

CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

CFMS: 733527

DHH: 060467

Agency # 305

Medical Vendor Administration

AND

Amerigroup Louisiana, Inc.

FOR

☐ Personal Services ☐ Professional Services ☐ Consulting Services ☒ Social Services

1) Contractor (Legal Name if Corporation) Amerigroup Louisiana, Inc.	5) Federal Employer Tax ID# or Social Security # 26467414900 (Must be 11 Digits)
2) Street Address 3850 N. Causeway Blvd, Suite 600	6) Parish(es) Served ST
City Metairie	7) License or Certification # N/A
State LA	8) Contractor Status
Zip Code 70002	Subrecipient: ☐ Yes ☒ No
3) Telephone Number (504) 834-1271	Corporation: ☒ Yes ☐ No
4) Mailing Address (if different)	For Profit: ☒ Yes ☐ No
	Publicly Traded: ☒ Yes ☐ No
City	8a) CFDA#(Federal Grant #)
State	
Zip Code	

9) Brief Description Of Services To Be Provided:

Contractor will function as a risk-bearing managed care organization (MCO) that provides services to eligible Louisiana Medicaid enrollees as defined in the Louisiana Medicaid State Plan, administrative rules, Medicaid Policy and Procedure manuals, and this contract

10) Effective Date 02-01-2015	11) Termination Date 01-31-2018
12) This contract may be terminated by either party DHH upon giving thirty (30) sixty (60) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.	
13) Maximum Contract Amount 1,984,731,789	

14) Terms of Payment

if progress and/or completion of services are provided to the satisfaction of the initiating Officer/Facility, payments are to be made as follows:
Contractor will be paid upon successful completion of deliverables in the manner outlined in Attachment C.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	First Name Mary T.C.	Last Name Johnson
	Title Deputy Medicaid Director	Phone Number 225-342-3426

15) Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):

- | | |
|--|---|
| Attachment A: HIPAA Addendum | Exhibit 1: Board Resolution |
| Attachment B: Statement of Work | Exhibit 2: Multi-Year Letter |
| Attachment C: Terms of Payment | Exhibit 3: RFP305PUR-DHHRFP-BH-MCO-2014-MVA |
| Attachment D: Rate Certification | Exhibit 4: Appendices to RFP305PUR-DHHRFP-BH-MCO-2014-MVA |
| Attachment E: Incentive-Based Performance Measures | Exhibit 5: Addenda to RFP305PUR-DHHRFP-BH-MCO-2014-MVA |
| Attachment F: Member Assignment Methodology | Exhibit 6: Contractor's proposal |
| Attachment G: Additional Terms and Conditions | Exhibit 7: Contractor's Emergency Preparedness Plan |
| Attachment H: Standard Provisions | |

DATE: 01-31-2018 BY: [Signature] OF: [Signature]

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.
2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)
3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.
- Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities relevant to this contract. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office**.
4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74.53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.
5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.
6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.
7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.
8. ~~In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.~~
9. No funds provided herein shall be used 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 legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.
10. ~~Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.~~

11. ~~All non-third party software and source code, 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. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. See Attachment G.~~
12. Except as otherwise permitted in this Contract or RFP, Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein. This section applies only to subcontracts, statements of work, memoranda of understanding, agreements, or any portions thereof, which affect Contractor's operations in Louisiana under this contract. Any subcontract, statement of work, memorandum of understanding, agreement, or portion thereof, entered into by Contractor's parent and/or affiliate relating to the operations or administration of that entity, or any of that entity's affiliates or subsidiaries outside Louisiana is not subject to the requirements of this section.
13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113 as amended in the 2008 Regular Session of the Louisiana Legislature.
14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, upon 30 days advance notice to the contractor, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.
15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds \$20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502.
16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations 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 reduction is 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 are not appropriated.
17. Pursuant to Section 25.1 of the RFP, 305PUR-DHHRFP-BH-MCO-2014-MVA, any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when approved by both parties and reduced to writing, as an amendment duly signed, and approved by both parties and required authorities of the Department; and, if contract exceeds \$20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.
18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.
19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.
20. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future franchising contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request for the purpose of this contract; equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of \$1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.
21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients or other parties acting on behalf of Contractor, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

Amerigroup Louisiana, Inc.	
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Sonyia Nelson 1/13/15
 SIGNATURE DATE

Sonyia Nelson
 NAME
 CEO
 TITLE

STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS	
--	--

SIGNATURE DATE

NAME
 Secretary, Department of Health and Hospital or Designee
 TITLE

--	--

Medical Vendor Administration	
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SIGNATURE DATE
 NAME
 TITLE

J. Ruth Kennedy 1/14/15
 SIGNATURE DATE
 J. Ruth Kennedy
 NAME
 Medicaid Director
 TITLE

APPROVED
 Office of the Governor
 Office of Contractual Review

JAN 30 2015

Patricia Bartley Rice
 DIRECTOR

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment A to the contract.

1. The Louisiana Department of Health and Hospitals ("DHH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of DHH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of DHH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for DHH involving the disclosure of PHI.
3. Definitions: As used in this addendum –
 - A. The term "HIPAA Rules" refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (DHHS) pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009.
 - B. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.
 - C. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.
 - D. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. Disclosures which must be reported by contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq.* At the option of DHH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by DHH, in which case contractor shall reimburse DHH for all expenses that DHH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of DHH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to DHH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR § 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR § 164.528 for at least six (6) years after the date of the last such disclosure.
11. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold DHH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between DHH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between DHH and contractor.
16. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of DHH, whichever occurs first, contractor shall return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor shall extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

Statement of Work

Goal/Purpose

Contractor will function as a risk-bearing managed care organization (MCO) that provides core benefits and services to eligible Louisiana Medicaid enrollees as defined in the contract, Louisiana Medicaid State Plan, administrative rules and Medicaid Policy and Procedure manuals.

Deliverables

The Contractor shall provide all deliverables required in the Request for Proposals issued July 28, 2014, RFP305PUR-DHHRFP-BH-MCO-2014-MVA, which includes all Appendices, Addenda, and responses to written comments.

Performance Measures

The contractor will provide to DHH, or maintain on file, all items that document the completion of deliverables outlined in the contract, including but not limited to:

- 1) Staffing Requirements
 - Develop and maintain written policies, procedures and job descriptions for each functional area.
 - Provide upon request a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed as required by law.
 - Provide a list of marketing training dates at least fourteen calendar days prior to the date of training.
- 2) Medical Loss Ratio
 - Provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.
- 3) Expanded Services/Benefits
 - The MCO shall provide a description of the expanded services/benefits to be offered by the MCO for approval. Additions, deletions or modifications to expanded services/benefits made during the contract period must be submitted to DHH, for approval.
- 4) Pharmacy Services
 - Submit pharmacy claims information at frequency established by DHH.
 - Submit reporting specific to the pharmacy program, including, but not limited to:
 - Pharmacy help desk performance
 - Prior authorization performance
 - Prior Authorization request turnaround time
 - Number of claims submitted as a 72-hour emergency supply
 - Denials (name of drug, number of requests, number of denials)
 - Pharmacy network access
 - Grievance and appeals
 - Medication therapy management initiatives
- 5) Provider Network
 - Develop and maintain a provider network development and management plan that must be submitted to DHH at least annually.
 - Maintain written agreements that document the existence of a provider network that is sufficient to provide adequate access to all required services.
 - Submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix TT. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them.

- Provide written provider credentialing and re-credentialing policies that are compliant with NCQA Health Plan Accreditation standards and all applicable state laws within 30 days of the signing of the contract.
- Develop and implement network development and management policies.
- Maintain a Provider Directory.
- Maintain and issue a provider handbook within thirty days of the date the contract is signed.
- Conduct provider satisfaction surveys annually.

6) Provider Complaint System

- Develop and implement a provider dispute and appeal process for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s). This process must be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.
- Provide the names, phone numbers and e-mail addresses of executives with the authority to require corrective actions to DHH within one week of contract approval, and within 2 business days of any changes.

7) Utilization Management

- Develop and maintain policies and procedures with defined structures and processes for a Utilization Management program that incorporates Utilization Review and Service Authorization.

8) Quality Assessment and Performance Improvement (QAPI) Plans

- Form a QAPI Committee.
- Develop a QAPI Work Plan and submit it to DHH thirty (30) days after the effective date of the contract, and annually thereafter.
- Submit QAPI reports annually.

9) Clinical and Administrative Performance Measures

- Report to DHH on administrative measures contained in Appendix J of the RFP on a quarterly basis.
- Report to DHH on clinical measures contained in Appendix J of the RFP on an annual basis 12 months after services begin.
- Report to DHH all clinical measures monthly based on HEDIS specifications, ignoring all continuous eligibility requirements for HEDIS in this monthly reporting.
- Publically report on HEDIS 2016 to NCQA.

10) Performance Improvement Projects (PIPs)

- Submit a description of each PIP to DHH for approval within three months of the execution of the contract and at the beginning of each contract year thereafter.
- Perform a minimum of two DHH-approved PIPs in each contract year, including the required three-year PIP and the one-year PIP associated with the contract year
- Submit project data analysis to DHH monthly.
- Report to DHH on PIP outcomes on an annual basis.

11) Member and Provider Call Centers

- Establish and maintain a member call center.
- Develop and submit to DHH for approval a script to be used during the welcome call.
- Develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards and emergencies including but not limited to hurricane-related evacuations. The MCO shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies.
- Develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette and submit to DHH for review and approval annually.
- Establish and maintain a provider call center.

Terms of Payment

Maximum Contract Amount:

The maximum contract amount for each contract year is the product of projected enrollment in the MCO and the projected Per Member Per Month capitation rate. For calculation purposes, the projected Per Member Per Month capitation rate is the statewide composite prior to risk adjustment.

Contract Year	Projected Member Months	Projected Per Member Per Month Capitation Rate	Maximum Contract Amount
Contract year 1 - February 1, 2015 to January 31, 2016	2,007,023	\$302.90	\$607,927,267
Contract year 2 - February 1, 2016 to January 31, 2017	2,156,211	\$310.90	\$670,366,000
Contract year 3 - February 1, 2017 to January 31, 2018	2,161,943	\$317.51	\$686,438,522
3-Year Total			\$1,964,731,789

DHH reserves the right to adjust Per Member Per Month capitation rates in the following instances:

1. Changes to core benefits and services included in the capitation rates;
2. Changes to Medicaid population groups eligible to enroll in an MCO;
3. Legislative appropriations and budgetary constraints; or
4. Changes in federal requirements.

Terms of Payment:

1. DHH shall make monthly risk-adjusted capitation rate payments for each member enrolled into the MCO. Capitation rates are developed in accordance with 42 CFR 438.6 and are actuarially sound.
2. MCO agrees to accept payment in full and shall not seek additional payment from a member for any unpaid costs, including costs incurred during the retroactive period of eligibility.
3. DHH reserves the right to defer remittance of the monthly capitation rate payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.
4. The monthly risk-adjusted capitation rate payment shall be based on the total number of Medicaid eligibles assigned to the MCO as of the last working day of the previous month and paid in the weekly payment cycle nearest the 15th calendar day of the month.
5. In addition to the monthly capitated rate, DHH shall provide MCOs a one-time supplemental lump sum payment for each obstetrical delivery. This kick payment is intended to cover the cost of prenatal care, the delivery event, and post-partum care and normal newborn hospital costs.
6. If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the MCO's net premiums written from DHH's Medicaid/CHIP lines of business, DHH shall make an annual payment to the MCO in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by

DHH (and its contracted actuary) as an adjustment to each MCO's capitation rates for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

Effective Date of Enrollment

MCO enrollment for members in a given month will be effective at 12:01AM on the first calendar day of the month of Medicaid eligibility not to exceed 12 months of retroactive eligibility.

