’s credentials and responsibilities. If your medical director is not full-time, describe the time commitment to your firm.

21. What qualifications are required of your in-house professional staff? Describe by practice and provide information on required continuing education.

22. Please describe your standards and protocols for monitoring provider practice patterns, treatment outcomes and telephone responsiveness. Is there a profiling system for MHSA practitioners? If yes, briefly describe. Is profile data available to members? Indicate how profiling information is used in monitoring and improve quality

23. With respect to your current book of business, describe current utilization in terms of:

A. Capitated, Full-Risk Book of Business

	MH	SA		Combined
		Rehab	Detox	
a. IP Admits/1,000 members				
b. Inpatient days/1,000 members				
c. Residential admits/1000 members				
d. Res days/1000 members				
e. Partial Hosp admits/1000 members				
f. Partial Hosp days/1000				
g. IOP admits/1000				
h. IOP visits/1000				
i. Outpatient encounters/1,000 members				
j. Emergency Visits/1,000 members				
k. Avg paid claim rate per IP acute care day				
l. Avg paid claim rate per 90801 procedure				
m. Avg paid claim rate per 90806 procedure				
n. Avg paid claim rate per 90862 procedure				

B. Administrative Services Only Book of Business

	MH	SA		Combined
		Rehab	Detox	
a. IP Admits/1,000 members				
b. Inpatient days/1,000 members				
c. Residential admits/1000 members				
d. Res days/1000 members				
e. Partial Hosp admits/1000 members				
f. Partial Hosp days/1000				
g. IOP admits/1000				

h. IOP visits/1000				
i. Outpatient encounters/1,000 members				
j. Emergency Visits/1,000 members				
k. Avg paid claim rate per IP acute care day				
l. Avg paid claim rate per 90801 procedure				
m. Avg paid claim rate per 90806 procedure				
n. Avg paid claim rate per 90862 procedure				

24. For OGB, using the experience data provided in the Exhibits to this NIC, please provide your projected utilization statistics for the first 18 months and the final 12 months of the contract using the above format.

A. Clinical Treatment Protocols

1. Describe in detail your systems and procedures for admission authorization of hospital admissions. If these are different for psychiatric, substance abuse and detoxification admissions, present the information for each separately. Your response should address how the MHPAEA interim final regulations will impact this process.

2. How does your firm conduct admission authorization? How is it initiated? It is carried out by telephone, forms, electronic submission, etc.? What is the average length of time from request to completion of the authorization process?

3. Describe the screening and referral process starting from the moment the patient contacts you. Provide a flow chart.

4. Do you require an authorization for outpatient services (your response should address how the MHPAEA interim final regulations will impact this process). Describe your processes for outpatient review, including:

   a. How many sessions (visits are ordinarily covered by the initial authorization?
   b. In-network outpatient concurrent review
   c. Out-of-network outpatient concurrent review

5. a. Do you send authorization letters for inpatient and outpatient cases?
   b. If so, to whom with copies to whom?
   c. Provide a sample authorization letter for acute hospital and outpatient visits.
   d. Provide a sample denial letter. Include a sample when there is a partial denial of services (number of day/sessions authorized are less than requested) for

acute hospital and outpatient visits.

6. Describe any automated member registration and referral technologies that your organization has available and propose for OGB.

7. What percentage of proposed service requests are referred by the intake reviewers to physician advisors?

   a. What are the types of cases (in addition to denial) that are sent for review by physician advisors?
   b. How do physician advisors interact with providers to address quality of care issues identified?

8. How do you identify alcohol and substance abuse cases that are admitted through the emergency room on a secondary medical diagnosis? What outreach or other intervention is initiated for those cases that are identified?

9. a. What is your procedure when a dual diagnosis (both psychiatric/medical and substance abuse) is apparent?
   b. Is this handled differently from when only one diagnosis is assigned?
   c. Please describe what criteria you use to determine medical necessity and appropriateness of care for dual diagnosis cases for each level of care.

10. Provide the criteria used to determine whether a patient should be treated for substance abuse on an inpatient basis or an outpatient basis.

11. What is the source for medical criteria used for MHSA admissions and continued stay reviews for each level of care?

12. List the clinical practice guidelines or evidence based practices adopted by your organization. Provide the name and source from which the guidelines/practices were developed.

13. How do you manage requests for alternative treatment and programs not specifically excluded or included in the benefit design, i.e. wilderness therapy, equestrian therapy, etc?

14. Describe any tele-psychiatry or tele-therapy services you have utilized with other customers and your approach for utilization of these and other technology products.

15. How does your organization track a patient's treatment and changes in the patient's condition during a hospital stay? Please be specific as to the responsibilities of the patient, hospital, physician and review organization.

16. a. What is reviewed during the concurrent review process: i.e. diagnosis, length of hospitalization, expected length of continued hospitalization, resources of the facility, alternative outpatient opportunities? Others?
    b. From whom do you receive the information?
    c. Is the review performed on-site at the facility or over the telephone or via secure web transmission or other?

17. a. How often are higher level of care concurrent reviews scheduled?
    b. When are high frequency reviews scheduled to focus on ongoing dynamic changes in the patient's status?
    c. What factors related to the patient's condition would increase this frequency of reviews, i.e., an unclear diagnosis?
    d. If concurrent reviews can not be done because of MHPAEA provisions, how do you plan to ensure efficacy of treatment and appropriate length of stay?

18. a. What criteria are used to screen cases for potential problems with discharge planning?
    b. At what point is discharge planning initiated?
    c. When does the process end?
    d. Describe your interaction with facilities, providers and patients in the discharge planning process.
    e. What data is collected during the discharge planning process and how is it used to prevent readmissions?
    f. What care management processes are in place after the discharge occurs?

19. What patient information is provided to the outpatient provider regarding the hospitalization and treatment plan to address ongoing treatment needs and facilitate continuity of care?

20. How are follow-up appointments made after discharge from an acute inpatient hospital? What strategies are employed by your organization to facilitate and encourage the client to keep appointments made after discharge? How are ambulatory follow-up appointments tracked to measure if appointments were kept within 7 days and 30 days after discharge?

21. When is a case considered closed?

22. How does coordination of services involving referrals between multiple providers and/or facilities occur? Who is responsible?

23. Describe your methodology for tracking a patient at 30, 90 and 365 days following inpatient care discharge.

24. Describe care management processes and programs for clients who are readmitted to acute inpatient care and other complex cases.

25. Do you utilize any type of data mining or predictive models to identify high risk clients for more intensive care management?

26. Describe your intensive care management program capability.

27. Describe your experience implementing integration initiatives with medical providers.

28. Describe your system for monitoring quality of care and intervening with providers. Please be specific, using hypothetical examples as may be appropriate.

29. Under what circumstances may patients use a non-network provider? How does care management differ when the provider is out of network?

30. Describe your denial and appeal process for adverse UR decisions.

    a. What are the qualifications of person(s) who can make an adverse decision (denial)?

31. How do physician advisors obtain clinical information to make adverse decisions?

    a. What is the protocol for denial when clinical information is insufficient to make an adverse decision?

32. Do your denial letters stipulate the right to and method of appeal?

33. If acute care facility treatment is deemed inappropriate, what alternatives are presented and how are they communicated to the client?

34. For your last fiscal year (or other most recent 12-month reporting period), indicate:

    a. the number of appeals handled and closed
    b. the number of appeals resolved in favor of the patient
    c. the number of appeals resolved in favor of the company
    d. the number of open appeals
    e. the average length of time from filing an appeal to final resolution.

35. Describe your firm's protocols for financial and clinical management responsibility and claims/services for covered plan members for each of the following:

    a. Tourette's
    b. ADD/ADHD

36. What methods do you use to monitor intake and care management staff

performance and quality? What is the frequency of the monitoring? How is feedback given to staff?

37. Describe an example of a QI project that resulted in improved quality of care.

B. MHSA Network Within the State of Louisiana Exhibit

1. For purposes of this NIC, OGB has established nine major service areas which are defined by the first three digits of the zip codes. The nine major service areas are as follows:

Region	Zip Code	Fee Schedule Area
1	70000-70199	New Orleans
2	70300-70399	Houma Thibodaux
3	70400-70499	Slidell Hammond Covington
4	70500-70531 70533-70545 70550-70580 70582-70590 70592-70599	Lafayette
5	70600-70699 70532 70546 70549 70581 70591	Lake Charles
6	70700-70899	Baton Rouge
7	71300-71499	Alexandria
8	71000-71199	Shreveport
9	71200-71299	Monroe

Based upon these nine service areas, complete Table 1 and Table 2 on the following pages with regard to your current MHSA provider network within the State of Louisiana. Do not include providers you may anticipate recruiting pending contract award.

Table–1 - MHSA Provider Network within the State of Louisiana

Complete Table 1 based on your current MHSA provider network.

Major Service Areas	Total Number of Available MHSA Network Professional Providers	Total Number of MHSA Network Professional Providers	Total Number of Available MHSA Network Facility Providers	Total Number of MHSA Network Facility Providers	Total EAP Providers
1. New Orleans					
2. Houma/Thibodaux					
3. Hammond					
4. Lafayette					
5. Lake Charles					
6. Baton Rouge					
7. Alexandria					
8. Shreveport					
9. Monroe					
Total State of Louisiana					

Table–2 - MHSA Provider Network within the State of Louisiana

Complete Table 1 based on your current MHSA provider network.

Major Service Areas	Psychiatrists	Child Psychiatrists	Psy.D	PhD	Ed.D	LPC	BCIA	LMSW	ARNP	DO	CEAP
1. New Orleans											
2. Houma/Thibodaux											
3. Hammond											
4. Lafayette											
5. Lake Charles											
6. Baton Rouge											
7. Alexandria											
8. Shreveport											
9. Monroe											
Total State of Louisiana											

SECTION VII

ATTACHMENTS TO PROPOSAL RESPONSE

Please provide the following:

1. Audited financial statements for the most recent two fiscal years.

2. Information documenting the current access of the covered employee/retiree to your existing provider network.

   Enclosed with the NIC is a compact disk/diskette containing a listing of covered plan members (employees and retirees) by five digit zip code of their home residence. The zip code census information is provided separately for active employees and retirees, please note that the data represents the current OGB member data and does not constitute a guarantee that all members will be available at January 1, 2011 for this MHSA enrollment. The MHSA firm should combine the active employee and retiree zip code information and conduct an analysis of the match between total covered plan members and your current MHSA provider network. The exact parameters for the information requested is identified below:

   a. Network Accessibility Summary Reports based on the following specifications:

      - Plan Member Groups
        - Employees, retirees and LACHIP with zip codes within the State of Louisiana;
        - Employees and retirees with zip codes outside of the State of Louisiana; and
        - All employees zip codes

      - Access Standard (for each of the above groups)
        -One (1) professional provider within ten (10) miles for urban, twenty (20) miles for suburban and forty-five (45) miles for rural areas; and
        -One (1) facility provider within thirty (30) miles for urban and suburban and sixty (60) miles for rural

   b. Generate a report identifying any of the nine designated service areas within Louisiana, as defined in Section VII(H)(1) for which your current MHSA network does not meet the minimum access standards as defined in the Minimum Requirement Checklist, Section VI (A). For each service area not meeting the minimum access standard, the MHSA firm should indicate the total number of employees, number of employees without desired access and average distance to one (1) professional and one (1) facility provider.

