DHH - CF - 1
Revised: 2011-06

CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
Medical Vendor Administration

CFMS: 733526
DHH: 060468
Agency # 305

AND

AmeriHealth Caritas Louisiana, Inc.

FOR

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

1) **Contractor (Legal Name if Corporation)** AmeriHealth Caritas Louisiana, Inc.	5) **Federal Employer Tax ID# or Social Security #** 273575066000 **(Must be 11 Digits)**
2) **Street Address** 10000 Perkins Rowe, Block G - 4th Floor	6) **Parish(es) Served** ST
City Baton Rouge **State** LA **Zip Code** 70810	7) **License or Certification #** N/A
3) **Telephone Number** (225)300-9124	8) Contractor Status Subrecipient: ☐ Yes ☒ No Corporation: ☒ Yes ☐ No For Profit: ☒ Yes ☐ No Publicly Traded: ☐ Yes ☒ No
4) **Mailing Address (if different)**	
City **State** **Zip Code**	8a) **CFDA#(Federal Grant #)**

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** 1,964,731,789

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/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
Attachment B: Statement of Work
Attachment C: Terms of Payment
Attachment D: Rate Certification
Attachment E: Incentive-Based Performance Measures
Attachment F: Member Assignment Methodology
Attachment G: Additional Terms and Conditions
Attachment H: Standard Provisions

Exhibit 1: Board Resolution
Exhibit 2: Multi-Year Letter
Exhibit 3: RFP305PUR-DHHRFP-BH-MCO-2014-MVA
Exhibit 4: Appendices to RFP305PUR-DHHRFP-BH-MCO-2014-MVA
Exhibit 5: Addenda to RFP305PUR-DHHRFP-BH-MCO-2014-MVA
Exhibit 6: Contractor's proposal
Exhibit 7: Contractor's Emergency Preparedness Plan
EXHIBIT 8- DISCLOSURE OF OWNERSHIP

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, 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 continuing 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~~ 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.

AmeriHealth Caritas Louisiana, Inc.	STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
J. Michael Jernigan 1/12/15 SIGNATURE DATE	SIGNATURE DATE
J. Michael Jernigan NAME	NAME
President TITLE	Secretary, Department of Health and Hospital or Designee TITLE
	Medical Vendor Administration
SIGNATURE DATE	J. Ruth Kennedy 1/14/15 SIGNATURE DATE
NAME	J. Ruth Kennedy NAME
TITLE	Medicaid Director TITLE

APPROVED
Office of the Governor
Office of Contractual Review

JAN 30 2015

Pamela Bartfay 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.
7. 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.

- Submit draft training materials for telephone agents.
- Develop a contingency plan for hiring call center staff to address overflow calls and emails.
- Submit telephone and internet activity reports monthly.

12) Member Services

- Develop and maintain a member handbook that adheres to federal requirements in required formats.
- Maintain grievance and appeals logs and submit to DHH monthly.
- Conduct Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys annually.
- Develop and implement a Member Advisory Council Plan.

13) Enrollment

- Maintain a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

14) Marketing and Member Education Materials

- Submit a plan detailing marketing and member education activities within 30 days of contract signature.
- Develop and maintain a welcome newsletter that adheres to federal requirements.
- Submit to DHH for approval all member materials.
- Maintain copies of all member materials including obsolete versions.
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the item.

15) Enrollment Website

- Submit website screenshots to DHH for approval.
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the item.
- Maintain provider directories.

16) Fraud, Waste, and Abuse Compliance

- Submit plan to DHH within 30 days from the date the contract is signed and annually thereafter.
- Submit fraud and abuse activity report quarterly with an annual summary of activity.
- Attest monthly that a search of websites referenced in Section 15.3.3 of the RFP has been completed.

17) Systems

- Maintain records documenting the exchange all required files with the Medicaid fiscal intermediary.
- Submit encounter data to DHH or its contractor as required.
- Submit refresh plan for review and approval annually.
- Develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.
- Develop a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.
- Enroll at least 75% of all contracted hospitals with an emergency department into the Louisiana Health Information Exchange by December 31, 2015.

18) Claims & Encounters

- Submit weekly encounters to Medicaid fiscal intermediary. Encounters must be submitted within 25 days of payment.
- Submit encounter data on the 25th calendar day of the month to the Medicaid fiscal intermediary.
- Submit claims payment accuracy report monthly.
- Submit claims processing interest payments on weekly encounter file.

- Submit denied claims report weekly.
- Submit weekly transaction records on all prior authorization requests.
- Develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to DHH for approval within thirty (30) days of the date the Contract is signed by the MCO.

19) Financial Reporting
- Submit audited financial statements annually.
- Submit unaudited financial statements quarterly.

20) TPL Reporting
- Report members with third party coverage to DHH on a weekly basis.
- Submit TPL collections on an annual basis.

21) Emergency Management Plan
- Submit annually.

Monitoring
Contract monitoring will be at the direction of the Medicaid Deputy Director for managed care or their designee.

Mary Johnson
Department of Health and Hospitals
Bureau of Health Services Financing
Bayou Health Program
628 North 4th St.
Baton Rouge, LA 70821
Phone: (225) 342-1304
Email: mary.johnson@la.gov

Monitoring activities include:

1) Thorough review and analysis of required work plans and monthly, quarterly and annual reports, as well as review and monitoring of corrective action plans if required of the contractor by DHH;
2) Minimum of weekly status calls between Contractor and DHH Contract Monitor and/or designated Medicaid staff;
3) Face-to-face meetings between Contractor and DHH Contract Monitor and/or designated Medicaid staff as warranted;
4) Solicitation of feedback on Contractor's performance from the Medicaid fiscal intermediary;
5) Annual evaluation through an independent external quality review contractor;
6) Real-time monitoring of member services hotline calls;
7) Investigation of all complaints regarding the Contractor;
8) Monitoring grievances and appeals to determine appropriate resolution;
9) Periodic navigation of contractor website to determine performance;
10) Spot checking to determine that provider listings on contractor website accurately reflects information provided by the providers;
11) Unannounced and scheduled visits to contractor's Louisiana administrative office; and
12) "Secret shopper" calls to Member Services and Provider Services call centers.

Payment: Fixed Rate
See Attachment C for details.

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

MERCER

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Ms. Mary Johnson
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Louisiana Department of Health and Hospitals
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628 North 4th Street
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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 (DHH) 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,

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.

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, DHH 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, Vermilion, 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.

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

- 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.

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

Fraud and Abuse Recoveries
DHH 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 DHH 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 DHH. 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

Prepaid Encounter ACA PCP Carve-Out	
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%**

Shared Savings/FFS ACA PCP Carve-Out	
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%**

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.

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:

- 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.

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.

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.

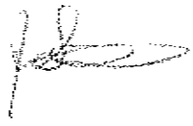
Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual Bayou Health MCO costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c), and in accordance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

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,



Jaredd Simons, ASA, MAAA
Senior Associate Actuary

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

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

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

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 (DW/W)	●			
Early Widow/Widowers	●			
Family Opportunity Program*	●		●	
Former SSI*	●		●	
Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	●			
PICKLE	●			
Provisional Medicaid	●			
Section 4913 Children	●			
SGA Disabled WW/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%	●			

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			●	

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
YAP (Young Adult Program)			●	
YAP/OYD			●	
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***	●	●	●	●

COA/Eligibility Category Name	Mandatory	Voluntary Opt-In	Voluntary Opt-Out	Excluded
Excluded				
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				●

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				●

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.

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.

Appendix D-1: Shared Savings/FFS IBNR Adjustment

Category of Service Description	COA Description						
	SSI	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**

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	9.7	N/A	N/A	N/A
Outpatient Hospital	2.4	3.0	2.6	2.6	N/A	N/A	N/A
Primary Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
Specialty Care Physician	2.8	3.0	2.8	3.0	N/A	N/A	N/A
FQHC/RHC	2.9	3.0	2.9	3.0	N/A	N/A	N/A
EPSDT	2.9	3.0	2.4	3.0	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
Lab/Radiology	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Home Health	1.1	0.0	1.3	0.0	N/A	N/A	N/A
Emergency Transportation	3.1	2.3	3.1	2.3	N/A	N/A	N/A
NEMT	1.3	1.5	1.6	2.4	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
DME	1.0	0.0	1.1	0.0	N/A	N/A	N/A
Clinic	2.5	3.1	2.7	2.9	N/A	N/A	N/A
Family Planning	2.8	3.0	2.8	2.8	N/A	N/A	N/A
Other	1.3	0.0	1.5	0.0	N/A	N/A	N/A
Prescribed Drugs	0.0	0.0	0.0	0.0	N/A	N/A	N/A
Emergency Room	2.3	2.9	2.4	2.6	N/A	N/A	N/A
Basic Behavioral Health	2.9	3.0	2.8	3.0	N/A	N/A	N/A
Hospice	4.6	6.1	4.6	0.0	N/A	N/A	N/A
Personal Care Services	3.8	2.4	0.0	0.0	N/A	N/A	N/A
Total	**1.4**	**2.9**	**1.9**	**2.2**	**N/A**	**N/A**	**2.1**

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
FQHC/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**

Appendix F: Managed Care Savings

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

Appendix G: Data Reliance Attestation

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

August 27, 2014

Mr. Jarodd Simons, ASA, MAAA
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 Jarodd:

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

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 225/342-9250 • Fax #: 225/342-9558 • www.MakingMedicaidBetter.com
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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 PMPM 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.	2.6.1.3The 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~~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 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. 5.15.1.The MCO shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements: 5.15.1.1. 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. 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. 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. 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. 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 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 1 – (HIPF% / (1 – AvgSIT% – AvgFIT% x (1 – AvgSIT%))) 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 capitation rates by multiplying the

		adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the MCO. 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 that the reporting requirements under this section have been satisfied. 5.15.5.The MCO shall advise DHH if payment of the final fee payment is less than the amount invoiced by the IRS. 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. 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. 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. The obligation outlined in this section shall survive the termination of the contract.
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 that shall be provided to members are:	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:

	• . . . • 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</u> ingredient costs of medications at least weekly; • <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 <u>and the court ordered requirements of Chisholm v. Kliebert and 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 39 weeks without a medical indication	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.	~~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	11.1.1. 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. 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~~11.8.
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 enrollment capacity limit or as a result of DHH-initiated sanctions. As specified in Section 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~~11.8, 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.	~~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.~~ 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. 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. 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. 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. 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. - 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. 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.
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 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.	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; • CPT codes for each	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; • Total billed charges;

	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.	• 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. • The date the letter was generated; and • Defects or reasons for rejection.
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 other financial 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. The audit period must be 12 consecutive months with no breaks between subsequent audit periods.
RFP Section 18.12 (Addition of new section)		18.12 Court Ordered Reporting 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.
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 Period Requirements**.	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 for entities that did not contract with DHH as a prepaid entity will be performed on site at the MCO's Louisiana administrative offices. Refer to

