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BOBBY JINDAL
GOVERNOR

KRISTY H. NICHOLS
COMMISSIONER OF ADMINISTRATION

State of Louisiana

Division of Administration
Office of Contractual Review

December 4, 2013

Ms. Mary Fuentes
Contract Review Administrator
Department of Health & Hospitals
Contract Management
Bienville Building
Post Office Box 4094
Baton Rouge, LA 70821-4904

Dear Ms. Fuentes:

Enclosed are approved copies of the following amendment submitted to us and received in our office on November 19, 2013.

Department of Health & Hospitals
AMENDMENT # 07 CFMS # 708106
Amerigroup Louisiana, Inc.

We appreciate your continued cooperation.

Sincerely,

Pamela Bartfay Rice

Pamela Bartfay Rice, Esq.
Interim Director

State Contracts/Grants Officer

Enclosures

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AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

(Regional/ Program/ Facility): Medical Vendor Administration

Bureau of Health Services Financing

AND

Amerigroup Louisiana, Inc.
Contractor Name

Amendment #: 7
CFMS #: 708106
DOA #: 305-200571
DHH #: 057751
Original Contract Amt 925,792,432
Original Contract Begin Date 02-01-2012
Original Contract End Date 01-31-2015

AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: 1,172,664,817

See Attachment A-7, which contains changes to several sections of the Bayou Health Prepaid Contract. The Health Plan's signature on this sheet signifies its agreement to all contract changes listed in the "Change From" and "Change To" columns of Attachment A-7. DHH reserves the right to revise, without the knowledge of the Health Plan, the material in the "Justification" column of Attachment A-7 for the benefit of the Office of Contractual Review (OCR). Any such revisions to the "Justification" verbiage do not change the substance or meaning of the amendment and do not become part of the contract. Their purpose is only to assist OCR in understanding the intent of the amendment.

Change To: Maximum Amount: 1,172,664,817

See Attachment A-7, which contains changes to several sections of the Bayou Health Prepaid Contract. The Health Plan's signature on this sheet signifies its agreement to all contract changes listed in the "Change From" and "Change To" columns of Attachment A-7. DHH reserves the right to revise, without the knowledge of the Health Plan, the material in the "Justification" column of Attachment A-7 for the benefit of the Office of Contractual Review (OCR). Any such revisions to the "Justification" verbiage do not change the substance or meaning of the amendment and do not become part of the contract. Their purpose is only to assist OCR in understanding the intent of the amendment.

Justification:

The justification for the changes is contained in the last column of Attachment A-7. DHH reserves the right to revise, without the knowledge of the Health Plan, the verbiage in the "Justification" column of Attachment A-7 for the benefit of the Office of Contractual Review (OCR). Any such revisions to the "Justification" material do not change the substance or meaning of the amendment and do not become part of the contract. Their purpose is only to assist OCR in understanding the intent of the amendment.

This Amendment Becomes Effective: 01-01-2013

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

Amerigroup Louisiana, Inc.

CONTRACTOR SIGNATURE 10/4/13 DATE

PRINT NAME: GEORGE BUCHER

CONTRACTOR TITLE: CEO

APPROVED
Office of the Governor
Office of Contractual Review

DEC - 4 2013

Pamela Bartfay Rice
DIRECTOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE 11/14/13 DATE