      Note: The report names and terminology utilized above are representative of the GeoAccess program. If you utilize a program other than GeoAccess, your response must identify the number and percentage of employees meeting and not meeting the

desired access standard.

3. Provide a proposed implementation plan and timetable, beginning with the award of business to effective date of coverage, include:

    a. Steps required to implement the program
    b. Role played by the plan sponsor/MHSA firm's
    c. Transfer of eligibility
    d. Production and distribution of directories and other employee materials
    e. Contacts and personnel assigned to each step of the implementation process

4. Résumés of your firm's key management staff and account management team which would be responsible for servicing the OGB.

5. Sample of educational material provided to plan members and participating providers.

6. Sample of communications material available to plan sponsors and plan participants with regard to network enrollment, network utilization, etc.

7. Directory of your MHSA provider network for the State of Louisiana.

8. Samples of all forms that would be used in the administration of this plan that are included in your quoted fees.

8. Sample of monthly, quarterly and annual reports.

10. Your firm's protocols for financial and clinical management responsibility and claims/services for covered plan members involving mixed diagnoses which are related to both medical and MHSA disorders.

11. Proposed changes/modifications to the terms of the Standard Contract attached as an Exhibit to the NIC.

12. Additional provisions, terms, and conditions that your firm wishes to include in any contract resulting from this NIC.

SECTION VIII

MHSA FIRM INFORMATION
AND
MANDATORY SIGNATURE PAGE

A. MHSA FIRM INFORMATION

Organization Name _____

Date Founded _____

Contact Person's Name _____

Title _____

Address _____

City/State _____

Telephone Number
(with extension) _____

Fax Number _____

A MHSA firm must provide the name, key contact, phone number, number of covered employees and retirees (not including dependents) for its three largest existing clients and two recently terminated clients. At least two (2) of the current references must be for clients with at least 25,000 or more covered employees and retirees (not including dependents), of which one must be a single employer client (corporate or government).

Current Client References				
Company Name	Name of Contact and Title	Phone Number and City Location	Number of Employees/ Retirees	Contract Start Date
1.				
2.				
3.				

Recently Terminated Client Information				
Company Name	Name of Contact and Title	Phone Number	Termination Reason*	Term. Date
1.				
2.				

**Please provide details of the reason for termination, please elaborate in the space below. Be brief.*

B. Mandatory Signature Page

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

MHSA PROGRAM

This proposal complies with all mandatory requirements of the NIC. In the event of any ambiguity or unclarity, the response is intended to be in compliance.

_____ certifies that this proposal was not prepared or developed using assistance or information illegally obtained.

_____ is solely responsible for this proposal meeting the requirements of the NIC. (Exceptions are not allowed.)

_____ is solely responsible for its compliance with all applicable laws and regulations to the preparation, submission and contents of this proposal.

_____
Date

_____
Signature

_____
Printed Name

_____
Title

SECTION IX
FEE QUOTATION

A. Option 1: Fully Insured

The MHSA firm is required to quote an all-inclusive monthly premium non-refundable cost per employee **per month.**

1.1 MHSA Benefits

Option 1: Fully Insured Premium

January 1, 2011 – June 30, 2011	$_____per employee/retiree per month
July 1, 2011 – June 30, 2012	$_____per employee/retiree per month
July 1, 2012 – June 30, 2013	$_____per employee/retiree per month

The contractor agrees that the Premium or Administrative Fee for Option 1 and 2 includes services to be provided by the Contractor to pay run out claims and continue reporting to OGB those claims.

B. Option 2: Self Insured

The MHSA firm is required to quote an all-inclusive monthly capitated non-refundable cost per employee **per month.** OGB will assume risk for all claims payments and will promptly reimburse MHSA firm for all claim payments.

2.1 MHSA Benefits

Option 2: Self Insured – Administrative Fee

January 1, 2011 - June 30, 2011	$_____ per employee/retiree per month
July 1, 2011 - June 30, 2012	$_____ per employee/retiree per month
July 1, 2012 - June 30, 2013	$_____ per employee/retiree per month

The contractor agrees that the Premium or Administrative Fee for Option 1 and 2 includes services to be provided by the Contractor to pay run out claims and continue reporting to OGB those claims.

MHSA firm:_____

By: _____

Title:_____

Signature_____

SECTION X

EXHIBITS

EXHIBIT 1 **OGB Standard Contract**
Business Associate Addendum
Attachment A – Financial Agreement

EXHIBIT 2 **Medical Necessity Review Organization Act**

EXHIBIT 3 **Census Data**

EXHIBIT 4 **Data File Layout and Requirements**

EXHIBIT 1

CONTRACT FOR MANAGED MENTAL HEALTH AND SUBSTANCES ABUSE PROGRAM

BY AND BETWEEN

THE STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

AND

(CONTRACTOR)

The STATE OF LOUISIANA, DIVISION OF ADMINISTRATION, OFFICE OF GROUP BENEFITS (hereinafter sometimes referred to as the State or OGB) located at 7389 Florida Blvd., Suite 400, Baton Rouge, LA 70806 and ("CONTRACTOR"), located at (Contractor Address) do hereby enter into a contract under the following terms and conditions:

1.0 SCOPE OF SERVICES

1.01 CONTRACTOR agrees to provide for OGB managed mental health and substance abuse (MHSA) treatment services, administration and payment of claims for such services, and all related services, utilization and management reports, all in accordance with the terms, conditions, requirements, specifications, and representations set forth in the following documents, attached hereto and incorporated herein by reference:

Attachment A – The Request for Proposal (NIC) issued by OGB on _____.

Attachment B – The proposal submitted by CONTRACTOR in response to the NIC, dated _____, including the cost proposal.

Attachment C – Group insurance policy issued by TBD covering the MHSA benefits provided by CONTRACTOR pursuant to this contract. (Applies to fully-insured option only).

1.02 CONTRACTOR shall provide medically necessary managed mental health and substance abuse treatment services up to the benefits provided in OGB's plan documents, subject to the deductibles, copayments, limitations, and exclusions set forth therein.

CONTRACTOR shall be financially responsible for the provision of managed mental health and substance abuse treatment services that are authorized by CONTRACTOR and received by a covered employee, retiree, or dependent during the term of this contract. In the event that OGB materially alters the benefit levels

of the Plan Document, the parties shall negotiate in good faith an adjustment to the compensation hereunder that fairly and adequately compensates CONTRACTOR in light of such alteration of benefits.

2.0 OGB FURNISHED INFORMATION

OGB will promptly furnish to CONTRACTOR, in a format agreed upon by the parties, all information necessary for CONTRACTOR to render services set forth herein, including, but not limited to:

2.01 A list of all eligible persons, and subsequent timely additions to and deletions from such list as changes occur; and

2.02 Copies of OGB's Plan Documents, in effect on the date of this Contract, pursuant to which it provides health and accident benefits for eligible persons. Thereafter, OGB shall provide CONTRACTOR with copies of all Plan Document amendments at least thirty (30) days prior to the effective date of such amendment, unless such amendments are implemented pursuant to a declaration of emergency, in which case notice shall be given within five (5) days after such declaration of emergency.

3.0 CONTRACT TERM; TERMINATION

3.01 This contract shall begin January 1, 2011 and end June 30, 2013. The initial term of the contract will be six-month and OGB shall have the option to renew this Contract for up to two additional one-year terms. The initial term, first optional renewal, and second optional renewal shall commence and terminate on the following dates:

Initial Term	January 1, 2011 – June 30, 2011
First Optional Renewal	July 1, 2011 – June 30, 2012
Second Optional Renewal	July 1, 2012 – June 30, 2013

This contract is not effective until approved by the Director of the Office of Contractual Review in accordance with La. R.S. 39:1502.

3.02 The foregoing notwithstanding, this Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana regarding agreements with an agency of the State.

3.03 Termination for Cause. State may terminate this Contract for cause based upon the failure of CONTRACTOR to comply with the material terms and/or conditions of the Contract; provided that the State shall give CONTRACTOR written notice specifying CONTRACTOR's failure. If within thirty (30) days after receipt of such notice, CONTRACTOR shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction,

then the State may, at its option, place CONTRACTOR in default and this Contract shall terminate on the date specified in such notice.

CONTRACTOR may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the State to comply with the terms and conditions of this Contract; provided that CONTRACTOR shall give the State written notice specifying the State's failure. Furthermore, CONTRACTOR shall be entitled to suspend any and all services until such time as when the State is not in default of its obligations under this contract.

3.04 Termination for Convenience. The State may terminate the contract at any time without penalty by giving thirty (30) days written notice to CONTRACTOR. Upon any termination of this contract CONTRACTOR shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

3.05 Availability of Funding. The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract. If the legislative fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced by veto of the Governor or by any means provided in the appropriation act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reductions to provide insufficient monies for the continuation of the Contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated. Such termination shall be without penalty or expense to the State except for payments which have been earned prior to the termination.

4.0 PAYMENT TO CONTRACTOR

4.01 For services provided pursuant to this Contract, OGB will pay CONTRACTOR as follows:

4.01.1 TBD Dollars per enrolled employee and retiree per month.

4.01.2 The amount of each monthly payment will be based upon the number of employees and retirees (exclusive of dependents) enrolled on the first day of the month in OGB's self-insured health and accident benefit plans for which CONTRACTOR provides services as described in this Contract. Adjustments to the fees based upon retroactive enrollments or disenrollments or lags in eligibility updates shall be made on the payment date next following the eligibility update.

4.01.3 OGB will remit each monthly payment to CONTRACTOR not later than 20 days after the end of the month in which the services are rendered.

4.02 Based upon the anticipated enrollment in OGB's plans at the time of execution of

this contract, the total payment by OGB to CONTRACTOR is not estimated to exceed TBD over the three-year term of the contract. The parties agree that the maximum payment amount will be appropriately increased by amendment of this contract, in light of changes in enrollment, if and when the total amount paid reaches within twenty (20%) of the maximum.

5.0 CONTRACTOR'S DUTIES UPON TERMINATION

a. In the event of termination for any reason, the Contractor agrees to perform the following tasks:

1. Administer the run out of claims including demands from CMS for the recovery of Medicare payments, for a period of two hundred forty (240) days from the date this Contract terminates. "Run out claims" refers to those claims for covered services, performed prior to termination of the Contract, but not yet paid and/or not submitted for payment to Contractor prior to the termination of this Contract. OGB acknowledges that it is possible that claims ("ITS Claims") may be received by other Blue Plans (i.e., "host plans") during the run out period, but are submitted for payment after the run out period has expired. In these cases, OGB will be responsible for paying these particular ITS Claims. No additional Administrative Fee will be paid after termination of contract.
2. Provide OGB with a copy of the register that identifies the deductible and coinsurance accumulations by Plan Participant that correspond to the termination date.
3. Provide OGB with a hard copy of the register of its claims by provider that are unprocessed at the time of termination.
4. Provide OGB with all statistical reports for the current Plan year up to the date of termination.
5. Provide OGB with a hard copy register of any Coordination of Benefits or Third Party Liability recovery initiative that is in progress at the time of the termination.
6. Provide OGB with its Plan Participant eligibility file.

b. **Continued Coverage for Inpatient Services** – Contractor shall continue to provide coverage for all services related to an inpatient confinement that commenced prior to the termination date until the date of discharge.