Withhold of Capitation Rate

As outlined in detail in Section 5.3 of the RFP, a withhold of a portion of the monthly capitation rate payment shall be applied to provide an incentive for MCO compliance with the requirements of this contract. The withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all MCO enrollees, exclusive of maternity kick payments.

Attachment D



Jaredd Simons, ASA, MAAA
Senior Associate Actuary

Government Human Services Consulting
3560 Lenox Road, Suite 2400
Atlanta, GA 30326
+1 404 442 3358
www.mercer-government.mercer.com

Ms. Mary Johnson
Bayou Health Program Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

August 29, 2014

Subject: Louisiana Bayou Health Program – Full Risk-Bearing Managed Care Organization
Rate Development and Actuarial Certification for the Period February 1, 2015 through January
31, 2016

Dear Ms. Johnson:

The Louisiana Department of Health and Hospitals (DH-H) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of February 1, 2015 through January 31, 2016.

The Bayou Health program began February 1, 2012, and operated under two separate managed care paradigms for the first three years of the program. The Bayou Health Prepaid program operated under an at-risk capitated arrangement, and the Shared Savings program was an enhanced Primary Care Case Management (ePCCM) program. Effective February 1, 2015, Bayou Health will begin operating as an at-risk capitated program only.

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses,



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August 29, 2014
Ms. Mary Johnson
Louisiana Department of Health and Hospitals

marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Rate Methodology Overview

Capitation rate ranges for the Bayou Health program were developed in accordance with rate-setting guidelines established by CMS. For rate range development for the Bayou Health managed care organizations (MCOs), Mercer used calendar year 2013 (CY13) Medicaid FFS medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. Restrictions were applied to the enrollment and claims data so that it was appropriate for the populations and benefit package defined in the contract.

Mercer reviewed the data provided by DHH and the Prepaid and Shared Savings plans for consistency and reasonableness and determined that the data are appropriate for the purpose of setting capitation rates for the MCO program. The data certification shown in Appendix G has been provided by DHH, and its purpose is to certify the accuracy, completeness, and consistency of the base data.

Adjustments were made to the selected base data to match the covered populations and Bayou Health benefit packages for rating year 2015 (RY15). Additional adjustments were then applied to the base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data.
- Provision for incurred-but-not-reported (IBNR) claims.
- Financial adjustments to encounter data for underreporting.
- Trend factors to forecast the expenditures and utilization to the contract period.
- Changes in benefits covered by managed care.
- Addition of new populations to the Bayou Health program.
- Opportunities for managed care efficiencies.
- Administration and underwriting profit/risk/contingency loading.

In addition to these adjustments, DHH takes two additional steps in the matching of payment to risk:

- Application of maternity supplemental (kick) payments.
- Application of risk-adjusted regional rates.



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The resulting rate ranges for each individual rate cell were net of Graduate Medical Education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan. Mercer removed GME amounts in the FFS and Shared Savings data to be consistent with DHH's intention to continue paying GME amounts directly to the teaching hospitals. Encounter data does not include GME payments and therefore no adjustment is required.

Bayou Health Populations Covered Populations

In general, the Bayou Health program includes individuals classified as Supplemental Security Income (SSI), Family and Children, Breast and Cervical Cancer, and LaCHIP Affordable Plan (LAP) as mandatory or voluntary opt-out populations. Voluntary opt-in populations include Home- and Community-Based Services (HCBS) Waiver participants and Chisholm Class Members (CCM).

Chisholm Class Members

Effective February 1, 2015, members of Louisiana's Chisholm class will be permitted to participate in Bayou Health on a voluntary opt-in basis. Previously, membership in the Chisholm class would make a recipient ineligible for Bayou Health.

Chisholm refers to a class action lawsuit (*Chisholm v. Hood*) filed in 1997. Chisholm class members are defined as all current and future recipients of Medicaid in the State of Louisiana, under age 21, who are now or will in the future be placed on the Office of Citizens with Developmental Disabilities' Request for Services Registry.

LaHIPP Population

Effective February 1, 2015, Bayou Health will include individuals covered by the Louisiana's Health Insurance Premium Payment (LaHIPP) Program. This program pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their job and someone in the family is enrolled in Medicaid. The program also covers out of pocket expenses incurred by the enrollee (Medicaid is the secondary payer). Premiums will continue to be paid by DHH, but out of pocket expenses incurred by the enrollee will be the responsibility of the MCO. LaHIPP is not a category of eligibility. Enrollees in this program are eligible under the other categories of aid (COA) and their experience are included in the applicable COA and Rate Cell combination for purposes of developing the capitation rate range.

Excluded Populations

The following individuals are excluded from participation in the Bayou Health program:



- Medicare-Medicaid Dual Eligible Beneficiaries
- Qualified Medicare Beneficiaries (QMB) (only where State only pays Medicare premiums)
- Specified Low-income Medicare Beneficiaries (SLMB) (where State only pays Medicare premiums)
- Medically Needy Spend-Down Individuals
- Individuals residing in Long-term Care Facilities (Nursing Home, Intermediate Care Facility/Developmentally Disabled (ICF/DD))
- Individuals enrolled in the Program for All-Inclusive Care for the Elderly (PACE)
- Individuals only eligible for Family Planning services
- Individuals enrolled in the Greater New Orleans Community Health Connection (GNOCHC) Demonstration waiver

Appendix B encompasses a comprehensive list of Bayou Health's covered and excluded populations.

Rate Category Groupings

Rates will vary by the major categories of eligibility. Furthermore, where appropriate, the rates within a particular category of eligibility are subdivided into different age bands to reflect differences in risk due to age. In addition, due to the high cost associated with pregnancies, DH-H will pay a maternity kickpayment to the MCOs for each delivery that takes place. Table 1 shows a list of the different rate cells for each eligibility category including the maternity kickpayments.

Table 1: Rate Category Groupings

COA Description	Rate Cell Description
SSI	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
Family and Children	Newborns, 0-2 Months of Age
	Newborns, 3-11 Months of Age
	Child, 1-18 Years of Age
	Adult, 19+ Years of Age
Breast and Cervical Cancer (BCC)	BCC, All Ages



LAP	LAP, All Ages
HCBS	Child, 0-18 Years of Age
	Adult, 19+ Years of Age
CCM	CCM, All Ages
Maternity Kickpayment	Maternity Kickpayment
Early Elective Delivery Kickpayment	EED Kickpayment

Region Groupings

For rating purposes, Louisiana has been split into four different regions. Table 2 lists the associated parishes for each of the four regions.

Table 2: Region Groupings

Region Description	Associated Parishes (Counties)
Gulf	Assumption, Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John, St. Mary, and Terrebonne
Capital	Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, St. Tammany, Tangipahoa, Washington, West Baton Rouge, and West Feliciana
South Central	Acadia, Allen, Avoyelles, Beauregard, Calcasieu, Cameron, Catahoula, Concordia, Evangeline, Grant, Iberia, Jefferson Davis, Lafayette, Lasalle, Rapides, St. Landry, St. Martin, Vermillion, Vernon, and Winn
North	Bienville, Bossier, Caddo, Caldwell, Claiborne, DeSoto, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Tensas, Union, Webster, and West Carroll

Bayou Health Services Covered Services

Appendix C lists the services that the Bayou Health MCOs must provide. The MCOs also have the ability to develop creative and innovative solutions to care for their members (i.e., provide other cost-effective alternative services) as long as the contractually-required Medicaid services are covered. Costs of alternative services are expected to be funded through savings on the contractually-required services for which these services are a cost-effective substitute.



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New Services

Effective February 1, 2015, DHH has decided to incorporate services covered historically by FFS in the Bayou Health program. The following services were previously excluded from the Bayou Health program and now are included:

- Hospice services
- Personal care services for ages 0-20

Additionally, non-emergency medical transportation (NEMT) will be the responsibility of the Bayou Health MCO, even if the service the recipient is being transported to is not a Bayou Health-covered service. Previously, NEMT to non-covered services would have been FFS.

Behavioral Health Mixed Services Protocol

In the Request for Proposals (RFP) issued by the State for the Bayou Health program to be effective February 1, 2015, Behavioral Health services are divided into two levels: basic and specialized. Basic Behavioral Health services will be the responsibility of Bayou Health MCOs. Basic services include:

- General hospital inpatient services, including acute detoxification
- General hospital emergency room (ER) services, including acute detoxification
- Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) encounters that do not include any service by a specialized behavioral health professional
- Professional services, excluding services provided by specialized behavioral health professionals
- Prescribed drugs prescribed by any professional that is not a specialized behavioral health professional

Specialized behavioral health services will be identified primarily based on provider type. Any service provided by behavioral health specialists, as well as behavioral health facilities are considered specialized behavioral health.

Excluded Services

Bayou Health MCOs are not responsible for providing acute care services and other Medicaid services not identified in Appendix C, including the following services:

- Applied Behavioral Analysis



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- Dental services with the exception of Early and Periodic Screening & Diagnostic Treatment (EPSDT) varnishes provided in a primary care setting
- ICF/DD services
- Personal Care services for those ages 21 and older
- Nursing Facility services
- School-based Individualized Education Plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures including school nurses
- HCBS Waiver services
- Specialized Behavioral Health,
- Targeted Case Management services
- Services provided through DHH's Early-Steps Program

Data Adjustments

IBNR Claims

Completion factors were developed to incorporate consideration for any outstanding claims liability.

To establish the completion factors for the Shared Savings/Legacy Medicaid FFS data, claims were grouped into three COA and seven main completion service categories. All remaining service categories were grouped into the other service category. Completion category mapping is provided in Appendix C. Note that the BCC and CCM populations utilized SSI completion factors and the LAP population utilized Family and Children completion factors, as these populations are expected to exhibit similar completion patterns. Appendix D-1 summarizes the completion factors adjustment that was applied to the Shared Savings/Legacy Medicaid FFS data.

Encounter claim completion factors, developed separately for each Prepaid plan, were compared to completion factors provided by the Prepaid plan actuaries and summarized by completion category of service. Appendix D-2 summarizes the completion factors adjustment that was applied to the Prepaid encounter data.

Under-reporting

Under-reporting adjustments were developed by comparing encounter data from the Medicaid management information system (MMIS) to financial information provided by the Prepaid plans. This adjustment was computed and applied on a plan basis resulting in an overall adjustment of 3.7%. Note this adjustment does not apply to the Shared Savings claims nor Legacy Medicaid/FFS data.



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Third-Party Liabilities

All claims are reported net of third party liability, therefore no adjustment is required.

Fraud and Abuse Recoveries

DHHS provided data related to fraud and abuse recoveries on the Shared Savings and Legacy FFS. The total adjustment applied was -0.1%. Prepaid plans included fraud and abuse recoveries in their financial reports. These recoveries were included in the development of the underreporting adjustment.