NAME: Jerry Phillips

TITLE: Undersecretary

OFFICE: Department of Health and Hospitals

PROGRAM SIGNATURE 11/14/13 DATE

NAME: Mary T.C. Johnson

Bayou Health – Prepaid Contract Amendment Attachment A-7

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**3.4.1.7** LaCHIP Program - Children with income at or below 200% FPL enrolled in the Title XXI Medicaid expansion CHIP program for low-income children under age 19 who do not otherwise qualify for Medicaid, including LaCHIP Phases I, II, and III. **3.6.9** Individuals enrolled in the LaCHIP Affordable Plan Program (LaCHIP Phase V) the separate state CHIP program that provides benchmark coverage with a premium to uninsured children under age 19 whose household income is from 201% FPL to 250% FPL	**3.4.1.7** LaCHIP Program - Children with income at or below 250% FPL enrolled in the Title XXI Medicaid expansion and separate CHIP programs for low-income children under age 19 who do not otherwise qualify for Medicaid. Delete 3.6.9 entirely	To add LaCHIP Affordable Plan enrollees as a mandatory Bayou Health population
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA		**5.16** Affordable Care Act Primary Care Services Enhanced Reimbursement - See attached document entitled "Implementation of Affordable Care Act Requirements"	To add provisions to comply with federal requirements
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**7.3.2.1.** Time and Distance to Primary Care Providers **7.3.2.1.1.** Travel distance for members living in rural parishes shall not exceed 30 miles; and **7.3.2.1.2.** Travel distance for members living in urban parishes shall not exceed 10 miles.	**7.3.2.1.** Time and Distance to Primary Care Providers **7.3.2.1.1.** Travel distance for members living in rural parishes shall not exceed 30 miles; and **7.3.2.1.2.** Travel distance for members living in urban parishes shall not exceed 20 miles.	To correct distance requirements
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-	**7.11.3.2.** By the end of the second year of operation under the Contract, January 31, 2014: • Total of 30% of practices shall be NCQA PPC®-	**7.11.3.2.** By the end of the second year of statewide operations, May 31, 2014: • Total of 30% of practices shall be NCQA	To revise timeframe requirement for meeting Patient-Centered Medical Home recognition or

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	MVA	PCMH Level 1 recognized or JCAHO PCH accredited; and • Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited. **7.11.3.3.** By the end of the third year of operation under the Contract, January 31, 2015: • Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; • Total of 40% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited; and • Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; and • Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited. **7.11.3.3.** By the end of the third year of statewide operations, May 31, 2015: • Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; • Total of 40% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited; and • Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	accreditation
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**8.2.2.** The UM Committee shall provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less than quarterly and shall submit meeting minutes to DHH within five (5) business days of each meeting. . . .	**8.2.2.** The UM Committee shall provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less than quarterly and shall submit meeting minutes to DHH. . . .	To remove 5-day requirement for submission of minutes
Exhibit E	RFP 305 PUR-		**9.10 Affordable Care Act Primary Care Services Enhanced Reimbursement** – See attached	To add provisions to comply with federal

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	DHHRFP-CCN-P-MVA		document entitled "Implementation of Affordable Care Act Requirements"	requirements
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**14.2.2. QAPI Committee Responsibilities** **14.2.2.1.** The Committee shall meet on a quarterly basis. Its responsibilities shall include: **14.2.2.2.** Direct and review quality improvement (QI) activities; **14.2.2.3.** Assure that QAPI activities take place throughout the CCN; **14.2.2.4.** Review and suggest new and/or improved QI activities; **14.2.2.5.** Direct task forces/committees to review areas of concern in the provision of healthcare services to members; **14.2.2.6.** Designate evaluation and study design procedures; **14.2.2.7.** Conduct individual PCP and practice quality performance measure profiling; **14.2.2.8.** Report findings to appropriate executive authority, staff, and departments within the CCN; **14.2.2.9.** Direct and analyze periodic reviews of members' service utilization patterns; and	**14.2.2. QAPI Committee Responsibilities** **14.2.2.1.** The Committee shall meet on a quarterly basis. Its responsibilities shall include: **14.2.2.2.** Direct and review quality improvement (QI) activities; **14.2.2.3.** Assure that QAPI activities take place throughout the CCN; **14.2.2.4.** Review and suggest new and/or improved QI activities; **14.2.2.5.** Direct task forces/committees to review areas of concern in the provision of healthcare services to members; **14.2.2.6.** Designate evaluation and study design procedures; **14.2.2.7.** Conduct individual PCP and practice quality performance measure profiling; **14.2.2.8.** Report findings to appropriate executive authority, staff, and departments within the CCN; **14.2.2.9.** Direct and analyze periodic reviews of members' service utilization patterns; and	To remove the 10-day requirement for submission of minutes and correction of typographical errors