6.0 TAXES

The Contractor hereby agrees that the responsibility for payment of taxes from the administrative fees received under this Contract and/or legislative appropriation shall be the Contractor's obligation and identified under Federal Tax Identification Number _____.

OGB shall reimburse the Contractor for any taxes, charge of fees which may be assessed against the Contractor by any governmental entity for providing any service or Benefits to

OGB, as set forth under the Plan or this Contract, with the exception of income taxes owed by the Contractor. In the event that the reimbursement of any Benefits of Plan Participants in connection with this Contract is subject to tax reporting requirements, OGB is responsible for complying with these requirements.

7.0 CONTRACT MANAGMENT

7.01 CONTRACTOR agrees to provide the following contract related resources:

7.01.1 Account Manager: CONTRACTOR shall provide an account manager to provide day-to-day coordination of CONTRACTOR's support and administrative activities, and for supervision of CONTRACTOR employees. The account manager shall possess the functional skills and knowledge to direct all aspects of the project.

7.01.2 Key Personnel: CONTRACTOR shall assign staff who possesses the knowledge, skills, and abilities to successfully perform assigned tasks.

7.02 OGB shall appoint a Contract Manager for this contract that will provide oversight of the activities conducted hereunder. The assigned OGB Contract Manager shall be the principal point of contact on behalf of the State and will be the principal point of contact for CONTRACTOR concerning CONTRACTOR'S performance under this contract.

8.0 MONITORING PLAN; PERFORMANCE MEASURES

7.01.1 Reporting Requirements. CONTRACTOR will provide to OGB's Contract Manager, and to others designated by the Contract Manager, the monthly, quarterly, and annual reports as specified in the NIC.

7.01.2 Performance Standards and Guarantees. CONTRACTOR will abide by the performance standards and guarantees specified in the NIC.

9.0 GOVERNING LAW, VENUE

The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties hereunder, shall be construed pursuant to, and in accordance with, the laws of the State of Louisiana, and venue of any action brought under this contract shall be the Nineteenth (19th) Judicial District Court for the parish of East Baton Rouge, Louisiana.

10.0 INSURANCE CERTIFICATE

a. The Contractor shall procure and maintain for the duration of the Contract liability insurance, including coverage for but not limited to: claims for injuries to persons or

damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, employees or sub-contractors; liability and insolvency protection, with a combined single limit liability of not less than Ten Million ($10,000,000.00) Dollars. The State of Louisiana, Office of OGB Benefits must be named as a loss payee.

b. The Contractor shall on request furnish OGB with certificate(s) of insurance effecting coverage required by this Contract. The certificate(s) for each insurance policy is to be signed by a person authorized by that insurer to bind coverage on its behalf. OGB reserves the right to require complete, certified copies of all required insurance policies, at any time required by this contract.

11.0 LIABILITY FOR DAMAGES BY THE CONTRACTOR

a. OGB shall not be held liable for claims for damages relating to any services rendered or arranged for by the Contractor.

b. The Contractor agrees to hold OGB harmless from all claims for damages relating to the Contractor negligence, including any claims relating to failure of the Contractor to provide services as specified in this Contract due to financial hardship or insolvency.

12.0 PERFORMANCE BOND

The Contractor shall furnish a performance bond in the amount of $1,000,000 (One Million) dollars.

13.0 RESPONSIBILITIES AND OTHER RIGHTS; THIRD PARTY LIABILITY

a. Both parties will use their best effort to advise the other party of matters regarding potential legal actions involving the Plan or this Contract and shall promptly advise the other party of such legal actions instituted against either party which come to its attention.

b. The Contractor shall make diligent but reasonable efforts to recover any erroneous payment of claims and any payment of claims for which an individual or entity other than the parties is primarily responsible. The Contractor shall not be required to institute legal proceedings or to provide legal representation to OGB to force its rights of subrogation and/or reimbursement, or coordination of Benefits, but may secure such representation for OGB at OGB's expense in those instances where institution of legal proceedings is warranted, if authorized by OGB.

1. Each of the parties hereto shall use reasonable efforts to identify these claims and shall notify the other party of any such claims which come to its attention.

2. The Contractor shall not be required to join as a party litigant in any such action,

except as required by law, but shall cooperate fully in all such recovery efforts. However, the Contractor, in its discretion and at its sole option, may join in any such action in which it has a justifiable interest.

3. The Contractor shall monitor any legal proceedings for the recovery of said payments on behalf of OGB and shall advise and consult with OGB during the course of litigation.

4. OGB shall be responsible for all attorney fees, court costs and other expenses associated with such recovery efforts unless the need for such efforts resulted from the grossly negligent, dishonest, fraudulent or criminal conduct of the Contractor.

14.0 REMEDIES FOR DEFAULT

Any claims or controversy arising out of this contract shall be resolved in accordance with the provisions of La R.S. 39:1524 – 1526.

15.0 SECURITY

CONTRACTOR's personnel will always comply with all security regulations in effect at the OGB's premises, and externally for materials belonging to the State or to the project. CONTRACTOR is responsible for promptly reporting any breach of security to the State.

16.0 CONFIDENTIALITY

The parties, their agents, staff members and employees agree to maintain as confidential all individually identifiable information regarding Louisiana Office of Group Benefits plan members, including but not limited to patient records, demographic information and claims history. All information obtained by CONTRACTOR from the Office of Group Benefits shall be maintained in accordance with state and federal law, specifically including but not limited to the Health Insurance Portability and Accountability Act of 1996, and any regulations promulgated thereunder (collectively, "HIPAA"). To that end, the parties have executed and hereby make a part of this Agreement a Protected Health Information (Business Associate) Addendum to be in full compliance with all relevant provisions of HIPAA, including but not limited to all provisions relating to Business Associates.

Further, the parties agree that all financial, statistical, personal, technical and other data and information relating to either party's operations which are designated confidential by such party and made available to the other party in carrying out this contract, shall be protected by the receiving party from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the OGB and/or Contractor. Neither party shall be required to keep confidential any data or information which is or becomes publicly available, is already rightfully in the party's possession, is independently developed by the party outside the scope of this contract, or

is rightfully obtained from third parties.

17.0 REPRODUCTION, PUBLICATION AND USE OF MATERIAL

Subject to the confidentiality obligations as set forth above, OGB shall have authority to reproduce, publish, distribute, and otherwise use, in whole or in part, any reports, data, studies, or surveys prepared by the Contractor for OGB in connection with this Contract or in the performance hereof which are not designated as proprietary by the Contractor.

18.0 ACKNOWLEDGEMENT OF PRIORITY POSITION

The Contractor acknowledges that OGB is a primary responsibility of the organization, and that such acknowledgement places performance of its Contractual duties for the State of Louisiana, Office of OGB Benefits in a high priority position relative to other clients of the organization

19.0 MOST FAVORED CUSTOMER GUARANTEE

The Contractor certifies and guarantees that the retention or other administrative charges to OGB, as forth in this Contract, are comparable to or better than the equivalent fees or charges being offered by the Contractor to any present or future customer or group of customers having a similar product design and of a comparable or lesser size. If the Contractor shall, during the term of this Contract, enter into an administrative services only agreement with any other customer or group customers having a similar product design to administer a comparable plan for a similar or lesser number of Participants in the Contractor's service area which provides for a lower retention or other administrative charges, this Contract shall be deemed thereupon amended to provide the same to OGB, with a retroactive finance adjusted to OGB dating back to the effective date of such lower retention or other administrative charge. An officer of the Contractor shall certify annually that, to the best of his or her knowledge, information, and belief, and predicated on his or her familiarity with the billing practices of the Contractor, the fees being charged to OGB by the Contractor are in full and complete compliance, in all respects, with the provisions of this Section. The Contractor shall provide such annual notice during the first quarter of each calendar year.

The Contractor certifies and guarantees that its medical reimbursement fee schedule is, in all respects, at least as low as any other medical reimbursement fee schedule presently in effect, or which shall be in effect, at any time during the term of this Agreement. If, at any time during the term of this Agreement, the Contractor offers a lower medical reimbursement fee schedule to any customer in the State of Louisiana it shall immediately notify OGB to this effect in writing and all medical reimbursement fee schedules shall be immediately reduces to such lower amounts with a retroactive financial adjustment to OGB dating back to the effective date of the lower medical reimbursement fee schedule.

20.0 INDEMNIFICATION

20.01 CONTRACTOR agrees to protect, defend, indemnify and hold harmless OGB, the State of Louisiana, all State Departments, Agencies, Boards and Commissions, their respective officers, directors, agents, servants and employees, including volunteers (each a State Affiliated Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any act or omission of CONTRACTOR, its agents, servants, and employees, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result of any such claim, demands, and/or causes of action **except** those claims, demands and/or causes of action arising out of the act or omission of OGB, the State of Louisiana, State Departments, Agencies, Boards, Commission, their officers, directors, agents, servants and/or employees. CONTRACTOR agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense, even if it (claims, etc.) is groundless, false or fraudulent, provided that (a) the State Affiliated Indemnified Party has given reasonable notice to CONTRACTOR of the claim or cause of action, and (b) no State Affiliated Indemnified Party has, by act or failure to act, compromised CONTRACTOR's position with respect to the resolution or defense of the claim or cause of action.

20.02 OGB agrees to protect, defend, indemnify and hold harmless CONTRACTOR, its officers, directors, agents, servants and employees, including volunteers (each an CONTRACTOR Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any act or omission of OGB, its agents, servants, and employees, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result of any such claim, demands, and/or causes of action **except** those claims, demands and/or causes of action arising out of the act or omission of CONTRACTOR, its officers, directors, agents, servants and/or employees. OGB agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense, even if it (claims, etc.) is groundless, false or fraudulent, provided that (a) the CONTRACTOR Indemnified Party has given reasonable notice to OGB of the claim or cause of action, and (b) no CONTRACTOR Indemnified Party has, by act or failure to act, compromised OGB's position with respect to the resolution or defense of the claim or cause of action.

21.0 PATENT, COPYRIGHT, AND TRADE SECRET INDEMNITY

CONTRACTOR warrants that all materials and/or products affiliated by or produced by CONTRACTOR hereunder will not infringe upon or violate any patent, copyright, or trade secret right of any third party. In the event of any such claim by any third party against OGB, OGB shall promptly notify CONTRACTOR, and CONTRACTOR shall defend such claim, in OGB's name, but at CONTRACTOR's expense, and shall indemnify OGB against any loss, expense, or liability arising out of such claim, whether or not such claim

is successful. Notwithstanding this paragraph, CONTRACTOR may delegate some responsibilities under this Contract to one or more affiliates of CONTRACTOR.