Co-payments

Copays are only applicable to prescription drugs. Pharmacy claims are reported net of any co-payments so no additional adjustment is necessary.

DSH Payments

DSH payments are made outside of the MMIS system and have not been included in the capitation rates.

Fee Schedule Adjustments Fee Changes

These capitation rates reflect changes in made by DHHS to the fee schedules used in the FFS program. The first of these changes, effective February 1, 2013, was a 1% cut in fees paid to non-rural, non-state hospitals. This 1% cut also applied to physician services, except for procedure codes affected by Section 1202 of the Affordable Care Act, when performed by a physician eligible for the enhanced payment rate. Fee changes also include estimation of cost settlements and reflect the most up to date cost settlement percentages for each facility. For most non-rural facilities, the cost settlement percentage is 66.46% however some facilities are settled at different amounts. Rural facilities are cost settled at 110%.

Hospital Privatization

During 2013 nine state hospitals privatized. As a result of this privatization, they no longer are paid for services based on the state hospital fee schedule, but rather on the non-state, non-rural fee schedule. Similarly, reimbursement for cost-based services for these hospitals is now based on the 66.46% cost settlement percentage for non-state, non-rural hospitals, rather than the 90% cost-settlement percentage applicable to state hospitals. Two additional state hospitals are closing. The utilization in these facilities was assumed to be absorbed by other facilities in the regions and claims were adjusted accordingly.



Tables 3 summarizes the overall fee schedule adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.

Table 3: Fee Schedule Adjustment

Prepaid Fee Schedule Adjustment		
COA Description		Rate Impact
SSI		0.8%
Family & Children		0.6%
BCC		-1.6%
LAP		1.3%
HCBS		0.0%
CCM		0.0%
Maternity Kickpayment		1.7%
EED Kickpayment		1.7%
Total		0.7%

Shared Savings/FFS Fee Schedule Adjustment		
COA Description		Rate Impact
SSI		-1.8%
Family & Children		-1.6%
BCC		-5.9%
LAP		-0.7%
HCBS		-0.1%
CCM		-1.1%
Maternity Kickpayment		-0.6%
EED Kickpayment		-0.6%
Total		-1.5%

ACA PCP

Under Section 1202 of the Affordable Care Act (ACA), state Medicaid programs were required to increase payments to primary care providers (PCPs) in 2013 and 2014. This requirement expires on December 31, 2014. As a result, 2013 Bayou Health encounter and FFS claims were adjusted to reflect the decrease in PCP payment rates between 2013 and 2015. The reduction, applied at the COA level is based on adjusting the provider fee schedule from the enhanced ACA rate to the Medicaid rate set by DH-H. Prepaid encounter data was adjusted based on submissions by the plans, and following discussions with them to identify the necessary adjustments to their experience. Table 4 summarizes the overall adjustment by COA that was applied to the Prepaid encounter and Shared Savings/FFS claims data.



Table 4: ACA PCP Adjustment

COA Description	Rate Impact
SSI	-1.3%
Family & Children	-3.9%
BCC	-0.7%
LAP	-4.4%
HCBS	0.0%
CCM	0.0%
Maternity Kickpayment	0.0%
EED Kickpayment	0.0%
Total	-2.5%

Program Changes

Act 312

Effective January 1, 2014, Act 312 requires that when medications are restricted for use by an MCO by a step therapy or fail first protocol, the prescribing physician shall be provided with and have access to a clear and convenient process to expeditiously request an override of such restriction from the MCO. The MCO is required to grant the override under certain conditions. Mercer reviewed this new requirement and estimated the impact of this change to be an increase of approximately 3% of pharmacy costs.

COA Description	Rate Impact
SSI	-1.5%
Family & Children	-4.7%
BCC	-0.7%
LAP	-5.2%
HCBS	-0.7%
CCM	-0.9%
Maternity Kickpayment	0.0%
EED Kickpayment	0.0%
Total	-3.1%



Early Elective Deliveries (EED)

Beginning February 2015, facility and delivering physician costs for early elective deliveries will not be covered under the Bayou Health program. These deliveries will trigger a reduced kickpayment to the MCO. Mercer identified the average facility and delivering physician costs included in the maternity kick payment by region and removed those costs to create the EED Kickpayment. Table 5 shows the adjustments and resulting EED Kickpayments.

Table 5: Early Elective Delivery Rate Reduction

Early Elective Delivery Rate Reduction			
Region Description	Reduction (%)	Reduction - Low	Reduction - High
Gulf	-34.3	\$ (3,706.64)	\$ (3,862.49)
Capital	-43.3	\$ (2,831.28)	\$ (2,950.33)
South Central	-41.2	\$ (2,918.12)	\$ (3,040.81)
North	-38.0	\$ (3,170.62)	\$ (3,303.94)
Total	-38.9	\$ (3,169.67)	\$ (3,302.95)

Retro-active Eligibility Adjustment

Beginning in February 2015 members granted retroactive eligibility will be capitated retroactively, based on their eligibility for Bayou Health, for up to 12 months prior to enrollment in a MCO. The MCO selected by these members will then receive the appropriate number of capitation months, and will be liable for all claims incurred during this retroactive eligibility period. In order to account for the inability of MCOs to manage these retro-active claims, an adjustment factor has been applied to the capitation rates. Mercer did not apply any savings adjustments to the retro-active period claims in the development of these factors. Table 6 summarizes the overall adjustment by rate cell for retro-active eligibility.



Table 6: Retro-Active Eligibility Adjustment

Retro-Active Eligibility Adjustment		
COA Description	Rate Cell Description	Adjustment (%)
SSI	0-2 Months	0.0
SSI	3-11 Months	0.0
SSI	Child 1-18	0.0
SSI	Adult 19+	0.5
Family & Children	0-2 Months	0.0
Family & Children	3-11 Months	0.0
Family & Children	Child 1-18	0.0
Family & Children	Adult 19+	1.7
BCC	BCC, All Ages	7.5
LAP	LAP, All Ages	0.0
HCBS	Child 0-18	0.0
HCBS	Adult 19+	0.0
CCM	CCM, All Ages	0.0
Maternity Kickpayment	Maternity Kickpayment	0.0
EED Kickpayment	EED Kickpayment	0.0
Total		0.7

Rating Adjustments

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the cost of providing health care services in a future period. Mercer studied historical cost and utilization data for each of the three data sources incorporated in the capitation rates: Prepaid encounters, Shared Savings, and FFS. Trends were selected based on Louisiana experience, as well as national trend information. Trends by population are shown in Appendix E.

Managed Care Adjustments

For those populations and services that had previously been excluded from Bayou Health, Mercer adjusted the capitation rates to reflect areas for managed care efficiency. Managed Care is able to generate savings by:



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- Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the ER or hospitalization.
- Using alternatives to the ER for conditions that are non-emergent in nature.
- Increasing access and providing member education.
- Minimizing duplication of services.
- Hospital discharge planning to ensure a smooth transition from facility-based care to community resources and minimize readmissions.

Managed care savings factors were applied to the HCBS and Chisholm class COA. Additionally, durable medical equipment (DME) and NEMT costs for Shared Savings enrollees were adjusted as part of this rate setting, as these services were excluded from Bayou Health Shared Savings. Appendix F summarizes the managed care savings adjustments that were applied to the Shared Savings/Legacy Medicaid FFS data.

Shared Savings Rx claims

Under the Bayou Health Shared Savings program, plans had limited ability to manage prescription drug costs. In order to use the Shared Savings experience to set capitated rates, adjustments were needed to account for generic dispense rate (GDR) differences between the Prepaid and Shared Savings experience. For the Prepaid program, GDR was approximately 84%, compared to approximately 77% for Shared Savings and FFS. Mercer assumed the change in GDR would be zero the first month the rates are in effect, increasing evenly over the next 3 months until an 84% GDR is achieved in May 2015. This results in prescription drug savings of 11% to 13%.

Outliers

As part of the State Plan, inpatient hospitals receive an additional payment for high cost stays for children under six, called outliers. These payments are for inpatient stays with a total cost to the hospital in excess of \$150,000, where the cost is determined based on the hospital's Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU)-specific cost-to-charge ratio (CCR). DHH makes payments to a maximum of \$10 million, annually. As payment of outlier liability is the responsibility of Bayou Health MCOs, this additional \$10 million was built into the rates based on the distribution by rate cell observed in State Fiscal Year (SFY)11 and SFY12. Outliers added an average cost of \$0.93 per member per month (PMPM) to the base data used in rate setting.

Graduate Medical Education

DHH will be making payments for GME outside of the capitation rates. Therefore, Mercer made adjustments to exclude GME payments from the capitation.



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Data Smoothing

For certain rate cells, there were not enough member months (MMs) within each region to produce a statistically credible rate. For these rate cells, Mercer calculated a statewide capitation rate. Affected rate cells include:

- SSI newborns 0-1 years of age
- BCC, All Ages
- LAP, All Ages
- HCBS, All Ages
- CCM, All Ages

Voluntary Opt-In Adjustments

It is unclear at this time if there will be a material difference in the risk profile of the Opt-in population from the historical FFS population. Therefore, Mercer made no adjustments for selection risk in the development of the HCBS and CCM rates.

Non-Medical Expense Load

The actuarially sound capitation rate ranges developed include a provision for MCO administration and other non-medical expenses. Mercer reviewed historical Prepaid plan expense data and relied on its professional experience in working with numerous State Medicaid programs to develop the administrative load. The load for each rate cell was determined using a fixed and variable cost model. Under this model, a fixed administrative expense is attributed to each member month, which reflects program requirements, such as state-mandated staffing. Added to this is a variable administrative amount, based on claims volume. For pharmacy, 2% of claims cost was targeted, while 6.1% was targeted for medical. Maternity kickpayment rate cells have only the variable medical administrative load. The total administrative cost is estimated to be between \$21.33 and \$22.86 PMPM.

Additionally, provision has been made in these rates for a 2% risk margin, as well as Louisiana's 2.25% premium tax.

Risk Adjustment

Risk adjustment will be applied to the rates in Attachment A to reflect differences in health status of the members served in each MCO using the Adjusted Clinical Groups (ACG) model. The risk adjustment process does not increase nor decrease the overall cost of the program, but can change the distribution across the various Bayou Health MCOs according to the relative risk of their enrolled members. Actuarially sound risk adjustment protocols have been developed so as to be appropriate to rates that have been developed by underlying age and gender cells.



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Federal Health Insurer Fee

Section 9010 of the ACA established a health insurance provider fee (HIPF), which applies to certain for-profit/tax-paying health insurers. For-profit Medicaid health plans are not exempt from the HIPF, which will become a cost of doing business that is appropriate to recognize in actuarially sound capitation rates.

At the time of this certification, many aspects of the calculation and application of this fee are not yet determined and/or finalized. These fees will be calculated and become payable sometime during the third quarter of 2016. As these fees are not yet defined by insurer and by market place, no adjustment has been made in the rate range development for the Bayou Health program. An adjustment and revised certification will be considered when the fee amount and impacted entities applicable to this rate period are announced in 2016.

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, encounter data, reimbursement level, benefit design, and other information supplied by DHH and its fiscal agent. DHH, its fiscal agent, and the Prepaid plans are responsible for the validity and completeness of the data supplied. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit them. In our opinion they are appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the rates in Attachment A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. Rate estimates provided are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual Bayou Health MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c), and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.