		Appendix JJ, **Transition Period Requirements**. Readiness reviews for entities that were previously contracted with DHH to serve as prepaid entities will be conducted via desk audit.
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~~ 25.29 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	**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.
RFP Glossary	**Behavioral ~~Health~~ 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.	**Specialized 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 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 those 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

LaCare

Minutes – June 12, 2012

Minutes of the Meeting of the Board of Directors AmeriHealth Mercy of Louisiana, Inc. June 12, 2012

A meeting of the Board of Directors of AmeriHealth Mercy of Louisiana, Inc. a Louisiana business corporation (the "Company"), was held pursuant to notice on Thursday, June 12, 2012 at 11:00 A.M. at the offices of AmeriHealth Mercy Health Plan, 200 Stevens Drive, Philadelphia, Pennsylvania and with participants via video conference who were located at the Company's offices in Louisiana at 10000 Perkins Rowe, Baton Rouge Louisiana. The following members of the Board, constituting a quorum, were present:

Michael A. Rashid
Anne Morrissey
Steven H. Bohner

Also in attendance were:
Robert H. Gilman, Esquire
Todd A. Borow, Esquire
J. Michael Jernigan (via video conference)
Kathy Stone (via video conference)
Yolanda Hill-Spooner, M.D. (via video conference)
Melissa Bezet (via video conference)

I. Call to Order

The Secretary, Mr. Gilman, called the meeting to order and delivered opening remarks. He introduced the board members and then the other attendees in Philadelphia and Baton Rouge introduced themselves and briefly discussed their roles with the company.

II. Reflection

Kathy Stone, Executive Director, relayed a story of AJ – a member who was without his needed medicines and the Care Management Team was able to resolve the situation within forty-five minute by helping him obtain the necessary medicines. Ms. Stone indicated that this story demonstrates the crux of why we are in business – to help people in need.

III. Appointment of Officers

Mr. Gilman presented a proposed new slate of officers for the company. Upon a motion duly made and seconded, the board unanimously appointed the following persons as officers of the corporation in the following roles:

J. Michael Jernigan – President
Anne M. Morrissey – Vice President
Steven H. Bohner – Vice President and Treasurer
Robert H. Gillman – Vice President and Secretary
Kathy Stone – Executive Director
Robert E. Tootle – Assistant Secretary

A motion was made and seconded that the Executive Director shall be given signature authority to sign legal documents on behalf of the Company. After a brief discussion, the board unanimously approved the motion.

IV. Approval of Corporate Name Change

A motion was made to change the name of the corporation from AmeriHealth Mercy of Louisiana, Inc. to LaCare Louisiana, Inc. Upon a motion duly made and seconded, the board unanimously approved the motion to change the corporate name. Ms. Stone asked for a clarification about the use of the name LaCare as the marketing name for the company and it was confirmed that LaCare will still be the trade name / doing business as name for the company.

V. Quality Improvement Program Description and Workplan

Dr. Hill-Spooner presented a report discussing the company's quality improvement program. She discussed the scope of the program. She discussed a document that had been distributed to the attendees entitled Quality Assurance and Performance Improvement Program and Description. She then discussed another distributed document, the Quality Assessment and Performance Improvement Work Plan. She

indicated that the work plan is included in the quality improvement program. A motion was made to approve the proposed quality improvement program. The motion was seconded and the board unanimously approved the motion.

VI. Compliance Program and Workplan

Ms. Bezet presented an overview of the compliance program. Documents distributed for review were the Compliance Program (policy number 185.301) and the 2012 LaCare Compliance Work Plan. A motion was made to approve the proposed compliance program. The motion was seconded and the board unanimously approved the motion to approve the compliance plan.

VII. Management Report

Ms. Stone, the Executive Director, presented this report. She gave an overview of the current state affairs of the company. She discussed different data related to membership and providers which was in her handout entitled Management Report June, 2012 which she distributed to the attendees. She discussed the current status of the provider network, the status of calls and claims and provided detailed data that related to these issues. Then she discussed certain meetings and activities that had occurred at the Company including the GSAA Member Advisory Council meeting and the GSAA Regional Provider Council meeting. She then discussed managed care and quality goals which were on a chart in the management report document. She discussed the People Goals for the organization and then the Growth Goals for the Company. The discussion then involved competition issues and she explained that the Company operates a pre-paid plan as does Centene (Louisiana Healthcare Connections) and AmeriGroup. United Healthcare and Community Health Solutions are shared savings plans. She believes that members may be transferring from pre-paid plans to shared services plans and that providers also prefer shared services plans. Also discussed were the actual membership numbers and projected membership numbers, other factors influencing membership and mitigation strategies. Reduction in provider rates are expected. Mr. Rashid asked if this reduction will cause LaCare to change the rates paid to all providers and the answer was yes. Dental carve in is expected to occur on October 1, 2012.

VIII. Financial Report

Steve Bohner, Treasurer, presented a report entitled AmeriHealth Mercy of Louisiana, Inc. Financial Update for the corporation and reviewed the balance sheet, the statement of operations, the statement of cash flows and the projected risk based on capital requirements for the period ending March 31, 2012. He then responded to questions from the board on financial issues.

IX. Adjournment

There being no further business, upon motion duly made and seconded, the meeting was adjourned at 12:20 PM.

Respectfully submitted,

Todd A. Borow
Acting Secretary for the Meeting

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

Exhibit 2

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 AmeriHealth Caritas Louisiana, Inc. (hereinafter referred to as "ACLA") to function as one of the Bayou Health managed care organizations. ACLA 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,

Mary T.C. Johnson
Medicaid Deputy Director

Exhibit 7

AmeriHealth Caritas
Louisiana

AmeriHealth Caritas Louisiana Emergency Response Plan

Prepared by:
Corporate Business Continuity and Emergency Management Office
Original Release Date
05/15/2012
Current Release Date:
01/02/2014
Document Version:
1.3

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AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana Emergency Response Plan

Table of Contents

REVISION HISTORY 5

APPROVALS 6

DISTRIBUTION 7

AMERIHEALTH CARITAS LOUISIANA EMERGENCY MANAGEMENT TEAM CONTACTS 8

A. PLAN REMARKS 9

- PLAN OVERVIEW 9
- PLAN SCOPE 9
- PLAN OBJECTIVES 9
- PLAN MAINTENANCE AND UPDATE 10
- AMERIHEALTH CARITAS LOUISIANA BUSINESS RECOVERY STRATEGY 10

B. MEMBER AND PROVIDER EDUCATION AND COMMUNICATION 11

- OUTREACH CAMPAIGNS 11
- CONTACT CENTER SCRIPTS 11
- MEMBER MEDICAL RECORDS 11
- NOTIFYING MEMBERS OF UNAVAILABLE PROVIDERS 11
  - Temporary member relocation and address change 12
- PROVIDER COMPLAINTS AND INQUIRIES 12

C. ADDRESSING THE PROVISION OF SERVICES 13

- MEDICAL MANAGEMENT 13
  - Members with special health care needs 13
  - Care plans 13
- REPLACEMENT OF EQUIPMENT 13
- MEMBER ACCESS TO EPSDT SERVICES (OUT-OF-NETWORK OR OUT-OF-STATE) 13
- TRANSPORTATION DURING A DISASTER 13
- BACKUP LIST OF MEDICAL OR PHARMACEUTICAL SUPPLIES 13
- SERVICES NOT NORMALLY COVERED UNDER STATE PLAN 14
  - Portable oxygen 14
- RELATIONSHIPS WITH OTHER HEALTH CARE ENTITIES 14
  - Evacuation requirements for members with special health care needs 14
  - Coordination of dialysis and hospital services to evacuated members 14

D. OUT-OF-NETWORK OR OUT-OF-STATE PROVIDERS 15

- PREPAID HEALTH PLANS ONLY 15
- PRIOR AUTHORIZATIONS AND REFERRALS 15

E. OUT-OF-SERVICE AREA FOR MEMBERS 16

- PRIOR AUTHORIZATIONS AND REFERRALS 16
- HANDLING LINKAGES 16

F. OPERATIONAL READINESS 17

- BUSINESS CONTINUITY 17
  - Emergency management response 18
  - Systems (technology) 25
- COMMUNICATION STRATEGIES WITH THE DHH 25

REPORTING REQUIREMENTS 25
DISASTER TRAINING 26
Business and technology recovery training and staff training 26
Natural disaster training (mock exercises) 27
Plan activation history 27

G. OTHER 28

REGISTRY OF VOLUNTEER HEALTH CARE PROVIDERS 28
EMERGENCY HEALTH RESOURCES (EHR) USAGE TO ACCESS MEMBERS; HEALTH HISTORY 28
COORDINATION WITH OTHER ENTITIES 28
DHH — Office of Emergency Preparedness and Office of Public Health 28

I. PLAN APPENDIX 30

DIRECTIONS TO STATE EOC (GOHSEP) 31

DIRECTIONS TO THE DHH EOC AT THE BATON ROUGE METROPOLITAN AIRPORT 33

DHH – ESF – 8 ORGANIZATIONAL CHART 35

MAP OF THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES (ESF-6) 36

AMERIHEALTH CARITAS LOUISIANA SHIFT SCHEDULE AT THE DHH EOC (TEMPLATE) 38

AMERIHEALTH EOC SHIFT SCHEDULE (TEMPLATE) 40

Revision History

New revision date	Previous revision date	Summary of changes
May 15, 2012 – Version 1.0	N/A	• Initial plan development. • Updated plan with lessons learned from the DHH and GOHSEP mock exercise.
May 31, 2013 – Version 1.2	July 1, 2012 – Version 1.1	• Updated plan with current release date and version. • Updated plan with parish emergency director contact information and websites. • Updated plan with current release date and version. • Updated plan with directions and map information of the DHH EOC. • Updated plan on page 20, removed language regarding contacting members. • Updated plan with new contact information. • Updated plan with lessons learned from Hurricane Isaac. • Added templates in the appendix.
January 2, 2014 — Version 1.3	May 31, 2013 – Version 1.2	• Updated plan with new name and logo, AmeriHealth Caritas Louisiana.

Note: The Business Continuity and Emergency Management Office of AmeriHealth Caritas Louisiana annually reviews and updates its documents and processes.