22.0 OWNERSHIP OF PRODUCT

All records, reports, documents and other material delivered or transmitted to CONTRACTOR by State shall remain the property of State, and shall be returned by CONTRACTOR to State, at CONTRACTOR's expense, at termination or expiration of this contract. CONTRACTOR may retain one copy of such records, documents or materials for archival purposes and to defend its work product. All records, reports, documents, or other material related to this contract and/or obtained or prepared by CONTRACTOR specifically and exclusively for State in connection with the performance of the services contracted for herein shall become the property of State, and shall, upon request, be returned by CONTRACTOR to State, at CONTRACTOR's expense, at termination or expiration of this contract.

23.0 ASSIGNMENT

CONTRACTOR shall not assign any interest in this contract and shall not transfer any interest in same (whether by assignment or novation), without prior written consent of the State, provided however, that claims for money due or to become due to CONTRACTOR from the State may be assigned to a bank, trust company, or other financial institution without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to the State and to the Office of Contractual Review, Division of Administration.

24.0 RIGHT TO AUDIT

CONTRACTOR hereby grants to the Legislative Auditor of the State of Louisiana and/or the Office of the Governor, Division of Administration Auditors, and/or OGB's Internal Audit Division, or any third party designated by OGB, the option of auditing all records of CONTRACTOR pertinent to the contract. Such audit or audits shall be performed in a manner so as not to interfere unreasonably with CONTRACTOR's obligations and shall be performed at OGB's expense upon adequate prior written notice, at reasonable intervals, and during regular business hours.

25.0 RECORD RETENTION

CONTRACTOR agrees to retain all books, records, and other documents relevant to this contract and the funds expended hereunder for at least three years after project completion of contract, or as required by applicable Federal law, whichever is longer.

26.0 AMENDMENTS IN WRITING

Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when it has been reduced to writing and duly signed. No amendment shall be valid

until it has been executed by all parties and approved by the Director of the Office of Contractual Review, Division of Administration.

27.0 FUND USE

CONTRACTOR agrees not to use funds received for services rendered under this contract to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition on any election ballot or a proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority.

28.0 NON-DISCRIMINATION

CONTRACTOR agrees to abide by the requirements of the following as applicable: Title VI and VII of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972, Federal Executive Order 11246, the Federal Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Act of 1972, and CONTRACTOR agrees to abide by the requirements of the Americans with Disabilities Act of 1990. CONTRACTOR agrees not to discriminate in its employment practices, and will render services under this contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, disabilities, or because of an individual's sexual orientation. Any act of discrimination committed by CONTRACTOR, or failure to comply with these obligations when applicable shall be grounds for termination of this contract.

29.0 CAUSES BEYOND CONTROL

Neither party shall be responsible for delays or failure in performance resulting from acts beyond the control of such party. Such acts shall include but not be limited to acts of God, strikes, riots, lockouts, acts of war, epidemics, governmental regulations superimposed after the fact, fire, communication line failures, power failure, earthquakes, or other disasters, or by reason of judgment, ruling, or order of any court or agency of competent jurisdiction.

30.0 HEADINGS

Descriptive headings in this contract are for convenience only and shall not affect the construction or meaning of contractual language.

31.0 WORKER'S COMPENSATION

Contract is not in lieu of and does not affect any requirements of coverage under the

Louisiana Worker's Compensation Act or any other federal or state mandated employer liability laws.

32.0 SUBCONTRACTORS

Upon approval of OGB the Contractor can use its affiliates or other subcontractors to perform its services under this contract. However, the Contractor will be responsible for those services to the same extent that the Contractor would have been had the Contractor performed those services without the use of an affiliate or Subcontractor.

33.0 INDEPENDENT CONTRACTOR RELATIONSHIP

No provision of this Contract is intended to create nor shall it be deemed or construed to create any relationship between the Contractor and OGB other than that of independent entities Contracting with each other hereunder solely for the purpose of effecting the provisions of this Contract. The terms "Contractor" and "OGB" shall include all officers, directors, agents, employees or servants of each party.

34.0 WAIVER OF BREACH

The waiver by either party of a breach or violation of any provision of the contract shall not operate as, or be construed to be, a waiver of any subsequent breach of the contract.

35.0 SEVERABILITY

The invalidity or unenforceability of any terms or conditions of the contract shall in no way effect the validity or enforceability of any other terms or provisions.

36.0 NOTICE

Any notice, demand, communication or payment required under the contract shall be deemed effectively given when personally delivered or mailed, postage prepaid, as follows:

OGB: Office of Group Benefits Program
Attention: Tommy D. Teague
Chief Executive Officer
7389 Florida Blvd., Ste. 400
Baton Rouge, LA 70806 OR
Post Office Box 44036
Baton Rouge, LA 70804

CONTRACTOR: TBD

37.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

37.1 This contract (together with the NIC issued thereto by the State, the Proposal submitted by CONTRACTOR in response to the State's NIC, and any exhibits specifically incorporated herein by reference) constitutes the entire agreement between the parties with respect to the subject matter.

37.2 This contract shall, to the extent possible, be constructed to give effect to all provisions contained therein: however, where provisions are in conflict, first priority shall be given to the provisions of the contract, excluding the NIC and the Proposal; second priority shall be given to the provisions of the NIC and amendments thereto; and third priority shall be given to the provisions of the Proposal.

THUS DONE AND SIGNED ON THE DATE(S) LISTED BELOW:

STATE OF LOUISIANA **DIVISION OF ADMINSTRATION** **OFFICE OF GROUP BENEFITS**	**CONTRACTOR**
_____	_____
Tommy D. Teague Chief Executive Officer	
_____	_____
Witness	Witness
_____	_____
Witness	Witness

EXHIBIT 1

SAMPLE

BUSINESS ASSOCIATE ADDENDUM (BAA)

State of Louisiana, Division of Administration
Office of Group Benefits
Protected Health Information Addendum

I. Definitions

a) "Administrative Safeguards" shall mean administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information., as more particularly set forth in 45 CFR § 164.308.
b) "Agreement" shall mean the agreement between Business Associate and OGB, dated _____ _____, 20___, pursuant to which Business Associate is to provide certain services to OGB involving the use or disclosure of PHI, as defined below.
c) "ARRA" shall mean the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
d) "Business Associate" shall mean _____.
e) "ePHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
f) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
g) "HIPAA Regulations" shall mean the Privacy Rule, the Security Rule, and the regulations promulgated pursuant to ARRA.
h) "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
i) "OGB" shall mean the State of Louisiana, Division of Administration, Office of Group Benefits, which is a covered entity under HIPAA, ARRA and the HIPAA Regulations, as defined below.
j) "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
k) "Physical Safeguards" shall mean physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion as more particularly set forth in 45 CFR § 164.310.
l) "Privacy Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Privacy of Individually Identifiable Health Information at 45 CFR, Part 160 and Part 164, Subparts A and E.
m) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
n) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
o) "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.
p) "Security Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Security Standards for Electronic Protected Health Information at 45 CFR, Part 160 and Part 164, Subparts A and C.
q) "Technical Safeguards" shall mean the technology and the policy and procedures for its use that protect electronic protected health information and control access to it, as more particularly set forth in 45 CFR § 164.312.

r) Any other terms used in this Addendum that are not defined herein but are defined in the HIPAA Regulations or ARRA shall have the same meaning as given in the HIPAA Regulations or ARRA.

II. Obligations and Activities of Business Associate

a) Business associate agrees to comply with OGB policies and procedures regarding the use and disclosure of PHI.
b) Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Addendum, or as Required by Law.
c) Business Associate agrees to limit all requests to OGB for PHI to the minimum information necessary for Business Associate to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement.
d) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum.
e) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.
f) Business Associate agrees to report to OGB any use or disclosure of the PHI not provided for by this Addendum of which it becomes aware. Such report shall be made within two (2) business days of Business Associate learning of such use or disclosure.
g) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, OGB agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information. However, Business Associate shall not enter into any subcontractor or other agency relationship with any third party that involves use or disclosure of such PHI without the advance written consent of OGB.
h) Business Associate agrees to provide access, at the request of OGB, and in the time and manner designated by OGB, to PHI maintained by Business Associate in a Designated Record Set, to OGB or, as directed by OGB, to an Individual in order to meet the requirements under 45 CFR § 164.524.
i) Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that OGB directs or agrees to pursuant to 45 CFR § 164.526 at the request of OGB or an Individual, and in the time and manner designated by OGB.
j) Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, OGB available to OGB, or at the request of OGB to the Secretary, in a time and manner designated by OGB or the Secretary, for purposes of the Secretary determining OGB's compliance with the HIPAA Regulations an ARRA.
k) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
l) Business Associate agrees to provide to OGB or an Individual, in a time and manner designated by OGB, information collected in accordance with Section II.j of this Addendum, to permit OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
m) At any time(s) requested by OGB, Business Associate agrees to return to OGB or destroy such PHI in its possession as directed by OGB.
n) Business Associate shall defend and indemnify OGB from and against any and all claims, costs, and/or damages arising from a breach by Business Associate of any of its obligations under this Addendum. Any limitation of liability provision set forth in the Agreement, including but not limited to any cap on direct damage liability and any disclaimer of liability for any consequential, indirect,

punitive, or other specified types of damages, shall not apply to the defense and indemnification obligation contained in this Addendum.

o) Business Associate shall immediately notify OGB when Business Associate receives a subpoena related to PHI and shall cooperate with OGB, at OGB's expense, in any attempt to obtain a protective order. Business Associate shall immediately notify OGB when Business Associate discloses PHI in response to a subpoena. Such notice shall include all information that would be required for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

p) Business Associate shall:
   1. Implement and document Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of OGB, specifically including, but not limited to, the following:
      i) Ensuring the confidentiality, integrity, and availability of all ePHI that it creates, receives, maintains, or transmits on behalf of OGB;
      ii) Protecting against any reasonably anticipated threats or hazards to the security or integrity of such information;
      iii) Protecting against any reasonably anticipated uses or disclosures of such information that are not permitted or required by this Addendum or Required by Law; and
      iv) Ensuring compliance with these requirements by its workforce;
   2. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate safeguards to protect it;
   3. Report to OGB any Security Incident of which it becomes aware. If no Security Incidents are reported, Business Associate shall certify to OGB in writing within ten (10) days of each anniversary date of the Agreement that there have been no Security Incidents during the previous twelve months.

q) Business Associate shall not permit PHI to be disclosed to or used by any individual or entity outside of the territorial and jurisdictional limits of the fifty United States of America.

r) Business Associate shall report to OGB any unauthorized acquisition, access, use or disclosure of PHI by Business Associate or its workforce or subcontractors immediately, but no later than five (5) business days after discovery or the date the breach should have been known to have occurred, and include with that report the remedial action taken or proposed to be taken with respect to such use or disclosure and account for such disclosure. Business Associate is responsible for any and all costs related to notification of individuals or next of kin (if the individual is deceased) of any security or privacy breach reported by Business Associate to OGB.

s) In the event of a breach of PHI, Business Associate shall provide a report to OGB including the date the breach was discovered, the plan participant(s) name(s), contact information, nature/cause of the breach, PHI breached and the date or period of time during which the breach occurred. Business Associate understands that such a report must be provided to OGB immediately but no later than five (5) business dates from the date of the breach or the date the breach should have been known to have occurred.