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		14.2.2.10. Maintain minutes of all committee and sub-committee meetings. Submit meeting minutes to DHH within ten (10) working days of the meetings. **14.2.2.11.** Report to DHH an evaluation of the impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, all care management services. **14.2.2.12.** Ensure that a QAPI committee designee attends DHH's quality meetings.	**14.2.2.10.** Maintain minutes of all committee and sub-committee meetings. Submit meeting minutes to DHH. **14.2.2.11.** Report to DHH an evaluation of the impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, all care management services. **14.2.2.12.** Ensure that a QAPI committee designee attends DHH's quality meetings.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA		**18.10** See attached document entitled "Implementation of Affordable Care Act Requirements"	To add reporting requirements for implementation of Affordable Care Act changes
Exhibit E	RFP 305 PUR-DHHRFP-CCN-P-MVA	**Table of Monetary Penalties** **Ad Hoc Reports** - As required by this Contract or upon request by DHH and mutually agreed upon by the CCN. Two thousand dollars ($2,000.00) per calendar day for each business day that a report is late or incorrect	**Table of Monetary Penalties** **Ad Hoc Reports** - As required by this Contract or upon request by DHH and mutually agreed upon by the CCN. Two thousand dollars ($2,000.00) per calendar day that a report is late or incorrect	Correction to ensure consistency across reporting requirements

9.10 Affordable Care Act Primary Care Services Enhanced Reimbursement

9.10.1 Minimum Payment

9.10.1.1 Pursuant to Section 1202 of the Patient Protection and Affordable Care Act of 2010 (ACA) and in accordance with 42 CFR 438.6(c)(5)(vi), for dates of service in calendar years 2013 and 2014 the minimum payment the CCN shall pay for specified services rendered by eligible providers, as defined in the published Affordable Care Act Primary Care Services Enhanced Reimbursement Chapter of the Medicaid Professional Services Provider Manual, is the lesser of:

9.10.1.1.1 The published ACA Enhanced Reimbursement fee-for-service rate in effect on the date of service reflective of place of service adjustments as specified in the published Medicaid Professional Services Provider Manual; or

9.10.1.1.2 The provider's actual billed charges.

9.10.1.2 Specified services are limited to those specified on the published ACA Enhanced Reimbursement fee schedules, in accordance with the CMS approved State Plan Amendment (SPA).

9.10.1.3 Payments under this section shall be made in accordance with State policy governing the reimbursement for services rendered by Physician Assistants and Advance Practice Registered Nurses. See the published Professional Services Provider Manual, Section 5.1 Covered Services, Subsection Advanced Practice Registered Nurses: Clinical Nurse Specialists, Certified Nurse Practitioners, and Certified Nurse Midwives and Subsection Physician Assistants.

9.10.1.4 The CCN shall not enter into and DHH shall not approve any provider-initiated alternative payment arrangements for claims subject to the minimum payment requirements of this section.

9.10.2 Identification of Eligible Providers

9.10.2.1 Eligible providers are limited to those specified in the published Affordable Care Act Primary Care Services Enhanced Reimbursement Chapter of the Medicaid Professional Services Provider Manual, including those that are out-of-network.

9.10.2.2 Services billed by Advance Practice Registered Nurses practicing independently or in a nurse managed clinic are not eligible to receive the enhanced reimbursement. Services billed on an encounter basis in the State's fee for service program by FQHCs and RHCs are not eligible to receive the enhanced reimbursement.

9.10.2.3 DHH shall transmit to the CCN a weekly provider file extract identifying Medicaid providers eligible for enhanced reimbursement and the provider's effective date for enhanced reimbursement as specified in the Bayou Health Prepaid Plan Systems Companion Guide. The CCN is responsible for accepting the data and updating systems as needed.

9.10.2.4 The CCN shall administer a process to identify non-Medicaid providers eligible for enhanced reimbursement, including those that are out-of-network, consistent with the procedures established by DHH for Medicaid providers as specified in the published Affordable Care Act Primary Care Services Enhanced Reimbursement Chapter of the Medicaid Professional Services Provider Manual.

9.10.2.4.1 The CCN shall use the Designated Physician and Advanced Practice Registered Nurse forms published by DHH.

9.10.2.4.2 The CCN shall establish policies and procedures to receive the forms, return incorrect or incomplete forms for correction, and notify the provider of the status of the form submission.