Approvals

Name	Title	Signature	Date of approval	Version
State of Louisiana Department of Health and Human Services (DHH)				
Approvers: Please legibly print your name and title in the appropriate fields.				
AmeriHealth Caritas Louisiana				
Michael J. Jernigan	Regional South President			
Rebecca Engelman	Executive Director, AmeriHealth Caritas Louisiana			
Richard Scanlon	Vice President, Corporate Risk Management			
Lesa Coberly	Facilities and Emergency Management Specialist, AmeriHealth Caritas Louisiana			
Melissa Bezet	Regulatory Affairs Director, AmeriHealth Caritas Louisiana			
Danny Pellegrini, C.B.C.P., M.B.C.I.	AmeriHealth Caritas Corporate Business Continuity and Emergency Management Office Director		1/29/2014	

Distribution

Plan distributed to	Organization	Collected previous versions of the emergency response plan on	Current plan version distributed on
Please legibly print your name and organization in the appropriate fields.			
Kellea Tuminello	Louisiana Department of Health and Hospitals	07/31/2012 05/31/2013	
Brandon Carter	Louisiana Department of Insurance	07/31/2012 05/31/2013	

AmeriHealth Caritas Louisiana Emergency Management Team Contacts

The names listed below should be contacted in the event of a Louisiana catastrophic disaster, local parish or state-declared disaster.

Contact name	Title	Direct office telephone	Mobile	Email
Rebecca Engelman	AmeriHealth Caritas Louisiana, Executive Director	1-225-300-9202	1-843-343-9293	REngleman@AmeriHealthCaritasla.com
Lesa Coberly	Facilities and Emergency Management Specialist	1-225-300-9225	1-225-226-2832	LCoberly@AmeriHealthCaritasla.com
Melissa Bezet	Director, Compliance and Regulatory Affairs	1-225-300-9226	1-225-678-2074	MBezet@AmeriHealthCaritasla.com
Karen Banks	Supervisor, Integrated Care Management, Case Management	1-225-300-9146	1-225-921-1817	KBanks-Turner@AmeriHealthCaritasla.com

A. Plan Remarks

Plan overview

The purpose of this plan is to provide Louisiana Department of Health and Hospitals with an understanding of how AmeriHealth Caritas Louisiana will respond with step-by step-procedures to fulfill services provided in the event of an incident or disaster impacting our covered population and its office in Baton Rouge.

Note: The Corporate Business Continuity and Emergency Management Office of AmeriHealth Caritas Health Plan and AmeriHealth Caritas Louisiana review and update these documents and processes annually.

Plan scope

This plan is intended to:

- Provide an effective system of actions, under skilled leadership, to respond to events, crises, planned and unplanned events that might disrupt services to our covered population, providers and/or associates. This includes National Incident Management System methods, Incident Command System compliant systems and Emergency Support Functions awareness.
- Provide a guide to effective leadership of response to emergencies and disasters.
- Provide an effective method of communication before, during and after a crisis situation. This includes communications pathways to and from state Department of Health and Hospitals personnel, parish and state Office of Emergency Preparedness (GOHSEP), FEMA, Red Cross and other important agencies.
- Eliminate or minimize the risk of service disruptions to our covered population, providers, associates and critical business functions caused by any or all (multi-) hazards.
- Assure that special-needs populations' additional needs are met among the covered populations and associates.

Plan objectives

The overall objective is to ensure the effective management of emergency efforts in preparing for and responding to situations associated with emergencies. This will include:

- Overall managing and coordinating of emergency operations, including on-scene incident management.
- Coordinating or maintaining liaisons with appropriate federal, state and other local governmental agencies.
- Requesting and allocating resources and other related support.
- Establishing priorities and adjudicating conflicting demands for support.
- Activating and using communication systems.
- Preparing and disseminating emergency public information.
- Disseminating community warnings and alerts.

- Collecting, evaluating and disseminating damage information and other essential data.
- Responding to requests for resources and other support.
- Restoring business operations

Plan maintenance and update

On or before May 1 of each year, the AmeriHealth Caritas Louisiana Emergency Management Team/Hurricane Committee will have reviewed its plan and updated the plan as necessary. One of the critical elements is to update its list of all members with special needs each year. This list is compiled from new member assessments care management plans and claim files analyses. We will maintain a list of all members who may need help in a disaster, such as a hurricane.

AmeriHealth Caritas Louisiana business recovery strategy

In the event that the AmeriHealth Caritas Louisiana Baton Rouge office is:

Inaccessible (due to a natural, man-made or regional disaster) or a disaster declared by AmeriHealth Caritas Louisiana

- Member and Provider Services business processes will continue as usual in Philadelphia, PA, and Salt Lake City, UT.
- Medical Management business processes will continue as usual in Philadelphia, PA, and Charleston, SC.
- AmeriHealth Caritas Louisiana is part of a joint mobile recovery contract (through Corporate Business Continuity Program and Emergency Management) to continue business operations from a mobile recovery unit.
- AmeriHealth Caritas Louisiana will work with the Corporate Crisis Management Team to obtain support throughout the disaster and its recovery phases.
    - As part of the Crisis Management Team, Corporate and Local Facilities Management will work together to find a temporary or new office space.
    - As part of the Crisis Management Team, Purchasing and Local Facilities Management will work together to purchase office equipment.
    - As part of the Crisis Management Team, Corporate IS and Local Facilities Management will work together to build the infrastructure.

Closed for a short-term period

- Member and Provider Services processes will continue as usual in Philadelphia, PA, and Salt Lake City, UT.
- Medical Management processes will continue as usual in Philadelphia, PA, and Charleston, SC.

B. Member and Provider Education and Communication

Outreach campaigns

AmeriHealth Caritas Louisiana will have an annual article in the member newsletter regarding hurricane and emergency preparedness, as well as evacuation planning. The Red Cross organization develops and distributes free hurricane preparedness guides with evacuation routes. AmeriHealth Caritas Louisiana's Community Education staff will provide copies of the Red Cross Emergency Preparedness Guide at member outreach summer events.

AmeriHealth Caritas Louisiana will add an Emergency Preparedness page to our AmeriHealth Caritas Louisiana website as an easy reference point for both members and providers that will answer FAQs during an emergency. We will also link to:

- State of Louisiana Department of Health and Hospitals (DHH) Emergency Preparedness page (http://new.dhh.louisiana.gov/index.cfm/subhome/17/n/173).
- Governor's Office of Homeland Security Emergency Preparedness (GOHSEP) (http://gohsep.la.gov/).
- Red Cross (http://www.redcross.org/).
- Other applicable websites as suggested by DHH.

Contact center scripts

Contact centers are located outside of the Baton Rouge office. Member and provider calls are serviced in the Philadelphia, PA, and Salt Lake City, UT, contact centers. Emergencies in Louisiana would not impact the member and provider 800 lines. Contact center agents would be able to provide uninterrupted service before, during and after a disaster.

Member medical records

AmeriHealth Caritas Louisiana will provide one free copy of a member's medical records upon request. The member may request a copy of their medical records on file with AmeriHealth Caritas Louisiana by calling our Member Services department at 1-888-756-0004. This number is printed on the back of all member ID cards and is available on our website. AmeriHealth Caritas Louisiana's Member Services representatives are available 24 hours a day, 7 days a week.

Notifying members of unavailable providers

If a provider's office is permanently closed, AmeriHealth Caritas Louisiana will notify its members in writing of the following information:

- The terminated practitioner or provider and the effective date of termination.
- For terminating PCPs, the letter also identifies the name, address and phone number of the new PCP assigned by the plan, a statement explaining the PCP assignment process, and notification that the member may select a different PCP anytime by calling Member Services.
- For terminating specialty practitioners, the letter contains a statement advising the member to contact his or her PCP to discuss any required ongoing medical needs, including transition to another participating specialist.

AmeriHealth Caritas Louisiana will post a listing of temporarily closed practices on its website. AmeriHealth Caritas Louisiana members can also call the Member Services department at 1-888-756-0004 for assistance in finding another provider for interim purposes. The AmeriHealth Caritas Louisiana Member Services number is printed on the back of the member ID card and available on our AmeriHealth Caritas Louisiana website. AmeriHealth Caritas Louisiana's Member Services representatives are available 24 hours a day, 7 days a week, and are located in Philadelphia, PA.

Temporary member relocation and address change

Members temporarily relocating should contact the Member Services department at 1-888-756-0004. This number is located on the back of each member's ID card. AmeriHealth Caritas Louisiana Member Service representatives are available 24 hours a day, 7 days a week. Member Services will assist members in selecting alternative providers in their areas.

Members may contact the Member Services department at 1-888-756-0004. AmeriHealth Caritas Louisiana's Member Services department is available 24 hours a day, 7 days a week, to assist members with updating personal information. They are also available to assist members with locating providers during emergencies.

Provider complaints and inquiries

Provider complaints and inquiries will be handled by directing members to our Provider Services call center at 1-888-922-0007 located in Philadelphia, PA. The Provider Services number is given to members through our member handbook and available on AmeriHealth Caritas Louisiana's website.

C. Addressing the Provision of Services

Medical management

Members with special health care needs

AmeriHealth Caritas Louisiana has identified member with special health care needs using historical data provided by DHH. Our medical management system is enterprise-wide and AmeriHealth Caritas Louisiana's regional office in South Carolina serves as back-up for technical support should Louisiana lose network connectivity and phone service. Information regarding members with special health care needs can be given to the appropriate DHH contact upon request.

Care plans

AmeriHealth Caritas Louisiana provides care plans for all members engaged in Care Management. Our medical management system is enterprise-wide and care plans can be accessed by AmeriHealth Caritas Louisiana's regional and corporate offices in South Carolina and Philadelphia. Information regarding members' care plans can be given to the appropriate DHH contact upon request.

Replacement of equipment

Equipment used by off-site staff and management will be used to immediately and temporarily replace damaged or destroyed equipment. AmeriHealth Caritas Louisiana is also provided off-site support by other affiliate office locations (Philadelphia, PA, and Charleston, SC) within our family of companies who are not directly impacted by the local emergency.

Member access to EPSDT services (out-of-network or out-of-state)

Members can call our Member Services department at 1-888-756-0004 for assistance in finding providers and transportation. AmeriHealth Caritas Louisiana's Member Services department is available 24 hours a day, 7 days a week, and is located in Philadelphia, PA. Consideration is given to out-of-network providers in the event of an emergency.

Providers who need assistance can call Provider Services at 1-888-922-0007 regarding EPSDT services. Information and phone numbers may be found on the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com.

Transportation during a disaster

Non-emergent medical transportation is coordinated through our Member Services department at 1-888-756-0004. AmeriHealth Caritas Louisiana's Member Services department is available 24 hours a day, 7 days a week, and is located in Philadelphia, PA. Member Service representatives are available to help coordinate transportation.
Information regarding transportation of members during disasters can be given to the appropriate DHH contact upon request.

Backup list of medical or pharmaceutical supplies

At the direction and approval of the DHH, AmeriHealth Caritas Louisiana can supply members temporarily through our pharmaceutical/supply provider for South Carolina (J&B). J&B is located out-of-state and can ship supplies to designated locations for members. A list of contracted providers for durable medical equipment (DME) can be accessed through AmeriHealth Caritas

Louisiana's Utilization Management department in South Carolina. These providers can obtain authorization for needed DME for any eligible member. Providers may also refer to our provider search on the website or contact Provider Network Management for a list of contracted providers.
Please refer to the AmeriHealth Caritas Louisiana resource directory in the appendix section of this plan.