III. Permitted Uses and Disclosures by Business Associate

a) Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by OGB or the minimum necessary policies and procedures of OGB.

b) Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

c) Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that such disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that it will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person promptly notifies the Business Associate of any known instances of breach of the confidentiality of the PHI.
d) Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation services to OGB as permitted by 45 CFR § 164.504(e)(2)(i)(B), provided that such services are contemplated by the Agreement.
e) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).
f) Business Associate may not use PHI to make any communications about a product or service that encourages recipients of the communication to purchase or use the product or service unless the communication is made as described in subparagraph (i), (ii) or (iii) of the definition of "Marketing" in 45 CFR 164.501. Such communication must be permitted under and consistent with the Agreement, including this Addendum.

IV. Obligations and Activities of OGB

a) With the exception of Data Aggregation services as permitted by 45 CFR § 164.504(e)(2)(i)(B), OGB shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by OGB.
b) OGB shall notify Business Associate of any limitation(s) in OGB's Notice of Privacy Practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
c) OGB shall notify Business Associate of any changes in, or revocation of, permission by any Individual to use or disclose PHI, to the extent such changes may affect Business Associate's use or disclosure of PHI.
d) OGB shall notify Business Associate of any restriction to the use or disclosure of PHI that OGB has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI.

V. Term and Termination

a) Term. The Term of this Addendum shall commence on the effective date set forth below, and shall terminate when all of the PHI provided by OGB to Business Associate, or created or received by Business Associate on behalf of OGB, is destroyed or returned to OGB, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.
b) Termination of Agreement for Cause. In the event that OGB learns of a material breach of this Addendum by Business Associate, OGB shall, in its discretion:
    1. Provide a reasonable opportunity for Business Associate to cure the breach to OGB's satisfaction. If Business Associate does not cure the breach within the time specified by OGB, OGB may terminate the Agreement for cause; or
    2. Immediately terminate the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or
    3. If neither termination nor cure is feasible, OGB may report the violation to the Secretary.
c) Effect of Termination.
    1. Except as provided in paragraph (2) below, upon termination of the Agreement for any reason, Business Associate shall return or destroy all PHI received from OGB, or created

or received by Business Associate on behalf of OGB. Business Associate shall retain no copies of the PHI. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.

2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to OGB written notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the parties that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such PHI.

VI. Miscellaneous

a) A reference in this Addendum to a section in the HIPAA Regulations means the section as in effect or as amended, and for which compliance is required.
b) The parties agree to amend this Addendum from time to time as necessary for OGB to comply with the requirements of HIPAA, ARRA and the HIPAA Regulations.
c) If applicable, the obligations of Business Associate under Section V.c.2 of this Addendum shall survive the termination of this Addendum.
d) Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits OGB to comply with HIPAA, ARRA and the HIPAA Regulations. It is the intent of the parties that neither this Addendum, nor any provision in this Addendum, shall be construed against either party pursuant to the common law rule of construction against the drafter.
e) Except as expressly stated herein, the parties to this Addendum do not intend to create any rights in any third parties. Nothing in this Addendum shall confer upon any person other that the parties and their respective successors or assigns any rights, remedies, obligations, or liabilities whatsoever.
f) In the event of any conflict between the terms of the Agreement and the terms of this Addendum, the terms of this Addendum will control, with the exception that if the Agreement contains any provisions relating to the use or disclosure of PHI that are more protective of the confidentiality of PHI than the provisions of this Addendum, then the more protective provisions will control. The provisions of this Addendum are intended to establish the minimum limitations on Business Associate's use and disclosure of PHI.
g) The terms of this Addendum shall be construed in light of any applicable interpretation or guidance on HIPAA, ARRA and/or the HIPAA Regulations issued from time to time by the Department of Health and Human Services or the Office for Civil Rights.
h) This Addendum may be modified or amended only by a writing signed by the party against which enforcement is sought.
i) Neither this Addendum nor any rights or obligations hereunder may be transferred or assigned by one party without the other party's prior written consent, and any attempt to the contrary shall be void. Consent to any proposed transfer or assignment may be withheld by either party for any or no reason.
j) Waiver of any provision hereof in one instance shall not preclude enforcement thereof on future occasions.
k) For matters involving the HIPAA, ARRA and the HIPAA Regulations, this Addendum and the Agreement will be governed by the laws of the State of Louisiana, without giving effect to choice of law principles.

In witness whereof, the parties have executed this Addendum through their duly authorized representatives. This Addendum shall be effective as of the _____ day of _____ ___, 20_____.

State of Louisiana,
Division of Administration
Office of Group Benefits

By:_____ **By:**_____

Name: Tommy D. Teague **Name:**_____

Title: Chief Executive Officer **Title:**_____

EXHIBIT 1

ATTACHMENT - A

FINANCIAL AGREEMENT
SELF-FUNDED ONLY

1. PAYMENT FACTORS:

Listed below identifies the applicable Administrative Fee charge Per Employee/Retiree Per Month (PEPM) for each Contract Year during the Contract term.

Administrative Fees

Plan Year 7/1/10 – 6/30/11	$ _____ PEPM
Plan Year 7/1/11 – 6/30/12	$ _____ PEPM
Plan Year 7/1/12 – 6/30/13	$ _____ PEPM

The Contractor agrees that the Administrative Fees includes services to be provided by the Contractor to pay run out claims and continue reporting to OGB those claims.

2. CLAIM PAYMENT PROCEDURES

The Contractor will provide OGB with an invoice, with an accompanying electronic check register (claims disbursements) file, on a weekly basis showing all paid claims. The total of the claims paid on the invoice shall match the total of the claims paid on the file. The Contractor shall use its best efforts to forward the invoice and file to OGB no later than 2:00 p.m. on each day. OGB shall pay the invoice (assuming the totals on the file and invoice match) within 48 hours after receiving the invoice(s) together with supporting details provided by the Contractor, by wire transfer.

The invoice prepared by the Contractor shall provide a breakdown of the claims paid by active and retiree participants.

The Contractor agrees to pay its providers within 48 hours from receipt of payment from OGB.

OGB shall pay interest on all delinquent payments. The interest rate shall be the average of the Money Market Fund rates reported on each day of delinquency in The Wall Street Journal.

3. FINAL SETTLEMENT

In the event of Contract termination, pursuant to provision 37.0, the Contractor will continue the claims payment and billing process described above for the run out of claims for a period of 240 days.

EXHIBIT 2

Louisiana Medical Necessity Review Organization (MNRO) Act

Please refer to the La. R.S. 22:1121 et seq. and
Louisiana Administrative Code, Title 37, Part XIII, Chapter 62
Louisiana Department of Insurance Regulation 77

EXHIBIT 3

CENSUS DATA

Available on request

Appendix A – File requirements and layout

The Contractor shall send and receive data files and act on the received data files as detailed in this section (Appendix A):

Files to be sent by the contractor to OGB:

Files are to be sent by the contractor to OGB on a monthly basis and no later than the 5th day of the following month. For example, the files for January shall be received by OGB by the 5th of February. All files shall be sent electronically using FTP (File Transfer Protocol) and must be encrypted using PGP (Pretty Good Privacy).

1. **Medical Claims File (Appendix A-1) –** the contractor shall send OGB all claims for which EOBs (Explanations of Benefits) or checks were sent or issued to the provider and/or claimant during a month. This is a file of records containing claim charge lines or service lines for a physician claim (CMS-1500), facility claim (UB-92), or a dental claim (ADA-1500) that has been received and processed. No claims in process are included.

2. **Provider File (Appendix A-2) -** This is a file of medical service providers for which checks and EOBs were issued in (1) above. This will include, for example, physicians, hospitals, urgent care facilities, and physician groups. The file will also contain separate records relevant to the entity paid for a provider's services.

3. **Check Register File (Appendix A-3) -** This file will contain one record for each check issued during the month. The amount of money reflected on this file should match the invoice sent to OGB for payment each month. Check numbers shall correspond to checks referenced in the paid claims provided in (1) above.

4. **Code Files (Appendix A-4)** – These files will contain codes used in claim processing that are not standard, universally accepted values. Codes that fall into this category include but are not limited to provider specialty codes, denial reason codes, types of service codes and override codes. Codes are subject to change over the life of this contract, and if a code changes, dates associated with the code are required for its meaning before and after the change. If the contractor's uses any other codes with which OGB is not familiar, the contractor will transmit a file of those codes in a file consistent with this format, if appropriate.

Prior to any transmission of claims data from the contractor to OGB, we must have an understanding of their procedures for processing, paying and adjusting claims so that the financial and clinical care of our members can be accurately reflected in our data warehouse. Information provided to OGB is also transmitted to our Living Well Louisiana health management program for management of ongoing health conditions, including diabetes, heart disease, heart failure, asthma, and chronic obstructive pulmonary disease (COPD). To clarify OGB needs, the following will apply to all claims:

- **Only processed claims –** the contractor will transmit all paid and denied claims as indicated above for which bills were submitted for our members. Claim transmissions will include detail for each charge or service line on the patient's bill. All coding in each line will adhere to standard medical coding procedures.

- **Adjusted Claims –** Claims that are reprocessed and subsequently adjusted, whether for financial reasons or for changes related to services provided, will include a reference to the original or preceding claim in all

claim lines. OGB must be able to reconstruct a representative processing history for each claim through final disposition.

- **Provider recognition –** Each provider must be clearly identified by their purpose in the data provided, specifically, service providers and "pay-to" providers must be distinguished from each other. Where possible, relationships between facilities, physician groups, physicians, and other ancillary service providers as it applies to patient care should be made available whenever possible.

- **Non-standard codes –** Codes and their meaning or description used to represent the contractor**'s** processing data for which an industry standard does not exist will be transmitted to OGB separately from the monthly transmission, beginning with contract initiation. Any changes to these codes will be transmitted to OGB prior to transmission of claim records with these codes being used. Examples of these codes include but are not limited to the contractor's physician specialty codes and denial codes.

- **Data standards –** Numeric data will be right-justified and zero-filled. Money amounts will be 15 digits including an explicit decimal point and accurate to two decimal places (**000009999999.99**). Negative amounts will have a minus sign as the first character (**-00009999999.99**). Dates will be formatted **CCYYMMDD** and valid. All text will be left-justified and space-filled. All SSN's, ICD-9 codes, phone numbers, NDC's and zipcodes will be left-justified, with no dashes, commas, decimals or other formatting.

Files to be sent to the contractor by OGB:

The contractor shall receive the following three files from OGB. Files shall be constructed using the layout as described in Appendix A-5 through A-7. All files from OGB shall be sent electronically using FTP (File Transfer Protocol) and WILL be encrypted using PGP (Pretty Good Privacy).

5. **Eligibility File (Appendix A-5)**
   This file shall be received the evening of every work day by the contractor and posted to their system before the next day. It will contain the contractor's entire membership plus any terminations that have been done in the last two months.

6. **ASO Administrative Fee Billing files(Appendix A-6)**
   This file shall be received monthly by the contractor and will contain the amount per contract holder that OGB will pay the ASO for administrative fee. OGB will pay the ASO based on this file. The file will contain adjustments to prior months billing resulting from retroactive terminations and enrollment.

7. **Claims Paid By Contractor After Termination or Stop Payment(Appendix A-7)**
   This file shall be received monthly by the contractor and will contain the claims paid in error after the termination or stop payment date. (This file is only provided when OGB is invoiced for claims.)