9.10.2.4.3 The CCN shall establish the provider's effective date for enhanced reimbursement based on the date a complete and correct form is received by the CCN consistent with the published Affordable Care Act Primary Care Services Enhanced Reimbursement Chapter of Medicaid Professional Services Provider Manual. The CCN shall notify the provider of the effective date established.

9.10.2.4.4 The CCN must maintain a hard copy of each provider's Designated Physician or Advanced Practice Registered Nurse form for a minimum of 5 years and provide access to the original documents as well as copies to DHH upon request.

9.10.2.4.5 The CCN shall transmit to DHH a weekly provider file extract identifying non-Medicaid providers eligible for enhanced reimbursement as specified in the Bayou Health Prepaid Plan Systems Companion Guide. DHH is responsible for accepting and storing the data.

9.10.3 Distribution of Payment

9.10.3.1 The CCN is responsible for ensuring that all specified services rendered by eligible providers are reimbursed the minimum payment as specified in §9.10.1 retroactive to the provider's effective date for enhanced reimbursement, consistent with the published Affordable Care Act Primary Care Services Enhanced Reimbursement Chapter of the Medicaid Professional Services Provider Manual. Specifically for sub-capitation and salaried arrangements, the CCN shall provide payments in an amount to ensure the minimum payment as specified in §9.10.1 and require that every unit of a specified service provided is reimbursed the minimum payment as specified in §9.10.1.

9.10.3.2 The CCN must update the claims payment system to pay eligible providers for specified services in accordance with §9.10.1 on a prospective basis, within thirty days of the CCN's receipt of the capitated rate inclusive of the enhanced rates. DHH shall provide the CCN with no less than thirty days advance written notice of when DHH intends to provide the CCN with such capitated rate.

9.10.3.3 For any retroactive period consistent with the Effective Date for Enhanced Reimbursement provisions of the published Affordable Care Act Primary Care Services

Enhanced Reimbursement Chapter of the Medicaid Professional Services Provider Manual, the CCN shall reimburse specified services rendered by eligible providers on a retrospective basis, if payment has not been made accordance with §9.10.1.

9.10.3.4 Within sixty days of the CCN's receipt of the capitated rate inclusive of the enhanced rates, the CCN must pay for specified services rendered by eligible providers the differential between the minimum payment as specified in §9.10.1 and the payment made for any claims processed before the CCNs claims payment system is updated in accordance with §9.10.3.2.

9.10.3.5 Retrospective payments may be made by the CCN through a lump sum payment or by systematically adjusting claims for specified services rendered by eligible providers to the minimum payment as specified in §9.10.1.

9.10.3.6 Retrospective payment of the enhanced reimbursement regardless of the method of distribution must be made within sixty days of the CCN's receipt of the capitated rate inclusive of the enhanced rates.

9.10.3.7 Regardless of the retrospective payment mechanism selected by the CCN, for retrospective payments the CCN must reimburse the minimum payment for which it has claims information without any additional effort by the eligible provider.

9.10.3.8 The CCN must provide sufficient documentation to DHH, as requested by DHH and/or the Centers for Medicare and Medicaid Services (CMS), to enable DHH to ensure that enhanced rates are implemented in accordance with this contract and DHH and federal regulations and guidance. This includes documentation that eligible providers receive the direct benefit of the increase even in sub-capitated and salary payment models. 9.10.4 Timeliness of Payment

9.10.4.1 Retrospective Adjustments

9.10.4.1.1 Claims Processing Requirements contained in §9.5.1 will not apply to retrospective payments made by the CCN to comply with requirements in §9.10.3 provided, however, that the requirements of §9.10.3.7 are met.

9.10.4.1.2 The CCN is required to provide an explanation of benefits summarizing payments in accordance with this Section.

9.10.5 Validation

9.10.5.1 The CCN shall on at least an annual basis review a statistically valid sample of non-Medicaid providers identified by the CCN as eligible for enhanced reimbursement to verify that the providers meet the requirements of §9.10.2.4.