Services not normally covered under state plan

At the direction and approval by the DHH, AmeriHealth Caritas Louisiana can service members not normally covered under the state plan.

Portable oxygen

Coordination of portable oxygen to serve members is initiated through our Member Services representatives to our Rapid Response and Outreach Team who will coordinate with Utilization Management to ensure that services and equipment are authorized. Members may call our Members Services department at 1-888-756-0004. AmeriHealth Caritas Louisiana's Member Services department is available 24 hours a day, 7 days a week, in Philadelphia, PA.

Relationships with other health care entities

At the direction and approval by the DHH, AmeriHealth Caritas Louisiana can service members not normally covered under the state plan.

Evacuation requirements for members with special health care needs

AmeriHealth Caritas Louisiana's designated Emergency Operations Center (EOC) point of contact can identify members needing evacuation assistance using our enterprise-wide medical management system, Jiva. All of AmeriHealth Caritas' lines of business can access member information and are trained to immediately assist as needed.

Coordination of dialysis and hospital services to evacuated members

Providers rendering services to members will be able to continue with uninterrupted utilization management support, as AmeriHealth Caritas Louisiana's Utilization Management department is located in South Carolina. Providers may continue to follow the same process of fax or phone requests for prior authorization of services.

D. Out-of-Network or Out-of-State Providers

Prepaid health plans only

AmeriHealth Caritas Louisiana's Utilization Management department will make provisions for evacuated members to allow for the use of non-participating providers for medically necessary services.

Prior authorizations and referrals

Prior authorization requirements, as posted on AmeriHealth Caritas Louisiana's website (http://www.amerihealthcaritasla.com/member/eng/info/prior-auth.aspx) will be maintained for non-emergent health care services. Emergent services will not require prior authorization. Requests will be reviewed for medical necessity.

E. Out-of-Service Area for Members

Prior authorizations and referrals

Prior authorization requirements, as posted on AmeriHealth Caritas Louisiana's website (http://www.amerihealthcaritasla.com/member/eng/info/prior-auth.aspx), will be followed. Provisions and consideration will be made for all evacuated members to allow for the use of out-of-network providers for medically necessary services.

Handling linkages

New linkages will be handled per AmeriHealth Caritas Louisiana's normal operating procedures, as these files are processed through our enrollment department in Philadelphia, PA.

F. Operational Readiness

Business continuity

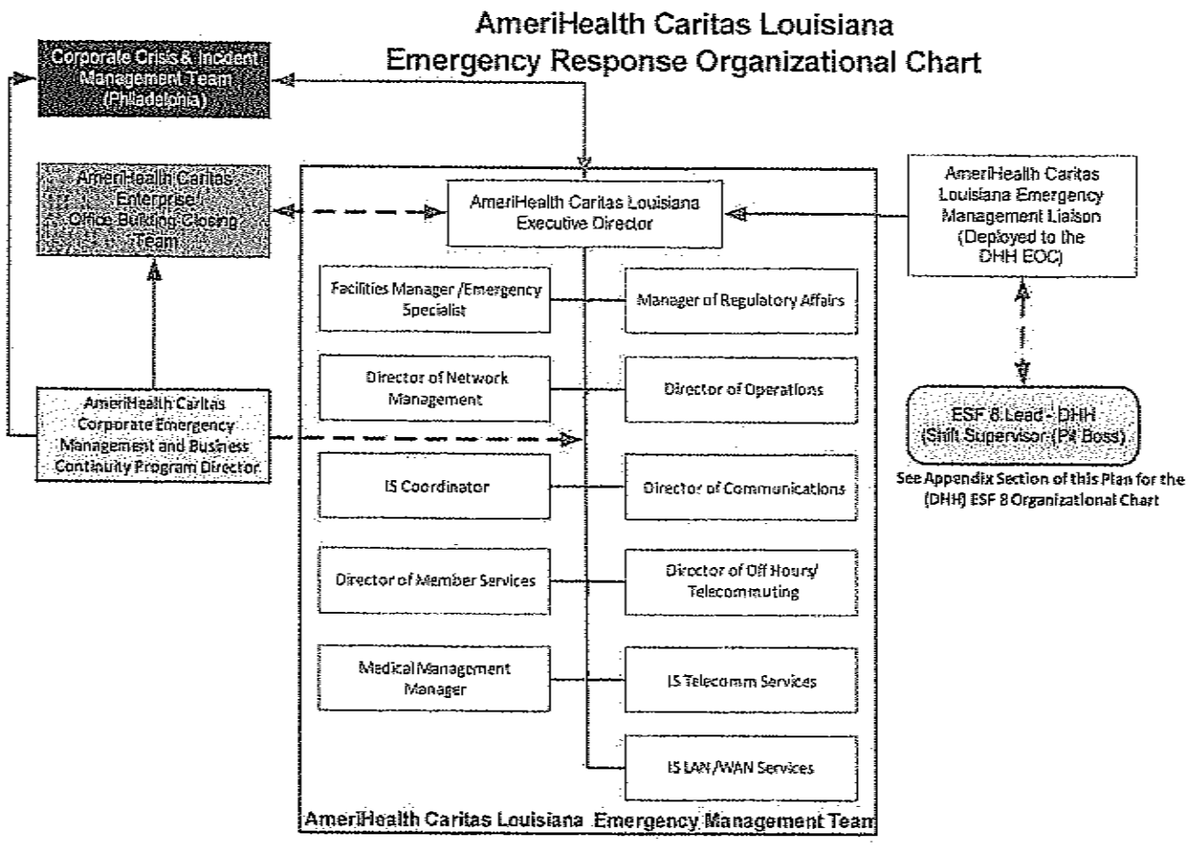
Throughout our experience in operating Medicaid managed care plans in other states, we have responded to hurricanes, fires, floods, snow storms and technology failures. Our practical experience through lessons learned, combined with our use of industry best practices, makes AmeriHealth Caritas uniquely equipped to respond quickly and efficiently to any disaster.

The AmeriHealth Caritas Business Continuity and Disaster Recovery program enables us to quickly return to operating capacity in the event of a hurricane, natural disaster, pandemic, technology failure, fire or other catastrophic scenario. Our program combines our plans to recover systems, networks, work stations and applications in the event of a disaster (disaster recovery), with plans to expeditiously restore all operational functions (business recovery).

Our Business Continuity and Disaster Recovery program:

- Prepares employees to respond to a crisis, emergency or natural disaster safely.
- Helps control risks and exposures to employees, members and providers.
- Provides methods and decision guidance for preventive measures, where appropriate.
- Enables efficient responses to business or technology interruptions to resume critical business operations and limit the operational downtime and costs.
- Minimizes delays and improves guidance for decision-making during an interruption or disaster.
- Connects parish, state and federal information (senders) with members, employees and providers (receivers).
- Prepares AmeriHealth Caritas Louisiana to continue to deliver critical business functions if employees are impacted due to influenza, other infectious diseases or other disasters.
- Reintegrates members and providers into the community.

The Business Recovery Management Team is responsible for making all critical decisions and directing the recovery process for all AmeriHealth Caritas affiliates and offices. The management team members will include the AmeriHealth Caritas Louisiana executive director, as well as the leaders from key AmeriHealth Caritas functional areas (such as the Contact Center, Claims, Facilities, Pharmacy and Medical Management). The executive director will guide and advise on AmeriHealth Caritas Louisiana's specific business continuity needs. In the event that the executive director or other members of the management team are unable to participate due to the nature of the incident, our executive team will immediately identify and mobilize a team of personnel to establish contact with local authorities, the state and other relevant emergency contacts.



In the event a disaster affects the staff, the AmeriHealth Caritas Louisiana office (or other portions of the AmeriHealth Caritas Louisiana business), we have business contingency plans in place that allow us to continue operations while minimizing downtime. Because AmeriHealth Caritas Louisiana is part of a national organization with facilities in other states, we are able to rapidly shift operations as necessary to our Philadelphia and/or South Carolina locations. Our IS infrastructure is shared throughout the organization: member services, provider services and medical management employees in other regions can be quickly granted permission to access AmeriHealth Caritas Louisiana member and provider data making the transition seamless to the caller.

We value and prioritize our ability to rapidly resume normal business operations in support of our members. To improve our ability to resume operations, we also plan to distribute information to our associates to help them maintain health and wellness after significant events so they can quickly return to normal operations, through alternative work sites if necessary.

Emergency management response

Effective and quick communication is critical to the success of AmeriHealth Caritas Louisiana's emergency management response.

AmeriHealth Caritas Louisiana's communication plan includes representatives from all levels of the organization to ensure everyone is on the same page and working together to quickly manage the incident.

AmeriHealth Caritas Louisiana's communication infrastructure provides a framework to:

- Receive critical community and company information and accurately determine the scope of the event and the need to expand a response.
- Communicate and escalate the critical incident or emergency to the appropriate crisis management team structure and the AmeriHealth Caritas key decision makers.
- Obtain support and assistance from other incident command/crisis management support teams.

The communication process will be engaged when a problem escalates into a critical incident that significantly impacts our members, providers and employees; business operations; or technology services. For example, in the event we anticipate a hurricane approaching Louisiana, the communication infrastructure will be implemented to make sure that management teams in all AmeriHealth Caritas affiliates understand how we will respond and work together to minimize the impact to AmeriHealth Caritas Louisiana.

AmeriHealth Caritas Louisiana will use the company's emergency notification system to assist with rapid communications before, during and after a crisis. AlertFind quickly and automatically notifies internal crisis management team members, senior management and employees of issues that may affect our operations.

AmeriHealth Caritas Louisiana emergency notification system mail or anyone, anywhere, at any time and on any device through emails, SMS (text) messages or voice calls. These notifications instruct, ask questions and/or collect responses. The emergency notification system is also used to provide updates, additional instructions or information to business continuity coordinators and employees related to business recovery.

AmeriHealth Caritas Louisiana emergency notification system is supplemented by other methods of communication, such as email and the companywide emergency hotline number. The Enterprise Emergency Hotline is available to provide updates, additional instructions or information for crisis management team members, senior management and employees to familiarize new employees with the components of our business continuity program. It is a long-term tool, frequently updated, to allow for the passive dissemination of information.

The AmeriHealth Caritas Louisiana website will be used to provide information such as updates, current impact, care recommendations, schedules of preventive activities in the event of larger and longer-lasting events, methods to access care, pandemic instructions and instructions to distant providers in the care of our members.