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: The Claim ID is the contractor's distinct identifier for all charges and services associated with a patient bill. Whenever OGB contacts the contractor relevant to information on a medical claim, this identifier will be used as reference to the specific claim.						
1	*	CLAIM ID	A/N	40	1-40	THE CONTRACTOR'S UNIQUE IDENTIFIER FOR THIS CLAIM.
Field 2: A service line references a discrete charge or service in a submitted claim. OGB uses service line detail for its reporting for the State of Louisiana whenever we are asked to study the potential effects of a change to existing benefits, whether financial or clinical.						
2	*	CLAIM LINE ID	A/N	40	41-80	THE CONTRACTOR'S IDENTIFIER FOR A PARTICULAR CHARGE OR SERVICE LINE.
Fields 3-4: Service Dates apply to the claim line, not the duration of the stay referenced for inpatient facility claims.						
3	*	FROM SERVICE DATE	D	8	81-88	THE START DATE OF SERVICE REFERENCED ON THIS LINE. **FORMAT- CCYYMMDD**
4	*	THRU SERVICE DATE	D	8	89-96	THE LAST/FINAL DATE OF SERVICE. **FORMAT- CCYYMMDD**
Field 5: For keyed claims, the date received, not the date keyed. For electronic claims, the date the contractor received the transmission.						
5	*	RECEIVED DATE	D	8	97-104	THE DATE THE CLAIM WAS RECEIVED BY THE CONTRACTOR **FORMAT- CCYYMMDD**
6	*	CLAIM SOURCE	A/N	1	105	"K": KEYED INPUT "A": AUTOMATIC/ELECTRONIC INPUT
7	*	SYSTEM ENTRY DATE	D	8	106-113	THE DATE THE CONTRACTOR FIRST ENTERED THE CLAIM INTO THE CLAIM PAYMENT SYSTEM **FORMAT- CCYYMMDD**
Field 8: For each action affecting the payment status or clinical information on a claim, the date that action was taken.						
8	*	ADJUDICATION DATE	D	8	114-121	THE DATE THE CONTRACTOR PROCESSED AN ORIGINAL CLAIM. FOR ADJUSTMENTS, THE DATE REPROCESSED **FORMAT- CCYYMMDD**
9	*	PAID DATE	D	8	122-129	THE DATE THE PROCESSED CLAIM WAS PAID OR ADJUSTED. FOR DENIED CLAIMS, THE DATE DENIED. **FORMAT- CCYYMMDD**

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
10	*	MEDICAL CLAIM DOC TYPE	A/N	10	130-139	THE TYPE OF DOCUMENT SUBMITTED, EITHER THE HCFA OR UB DESIGNATION.
11		SUBMITTED DRG	A/N	20	140-159	FOR INPATIENT CLAIMS, THE V25 DRG CODE THAT WAS SUBMITTED ON THE CLAIM
Field 12: Revenue code is required for UB-92 claims. OGB will calculate the patient's length of stay for our data warehouse reports based on revenue coding.						
12		REVENUE CODE	A/N	10	160-169	THE 3 CHARACTER REVENUE CODE USED ON UB92 CLAIM FORMS.
Field 13: The original billed charge for each claim line will be provided on all activity affecting the claim or claim line.						
13	*	CHARGE AMOUNT	N	15	170-184	THE DOLLARS BILLED/CHARGED BY THE PROVIDER FOR THIS CLAIM LINE.
Field 14: For in-network providers, the allowed amount is determined after repricing and applying rate tables. For out-of-network providers, the allowed amount is determined from the contractor's fee schedule for that service.						
14	*	ALLOWED AMOUNT	N	15	185-199	THE AMOUNT THAT IS ALLOWED PER THE PROVIDERS PRICING CONTRACT OR FOR OUT-OF-NETWORK PROVIDERS
Field 15: Copay is a fixed component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. Copays are established by the state and are listed in the plan benefits document.						
15	*	COPAY AMOUNT	N	15	200-214	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER AT THE TIME OF SERVICE SEPARATE FROM THE AMOUNT PAID BY THE CONTRACTOR.
Field 16: Coinsurance is a variable component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. This value is normally zero except for out-of network providers.						
16	*	COINSURANCE AMOUNT	N	15	215-229	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT NOT BY THE CONTRACTOR DUE TO THE MEMBER'S COINSURANCE ARRANGEMENTS.
Field 17: The deductible is a component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. This value is normally zero except for out-of network providers for which the member is subject to an annual limit.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
17	*	DEDUCTIBLE AMOUNT	N	15	230-244	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT NOT BY THE CONTRACTOR BASED ON PLAN BENEFITS.
18	*	COB PAID AMOUNT	N	15	245-259	THE AMOUNT PAID BY ANOTHER INSURER AGAINST THE MEMBER'S CLAIM, (COORDINATION OF BENEFITS)
19	*	WITHHELD AMOUNT	N	15	260-274	THE AMOUNT WITHHELD FROM PAYMENT DUE TO TERMS OF THE PROVIDER'S CONTRACT OR ACCOUNT.
20	*	PROVIDER PAID AMOUNT	N	15	275-289	THE NET AMOUNT THAT WAS EVENTUALLY PAID DIRECTLY BY THE CONTRACTOR TO THE PAY-TO PROVIDER FOR THIS CLAIM LINE.
21	*	MEMBER PAID AMOUNT	N	15	290-304	THE NET AMOUNT THAT WAS EVENTUALLY PAID DIRECTLY BY THE CONTRACTOR TO THE MEMBER, SUBSCRIBER OR EMPLOYEE FOR THIS CLAIM LINE.
Field 22: The net paid amount must equal the total of the provider paid amount and the member paid amount.						
22	*	NET PAID AMOUNT	N	15	305-319	THE NET AMOUNT THAT WAS PAID IN TOTAL FOR THIS CLAIM LINE BY THE CONTRACTOR.
23	*	TRANSACTION TYPE	A/N	20	320-339	THE TRANSACTION TYPE (OUTCOME). SPECIFICALLY, 'APPROVED', 'DENIED', 'DUPLICATE', 'REVERSED', 'REVERSAL', 'ADJUSTMENT'.
Field 24: The Adjusted From Claim ID field is blank for the first activity or transaction against a patient's bill, the "original claim". Depending on the contractor's procedures, for reprocessed claims this field will either contain the claim number of the original transaction or the claim number of the immediately prior transaction against the originally submitted claim. OGB will use this field to reconstruct a transaction history against the original claim. Note: Claim Line IDs remain the same throughout the transaction history of a member's claim (see Field 2 above).						
24		ADJUSTED FROM CLAIM ID	A/N	40	340-379	IF THIS CLAIM IS A REPROCESSING OF A MEMBER'S CLAIM, THIS FIELD WILL CONTAIN THE CLAIM ID OF THE PRIOR CLAIM.

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 25: The contractor will provide OGB a file of their denial codes and the corresponding descriptions for the reasons a claim may be denied. Codes provided on denied claims will exist in the list provided, and any changes to the list will be provided to OGB in a timely manner. All denial reasons will be clear and accurately reflect the actual condition causing the denial. Note: The denial reason code is required for all denied claims						
25		DENIED REASON	A/N	20	380-399	IF DENIED, THE REASON CODE FOR THIS DENIAL.
26		BILL TYPE CODE	A/N	3	400-402	CREATED BY HCFA AND PROVIDES THREE SPECIFIC PIECES OF INFORMATION. THE FIRST CHARACTER IDENTIFIES THE TYPE OF FACILITY. THE SECOND CLASSIFIES THE TYPE OF CARE. THE THIRD INDICATES THE SEQUENCE OF THIS BILL IN THIS PARTICULAR EPISODE OF CARE.
27	*	PLACE OF SERVICE	A/N	20	403-422	THE HCFA STANDARD PLACE OF SERVICE CODE
28	*	TYPE OF SERVICE	A/N	20	423-442	THE HCFA STANDARD TYPE OF SERVICE CODE ON THE CLAIM.
29	*	SERVICE UNITS COUNT	N	11	443-453	THE NUMBER OF UNITS OF SERVICE DESCRIBED BY THE PROCEDURE REFERENCED ON THIS CLAIM LINE.
30		ANESTHESIA MINUTES	N	11	454-464	WHEN APPROPRIATE, THIS CLAIM LINE LISTS THE NUMBER OF MINUTES OF ANESTHESIA THAT WAS RENDERED.
Fields 31-36: Employee refers to the contract holder (subscriber), identified as relation = '01' in the State of Louisiana's eligibility file provided to the contractor in a daily transmission.						
31	*	EMPLOYEE SSN	A/N	11	465-475	THE CONTRACT HOLDER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
32	*	EMPLOYEE LAST NAME	A/N	40	476-515	THE LAST NAME OF THE CONTRACT HOLDER.
33	*	EMPLOYEE SEX	A/N	1	516	THE GENDER OF THE CONTRACT HOLDER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
34	*	EMPLOYEE DATE OF BIRTH	D	8	517-524	THE CONTRACT HOLDER'S DATE OF BIRTH **FORMAT- CCYYMMDD**

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
35	*	EMPLOYEE ZIP CODE	A/N	9	525-533	THE CONTRACT HOLDER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Fields 36-45: Member refers to the patient for whom the charge or service was provided. For a claim to be paid, a member must be eligible as of the date of the service. Member information must correspond to OGB's eligibility transmission.						
36	*	UNIQUE MEMBER ID	A/N	8	534-541	THE MEMBER'S UNIQUE IDENTIFIER FROM THE STATE OF LOUISIANA'S ELGIBILITY FEED.
37		MEMBER SSN	A/N	11	542-552	THE MEMBER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
38	*	MEMBER FIRST NAME	A/N	40	553-592	THE FIRST NAME OF THE MEMBER (PATIENT)
39	*	MEMBER LAST NAME	A/N	40	593-632	THE LAST NAME OF THE MEMBER (PATIENT)
40	*	MEMBER SEX	A/N	1	633	THE GENDER OF THE MEMBER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
41	*	MEMBER DATE OF BIRTH	D	8	634-641	THE MEMBER'S DATE OF BIRTH. **FORMAT- CCYYMMDD**
42	*	MEMBER ZIP CODE	A/N	9	642-650	THE MEMBER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Field 43: The relationship code will be consistent with that provided to the contractor in the daily eligibility transmission.						
43	*	RELATIONSHIP TO EMPLOYEE	A/N	2	651-652	THE RELATIONSHIP THIS MEMBER HAS TO THE CONTRACT HOLDER. '01 = EMPLOYEE/CONTRACT HOLDER '02' = SPOUSE '03' AND ABOVE= OTHER DEPENDENTS
Fields 44-45: The following should relate directly to a check written to a member in the check register transmitted along with the month's claim file.						
44		MEMBER CHECK NUMBER	A/N	10	653-662	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE MEMBER
45		MEMBER CHECK AMOUNT	N	15	663-677	THE AMOUNT ON THE MEMBER'S CHECK