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Bayou Health MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by Bayou Health MCOs for any purpose. Mercer recommends that any Bayou Health MCO considering contracting with the DHH should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the DHH.

This certification letter assumes the reader is familiar with the Bayou Health Program, Medicaid eligibility rules, and actuarial rate-setting techniques. It is intended for DHH and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call me at +1 404 442 3358.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Jared Simons'.

Jared Simons, ASA, MAAA
Senior Associate Actuary



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Appendix A: Bayou Health Capitation Rate Range

Region Description	COA Description	Rate Cell Description	CY13 MMs or Deliveries	Lower Bound PMPM or Cost per Delivery	Upper Bound PMPM or Cost per Delivery
Gulf	SSI	0-2 Months	291	\$21,714.18	\$23,187.74
Gulf	SSI	3-11 Months	1,790	\$4,268.75	\$4,554.33
Gulf	SSI	Child 1-18	122,394	\$315.40	\$338.01
Gulf	SSI	Adult 19+	276,704	\$744.61	\$794.63
Gulf	Family & Children	0-2 Months	43,180	\$1,247.14	\$1,333.03
Gulf	Family & Children	3-11 Months	104,549	\$209.39	\$225.60
Gulf	Family & Children	Child 1-18	2,053,265	\$100.88	\$108.38
Gulf	Family & Children	Adult 19+	374,005	\$243.76	\$260.34
Gulf	BCC	BCC, All Ages	3,702	\$1,558.12	\$1,682.05
Gulf	LAP	LAP, All Ages	9,457	\$130.97	\$140.95
Gulf	HCBS	Child 0-18	6,826	\$1,436.85	\$1,562.34
Gulf	HCBS	Adult 19+	21,296	\$471.84	\$514.04
Gulf	CCM	CCM, All Ages	15,710	\$766.57	\$841.00
Gulf	Maternity Kickpayment	Maternity Kickpayment	10,993	\$5,645.11	\$5,882.47
Gulf	EED Kickpayment	EED Kickpayment	N/A	\$1,938.47	\$2,019.98
Capital	SSI	0-2 Months	168	\$21,714.18	\$23,187.74
Capital	SSI	3-11 Months	1,491	\$4,268.75	\$4,554.33
Capital	SSI	Child 1-18	89,519	\$350.07	\$375.54
Capital	SSI	Adult 19+	210,439	\$828.40	\$884.04
Capital	Family & Children	0-2 Months	38,789	\$1,269.87	\$1,358.14
Capital	Family & Children	3-11 Months	94,611	\$234.54	\$252.93
Capital	Family & Children	Child 1-18	1,863,396	\$108.21	\$116.37
Capital	Family & Children	Adult 19+	268,984	\$284.36	\$303.49
Capital	BCC	BCC, All Ages	3,946	\$1,558.12	\$1,682.05



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Capital	LAP	LAP, All Ages	10,487	\$130.97	\$140.95
Capital	HCBS	Child 0-18	7,164	\$1,436.85	\$1,562.34
Capital	HCBS	Adult 19+	21,638	\$471.84	\$514.04
Capital	CCM	CCM, All Ages	15,831	\$766.57	\$841.00
Capital	Maternity Kickpayment	Maternity Kickpayment	9,776	\$4,993.41	\$5,203.37
Capital	EED Kickpayment	EED Kickpayment	N/A	\$2,162.13	\$2,253.04
South Central	SSI	0-2 Months	217	\$21,714.18	\$23,187.74
South Central	SSI	3-11 Months	1,692	\$4,268.75	\$4,554.33
South Central	SSI	Child 1-18	91,728	\$366.85	\$392.21
South Central	SSI	Adult 19+	247,354	\$753.10	\$803.99
South Central	Family & Children	0-2 Months	43,502	\$1,362.72	\$1,457.24
South Central	Family & Children	3-11 Months	104,512	\$238.42	\$256.64
South Central	Family & Children	Child 1-18	2,038,315	\$116.59	\$125.16
South Central	Family & Children	Adult 19+	285,454	\$271.50	\$289.77
South Central	BCC	BCC, All Ages	2,893	\$1,558.12	\$1,682.05
South Central	LAP	LAP, All Ages	12,222	\$130.97	\$140.95
South Central	HCBS	Child 0-18	6,665	\$1,436.85	\$1,562.34
South Central	HCBS	Adult 19+	23,110	\$471.84	\$514.04
South Central	CCM	CCM, All Ages	16,556	\$766.57	\$841.00
South Central	Maternity Kickpayment	Maternity Kickpayment	10,509	\$4,964.46	\$5,173.20
South Central	EED Kickpayment	EED Kickpayment	N/A	\$2,046.35	\$2,132.39
North	SSI	0-2 Months	239	\$21,714.18	\$23,187.74
North	SSI	3-11 Months	1,678	\$4,268.75	\$4,554.33
North	SSI	Child 1-18	100,260	\$318.45	\$340.17
North	SSI	Adult 19+	212,259	\$706.03	\$754.16
North	Family & Children	0-2 Months	32,253	\$1,387.94	\$1,484.93
North	Family & Children	3-11 Months	80,214	\$226.40	\$243.68
North	Family & Children	Child 1-18	1,587,962	\$102.79	\$110.29
North	Family & Children	Adult 19+	213,631	\$253.70	\$271.21
North	BCC	BCC, All Ages	2,395	\$1,558.12	\$1,682.05
North	LAP	LAP, All Ages	6,545	\$130.97	\$140.95



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North	HCBS	Child 0-18	4,164	\$1,436.85	\$1,562.34
North	HCBS	Adult 19+	17,320	\$471.84	\$514.04
North	CCM	CCM, All Ages	16,472	\$766.57	\$841.00
North	Maternity Kickpayment	Maternity Kickpayment	8,136	\$5,110.00	\$5,324.86
North	EED Kickpayment	EED Kickpayment	N/A	\$1,939.38	\$2,020.92



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Appendix B: Bayou Health Eligibility Designation

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI (Aged, Blind and Disabled)				
Acute Care Hospitals (LOS > 30 days)	●			
BPL (Walker vs. Bayer)	●			
Disability Medicaid	●			
Disabled Adult Child	●			
Disabled Widow/Widower (DWW)	●			
Early Widow/Widowers	●			
Family Opportunity Program*	●		●	
Former SSI*	●		●	
Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	●			
PICKLE	●			
Provisional Medicaid	●			
Section 4913 Children	●			
SGA Disabled VWW/DS	●			
SSI (Supplemental Security Income)*	●		●	
SSI Conversion	●			
Tuberculosis (TB)	●			
SSI (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
Foster Care IV-E - Suspended SSI			●	
SSI (Supplemental Security Income)			●	
TANF (Families and Children, LIFC)				
CHAMP Child	●			
CHAMP Pregnant Woman (to 133% of FPIG)	●			
CHAMP Pregnant Woman Expansion (to 185%	●			



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COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
FPIG)				
Deemed Eligible	●			
ELE - Food Stamps (Express Lane Eligibility-Food Stamps)	●			
Grant Review	●			
LaCHIP Phase 1	●			
LaCHIP Phase 2	●			
LaCHIP Phase 3	●			
LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion	●			
LIFC - Unemployed Parent / CHAMP	●			
LIFC Basic	●			
PAP - Prohibited AFDC Provisions	●			
Pregnant women with income greater than 118% of FPL and less than or equal to 133% of FPL	●			
Regular MNP (Medically Needy Program)	●			
Transitional Medicaid	●			
FCC (Families and Children)				
Former Foster Care children	●			
Youth Aging Out of Foster Care (Chaffee Option)	●			
FCC (OCS Foster Care, IV-E OCS/OYD and OCS/OYD (XIX))				
CHAMP Child			●	
CHAMP Pregnant Woman (to 133% of FPIG)			●	
IV-E Foster Care			●	
LaCHIP Phase 1			●	
OYD - V Category Child			●	
Regular Foster Care Child			●	



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COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
YAP (Young Adult Program)			●	
YAPIOYD			●	
BCC (Families and Children)				
Breast and/or Cervical Cancer	●			
LAP (Families and Children)				
LaCHIP Affordable Plan	●			
HCBS Waiver				
ADHC (Adult Day Health Services Waiver)		●		
Children's Waiver - Louisiana Children's Choice		●		
Community Choice Waiver		●		
New Opportunities Waiver - SSI		●		
New Opportunities Waiver Fund		●		
New Opportunities Waiver, non-SSI		●		
Residential Options Waiver - non-SSI		●		
Residential Options Waiver - SSI		●		
SSI Children's Waiver - Louisiana Children's Choice		●		
SSI Community Choice Waiver		●		
SSI New Opportunities Waiver Fund		●		
SSI/ADHC		●		
Supports Waiver		●		
Supports Waiver SSI		●		
CCM				
Chisholm Class Members**		●		
LaHIPP				
Louisiana's Health Insurance Premium Payment Program***	●	●	●	●



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COA/Eligibility Category Name	Mandatory		Voluntary		Excluded
	Excluded		Opt-In	Opt-Out	
CHAMP Presumptive Eligibility					●
CSOC					●
DD Waiver					●
Denied SSI Prior Period					●
Disabled Adults authorized for special hurricane Katrina assistance					●
EDA Waiver					●
Family Planning, New eligibility / Non LaMOM					●
Family Planning, Previous LAMOMs eligibility					●
Family Planning/Take Charge Transition					●
Forced Benefits					●
GNOCHC Adult Parent					●
GNOCHC Childless Adult					●
HPE B/CC					●
HPE Children under age 19					●
HPE Family Planning					●
HPE Former Foster Care					●
HPE LaCHIP					●
HPE LaCHIP Unborn					●
HPE Parent/Caretaker Relative					●
HPE Pregnant Woman					●
LBHP - Adult 1915(i)					●
LTC (Long-Term Care)					●
LTC Co-Insurance					●
LTC MNP/Transfer of Resources					●



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COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
LTC Payment Denial/Late Admission Packet				●
LTC Spend-Down MNP				●
LTC Spend-Down MNP (Income > Facility Fee)				●
OCS Child Under Age 18 (State Funded)				●
OYD (Office of Youth Development)				●
PACE SSI				●
PACE SSI-related				●
PCA Waiver				●
Private ICF/DD				●
Private ICF/DD Spendown Medically Needy Program				●
Private ICF/DD Spendown Medically Needy Program/Income Over Facility Fee				●
Public ICF/DD				●
Public ICF/DD Spendown Medically Needy Program				●
QI-1 (Qualified Individual - 1)				●
QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)				●
QMB (Qualified Medicare Beneficiary)				●
SLMB (Specified Low-Income Medicare Beneficiary)				●
Spend-Down Medically Needy Program				●
Spendown Denial of Payment/Late Packet				●
SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic				●
SSI DD Waiver				●
SSI Payment Denial/Late Admission				●
SSI PCA Waiver				●



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COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
SSI Transfer of Resource(s)/LTC				●
SSI/EDA Waiver				●
SSI/LTC				●
SSI/Private ICF/DD				●
SSI/Public ICF/DD				●
State Retirees				●
Terminated SSI Prior Period				●
Transfer of Resource(s)/LTC				●

* Children under 19 years of age who are automatically enrolled into Bayou Health, but may voluntarily disenroll.
** Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the OCDD's Request for Services Registry who are *Chisholm* Class Members.
*** LaHIPP is not a category of eligibility. Eligibility designation for LaHIPP enrollees will vary according to the qualifying category of eligibility.