Certain information will be pre-scripted and seasonal, such as hurricane season reminders and preparedness activities. We will also distribute materials regarding childhood immunizations, disease outbreaks, pandemic briefings and environmental events (such as flu, H1N1, HSN1 and West Nile Virus) that could affect the health or safety of our members, providers and employees. This will directly benefit the public health professionals of Louisiana. It also will reduce the impact of insidious disease on the members AmeriHealth Caritas Louisiana serves.

The ultimate goal of these communication programs is to assist our members, providers and associates to appropriately and quickly respond to events that may affect their health, health care, safety, resilience and recovery. We will partner with providers locally and remotely to ensure access to quality and safe care for our members, regardless of their locations.

Maintaining a constant flow of information with all members, providers, suppliers and employees is key to managing continuity of services during an emergency. During an emergency, the state, local parishes and federal government will release information that directly benefits our stakeholders.

Following a disaster, we will distribute information to help members reintegrate to the community of providers and to provide community safety and wellness information. We will also gather and distribute information generated by government entities related to wellness or the re-establishment of primary care and other covered care. AmeriHealth Caritas Louisiana will also coordinate this information with the DHH and other agencies.

AmeriHealth Caritas Louisiana Emergency Management Team		
Title	**Location**	**Name**
Executive Director	Louisiana	Rebecca Engelman
Facilities Manager/Emergency Specialist	Louisiana	Lesa Coberly
Director, Compliance and Regulatory Affairs	Louisiana	Melissa Bezet
Director of Network Management	Louisiana	Sherry Wilkerson
Director of Operations	Louisiana	Renee Simmons
IS Coordinator	Louisiana	Mickey Poche
DHH EOC Response Team Member	Louisiana	Nancy Gervais
DHH EOC Response Team Member	Louisiana	Karen Banks
Director of Member Services	Philadelphia	Cynthia West
Director of Off Hours/Telecommuting	Philadelphia	Michael Metzradt
Medical Management Manager	Louisiana	Rachel Weary
	South Carolina	Angela Glyder Vicki Vacchiano
Director of National Health Plan Communications	Corporate (Philadelphia)	Tracey Pou
Manager of Plan Communications	Corporate (Philadelphia)	Jillian Gonzales
Corporate Emergency Management and Business Continuity Program Director	Corporate (Philadelphia)	Danny (Dan) Pellegrini
IS Telecomm Services	Corporate (Philadelphia)	Elizabeth Seymour
IS LAN/WAN Services	Corporate (Philadelphia)	Jose Alvarez

AmeriHealth Caritas Louisiana will update its website as appropriate. AmeriHealth Caritas Louisiana will also send information by multiple media and pathways to all members, providers and associates relating how we monitor storms, how to prepare for a storm and how we plan to communicate should there be a storm that affects their geographic areas. We will supply a listing of informational outlets that can be used to obtain hurricane-related information before and during any approaching emergency. These include, but are not limited to:

- GOHSEP.
- 211.org.
- 511LA.org.
- Emergency.Louisiana.gov.
- FEMA.gov.
- The AmeriHealth Caritas Louisiana website.
- Internal AmeriHealth Caritas Louisiana phone numbers.

Definitions, terms and acronyms

EOC	**Emergency Operations Center** — GOHSEP EOC is referred to as the state EOC. As with other state agencies, the DHH also maintains a free-standing EOC that coordinates with the state EOC. ESF-8 Incident Command is embedded in the state EOC.
GOHSEP	Governor's Office of Homeland Security Emergency Preparedness.
H-Hour	The time at which a tropical storm force winds hit the coast of Louisiana. H-0 is set by GOHSEP.
ESF	**Emergency support function** — Organized into branches at the state Emergency Operations Center (EOC).
CTNS	**Critical transportation needs shelter** — Used for those persons evacuated by local governments from affected areas. These are bus-only general population shelters.
MSNS	**Medical special needs shelter** — Used for those persons who require medical assistance in a shelter environment. MSNSs receive both buses and drive-ups but must be triaged/screened by OPH to ensure that they meet criteria.
AMP	**Aero-medical marshaling point** — The airport and associated incident command staff and equipment used for hospital evacuations. Also referred to as an "air head."

Saffir-Simpson Hurricane Scale

Max 1 minute sustained winds		
Category	**Miles per hour**	**Knots**
Category 1	74 to 95	64 to 82
Category 2	96 to 110	83 to 95
Category 3	111 to 130	96 to 113
Category 4	131 to 155	114 to 135
Category 5	>155	>135

Watches and warnings

Tropical storm watch — An announcement that a tropical storm poses or tropical storm conditions pose a threat to coastal areas generally within 36 hours. A tropical storm watch should normally not be issued if the system is forecast to attain hurricane strength.

Tropical storm warning — A warning for sustained surface winds, associated with a tropical cyclone, within the range of 34 to 63 knots (39 to 73 mph), expected in a specified coastal area within 24 hours.

Hurricane watch — An announcement of specific coastal areas that a hurricane or an incipient hurricane condition poses a possible threat, generally within 36 hours.

Hurricane warning — A warning stating that sustained winds 64 kt (74 mph or 119 kph) or higher associated with a hurricane are expected in a specified coastal area within 24 hours. A hurricane warning can remain in effect when dangerously high water or a combination of dangerously high water and exceptionally high waves continues, even though winds may be less than hurricane force.

H – Hour: early hours of storm detection

Note: At this time, GOHSEP has not set an H – Hour and is not requiring other state agencies to take further actions. **If GOHSEP sets an H – Hour, immediately go to the H – Hour: set by GOHSEP steps below.**

Initial notification and communication steps from the DHH to AmeriHealth Caritas Louisiana:

1. The DHH will notify via email (primary means) or phone the following AmeriHealth Caritas Louisiana Emergency Management team members when:
    - GOHSEP sets the H – Hour.
    - The governor of Louisiana declares a state of emergency or disaster.
    - The DHH partially or fully activates its EOC at the Baton Rouge airport.

Contact name	Title	Direct office telephone	Mobile	Email
Rebecca Engleman	AmeriHealth Caritas Louisiana, Executive Director	1-225-300-9275	1-843-697-5190	REngleman@AmeriHealthCaritasla.com
Lesa Coberly	Facilities and Emergency Management Specialist	1-225-300-9225	1-225-226-2832	LCoberly@AmeriHealthCaritasla.com
Melissa Bezet	Director, Compliance & Regulatory Affairs	1-225-300-9226	1-225-678-2074	MBezet@AmeriHealthCaritasla.com
Dan Pellegrini	AmeriHealth Caritas Corporate Business Continuity Program and Emergency Management Director	1-215-863-5147	1-215-704-9531	DPellegrini@amerihealthcaritas.com

2. The DHH will continually communicate via email (primary means) or phone to the AmeriHealth Caritas Louisiana Emergency Management team members above any important daily situation report or information from GOHSEP.

Initial AmeriHealth Caritas Louisiana communication and action steps:

1. AmeriHealth Caritas Louisiana's Emergency Management Team will be put on alert and will be provided with information on the storm forming in the Atlantic Ocean and/or Gulf Coast. Other AmeriHealth Caritas Louisiana personnel may be placed on standby for possible activation.

2. AmeriHealth Caritas Louisiana's leadership and staff will review their emergency procedures and contingency plans.

3. AmeriHealth Caritas Louisiana's Emergency Management liaison will continue to monitor weather reports and communicate with the DHH as needed to receive reports and instructions.

4. AmeriHealth Caritas Louisiana's Emergency Management liaison will communicate all weather reports, updates and important information received by the DHH to the AmeriHealth Caritas Louisiana Emergency Management Team.

H – Hour: 72 hours prior to scheduled event

Approximately 72 hours before the storm's arrival, the AmeriHealth Caritas Louisiana Emergency Management Team and staff begin to implement protective measures such as notification to employees, members and providers of AmeriHealth Caritas Louisiana service information.

1. AmeriHealth Caritas Louisiana will fax-blast to providers to remind them to contact the AmeriHealth Caritas Louisiana Provider Services 800 number for potential office closures.

2. AmeriHealth Caritas Louisiana's case managers will reach out to members identified with medical special needs to ensure they have their DME and run through their evacuation plan.

3. AmeriHealth Caritas Louisiana will update the AmeriHealth Caritas Louisiana website with a provider's office closure information.

4. AmeriHealth Caritas Louisiana will update its list of members who have been designated as medical special needs and upon request pass this information to the appropriate emergency support function (ESF) #8 upon request.

H – Hour: 48 hours prior to scheduled event

AmeriHealth Caritas Louisiana's emergency operations staff will begin providing instructions to associates regarding our immediate needs and plans moving forward. All noncritical staff will be sent home. If the AmeriHealth Caritas Louisiana building is at risk from the storm, remaining personnel may work remotely. The AmeriHealth Caritas Louisiana Emergency Operations Center can be virtual, depending on the potential impact. Throughout the process, AmeriHealth Caritas Louisiana will maintain contact with the LA DHH EOC, and the South Carolina and Philadelphia EOCs.

H – Hour: 24 hours prior to scheduled event

AmeriHealth Caritas Louisiana will make final efforts to anticipate and mitigate any potential damage to the structure, function and internal equipment of the AmeriHealth Caritas Louisiana facility.

AmeriHealth Caritas Louisiana will maintain near-constant communications with the DHH EOC, and remind employees, members and providers to tune into their local radio and television stations for real-time information through AmeriHealth Caritas Louisiana's Member and Provider Services.

H – Hour: set by GOHSEP

AmeriHealth Caritas Louisiana communication and action steps:

1. The AmeriHealth Caritas Louisiana executive director will notify the Office Building Closing Team of the H – Hour set by GOHSEP.

   Tool: Outlook: ***DL – Office Building Closing Team***

   Note: AmeriHealth Caritas Louisiana will adjust its response procedures and action items in coordination with GOHSEP and the DHH.

2. AmeriHealth Caritas Louisiana will fully activate the emergency response plan and business contingency plans as needed.
   - Leadership will activate an "all hands on deck" with their staffs.

   Tool: Outlook: ***DL-LC: Emergency Management Team***

3. The AmeriHealth Caritas Louisiana Emergency Management liaison will directly deploy upon request to the DHH EOC at the Baton Rouge airport within the DHH required time or activate a virtual AmeriHealth Caritas Louisiana EOC liaison. (***See DHH EOC shifts template in Appendix***).

4. The EOCs of AmeriHealth Caritas Louisiana, the South Carolina regional office and AmeriHealth Caritas corporate will activate and be fully staffed.