9.10.5.2 The CCN is responsible for recoupment of the enhanced reimbursement paid in error by the CCN or when it determines that the provider did not meet the criteria in accordance with §9.10.2. The CCN will report recoupments to DHH in the semi-annual reconciliation process as specified in §5.16.3. DHH will deduct reported recoupments from the amount due to

the CCN through the reconciliation process or the next monthly capitation payment if no lump sum supplemental payment is due to the CCN in accordance with §5.16.

[5.0 CCN Reimbursement]

5.16 Affordable Care Act Primary Care Services Enhanced Reimbursement

5.16.1 For calendar years 2013 and 2014, the actuarially sound capitation rates will reflect requirements in §9.10.1 in accordance with 42 CFR 438.6 (c)(2005, as amended), the CMS approved SPA and the CMS approved Bayou Health Prepaid MCO Model approved by CMS for Implementation of ACA Section 1202: Increased Payments for Medicaid Primary Care Services.

5.16.2 DHH will update monthly capitation rates for calendar year 2013 and retrospectively reimburse the CCN if monthly capitation payments have not been made in accordance with §5.16.1.

5.16.3 In addition to the monthly capitated rate, DHH shall perform semi-annual reconciliations that may result in a supplemental lump sum payment or recoupment for the unit cost differential between the CCN's reported actual utilization and the expected utilization used in the development of the capitated rates to comply with 438.6(c)(5)(vi) as detailed below.

5.16.3.1 Pursuant to Section 1202 of the Health Care and Education Reform Act of 2010 and implementing federal regulations at 42 CFR 438.6 and 42 CFR 438.804 in accordance with the SPA approved by CMS, DHH shall develop an actuarially sound payment mechanism with a semi-annual reconciliation process as specified by the Department.

5.16.3.2 Semi-Annual Reconciliation Process. DHH will reconcile the amounts paid to the plan against the CCN's actual experience reported as specified in §18.20. DHH will allow for a six-month period for claims run-out. Therefore, the reconciliation will use:

- Claims paid through December 31, 2013 for the period January 1, 2013 through June 30, 2013
- Claims paid through June 30, 2014 for the period July 1, 2013 through December 31, 2013;
- Claims paid through December 31, 2014 for the period January 1, 2014 through June 30, 2014; and,
- Claims paid through June 30, 2015 for the period July 1, 2014 through December 31,

5.16.3.3 Amounts due to or from the CCN will be made through the reconciliation process. DHH will reconcile based on expected utilization included in the capitation rate and actual CCN utilization during the rate period. The reconciliationwill not compare expected unit costs included in the capitation rate and actual unit costs paid by the CCN.

5.16.3.4 If actual unit cost varies, there will be no re-pricing of unit costs. The reconciliation will be based on the unit costs built into the capitation rate which is reflective of

requirements in §9.10.1. Additionally, DHH will not be collecting or paying the 2013 base Medicaid payment amount if utilization is lower or higher than what is projected in the capitation.

5.16.3.5 Amounts due to the CCN through the reconciliation process will be paid in a lump sum supplemental payment no later than ninety days following receipt of the ACA Primary Care Services Enhanced Reimbursement Semi-Annual Reconciliation workbook from the CCN as specified in §18.20.1.

5.16.3.6 Amounts due to DHH through the reconciliation process will be deducted from the CCN's monthly capitation payment no later than ninety days following receipt of the ACA Primary Care Services Enhanced Reimbursement Semi-Annual Reconciliation workbook from the CCN as specified in §18.20.1.

[18 Reporting Requirements]

18.20

18.20.1 Not later than 60 days following the Paid Through Date of each semi-annual reconciliation period as specified in §5.16.3.2, the CCN shall complete and submit to DHH the ACA Primary Care Services Enhanced Reimbursement Semi-Annual Reconciliation workbook for reconciling rate differentials of amounts for each specified service, pursuant to the CMS approved Bayou Health Prepaid MCO Model for Implementation of ACA Section 1202: Increased Payments for Medicaid Primary Care Services and consistent with the process specified by DHH.

18.20.2 The CCN must submit a report regarding the Timeliness of Payment in accordance with §9.10.3.4 as specified by DHH The CCN shall submit the report to DHH not later than 90 days following CCN's receipt of the capitated rate inclusive of the enhanced rates.