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Appendix C: Bayou Health Covered Services

Medicaid Category of Service	Units of Measurement	Completion Category of Service
Inpatient Hospital	Days	Inpatient
Outpatient Hospital	Claims	Outpatient
Primary Care Physician	Visits	Physician
Specialty Care Physician	Visits	Physician
FQHC/RHC	Visits	Physician
EPSDT	Visits	Physician
Certified Nurse Practitioners/Clinical Nurse	Claims	Physician
Lab/Radiology	Units	Other
Home Health	Visits	Other
Emergency Transportation	Units	Transportation
NEMT	Units	Transportation
Rehabilitation Services (occupational therapy {OT}, physical therapy {PT}, speech therapy {ST})	Visits	Other
DME	Units	Other
Clinic	Claims	Physician
Family Planning	Visits	Physician
Other	Units	Other
Prescribed Drugs	Scripts	Prescribed Drugs
ER	Visits	Outpatient
Basic Behavioral Health	Claims	Physician
Hospice*	Admits	Inpatient
Personal Care Services (Age 0-20)*	Units	Physician

* Services that were previously excluded from the Bayou Health program and now are included.



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Appendix D-1: Shared Savings/FFS IBNR Adjustment

Category of Service Description	SSI (%)	COA Description					
		Family & Children (%)	BCC (%)	LAP (%)	HCBS (%)	CCM (%)	Maternity Kickpayment (%)
Inpatient Hospital	4.6	6.1	4.6	6.1	2.6	4.6	N/A
Outpatient Hospital	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Primary Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Specialty Care Physician	3.8	2.4	3.8	2.4	3.9	3.8	N/A
FQHC/RHC	3.8	2.4	3.8	2.4	3.9	3.8	N/A
EPSDT	3.8	2.5	0.0	2.4	3.9	3.8	N/A
Certified Nurse Practitioners/Clinical Nurse	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Lab/Radiology	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Home Health	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Emergency Transportation	2.4	3.8	2.4	3.8	1.3	2.4	N/A
NEMT	2.4	3.8	2.4	3.8	1.3	2.4	N/A
Rehabilitation Services (OT, PT, ST)	3.3	3.0	0.0	3.0	1.5	3.3	N/A
DME	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Clinic	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Family Planning	3.8	2.4	3.8	2.4	3.9	3.8	N/A
Other	3.3	3.0	3.3	3.0	1.5	3.3	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	0.0	0.0	N/A
Emergency Room	2.9	2.6	2.9	2.6	2.4	2.9	N/A
Basic Behavioral Health	3.8	2.5	3.8	2.4	3.9	3.8	N/A
Hospice	4.6	6.1	4.6	0.0	2.6	4.6	N/A
Personal Care Services	3.8	2.6	0.0	0.0	3.9	3.8	N/A
Total	2.2	2.3	2.4	1.7	1.6	2.6	4.0



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Appendix D-2: Prepaid IBNR Adjustment

COA Description									
Category of Service Description	SSI (%)	Family & Children		BCC (%)	LAP (%)	HCBS (%)	CCM (%)	Maternity Kickpayment	
		(%)	(%)					(%)	(%)
Inpatient Hospital	2.0	6.9	1.7	2.6	9.7	N/A	N/A	N/A	N/A
Outpatient Hospital	2.4	3.0	2.6	2.6	2.6	N/A	N/A	N/A	N/A
Primary Care Physician	2.8	3.0	2.8	3.0	3.0	N/A	N/A	N/A	N/A
Specialty Care Physician	2.8	3.0	2.8	3.0	3.0	N/A	N/A	N/A	N/A
FQHC/RHC	2.9	3.0	2.9	3.0	3.0	N/A	N/A	N/A	N/A
EPSDT	2.9	3.0	2.4	3.0	3.0	N/A	N/A	N/A	N/A
Certified Nurse Practitioners/Clinical Nurse	2.8	3.0	2.8	3.1	N/A	N/A	N/A	N/A	N/A
Lab/Radiology	1.1	0.0	1.3	0.0	N/A	N/A	N/A	N/A	N/A
Home Health	1.1	0.0	1.3	0.0	N/A	N/A	N/A	N/A	N/A
Emergency Transportation	3.1	2.3	3.1	2.3	N/A	N/A	N/A	N/A	N/A
NEMT	1.3	1.5	1.6	2.4	N/A	N/A	N/A	N/A	N/A
Rehabilitation Services (OT, PT, ST)	1.1	0.0	0.5	0.0	N/A	N/A	N/A	N/A	N/A
DME	1.0	0.0	1.1	0.0	N/A	N/A	N/A	N/A	N/A
Clinic	2.5	3.1	2.7	2.9	N/A	N/A	N/A	N/A	N/A
Family Planning	2.8	3.0	2.8	2.8	N/A	N/A	N/A	N/A	N/A
Other	1.3	0.0	1.5	0.0	N/A	N/A	N/A	N/A	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	N/A	N/A	N/A	N/A	N/A
Emergency Room	2.3	2.9	2.4	2.6	N/A	N/A	N/A	N/A	N/A
Basic Behavioral Health	2.9	3.0	2.8	3.0	N/A	N/A	N/A	N/A	N/A
Hospice	4.6	6.1	4.6	0.0	N/A	N/A	N/A	N/A	N/A
Personal Care Services	3.8	2.4	0.0	0.0	N/A	N/A	N/A	N/A	N/A
Total	1.4	2.9	1.9	2.2	N/A	N/A	N/A	2.1	



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Appendix E: Trend

Category of Service Description	SSI/BCC		Family & Children/LAP		HCBS/CCM	
	Low PMPM (%)	High PMPM (%)	Low PMPM (%)	High PMPM (%)	Low PMPM (%)	High PMPM (%)
Inpatient Hospital	0.0	3.0	0.0	3.0	1.0	3.0
Outpatient Hospital	2.0	7.1	3.0	8.2	3.5	8.7
Primary Care Physician	2.0	7.1	2.0	7.1	2.0	6.1
Specialty Care Physician	2.0	7.1	2.0	7.1	2.0	6.1
FOHC/RHC	3.0	7.1	3.0	7.1	3.0	7.1
EPSDT	2.0	7.1	2.0	7.1	2.0	6.1
Certified Nurse Practitioners/Clinical Nurse	2.0	7.1	2.0	7.1	2.0	6.1
Lab/Radiology	2.0	4.0	2.0	4.0	2.0	4.0
Home Health	2.0	4.0	2.0	4.0	2.0	4.0
Emergency Transportation	2.0	4.0	2.0	4.0	1.0	4.0
NEMT	2.0	4.0	2.0	4.0	1.0	4.0
Rehabilitation Services (OT, PT, ST)	2.0	4.0	2.0	4.0	2.0	4.0
DME	2.0	4.0	2.0	4.0	2.0	4.0
Clinic	2.0	7.1	2.0	7.1	2.0	6.1
Family Planning	2.0	7.1	2.0	7.1	2.0	6.1
Other	2.0	4.0	2.0	4.0	2.0	4.0
Prescribed Drugs	5.4	7.2	5.4	7.2	2.0	3.0
Emergency Room	1.0	4.0	1.0	3.0	3.5	8.7
Basic Behavioral Health	2.0	7.1	2.0	7.1	2.0	6.1
Hospice	2.0	4.0	2.0	4.0	2.0	4.0
Personal Care Services	2.0	4.0	2.0	4.0	2.0	6.1
Total	2.7	5.7	2.6	5.7	2.0	4.6



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Appendix F: Managed Care Savings

Category of Service Description	HCBS Waiver/CCM*			Shared Savings**	
	Low PMPM (%)	High PMPM (%)	Low PMPM (%)	High PMPM (%)	
Inpatient Hospital	-11.6	-5.5	0.0	0.0	0.0
Outpatient Hospital	-9.1	-4.7	0.0	0.0	0.0
Primary Care Physician	7.6	12.4	0.0	0.0	0.0
Specialty Care Physician	-12.5	-8.2	0.0	0.0	0.0
FQHC/RHC	0.0	4.5	0.0	0.0	0.0
EPSDT	5.0	7.0	0.0	0.0	0.0
Certified Nurse Practitioners/Clinical Nurse	7.6	12.4	0.0	0.0	0.0
Lab/Radiology	-10.0	-3.1	0.0	0.0	0.0
Home Health	0.0	2.0	0.0	0.0	0.0
Emergency Transportation	-5.0	-0.6	0.0	0.0	0.0
NEMT	0.0	4.5	0.0	0.0	7.1
Rehabilitation Services (OT, PT, ST)	-5.0	-0.6	0.0	0.0	0.0
DME	-10.0	-5.6	-20.0	-13.3	
Clinic	-10.0	-5.6	0.0	0.0	0.0
Family Planning	0.0	4.5	0.0	0.0	0.0
Other	0.0	4.5	0.0	0.0	0.0
Prescribed Drugs	-10.4	-10.4	0.0	0.0	0.0
Emergency Room	-8.1	-3.7	0.0	0.0	0.0
Basic Behavioral Health	0.0	2.0	0.0	0.0	0.0
Hospice	0.0	0.0	0.0	0.0	0.0
Personal Care Services	-10.0	-5.0	-10.0	-5.0	-5.0
Total	-8.3	-4.8	-5.2	-4.1	

*Previously unmanaged populations utilizing Legacy Medicaid/FFS claims.

**Covered services previously not covered under the Shared Savings program.

***Current services for Prepaid, Shared Savings, and LaHIPP populations are managed and Managed Care savings are not applied.



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Appendix G: Data Reliance Attestation

Buddy Lindat
GOVERNOR



Kathy H. Kriebert
SECRETARY

State of Louisiana Department of Health and Hospitals Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

August 27, 2014

Mr. Jared Simon, ASA, MA,AA
Senior Associate
Mercer Government Human Services
3560 Lenox Road, Suite 2400
Atlanta, GA 30326

Subject: Capitation Rate Range Certification for the Bayou Health Prepaid Program –
Implementation Year (February 1, 2015 – January 31, 2016)

Dear Jared:

I, Jen Steele, Medicaid Deputy Director and Chief Financial Officer, for the State of Louisiana's Department of Health and Hospitals (DHH), hereby affirm that the data prepared and submitted to Mercer Government Human Services Consulting (Mercer) for the purpose of certifying the February 1, 2015 – January 31, 2016 Prepaid rates were prepared under my direction, and to the best of my knowledge and belief, are accurate, complete, and consistent with the data used to develop the capitation rates. This data includes calendar year (CY) 2013 fee-for-service (FFS) data files, MCO submitted encounter data, and supplemental information on payments made outside of Louisiana's Medicaid Management Information Systems (MMIS).

Mercer relied on DHH and its fiscal agent for the collection and processing of the FFS data, encounter data, and other information used in setting these capitation rates. Mercer did not audit the data, but did assess the data for reasonableness as documented in the rate certification letter.