Emergency Operation Centers			
Location/building	**Primary/telephone**	**Secondary/telephone**	**Off-site/other location**
AmeriHealth Caritas Louisiana 10000 Perkins Rowe, 4th Floor Baton Rouge, LA 70810	Community Room 4th Floor Telephone: 1-225-300- Capacity: 50 View conference: yes/dual	N/A	This location will be determined should the Baton Rouge office become inaccessible.
South Carolina Regional Office 4390 Belle Oaks Drive, Suite 400 N. Charleston, SC 29405	Compassion Conference Room 4th Floor Telephone: 1-843-569-4592 Capacity: 30 View conference: XX	Care of the Poor Conference Room 4th Floor Telephone: 1-843-569-4633 Capacity: 30 View conference: XX	Columbia Service Center 3315 Broad River Road Columbia, SC 29210
Philadelphia — Building 100 Airport Business Center 100 Stevens Drive Philadelphia, PA 19113	Competence Training Room 2nd Floor Capacity: XX View conference: No	Diversity Training Room 2nd Floor Telephone: 1-215-937-8357 Capacity: XX View conference: No	International Plaza 200 Scott Way 3rd Floor Conference Room 603 A and B Capacity: 25 View conference: Yes
Philadelphia — Building 200 Airport Business Center 200 Stevens Drive Philadelphia, PA 19113	Conference Room X 1st Floor Telephone: 1-215-937-8535 Capacity: 20 View conference: Yes	Conference Room L 3rd Floor Telephone: 1-215-937-8357 Capacity: 20 View conference: Yes IS Training Rooms 3rd Floor Capacity: 20 View conference: No	

Emergency Operations Center Conference Bridge Lines			
Bridge line for the DHH EOC and AmeriHealth Caritas Louisiana EOC (pre H-Hour)			
Toll-free	**Host pass code**	**Participate pass code**	**Number of participants permitted**
1-719-867-1571	2197262	219726	125
Bridge line for Philadelphia, South Carolina and AmeriHealth Caritas Louisiana (assigned H-Hour)			
Toll-free	**Chair pass code**	**Participate pass code**	**Number of participants permitted**
1-719-867-1571	1592481	159248	125

H – Hour: 0 (the storm arrives and passes)

1. AmeriHealth Caritas Louisiana will perform a damage assessment of its Baton Rouge office and determine the estimated time needed to return to full operations.

2. AmeriHealth Caritas Louisiana will provide the DHH upon request with our estimated time to recovery and update all available informational communication vehicles, including phone messages, emails and websites.

3. AmeriHealth Caritas Louisiana will help providers access our web-based provider portal to access member, clinical and claims data as providers recover to get back into their offices.

4. AmeriHealth Caritas Louisiana will also provide pre- and post-storm member needs and assessments and additional information, as needed, to ensure we can guide members to participating providers in other areas. AmeriHealth Caritas Louisiana will work with the proper entities to coordinate necessary care for our members regardless of their locations. If appropriate, we will revise our system to accept and honor out-of-state, nonparticipating provider service claims for a defined period of time to ensure service continuity.

5. AmeriHealth Caritas Louisiana will continue to update all available communication vehicles, including the website and phone messages. Throughout the process, our contact centers will field telephone calls and share information with providers, members and employees.

6. AmeriHealth Caritas Louisiana will coordinate alternate worksites as necessary for any required employees.

Deactivation steps

1. AmeriHealth Caritas Louisiana's Emergency Management liaison will deactivate the EOCs of AmeriHealth Caritas Louisiana, the South Carolina regional office and AmeriHealth Caritas corporate when needed.

2. AmeriHealth Caritas Louisiana's executive director or appointed designee will deactivate the AmeriHealth Caritas Louisiana emergency response plan when needed.

Post-incident reporting

After each crisis, a detailed debriefing will be conducted to evaluate system readiness and execution during the crisis. The debriefing will cover how well we were able to locate and communicate to members and our providers' readiness. A complete report will be generated and used to modify the existing emergency management plan and business continuity plans to prepare for future disasters. The report will be shared with the DHH.

Systems (technology)

All AmeriHealth Caritas Louisiana's data is backed up regularly and stored off-site, making it accessible to locations in other states that can duplicate AmeriHealth Caritas Louisiana's Provider and Member Contact Center functions.

Communication strategies with the DHH

Bridge line between the DHH EOC and AmeriHealth Caritas Louisiana EOC			
Toll-free	Host pass code	Participate pass code	Number of participants permitted
1-719-867-1571	2197262	219726	125

Reporting requirements

Reporting requirements will be determined at before, during and after the event.

Disaster training

AmeriHealth Caritas Louisiana is part of the AmeriHealth Caritas Family of Companies. AmeriHealth Caritas uses several methods to keep associates aware of their critical roles in preparing for any potential business disruption or natural disaster. Our primary methods include recovery tests, tabletop exercises, building evacuations (i.e., fire drills) and regular employee communications. Employees in key areas are included in all testing and exercises.

Business and technology recovery training and staff training

AmeriHealth Caritas testing strategy includes, at a minimum, an annual simulated disaster recovery test to assure full recovery of our operations at our contacted recovery facility. The overall goals for the tests are:

- To enhance AmeriHealth Caritas' ability to perform necessary procedures and critical business functions in the event of a disaster.
- To identify areas of potential improvement in the plans.
- To identify problems, issues and lessons learned during testing, which are rolled up into the maintenance phase and retested during the next test cycle.

The disaster recovery plan and business area continuity plans will be included in our annual test to ensure the adequacy of their technical recovery procedures, recovery teams' contact information, communication and recovery of all critical systems and vendor information (e.g., names, phone numbers and escalation process). Our annual test is a simulation of a disaster and recovery of all of our critical systems at our contracted recovery location. This ensures critical systems will be available to meet the recovery-time objectives and business requirements.

In parallel with the disaster recovery technology recovery activities, the business recovery activities will be tested. The tests will include:

- Crisis management testing.
- Business recovery activation testing.
- Business recovery testing.

Crisis management component test

Tabletop walk-through tests of the crisis management action plan are to determine if team members are aware of their assigned activities, if documentation is complete and accurate and if communication among teams is effective.

- Establishment of a crisis command center is to determine if an on-call recovery executive can set up a location from which to control the crisis and recovery effort.
- Notification test of Crisis Management Team members and other support staff members as needed.
- Notification test of the business recovery coordinator and disaster recovery coordinator.
- Notification test of the senior executive management team.

Business recovery activation component test

Tabletop walk-through tests of the business continuity activation plan are to determine if team members are aware of their assigned activities, if documentation is complete and accurate and if communication among teams is effective.

- Notification test of business continuity coordinator.
- Notification test of critical employees, and/or outside vendors and services.

Business recovery component test

Tabletop walk-through tests of the business area continuity plans are to determine if team members are aware of their assigned activities, if documentation is complete and accurate and if communication among teams is effective.

Natural disaster training (mock exercises)

As part of the AmeriHealth Caritas Family of Companies, AmeriHealth Caritas Louisiana periodically participates in tabletop or mock exercises and scenarios to test the response capability of its staff to a given event. AmeriHealth Caritas Louisiana's exercise scenarios require a coordinated response to a realistic situation that develops in real time with participants gathered to formulate responses to each development. This is a facilitated group analysis of an emergency situation in an informal, stress-free environment. These exercises allow us to examine our operational plans, identify problems and conduct in-depth problem solving.

Exercise history		
Type (i.e., tabletop, mock)	Date of exercise	Synopsis
DHH Mock Exercise	April 2012	

Plan activation history

Plan activation history		
Type of crisis	Date of crisis	Synopsis
Hurricane	August 2012	Isaac

G. Other

Registry of volunteer health care providers

AmeriHealth Caritas Louisiana does not have a registry of volunteer health care providers. AmeriHealth Caritas Louisiana's Provider Contract Services will encourage providers to self-register with Louisiana Volunteers in Action (LAVA).

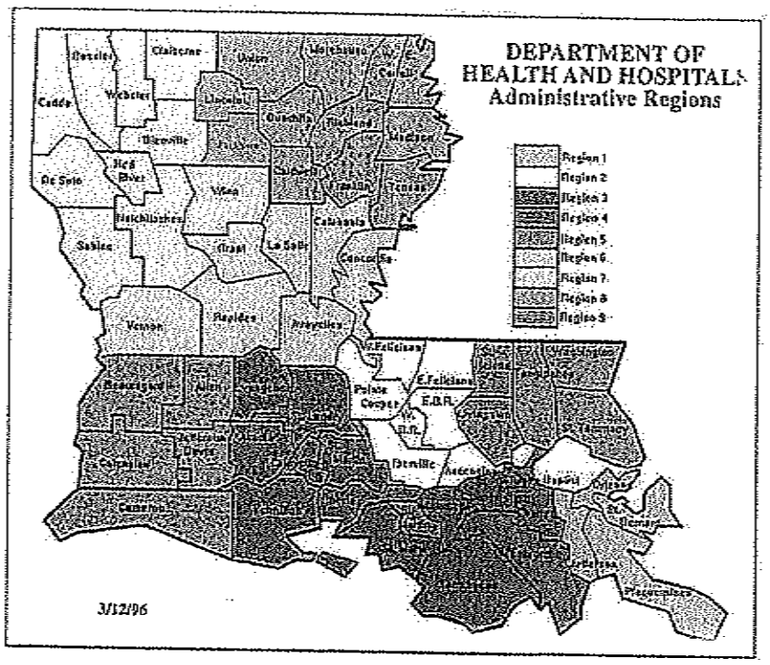
Emergency health resources (EHR) usage to access members; health history

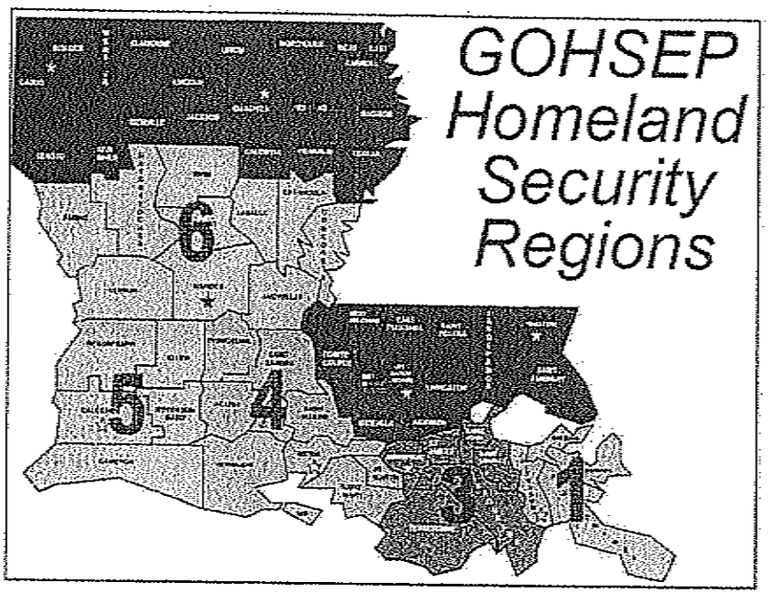
All critical business functions of AmeriHealth Caritas Louisiana performed outside of Louisiana will continue to have access to all of its enterprise-wide solutions.