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
FIELDS 46-56 AND 60-65: DIAGNOSIS AND PROCEDURE CODING WILL ADHERE TO ICD-9 STANDARD CODING. ONCE A PLAN AND SCHEDULE FOR TRANSITION TO ICD-10 CODING IS ESTABLISHED, DIAGNOSIS CODES AND PROCEDURE CODES WILL BE REVISITED TO PROVIDE OGB WITH AN ACCURATE REPRESENTATION OF THE CLINICAL ASPECTS OF THE CLAIM.						
46	*	PRIMARY DIAGNOSIS CODE	A/N	10	678-687	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE PRIMARY DIAGNOSIS FOR THE SERVICE PROVIDED
47		DIAGNOSIS CODE 2	A/N	10	688-697	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SECOND DIAGNOSIS FOR THE SERVICE
48		DIAGNOSIS CODE 3	A/N	10	698-707	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE THIRD DIAGNOSIS FOR THE SERVICE
49		DIAGNOSIS CODE 4	A/N	10	708-717	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FOURTH DIAGNOSIS FOR THE SERVICE
50		DIAGNOSIS CODE 5	A/N	10	718-727	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FIFTH DIAGNOSIS FOR THE SERVICE
51		DIAGNOSIS CODE 6	A/N	10	728-737	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SIXTH DIAGNOSIS FOR THE SERVICE
52		DIAGNOSIS CODE 7	A/N	10	738-747	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SEVENTH DIAGNOSIS FOR THE SERVICE
53		DIAGNOSIS CODE 8	A/N	10	748-757	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE EIGHTH DIAGNOSIS FOR THE SERVICE
54		DIAGNOSIS CODE 9	A/N	10	758-767	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE NINTH DIAGNOSIS FOR THE SERVICE
55		ADMIT DIAGNOSIS CODE	A/N	10	768-777	FOR INPATIENT CLAIMS, THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE ADMIT DIAGNOSIS FOR THIS CLAIM
56	*	PROCEDURE CODE	A/N	10	778-787	THE ACTUAL PROCEDURE PERFORMED: - THE CPT PROCEDURE CODE ON HCFA FORMS - THE HCPCS PROCEDURE CODE ON UB92 FORMS - THE ADA PROCEDURE CODE ON DENTAL FORMS.

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
57		MODIFIER CODE 1	A/N	5	788-792	THE FIRST MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
58		MODIFIER CODE 2	A/N	5	793-797	THE SECOND MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
59		MODIFIER CODE 3	A/N	5	798-802	THE THIRD MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
60		ICD9 PROCEDURE CODE 1	A/N	10	803-812	THE PRIMARY ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
61		ICD9 PROCEDURE CODE 2	A/N	10	813-822	THE SECOND ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
62		ICD9 PROCEDURE CODE 3	A/N	10	823-832	THE THIRD ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
63		ICD9 PROCEDURE CODE 4	A/N	10	833-842	THE FOURTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
64		ICD9 PROCEDURE CODE 5	A/N	10	843-852	THE FIFTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
65		ICD9 PROCEDURE CODE 6	A/N	10	853-862	THE SIXTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
66		RX DRUG CODE	A/N	11	863-873	FOR DRUGS ADMINISTERED, THE PRESCRIPTION DRUG CODE (NDC) FOR THE CLAIM LINE, FORMATTED 542, NO DASHES
Fields 67-68: The service provider must exist in the provider file transmitted along with the month's claim file.						
67	*	SERVICE PROVIDER ID	A/N	20	874-893	THE UNIQUE ID OF THE SERVICE PROVIDER ASSIGNED IN THE CONTRACTOR'S CLAIMS PROCESSING SYSTEM.
68	*	NPI	A/N	10	894-903	THE SERVICE PROVIDER'S NPI
Fields 69-71: The pay-to provider must exist in the provider file transmitted along with the month's claim file.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
69		PAY-TO PROVIDER ID	A/N	20	904-923	THE UNIQUE ID OF THE PAY-TO PROVIDER ASSIGNED IN THE CONTRACTOR'S CLAIMS PROCESSING SYSTEM. THIS MAY BE THE SAME ID LISTED FOR THE SERVICE PROVIDER IF A SEPARATE PAYMENT ENTITY IS NOT ESTABLISHED. **NOTE: REQUIRED UNLESS ONLY MEMBER PAID OR CLAIM DENIED.**
70		NETWORK INDICATOR	A/N	1	924	AT THE TIME OF SERVICE, THE PROVIDER'S STATUS: 'I' = IN NETWORK; 'O' = OUT OF NETWORK **NOTE: REQUIRED UNLESS ONLY MEMBER PAID OR CLAIM DENIED.**
71		PAY-TO TAX ID	A/N	10	925-934	THE TAX ID NUMBER FOR THE PAY-TO ENTITY FOR THIS PROVIDER IF PROVIDER PRESCRIBED DRUGS.
Fields 73-74: The following should relate directly to a check written to a provider in the check register transmitted along with the month's claim file.						
72		PROVIDER CHECK NUMBER	A/N	10	935-944	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE PROVIDER
73		PROVIDER CHECK AMOUNT	N	15	945-959	THE AMOUNT ON THE PROVIDER'S CHECK
74		OVERRIDE CODE	A/N	3	960-962	IDENTIFIES THAT THE APPROVER OVERRODE THE SYSTEM-GENERATED PAYMENT AMOUNT. IDENTIFIES THE REASON THE APPROVER OVERRODE THE SYSTEM (CLAIM RELATED TO DETOXIFICATION, PAY BENEFIT FROM CREDIT-RESERVE, REJECTED LINE ITEM. ETC.)

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
75		BENEFIT LEVEL CAUSE CODE	A/N	2	963-964	IDENTIFIES THE REASON THE PATIENT SOUGHT MEDICAL CARE BLANK=N/A 0=GENERAL SICKNESS 1=PSYCHIATRIC 2=NORMAL MATERNITY 3=EMERGENCY ILLNESS 4=ROUTINE CARE 5=COMPLICATIONS OF PREGNANCY 6=ALCOHOLISM AND DRUG ADDICTION A=ACCIDENT
76		DISCHARGE STATUS CODE	A/N	2	965-966	IDENTIFIES THE STATUS OF THE MEMBER'S INPATIENT STAY AS OF THE LAST SERVICE DATE ON THE CLAIM, RIGHT JUSTIFIED AND PREFIXED WITH ZERO

Appendix A-2 Provider File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: To simplify references, a provider may have more than one entry in the provider file. Specifically, a provider must be identified by services performed but may be paid as a separate entity from its identity as a service provider. Multiple entries may be caused by different addresses, tax requirements, and/or contractual responsibility to a group. Service providers are referenced in Fields 67 and 68 of Appendix A-1, Medical Claims File. Pay-to providers are referenced in Fields 69 through 73 of Appendix A-1.						
1	*	PROVIDER INTERNAL ID	A/N	20	1-20	THE UNIQUE ID FOR SERVICE OR PAY-TO PROVIDER ASSIGNED BY CONTRACTOR IN CLAIMS PROCESSING
2	*	PROVIDER TAX ID	A/N	10	21-30	TAX ID OF THIS PROVIDER
3	*	NPI	A/N	10	31-40	THIS PROVIDER'S NATIONAL PROVIDER IDENTIFIER
4		PROVIDER DEA ID	A/N	10	41-50	THE FEDERAL DEA NUMBER OF THIS PROVIDER IF PROVIDER PRESCRIBES DRUGS.
Fields 5-8: A provider may refer to a physician, a facility, or another care provider. Either an office (Field 8) or a person (Fields 5-7) or both must be named in the following 4 fields.						
5		PROVIDER LAST NAME	A/N	40	51-90	THE LAST NAME FOR THIS PROVIDER
6		PROVIDER FIRST NAME	A/N	40	91-130	THE FIRST NAME FOR THIS PROVIDER
7		PROVIDER MIDDLE INITIAL	A/N	1	131	THE MIDDLE INITIAL FOR THIS PROVIDER
8		PROVIDER OFFICE NAME	A/N	40	132-171	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE THIS PROVIDER OFFERS SERVICES.
9	*	PROVIDER ADDRESS LINE1	A/N	40	172-211	LINE 1 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
10		PROVIDER ADDRESS LINE2	A/N	40	212-251	LINE 2 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
11	*	PROVIDER CITY	A/N	40	252-291	THE CITY PORTION OF THIS PROVIDER'S ADDRESS
12	*	PROVIDER STATE	A/N	2	292-293	THE STATE PORTION OF THIS PROVIDER'S ADDRESS
13	*	PROVIDER ZIP	A/N	9	294-302	THE ZIPCODE OF THIS PROVIDER'S ADDRESS, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
14		PROVIDER UPIN	A/N	20	303-322	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
15		PROVIDER MEDICARE ID	A/N	20	323-342	THE MEDICARE IDENTIFIER FOR THIS PROVIDER

Fields 16-19: The contractor will send initially and keep current a file of specialty codes and descriptions used in their claims processing to OGB						
16	*	PROVIDER SPECIALTY	A/N	10	343-352	THE CODE FOR THE PROVIDER'S PRIMARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
17		PROVIDER SPECIALTY 2	A/N	10	353-362	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
18		PROVIDER SPECIALTY 3	A/N	10	363-372	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE THE CONTRACTOR'S SYSTEM.
19		PROVIDER SPECIALTY 4	A/N	10	373-382	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR'S SYSTEM.
20	*	PROVIDER TYPE	A/N	1	383	**"F" – FACILITY, "P" – PHYSICIAN, "O" – OTHER, "Y" – PAY-TO, "G" - GROUP**

Appendix A-3 Check Register						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: The check number should relate directly to the check number in the claim or claims paid by this check. This assumes that all claims for OGB members are paid from the same checking account. If this is not so, a separate account field will be required.						
1	*	CHECK NUMBER	A/N	10	1-10	THE NUMBER PRINTED ON THE CHECK
2	*	CHECK ISSUE DATE	A/N	8	11-18	DATE THE CHECK WAS ISSUED AS PAYMENT **FORMAT- CCYYMMDD**
Field 3: The amount of the check should equal the sum of the amounts on the claim or claims paid to the provider or member paid by this check.						
3	*	CHECK ISSUE AMOUNT	N	15	19-33	AMOUNT PAID BY THIS CHECK
4	*	PAYEE TYPE	A/N	1	34	'P' – PROVIDER, 'M' – MEMBER, 'O' - OGB
Field 5: If the check is to a provider, the provider ID must exist in the contractor's provider file transmitted with the check register. If the check is written to a member, the member ID must correspond to OGB's member ID provided in the related eligibility transmission to the contractor. Financial adjustments to payments from OGB to the contractor may or may not reference a distinct claim transaction. Payments to OGB by the contractor, if any, should reference the relevant line on the contractor's invoice.						