Jen Steele
Signature

8/27/14
Date

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Incentive-Based Performance Measures
Targets for Improvement

Identifier	Measure	Measure Description	Target Population	Condition	Target for Improvement
PTB \$\$	Initiation of Injectable Progesterone Therapy in Women with Previous Pre-Term Births	The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation.	Children's and Maternal Health	Perinatal and Reproductive Health	20.00
NQF #0471 (CSEC) \$\$	Cesarean Rate for Low-Risk First Birth Women	The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).	Children's and Maternal Health	Perinatal and Reproductive Health	26.47
(AWC) \$\$	Adolescent Well Care Visit	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement Year	Children's Health	Utilization	40.69
NQF # 0108 \$\$	Follow-up Care for Children Prescribed ADHD Medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Children's Health	Behavioral Health	Initiation 42.07 C&M 48.49
NQF #2082 (HIV) \$\$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	Chronic Disease	HIV	54.34
NQF #0272 (PQI 1) \$\$	Diabetes Short Term Complications Rate	Number of discharges for diabetes short term complications per 100,000 Medicaid enrollees age 18 and older.	Chronic Disease	Diabetes	17.15
NQF # 1517 (PPC) \$\$	Postpartum Care (PPC Submeasure)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	Maternal Health	Perinatal and Reproductive Health	63.12
(AMB) \$\$	Ambulatory Care	Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months	Population Health	Utilization	ED Visits 68.37

Bayou Health Enrollment-- MCO Assignment Methodology 2015-2018 Contract Period

All existing Bayou Health members as of November 1, 2014 will be given the option to select the plan of their choice during open enrollment (November 13, 2014 – January 20, 2015). If a member does not actively select a health plan, DHH will seek to preserve the continuity of care for the member by maintaining existing patient/provider relationships, as well as the continuation of care coordination provided by the incumbent health plans as detailed below.

A. Members in Incumbent CCN-P Plan

1. Member may make a proactive choice to select the plan of their choice.
2. If the member does not make a proactive choice, they will remain in their current plan.

B. Members in Incumbent CCN-S Plan

1. Member may make a proactive choice to select the plan of their choice.
2. If the member does not make a proactive choice:
 - a. Members of the Community Health Solutions CCN-S Plan will be assigned to the Louisiana Healthcare Connections (LHC) MCO plan if their current PCP is in network with LHC.
 - b. Members of the United Healthcare (UHC) CCN-S Plan will be assigned to the United Healthcare MCO if their current PCP is in network with the UHC MCO.
 - c. If a CCN-S member's PCP is not in network with one of the successors identified above, the member will be assigned randomly to an MCO in which the PCP participates.
 - d. If the PCP is not contracted with any MCOs, they will be randomly assigned to one of the five MCOs in accordance with the procedure described in paragraph E below.

C. New Members Enrolled in Louisiana Medicaid Between 12/30/14 and 1/29/15

1. New members will be given the opportunity to proactively select a plan of their choice during the application process.
2. If the new member does not make a proactive choice:
 - a. If a family member has an existing MCO relationship, the new member will be assigned to that MCO.
 - b. If there is no family member relationship but the member has had a Medicaid PCP visit in the past 6 months, the member will be assigned randomly to an MCO in which the PCP participates.
 - c. If the member has neither an existing MCO relationship nor recent PCP visit, the member will be assigned to the new MCO entrant.

D. New Members Enrolled in Louisiana Medicaid On or After 1/30/2015 Through 1/29/2016

1. New members will be given the opportunity to proactively select a plan of their choice during the application process.
2. If the new member does not make a proactive choice:
 - a. If a family member has an existing MCO relationship, the new member will be assigned to that MCO.
 - b. If there is no family member relationship but the member has had a Medicaid PCP visit in the past 6 months, the member will be assigned randomly to an MCO in which the PCP participates.
 - c. If the member has neither an existing MCO relationship nor recent PCP visit, the member will be randomly assigned to one of the five MCOs in accordance with the procedure described in paragraph E below.

E. Random Assignment Procedure

When members are randomly assigned on or after 1/21/2015 through 1/29/2016, the new MCO entrant will receive 2 members for each 1 member that each of the other four MCOs receives. (Two out every six new members). All random assignments on or after 1/30/2016 will be distributed without preference to the new MCO entrant.

- f. DHH reserves the right to end the preference for the new MCO entrant (see paragraphs C.2.c and E above) if its enrollment exceeds 80,000 members.

Auto-assignments on any basis other than family member in MCO will not be made to an MCO whose membership share is at or above 40% of the total membership.

During the 2014-2015 open enrollment, all members will be given through April 29, 2015 to change plans without cause.

Additional Terms and Conditions

The following changes shall be made to the RFP language as incorporated into the contract. Corrections are struck through and additions are underlined.

Document/Location	Existing language	Revised Language
CF-1 Page 1, Line 12	Add new language	The contract may be terminated by the contractor only if DHH fails, without reason as determined by DHH, to remit appropriate PM/PM payment within 120 days of the date the payment was due.
CF-1 Page 3, Paragraph 11	Replace existing language	Third party software and source code, 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. All non-third party software and source code related to this contract and/or obtained or prepared by Contractor exclusively in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract, except for any materials, information, processes, programs, and payments that are owned by, are licensed to, or are proprietary to, Contractor, including any modifications or enhancement thereto, which shall remain the property of Contractor. All records, reports, and documents related to this Contract shall be provided to DHH upon request.
RFP Section 2.6.1.3	2.6.1.3 The initial amount of the bond shall be equal to fifty (50) million dollars. The initial bond must be submitted to DHH with the original signed contract.	2.6.1.3 The initial amount of the bond shall be equal to fifty (50) million dollars. The initial bond must be submitted to DHH with the <u>original signed contract</u> within 10 days of contract approval by the Office of Contractual Review.
RFP Section 5.15	Addition of new section	5.15. Health Insurance Provider Fee (HIPF) Reimbursement If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee ("Annual Fee") whose final calculation includes an applicable portion of the MCO's net premiums written from DHH's Medicaid/CHIP lines of business, DHH shall, upon the MCO satisfying completion of the requirements below, make an annual payment to the MCO in each calendar year payment is due to the

	<u>IRS (the "Fee Year"). This annual payment will be calculated by DHH (and its contracted actuary) as an adjustment to each MCO's capitation rates for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.</u> <u>5.15.1.1. The MCO shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:</u> <u>5.15.1.1.1. Provide DHH with a copy of the final Form 8963 submitted to the IRS by the deadline to be identified by DHH each year. The MCO shall provide DHH with any adjusted Form 8963 filings to the IRS within 5 business days of any amended filing.</u> <u>5.15.1.2. Provide DHH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline to be identified by DHH each year (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing.</u> <u>5.15.1.3. If the MCO's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the MCO's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the MCO pursuant to this Contract) was determined. The MCO will indicate for DHH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, if applicable, beginning with Data Year 2014.</u> <u>5.15.1.3.1. The MCO shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606.</u> <u>5.15.1.3.2. If a portion of the Louisiana-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, the MCO shall submit the calculations and methodology for the</u>
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amount excluded.

5.15.1.4. Provide DHH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline to be identified by DHH each year.

5.15.1.5. Provide DHH with the final calculation of the Annual Fee as determined by the IRS by the deadline to be identified by DHH each year.

5.15.1.6. Provide DHH with the corporate income tax rates – federal and state (if applicable) -- by the deadlines to be identified by DHH each year, and include a certification regarding the corporate income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606

5.15.2. For covered entities subject to the HIPF, DHH will perform the following steps to evaluate and calculate the HIPF percentage based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by DHH.

5.15.2.1. Review each submitted document and notify the Contractor of any questions.

5.15.2.2. DHH will check the reasonableness of the MCO's Louisiana-specific Medicaid/CHIP premium revenue included on the MCO's Form 8963/supplemental delineation. This reasonableness check will include, but may not be limited to comparing the MCO's reported Louisiana-specific Medicaid/CHIP premium revenue to DHH's capitation payment records.

5.15.2.3. DHH and its actuary will calculate revised Data Year capitation rates and rate ranges to account for the Louisiana portion (specific to this contract) of the Contractor's HIPF obligation per the IRS HIPF final fee calculation notice (as noted in 5.17.1.5. above). To calculate the capitation payment adjustment, the DHH will:

5.15.2.3.1. Calculate the HIPF obligation as a percentage of the total data year premiums subject to the HIPF (this total will include all of the first \$25 million and 50% of the next \$25 million of premium deducted by the IRS). This is the "HIPF%", which is unique to each MCO that is subject to the HIPF.

5.15.2.3.2. Calculate Figure A, Figure A

is the total premium revenue for coverage in the Data Year from item 5.17.1.2. above. The Figure A amount has no provision for the HIPF obligation.

5.15.2.3.3. Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for services that are excludable under Section 9010 of the Patient Protection and Affordable Care Act of 2010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation.

5.15.2.3.4. Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and applicable taxes. DHH will use the following formula to calculate Figure C. If the Contractor has not provided satisfactory documentation of federal income tax obligations under section 5.17.1.5., then the Average Federal Income Tax Rate (AvgFIT%) in the formula will be zero. If the Contractor has not provided satisfactory documentation of corporate net income tax obligations under section 5.17.1.6. or if state income taxes are not applicable, then the Average State Income Tax Rate (AvgSIT%) in the formula will be zero. The Louisiana Department of Insurance has determined that state premium tax is not applicable to the HIPF payment; as such, no consideration for premium tax will be made. If in the future, however, the applicability of premium tax to the HIPF payments changes, the formula will be modified accordingly.

Figure B

$$\frac{1 - (\text{HIPF}\% / (1 - \text{AvgSIT}\% - \text{AvgFIT}\% \times (1 - \text{AvgSIT}\%)))}{1}$$

5.15.2.3.5. Calculate Figure D. DHH will calculate Figure D by subtracting Figure B from Figure C. This is the final HIPF adjustment amount that will serve as the basis for DHH payment to the impacted contractors.

5.15.2.3.6. DHH will compare Figure D with Figure B to calculate the percentage adjustment to the Data Year capitation rates and rate ranges for submission to CMS for approval.