Coordination with other entities

DHH — Office of Emergency Preparedness and Office of Public Health

State of Louisiana — agency contact information						
Contact name	Title	Main office telephone	Main office fax	Direct office telephone	Mobile	Email
Kellea Tuminello	LA DHH Bureau of Health Service Financing	1-225-342-7882	1-225-389-2707	1-225-342-7882		kellea.tuminello@la.gov
Faith Roussell Willis	Medicaid Emergency Preparedness Manager	1-225-342-1139	1-225-376-4689	1-225-342-1139	1-225-776-6677	faith.roussell@la.gov
Steve Annison	Medicaid Program Manager	1-225-342-5935	1-225-389-2607	1-225-342-5935		steve.annison@la.gov
Dr. Rosanne Prats	Emergency Preparedness Director			1-225-342-5168		rosanne.prats@la.gov


DEPARTMENT OF
HEALTH AND HOSPITALS
Administrative Regions
Region 1
Region 2
Region 3
Region 4
Region 5
Region 6
Region 7
Region 8
Region 9
3/12/96


GOHSEP
Homeland
Security
Regions
6
5
4
3
2
1

I. Plan Appendix

Directions to State EOC (GOHSEP)

Directions to the DHH EOC at the Baton Rouge Metropolitan Airport

DHH – ESF – 8 Organizational Chart

Map of the Department of Children and Family Services (ESF-6)

AmeriHealth Caritas Louisiana Shift Schedule at the DHH EOC (Template)

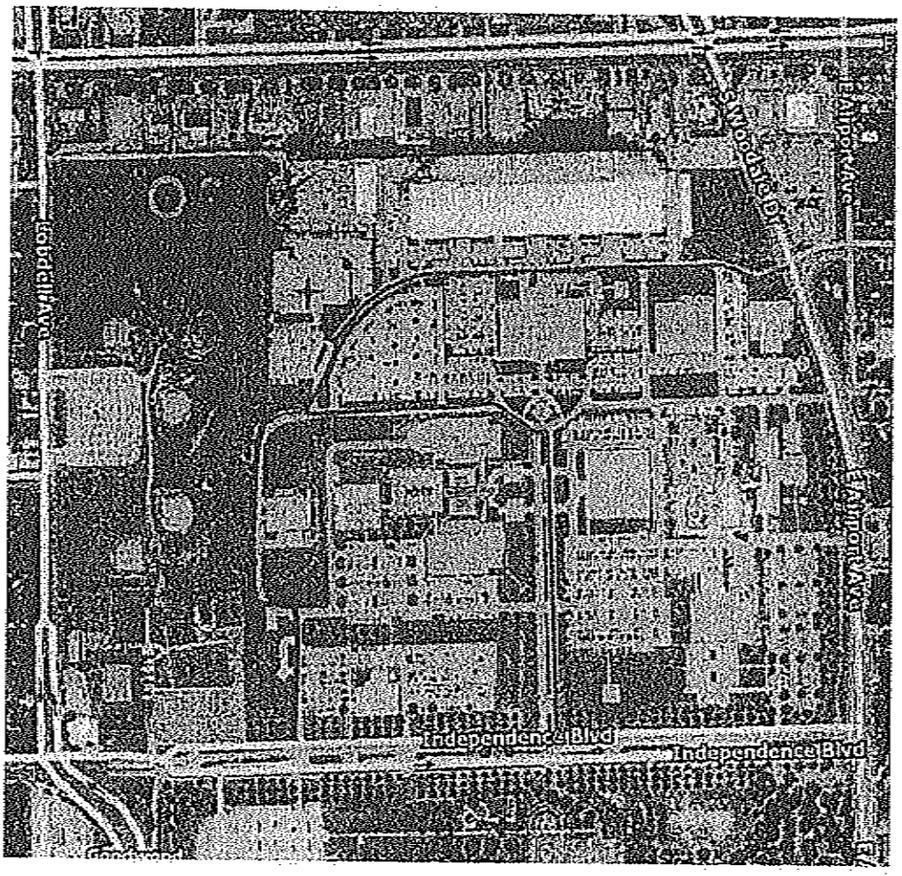
AmeriHealth Caritas EOC Shift Schedule (Template)

Directions to state EOC (GOHSEP)

Governor's Office of Homeland Security and Emergency Preparedness

7667 Independence Blvd.
Baton Rouge, LA 70806

Phone: 1-225-925-7500
Fax: 1-225-925-7501



From I-110

- Take the Florida Blvd. exit going east (downtown Baton Rouge is to the west).
- Continue to East Airport Dr. (right at Jack in the Box).
- Turn right onto East Airport Dr.
- Turn right into the state police campus (first right).

- Follow signs (building next to radio tower). Visitors park in the front parking lot and must obtain a visitor badge at the front lobby desk.

From I-10

- Take the College Dr. exit going north.
- Take right onto Corporate Blvd. and continue to Jefferson Hwy. traffic light.
- Turn left onto Jefferson Hwy. and continue to the next traffic light.
- Turn right onto Lobdell Ave.
- Continue through one traffic light.
- Stay in the right lane and before the next light, veer right (island) onto Independence Blvd.
- Merge into left lane and take first left into the state police campus.
- Follow signs (building next to radio tower). Visitors park in the front parking lot and must obtain a visitor badge at the front lobby desk.

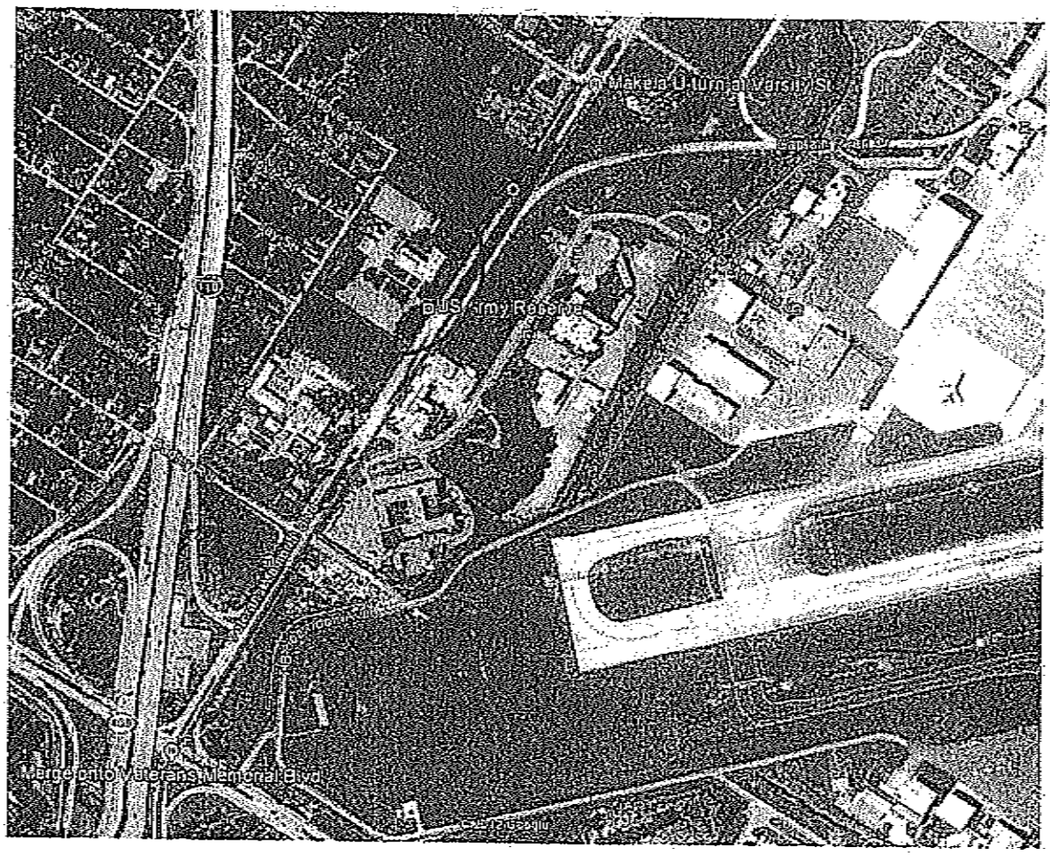
From I-12

- Take Airline Hwy. exit going north.
- Continue on Airline Hwy. to Goodwood Blvd.
- Take left onto Goodwood Blvd. and continue to East Airport Dr.
- Turn right onto East Airport Dr.
- Continue through one traffic light and take the second left into the state police campus.
- Follow signs (building next to radio tower). Visitors park in the front parking lot and must obtain a visitor badge at the front lobby desk.

Directions to the DHH EOC at the Baton Rouge Metropolitan Airport

8453 Veterans Memorial Blvd.
Baton Rouge, LA 70807

EOC location



EOC Access
Anyone who is assigned to the EOC and attended at least one training will be issued a badge (activated only during events) that grants access to the EOC.