Appendix A-4 Code Files						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: A Code is the contractor's distinct identifier for all codes of a type used in the data transferred to OGB. Code files are named by their type and must be transferred to OGB initially and whenever any changes to the codes of a type change or when codes are added. There are code tables for each non-standard code type, currently including provider specialties, denial reasons, types of service and override codes. Other non-standard coding may be discovered in the future, and, if so, this format may be used if appropriate for that use.						
1	*	CODE	A/N	20	1-20	THE CONTRACTOR'S UNIQUE IDENTIFIER FOR THIS CODE TYPE.
2	*	SHORT DESCRIPTION	A/N	100	21-120	THE CONTRACTOR'S MEANING FOR THE CODE IDENTIFIED.
3		LONG DESCRIPTION	A/N	400	121-520	IF NECESSARY, A MORE THOROUGH DESCRIPTION OF THE MEANING OF THE CODE DESCRIBED ABOVE.
Fields 3-4: Effective and Termination Dates may or may not apply to the code referenced. These fields may be left blank.						
4		EFFECTIVE DATE	D	8	521-528	THE FIRST DATE THE CODE CAME INTO USE. **FORMAT- CCYYMMDD**
5		TERMINATION DATE	D	8	529-536	THE LAST/FINAL DATE THE CODE WAS USED. **FORMAT- CCYYMMDD**

Appendix A-5 Eligibility File					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	CONTRACT HOLDER'S SSI	A/N	9	001-009	CONTRACT HOLDER'S SSN
2	MEMBER LAST NAME	A/N	20	010-029	MEMBER LAST NAME
3	MEMBER FIRST NAME	A/N	15	030-044	MEMBER FIRST NAME
4	MEMBER MIDDLE INITIAL	A/N	1	045-045	MEMBER MIDDLE INITIAL
5	ADDRESS 1	A/N	35	046-080	ADDRESS LINE 1
6	ADDRESS 2	A/N	35	081-115	ADDRESS LINE 2
7	CITY	A/N	30	116-145	CITY
8	STATE	A/N	2	146-147	STATE
9	ZIP CODE	A/N	13	148-160	ZIP CODE
10	BIRTH DATE	A/N	8	161-168	CCYYMMDD
11	PLAN EFFECTIVE DATE	A/N	8	169-176	CCYYMMDD- EARLIEST EFFECTIVE DATE OF UNINTERRUPTI COVERAGE WITHIN THE HEALTH PLAN/RATE TABLE/COVERAGE LEVEL COMBINATION.
12	TERMINATION DATE	A/N	8	177-184	CCYYMMDD- BLANK IF ACTIVE
13	CLIENT / AGENCY CODE	A/N	8	185-192	CODE CLIENT /AGENT
14	SUB CLIENT / SECTION OF AGENCY	A/N	4	193-196	SUB CLIENT OR SECTION AGENCY
15	TYPE OF COVERAGE	A/N	1	197-197	"E" – MEMBER ONLY "C" – MEMBER AND CHILD(REN) "S" – MEMBER AND SPOUSE "F" – FAMILY
16	MEDICARE A PRIMARY EFFECTIVE DATE	A/N	8	198-205	CCYYMMDD(CAN BE BLANK)
17	MEDICARE B PRIMARY EFFECTIVE DATE	A/N	8	206-213	CCYYMMDD(CAN BE BLANK)
18	SEX CODE	A/N	1	214-214	MALE OR FEMALE(M/F)
19	STUDENT DATE	A/N	8	215-222	CCYYMMDD(CAN BE BLANK)
20	RELATION CODE	A/N	2	223-224	01 – ENROLLEE 02 – SPOUSE

Appendix A-5 Eligibility File					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					03 – CHILDREN OR OTHER DEPENDENTS
21	TRANSACTION DATE	A/N	8	225-232	CCYYMMDD
22	AGENCY EMPLOYMENT DATE	A/N	8	233-240	CCYYMMDD
23	PREEXISTING TERMINATION DATE	A/N	8	241-248	CCYYMMDD- PREEXISTING TERMINATION DATE(CAN BE BLANK)
24	CONTRACT HOLDER PHONE	A/N	12	249-260	
25	ENROLLEE STATUS FIELD	A/N	1	261-261	C - FOR THE WHOLE FAMILY IF THE SUBSCRIBER IS ON COBI R- FOR THE SUBSCRIBER AND SPOUSE IF THE SUBSCRIBER IS RETIRED AND ACTIVE FOR THE CHILDREN A-FOR THE WHOLE FAMILY IF THE SUBSCRIBER IS ACTIVE
Appendix A-5 Eligibility File					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
26	HANDICAPPED INDICATOR	A/N	1	262-262	“Y” = YES “N” = NO
27	MARRIAGE DATE	A/N	8	263-270	CCYYMMDD(CAN BE BLANK)
28	HIC NUMBER	A/N	12	271-282	MEDICARE CARD NUMBER.
29	COB DATE	A/N	8	283-290	CCYYMMDD- BEGINNING COVERAGE BY OTHER CARRIER NOT INCLUDING MEDICARE.
30	MEDICARE PRIMARY	A/N	1	291-291	“Y” = YES “N” = NO
31	MEMBER SSN	A/N	9	292-300	MEMBER SSN
32	RETIREE 100	A/N	1	301-301	SWITCH IS ALWAYS BLANK FOR DEPENDENTS Y/N
32	LAST CHANGE DATE	A/N	8	302-309	CCYYMMDD- DATE THE ENROLLMENT RECORD WAS LAST CHANGED
33	MEMBER RECORD ID	A/N	8	310-317	OGB INTERNAL ID
34	CLAIM PAYMENT STOP DATE	A/N	8	318-325	CCYYMMDD- DATE BEYOND WITH CLAIMS SHOULD NOT BE PAID BECAUSE OF NON-PAYMENT OF PREMIUMS
35	RATE TABLE	A/N	2	326-327	AC – ACTIVE CB - COBRA

Appendix A-5 Eligibility File					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					CD - COBRA DISABILITY CP - COBRA PART-TIME CS – COBRA STATE SUBSIDIZED R1 - RETIRED MEDICARE 1 R2 - RETIRED MEDICARE 2 RN - RETIRED NO MEDICARE THIS FIELD IS ALWAYS BLANK FOR DEPENDENTS
36	PLAN	A/N	4	328-331	
37	LIFETIME ACCUM	N	10	332-341	9999999.99 LEADING SPACES: SUM OF DRUG AND MEDICAL, CLAIMS PAID. MAX: 5,000,000.00
38	DRUG ACCUM	N	10	342-351	9999999.99 LEADING SPACES: SUM OF DRUG CLAIMS PAID. INCLUDED IN LIFETIME ACCUM.

Appendix A-6 ASO Administrative Fee Billing					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	INVOICE DATE	A/N	8	001-008	CCYYMMDD
2	ENROLLEE SSN	A/N	9	009-017	SOCIAL SECURITY NUMBER
3	ENROLLEE LAST NAME	A/N	20	018-037	LAST NAME
4	ENROLLEE FIRST NAME	A/N	20	038-057	FIRST NAME
5	ENROLLEE MIDDLE INITIAL	A/N	1	058-058	INITIAL
6	ENROLLEE COVERAGE TYPE	A/N	2	059-060	"EE" -EMPLOYEE ONLY "ES"-EMPLOYEE AND SPOUSE "EC"-EMPLOYEE AND CHILD(REN) "FM"-FAMILY
7	RATE TABLE CODE	A/N	2	061-062	"AC"- ACTIVE "CB"- COBRA "CD"- COBRA DISABILITY "CP"- COBRA PART-TIME "R1" - RETIRED MEDICARE 1 "R2"- RETIRED MEDICARE 2 "RN"- RETIRED NO MEDICARE
8	BILLING OR COVERAGE	A/N	8	063-070	CCYYMMDD
9	PREMIUM AMOUNT	N	7	071-80	FORMAT-SHOULD BE 7 CHARACTERS LONG, ZERO FILLED, WITH AN EXPLICIT DECIMAL POINT AND LEADING SIGN ONLY WHEN NEGATIVE EXAMPLE: 123.45 WOULD BE EXPRESSED AS "0000123.45" -123.45 WOULD BE EXPRESSED AS "-000123.45"

Appendix A-7 Claims Paid by Contractor after Termination or Stop Payment					
FIELD	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	ASO CLAIM NUMBER	A/N	15	001-015	
2	TOTAL CHARGE	N	10	016-025	DECIMAL + 2 DECIMAL PLACES. IF NEGATIVE THE SIGN WILL BE IMMEDIATELY TO THE LEFT OF THE NUMBER
3	TOTAL PAID AMOUNT	N	10	026-035	DECIMAL + 2 DECIMAL PLACES. IF NEGATIVE THE SIGN WILL BE IMMEDIATELY TO THE LEFT OF THE NUMBER
4	PROVIDER OFFICE OR FULL NAME	A/N	30	036-065	
5	DATE OF SERVICE FROM	A/N	8	066-073	CCYYMMDD
6	TERM/STOP SENT DATE	A/N	8	074-081	CCYYMMDD
7	PAID DATE	A/N	8	082-089	CCYYMMDD
8	FAMILY SSN	A/N	9	090-098	
9	RELATION CODE	A/N	2	099-100	01-ENROLLEE 02-SPOUSE 03-DEPENDENT 05-GRANDCHILD 17-STEPCHILD 24- DEPENDENT CHILD OF A DEPENDENT CHILD
10	PATIENT FIRST NAME	A/N	15	101-115	
11	TERM/STOP DATE	A/N	8	116-123	CCYYMMDD
12	TERM/STOP FLAG	A/N	1	124-124	T-TERMINATED, S-STOP

STATE EMPLOYEES GROUP BENEFITS PROGRAM
2011 BILLING SCHEDULE

Billing Preparation	Billing Month	Agency Transactions Received By*	Billings and Files Completed
12/28 & 12/29	January Active Bill	12/22/2010	12/30/2010
01/06 & 01/07	February Retiree Bill	01/04/2011	01/10/2011
01/27 & 01/28	February Active Bill	01/24/2011	01/31/2011
02/08 & 02/09	March Retiree Bill	02/04/2011	02/10/2011
02/24 & 02/25	March Active Bill	02/22/2011	02/28/2011
03/08 & 03/09	April Retiree Bill	03/04/2011	03/10/2011
03/29 & 03/30	April Active Bill	03/25/2011	03/31/2011
04/07 & 04/08	May Retiree Bill	04/05/2011	04/10/2011
04/27 & 04/28	May Active Bill	04/25/2011	04/29/2011
05/06 & 05/09	June Retiree Bill	05/05/2011	05/10/2011
05/27 & 05/30	June Active Bill	05/25/2011	05/31/2011
06/08 & 06/09	July Retiree Bill	06/06/2011	06/10/2011
06/28 & 06/29	July Active Bill	06/24/2011	06/30/2011
07/07 & 07/08	August Retiree Bill	07/05/2011	07/10/2011
07/28 & 07/29	August Active Bill	07/26/2011	07/31/2011
08/08 & 08/09	September Retiree Bill	08/04/2011	08/10/2011
08/29 & 08/30	September Active Bill	08/26/2011	08/31/2011
09/08 & 09/09	October Retiree Bill	09/05/2011	09/10/2011
09/28 & 09/29	October Active Bill	09/26/2011	09/30/2011
10/06 & 10/07	November Retiree Bill	10/04/2011	10/10/2011
10/27 & 10/28	November Active Bill	10/25/2011	10/31/2011
11/08 & 11/09	December Retiree Bill	11/04/2011	11/10/2011
11/28 & 11/29	December Active Bill	11/25/2011	11/30/2011
12/08 & 12/09	January Retiree Bill	12/06/2011	12/10/2011