5.15.3.DHH (and its contract actuary) will compute the change in capitation revenue that is due to the higher

		<u>capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the MCO.</u> <u>5.15.4. In accordance with a schedule to be provided by DHH each contract year, DHH will make a payment to the MCO that is based on the final Annual Fee amount provided by the IRS and calculated by DHH (and its contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if DHH determines that the reporting requirements under this section have been satisfied.</u> <u>5.15.5. The MCO shall advise DHH if payment of the final fee payment is less than the amount invoiced by the IRS.</u> <u>5.15.6. The MCO shall reimburse DHH for any amount applicable to Louisiana Medicaid/CHIP premiums that are not paid towards the fee and/or are reimbursed back to the MCO, at any time and for any reason, by the IRS.</u> <u>5.15.7. DHH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee.</u> <u>5.15.8. Payment by DHH is intended to put the MCO in the same position as the MCO would have been in had the MCO's health insurance providers fee tax rate (the final Annual Fee as a portion of the covered entity's premiums filed on Form 8963) and corporate tax rates been known in advance and used in the determination of the Data Year capitation rates.</u> <u>The obligation outlined in this section shall survive the termination of the contract.</u>
RFP Section 5.3.2	5.3.2. The capitation rate payment withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all MCO enrollees, exclusive of maternity kick payments	5.3.2. The capitation rate payment withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all MCO enrollees, exclusive of maternity kick payments and the Full Medicaid Payment (FMP) component of the monthly capitation rate payment.
RFP Section 6.1.4	6.1.4 The MCO shall provide core benefits and services to Medicaid members. The core benefits and services	6.1.4 The MCO shall provide core benefits and services to Medicaid members. The core benefits and services

	that shall be provided to members are:	that shall be provided to members are:
	• ... • Pharmacy Services (Outpatient prescription medicines dispensed except those prescribed by a specialized behavioral health provider). • ...	• ... • Pharmacy Services (Outpatient prescription medicines dispensed except those prescribed by a specialized behavioral health provider). • ...
RFP Section 6.2	6.2. Eye Care and Vision Services The MCO shall provide coverage of vision services that are performed by a licensed ophthalmologist or optometrist, conform to accepted methods of screening, diagnosis and treatment of eye ailments or visual impairments/conditions for members. Medicaid covered eye wear services provided by opticians are available to enrollees who are under the age of 21. The MCO shall not require a referral for in-network providers.	6.2. Eye Care and Vision Services The MCO shall provide coverage of vision services that are performed by a licensed ophthalmologist or optometrist, conform to accepted methods of screening, diagnosis and treatment of eye ailments or visual impairments/conditions for members. Medicaid covered eye wear services provided by opticians are available to enrollees who are under the age of 21. The MCO shall not require a referral for in-network providers. <u>The MCO's requirements for provision and authorization of services within the scope of licensure for optometrists cannot be more stringent than those requirements for participating ophthalmologists.</u>
RFP Section 7.15.1.8.	7.15.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than \$2.50. Ingredient costs of medications must be updated at least weekly.	7.15.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • Pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than \$2.50; • <u>Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by DHH;</u> • <u>Update ingredient costs of medications at least weekly;</u> • <u>Make drug pricing list available to pharmacies for review; and</u> • <u>Afford individual pharmacies a chance to appeal inadequate reimbursement.</u>
RFP Section 8.4.2	8.4.2 The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following: ...	8.4.2 The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, state laws, regulations and the court ordered requirements of <u>Chisholm v. Kliebert</u> and <u>Wells v. Kliebert</u> for initial and continuing authorization of services that include, but are not limited to, the following: ...
RFP Section 9.8.6.	9.8.6.1 The MCO shall deny payment to providers for deliveries occurring before	9.8.6.1 The MCO shall deny payment to providers for deliveries occurring before

	39 weeks without a medical indication noted in LEERS in accordance with Louisiana Medicaid Program policy.	39 weeks without a medical indication. noted in LEERS in accordance with Louisiana Medicaid Program policy. MCO will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks.
RFP Section 11.1.1.1	11.1.1.1. In order to minimize member disruptions, the initial contract enrollment period and annual open enrollment will be aligned with the contract start date. In subsequent years, the annual open enrollment will be in conducted in accordance with Section 11.7.	11.1.1.1. In order to minimize member disruptions, the initial contract enrollment period and annual open enrollment will be aligned with the contract start date. In subsequent years, the annual open enrollment will be in conducted in accordance with Section 11.7 <u>11.8</u> .
RFP Section 11.3.1	11.3.1. DHH will auto-assign potential enrollees who do not request enrollment in a specified MCO at the time of financial application for Medicaid or through the help of the enrollment broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the MCO having reached its capacity limit or as a result of DHH-initiated sanctions. As specified in 11.7, members who fail to select a new MCO during their annual open enrollment period will remain enrolled with their existing MCO. These members will not be subject to the automatic assignment process.	11.3.1. DHH will auto-assign potential enrollees who do not request enrollment in a specified MCO at the time of financial application for Medicaid or through the help of the enrollment broker, or who cannot be enrolled into the requested MCO for reasons including, but not limited to, the MCO having reached its enrollment capacity limit or as a result of DHH-initiated sanctions. As specified in Section 11.7 <u>11.8</u> , members who fail to select a new MCO during their annual open enrollment period will remain enrolled with their existing MCO. These members will not be subject to the automatic assignment process.
RFP Section 11.10.2	11.10.2 Effective Date of Enrollment The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker. In general, a member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid. Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in an MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO being notified of the person's enrollment. Therefore, enrollment of individuals in the MCO may occur without prior notice to the MCO or enrollee. The MCO shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of enrollment/eligibility.	11.10.2 Effective Date of Enrollment The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker. In general, a member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid. Because individuals can be retroactively eligible for Medicaid, and the effective date of initial enrollment in an MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO being notified of the person's enrollment. Therefore, enrollment of individuals in the MCO may occur without prior notice to the MCO or enrollee. The MCO shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of enrollment/eligibility.

	DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's date of MCO enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, providers shall submit claims directly to the Medicaid Fiscal Intermediary for payment. Except for applicable Medicaid cost sharing, the MCO shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO.	<u>enrollment/eligibility-</u> DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's date of MCO enrollment/eligibility. If the effective date of enrollment/eligibility precedes the start date of operations, providers shall submit claims directly to the Medicaid Fiscal Intermediary for payment. Except for applicable Medicaid cost sharing, the MCO shall ensure that members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO. <u>The effective date of initial enrollment in an MCO shall be the date provided on the outbound ANSI ASC X12 834 Benefit Enrollment & Maintenance electronic transaction initiated by the Enrollment Broker.</u> <u>A member's effective date of enrollment in an MCO will be the member's effective date of eligibility for Medicaid, subject to the following limitation.</u> <u>Individuals may be retroactively eligible for Medicaid. Individuals retroactively eligible for Medicaid may be retroactively enrolled in an MCO. However, retroactive enrollment in an MCO is limited to 12 months.</u> <u>In cases of retroactive eligibility, the effective date of MCO enrollment may occur prior to either the individual or the MCO being notified of the person's MCO enrollment.</u> <u>The MCO shall not be liable for the cost of any covered services prior to the effective date of MCO enrollment, but shall be responsible for the costs of covered services obtained on or after 12:01 am on the effective date of MCO enrollment. -</u> <u>DHH shall make monthly capitation payments to the MCO from the effective date of an enrollee's MCO enrollment. Claims for dates of service prior to the effective date of MCO enrollment shall be submitted by providers directly to the Medicaid Fiscal Intermediary for payment.</u> <u>Except for applicable Medicaid cost sharing, the MCO shall ensure that</u>
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		members are held harmless for the cost of covered services provided as of the effective date of enrollment with the MCO.
RFP Section 14.2.3	14.2.3. The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the MCO and annually thereafter, and prior to implementation of revisions.	14.2.3. The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the MCO thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions.
RFP Section 15.7.2	15.7.2. The MCO has the exclusive right of review and recovery for 356 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment, by notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.	15.7.2. The MCO has the exclusive right of review and recovery for 356 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment, by delivering notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.
RFP Section 17.2.2	17.2.2 Rejected Claims 17.2.2.1 The MCO may reject claims because of missing or incomplete information. The original claim must be returned to the provider accompanied by a reject letter. 17.2.2.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system. 17.2.2.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. As required by La. R.S. 46:460.71, the letter shall contain at a minimum the following information: • The patient or member name; • The MCO claim number; • The date of each service; • The patient account number assigned by the provider;	17.2.2 Rejected Claims 17.2.2.1 The MCO may reject claims because of missing or incomplete information. The original claim must be returned to the provider accompanied by a reject letter. 17.2.2.2 A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system. 17.2.2.3 The rejection letter shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. As required by La. R.S. 46:460.71, the letter shall contain at a minimum the following information: • The patient or member name; • The MCO claim number; • The date of each service; • The patient account number assigned by the provider;

	• CPT codes for each procedure, including the amount allowed and any modifiers and units; • The amount due from the member that includes but is not limited to copayments and coinsurance or deductibles; • Identification of the MCO on whose behalf the payment would be made; and • If the MCO is a secondary payer, then the MCO shall also send acknowledgement of payment as a secondary payer, the primary payer's COB information, and the third-party liability carrier code.	• <u>Total billed charges;</u> • CPT codes for each procedure, including the amount allowed and any modifiers and units; • The amount due from the member that includes but is not limited to copayments and coinsurance or deductibles; • Identification of the MCO on whose behalf the payment would be made, i.e., the MCO's name; and • If the MCO is a secondary payer, then the MCO shall also send acknowledgement of payment as a secondary payer, the primary payer's COB information, and the third-party liability carrier code. • <u>The date the letter was generated; and</u> • <u>Defects or reasons for rejection.</u>
RFP Section 17.11.2.1	17.11.2.1. The MCO shall, at its own expense, be required to submit to an annual independent Statement on Standards for Attestation Engagements (SSAE) No. 16 Service Organization Control (SOC) Type II audit of its internal controls and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance.	17.11.2.1. The MCO shall, at its own expense, be required to submit to an annual independent Statement on Standards for Attestation Engagements (SSAE) No. 16 Service Organization Control (SOC) Type II audit of its internal controls and other financial and performance systems by an external company to ensure financial and operational viability and to ensure contract compliance. <u>The audit period must be 12 consecutive months with no breaks between subsequent audit periods.</u>
RFP Section 18.12 (Addition of new section)		<u>18.12 Court Ordered Reporting</u> <u>The MCO shall comply with all court-ordered reporting requirements currently including but not limited to the Wells v. Kliebert and Chisholm v. Kliebert cases in the manner determined by DHH.</u>
RFP Section 19.5	19.5. DHH will assess the performance of the selected MCOs prior to and after the begin date for operations. DHH will complete readiness reviews of MCOs prior to implementation. This includes evaluation of all MCOs' program components including IT, administrative services and medical management. Each readiness review will be performed on site at the MCO's Louisiana administrative offices. Refer to Appendix JJ, Transition	19.5. DHH will assess the performance of the selected MCOs prior to and after the begin date for operations. DHH will complete readiness reviews of MCOs prior to implementation. This includes evaluation of all MCOs' program components including IT, administrative services and medical management. Each readiness review <u>for entities that did not contract with DHH as a prepaid entity will be performed on site at the MCO's</u>

Period Requirements.		Louisiana administrative offices. Refer to Appendix JJ, Transition Period Requirements . <u>Readiness reviews for entities that were previously contracted with DHH to serve as prepaid entities will be conducted via desk audit.</u>
RFP Section 19.7	19.7. DHH will conduct on-site readiness reviews prior to member enrollment under this contract and as an ongoing activity during the Contract period. The MCO's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of MCO performance. These focus areas may include, but are not limited to the following...	19.7. DHH will conduct on-site readiness reviews for entities that did not contract with DHH previously as prepaid entities prior to member enrollment under this contract and as an ongoing activity during the Contract period. The MCO's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of MCO performance. These focus areas may include, but are not limited to the following...
RFP Section 25.1	Numbering correction.	This section should be numbered 25.3, and all sections thereafter have been updated accordingly.
RFP Section 25.7	25.7. Subject to Section 25.30 of the RFP, the MCO and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern."	25.7. Subject to Section 25.30 <u>25.29</u> of the RFP, the MCO and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern."
RFP Glossary	Add a new term	<u>Basic Behavioral Health Services - Mental health and substance abuse services which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders that are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities.</u>
RFP Glossary	Behavioral Health Services (BHS) – Mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities as well as those services provided in an FQHC. Specialized mental health services shall include, but not be limited to, services specifically defined in state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those enrollees with a primary diagnosis of a behavioral disorder.	<u>Specialized Behavioral Health Services (BHS)</u> – Mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities as well as those services provided in an FQHC. Specialized Mental health services and substance abuse services that shall include, but is are not be limited to, services specifically defined in the state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider. to these enrollees with a primary diagnosis of a behavioral disorder

Standard Provisions

Entire Agreement Clause

This contract, together with the RFP and addenda issued thereto by the Department, the proposal submitted by the Contractor in response to the Department's RFP, and any exhibits specifically incorporated herein by reference, constitute the entire agreement between the parties with respect to the subject matter.

Order of Precedence

In the event of any inconsistent or incompatible provisions, this signed agreement (excluding the RFP and Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's proposal.

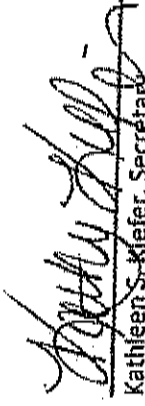
Exhibit 1

INCUMBENCY CERTIFICATE

I, the undersigned, certify that I am the duly elected and acting Secretary of AMERIGROUP Louisiana, Inc., a Louisiana corporation (the "Corporation"), and that, as such, I am authorized to execute and deliver this Certification on behalf of the Corporation.

I further certify that Sonya K. Nelson is the duly elected President and Chief Executive Officer of the Corporation and that as President and Chief Executive Officer, and consistent with the Corporation's policies and bylaws, has the signatory authority to bind the Corporation.

IN WITNESS WHEREOF, the undersigned has duly executed and delivered this Certificate as of the 13th day of May, 2014.


Kathleen S. Klefer, Secretary
AMERIGROUP Louisiana, Inc.



State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

January 9, 2015

Ms. Pamela Bartfay Rice, Esq.
Interim Director, Professional Contracts
DOA-Office of State Procurement
P.O. Box 94095
Baton Rouge, Louisiana 70804-9095

RE: Request for Multi-Year Contract

Dear Ms. Rice:

The Department of Health and Hospitals' Bureau of Health Services Financing seeks to enter into a three-year contract with Amerigroup Louisiana, Inc. (hereinafter referred to as "Amerigroup") to function as a Bayou Health managed care organization (MCO). Amerigroup was selected pursuant to the request for proposal issued July 28, 2014 (RFP#305PUR-DHHRFP-BH-MCO-2014-MVA). The department understands that payment for subsequent fiscal years shall be subject to the availability of funds.

We appreciate your assistance in this matter and we hope that you will give this contract your favorable consideration and approval.

Should you need further information, please contact Stacy Guidry via telephone at (337) 857-6115 or via e-mail at stacy.guidry@la.gov.

Sincerely,

A handwritten signature in dark ink, appearing to read "Mary T.C. Johnson".

Mary T.C. Johnson
Medicaid Deputy Director

WellPoint, Inc. and its Companies as well as participating Affiliated/Specialty Companies

9.3 Statements for External Release

The following represents a point-in-time overview that will be distributed to external parties and updated from time-to-time by the Staff VP.

9.3.1 Business Continuity Program (BCP) Overview for External Release

WellPoint maintains a documented and tested disaster recovery plan for its IT infrastructure for both voice and data center services. WellPoint has implemented remote data replication and has "hot-site" contracts with leading vendors for disaster recovery services for its data centers. The WellPoint networks have been designed to provide a high level of availability.

WellPoint has implemented and maintains a substantial workspace recovery capability utilizing a combination of resources, including: network redirection of work, WellPoint owned worksite recovery capacity, mobile recovery resources and secure satellite connectivity for voice and data.

WellPoint launched a major effort in 1999 to build and maintain a comprehensive enterprise wide business continuity program. The WellPoint business continuity program aligns the business requirements of the operating units and the deliverables of the support areas; so that WellPoint is assured that it can meet its stakeholder commitments following an "unplanned event". The program identifies business process critical paths, documents the recovery strategies and resources required to support those critical paths, defines roles and responsibilities, links the critical path business processes with the resources, systems and vital records required to support WellPoint's response, recovery and survival. Remedial action is taken as necessary to assure mission critical resource availability.

WellPoint first implemented its "Virtual Command Center" (VCC) during the fourth quarter of 2001. WellPoint's VCC is a web-accessed set of tools that is hosted independently of WellPoint's corporate infrastructure. It is the vehicle that provides WellPoint the ability to "command, control & communicate" when dealing with an unplanned event. It enables appropriate management of any event-based activity (planned or unplanned). Additional elements include: redundant communication tools issued to key managers and role players, automated call tree notification and management functionality, repositories for business continuity documents, associate information, site information, vendor information and other mission critical information, and collaborative meeting tools.

WellPoint first deployed its "Mobile Recovery Strategy Solution" during the second quarter of 2003. This solution currently provides for up to 500 call center seats on a scaled basis within 96 hours following an unplanned event. Solution components include two owned technology vans [satellite connectivity for voice and data (bandwidth equivalent to 2 DS-3s), VOIP phone switch (ACD) for 500 seats/1,000 lines, servers, data switches, on-board generator and HVAC], 2 satellite ground stations, 2 mobile satellite units (data connectivity for 1,000 seats each including servers, data switches, on-board generator and HVAC) and PCs to use with mobile recovery seats for scaled delivery within 96 hours following declaration.

The Business Continuity program (including the supporting disaster recovery plans) is a top priority for WellPoint, Inc. New, acquired, and reorganized business units are required to comply with WellPoint's enterprise business continuity program standards in a timely manner. WellPoint units with business continuity plans for critical processes are subject to annual facilitated exercises. Annual update and exercise activity will continue on a routine facilitated basis throughout the life of the enterprise. WellPoint has achieved a significant state of readiness and continues to improve its readiness capability.

9.3.2 Pandemic Statement for External Release

WellPoint's business continuity planning methodology includes strategies for "People Unavailable" as well as for other key resources being unavailable. We continually engage in a thoughtful review of potential exposures, risk assessment and practical mitigation steps available, relevant to a potential pandemic event, to determine if and what we need to do to adjust the scope and scale of WellPoint's business continuity strategies and resources.

WellPoint builds on the foundation of the existing business continuity program, to define and implement appropriate mitigation steps for a pandemic event to assure the survival of the critical business processes that support meeting our stakeholder commitments.

WellPoint, Inc. and its Companies as well as participating Affiliated/Specialty Companies

WellPoint has strategically staged supplies of masks and gloves, to aid in infection control, at company-controlled distribution points. In addition, WellPoint has established policies and procedures to support Pandemic response measures and heightened workplace hygiene during a Pandemic threat event.

9.3.3 IT DR Statement for External Release

WellPoint Disaster Recovery Plan Overview

WellPoint's Disaster Recovery Plan is designed to protect against data loss and provide recovery from major unplanned interruptions to computing services. Several types of plans ensure that critical business functions can be maintained. Crisis management plans specify overall response, command and control. Business continuity plans provide for recovery of critical business functions. Disaster recovery plans provide for the recovery of system infrastructure, data and applications.

Business Priorities

WellPoint's disaster recovery strategies and priorities are based on business need. The Business Continuity Office identifies critical business processes and recovery objectives. The supporting applications and technology systems for each business process are identified and appropriate recovery strategies developed to meet the required recovery objectives. Recovery strategies include data replication to an internal recovery site, and offsite recovery at a DR hot site.

Internal Recovery

Several midrange DR solutions are being built to replicate from the Richmond, VA data center to standby hardware in WellPoint's St. Louis, MO data center.

Hot Site Recovery

Selected mainframe and midrange systems replicate data in real time from the production site in Richmond, VA to a dedicated DR site at IBM Business Continuity and Resiliency Services (BCRS) in Sterling Forest, NY. There is dedicated DR hardware in Sterling Forest that can be brought up within twenty four hours with minimal data loss.

Critical systems not being replicated for disaster recovery are protected by a hot site agreement with IBM. IBM provides a data center facility and equipment for recovery of WellPoint systems. Sterling Forest, NY is the primary recovery site. Applications and data would be recovered from backups at time of disaster. Backups for the most critical non-replicated systems are sent over the network each day and stored on disk at the DR site. These backups would be used to recover without needing to send tapes from offsite storage. Other system would be recovered from tape backups that are sent each day to secure offsite storage. Recovery times would range from three days to two weeks or more, depending on system criticality.

Network

Redundant OC3 circuits connect WellPoint to its disaster recovery sites. In the event of disaster, the recovery sites become part of the production network. The circuits are tested regularly.

Data Backup and Offsite Storage

Data files for some systems are replicated in real time from the production site in Richmond to the DR site in Sterling Forest, NY. All systems are backed up to tape and tapes are stored at Iron Mountain or Recall, two leading providers of offsite storage services. If needed, they would be shipped from offsite storage to the recovery site. Some systems send backup files across the network each day to the DR site. These would be immediately available for recovery without waiting for offsite tapes to be sent.

Testing

WellPoint conducts at least five disaster recovery exercises a year. Individual critical systems are exercised at least once a year. Recovery objectives are set in advance. Results are documented and problems are tracked to resolution.

Tom Schedler
Secretary of State

State of
Louisiana
Secretary of
State

COMMERCIAL DIVISION
225.925.4704



Fax Numbers
225.932.5317 (Admin. Services)
225.932.5314 (Corporations)
225.932.5318 (UCC)

Name	Type	City	Status
AMERIGROUP LOUISIANA, INC.	Business Corporation	BATON ROUGE	Active
Business: AMERIGROUP LOUISIANA, INC.			
Charter Number:	37009533D		
Registration Date:	3/30/2009		
State Of Origin:			
Domicile Address			
5615 CORPORATE BLVD, STE. 400B			
BATON ROUGE, LA 70808			
Mailing Address			
3850 N. CAUSEWAY BLVD., STE 600			
METAIRIE, LA 70002			
Status			
Status:	Active		
Annual Report Status: In Good Standing			
File Date:	3/30/2009		
Last Report Filed:	3/18/2014		
Type:	Business Corporation		

Registered Agent(s)

Agent:	C T CORPORATION SYSTEM
Address 1:	5615 CORPORATE BLVD., STE. 400B
City, State, Zip:	BATON ROUGE, LA 70808
Appointment Date:	3/30/2009

Officer(s)

Officer:	KATHLEEN S. KIEFER	Additional Officers: No
Title:	Secretary	
Address 1:	3850 N. CAUSEWAY BLVD., STE 600	
City, State, Zip:	METAIRIE, LA 70002	
Officer:	R. DAVID KRETSCHMER	
Title:	Treasurer	
Address 1:	3850 N. CAUSEWAY BLVD., STE 600	
City, State, Zip:	METAIRIE, LA 70002	
Officer:	CARTER A. BECK	
Title:	Director	
Address 1:	3850 N. CAUSEWAY BLVD., STE 600	
City, State, Zip:	METAIRIE, LA 70002	

Officer:	SONYA NELSON
Title:	President, Director
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Title:	Director
Address 1:	120 MONUMENT CIRCLE
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Officer:	BRIAN SHIPP
Title:	Director
Address 1:	22 CENTURY BOULEVARD
Address 2:	SUITE 220
City, State, Zip:	NASHVILLE, TN 37214

Amendments on File (1)

Description	Date
Disclosure of Ownership	7/29/2011

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