From New Orleans or Baton Rouge

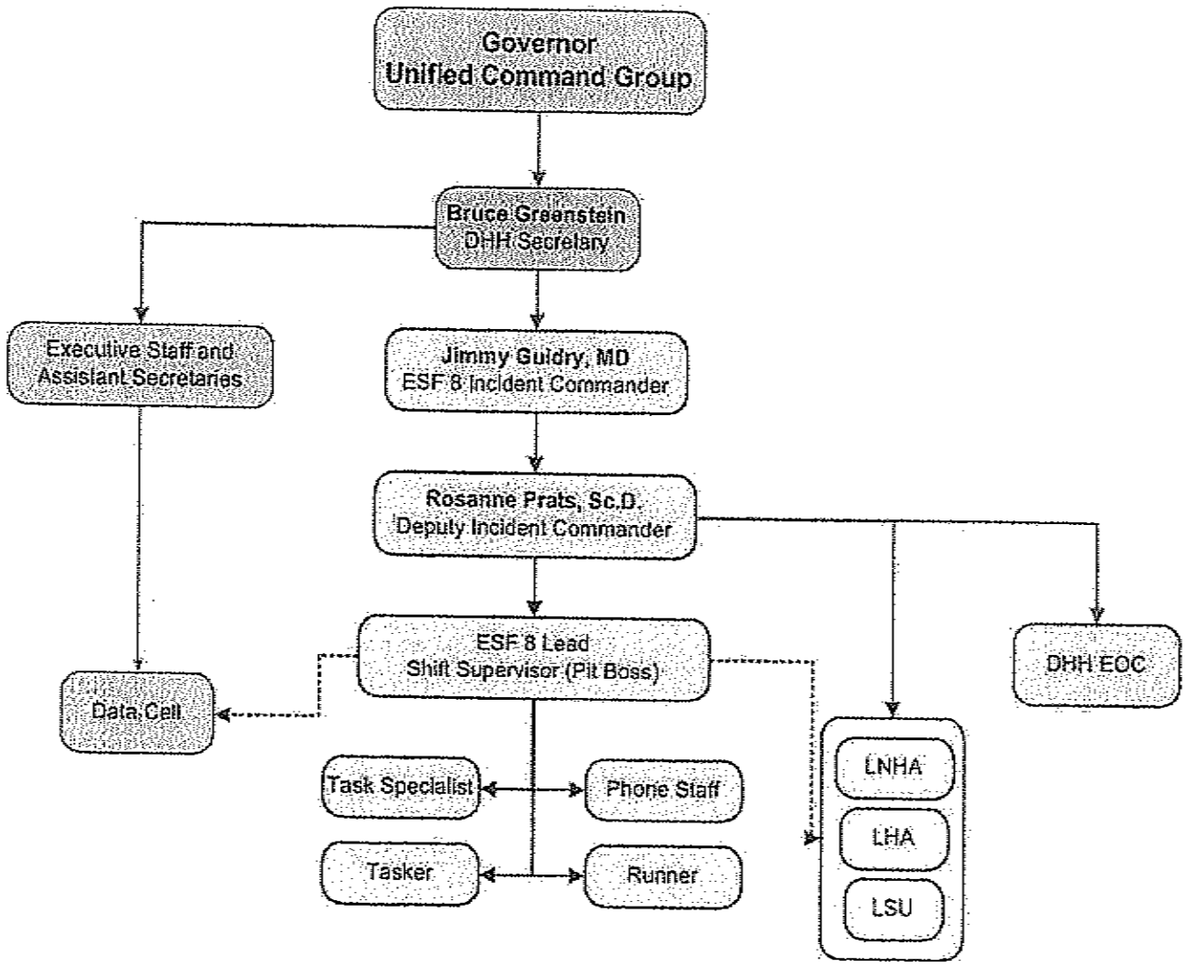
- Take Interstate I-10 West toward Baton Rouge for approximately 74 miles.
- Merge onto I-110 North Downtown Baton Rouge/Baton Rouge Metropolitan Airport.

- Proceed approximately 6.2 miles north on I-110.
- Take Exit 6 toward Baton Rouge Metropolitan Airport.
- Cross over Harding Boulevard (four-lane highway) to Veterans Memorial Boulevard.
- Make a U-turn at Varsity Street.

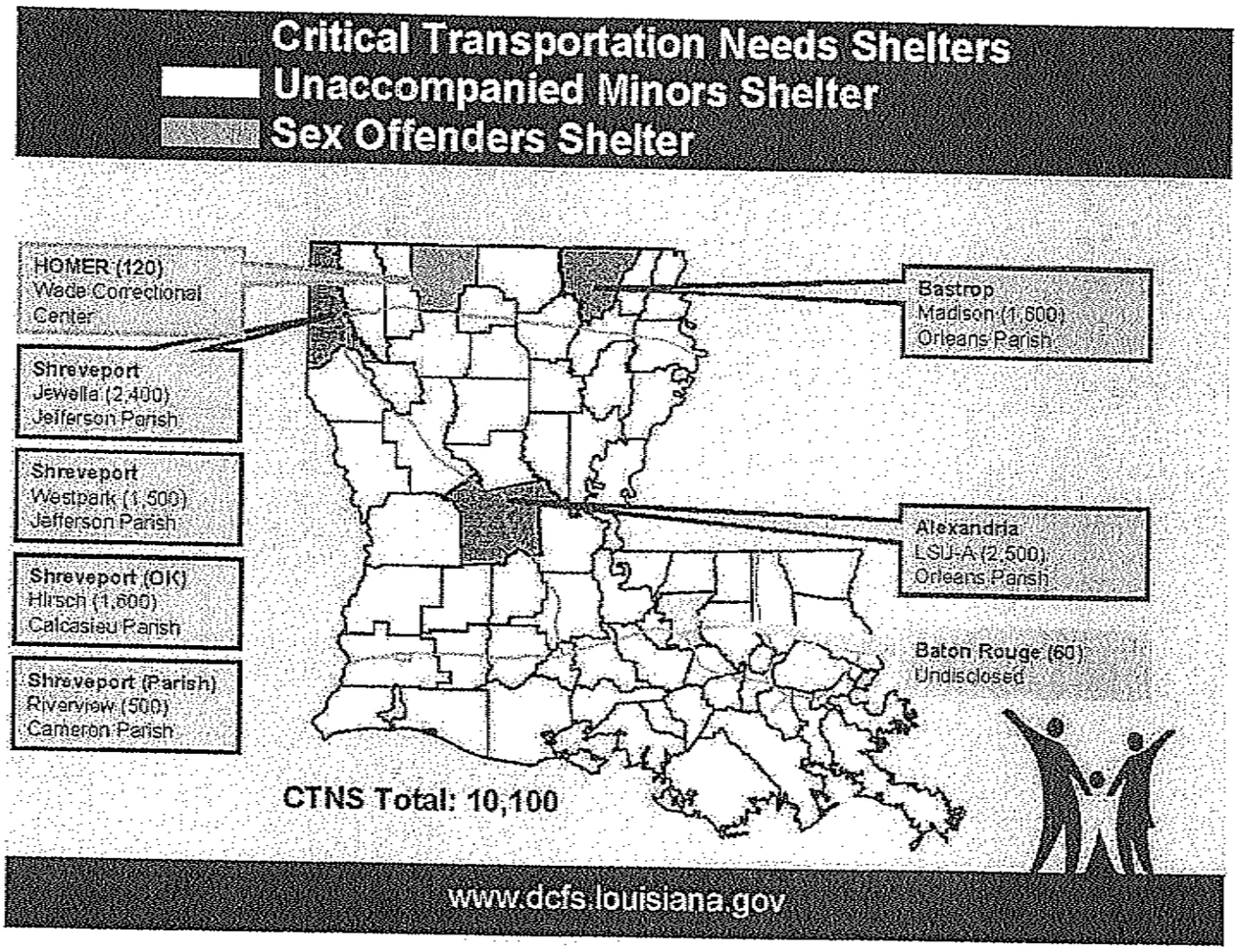
From Lafayette

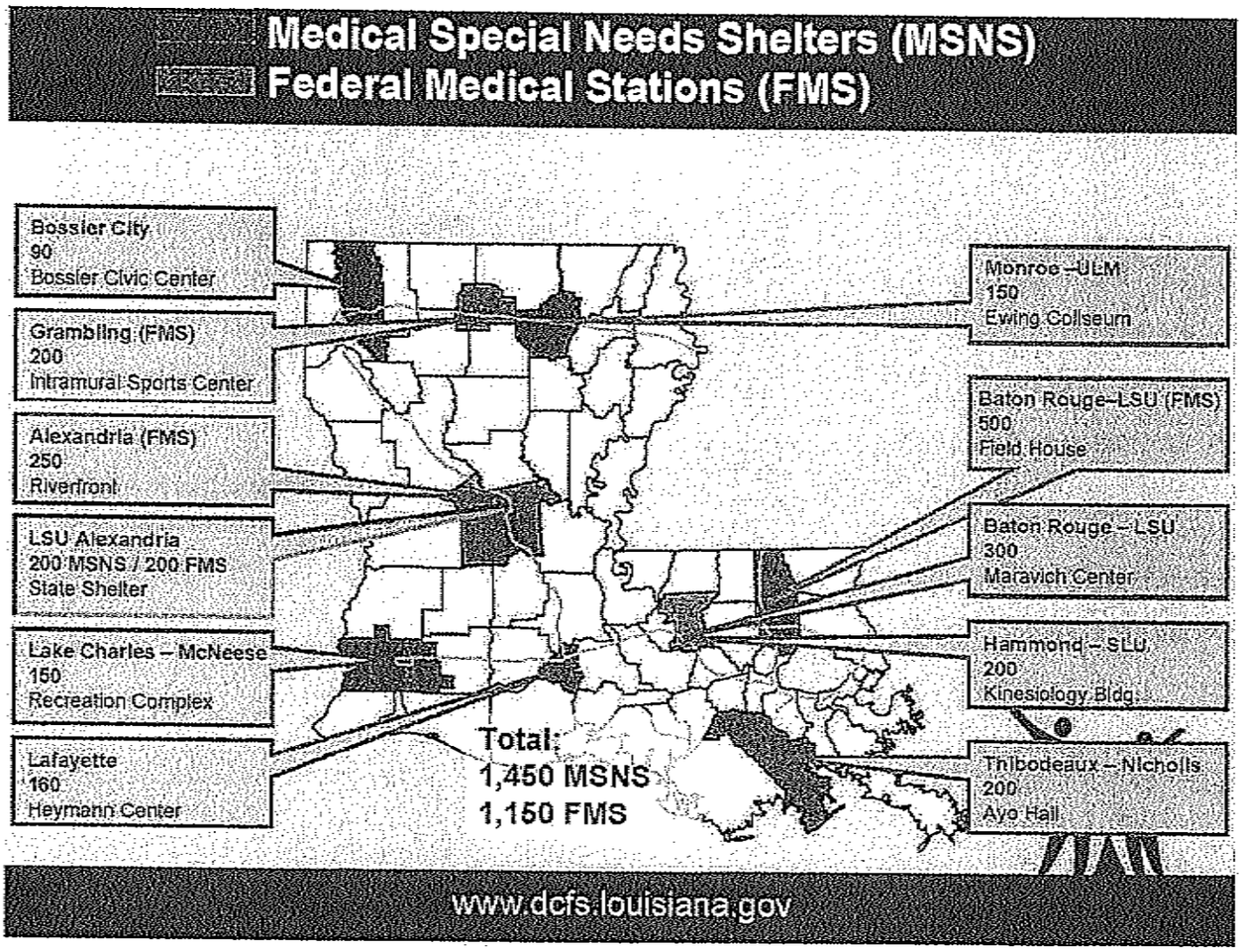
- Take interstate I-10 East toward Baton Rouge for approximately 52 miles.
- Cross over the Mississippi River Bridge to merge left onto I-110 North via Exit 155B toward the Downtown Business District of Baton Rouge/Baton Rouge Metropolitan Airport.
- Proceed approximately 6.2 miles north on I-110.
- Take Exit 6 toward Baton Rouge Metropolitan Airport. Cross over Harding Boulevard (four-lane highway) to Veterans Memorial Boulevard.
- Make a U-turn at Varsity Street.

DHH – ESF – 8 Organizational Chart



Map of the Department of Children and Family Services (ESF-6)




Medical Special Needs Shelters (MSNS)
Federal Medical Stations (FMS)
Bossier City
90
Bossier Civic Center
Grambling (FMS)
200
Intramural Sports Center
Alexandria (FMS)
250
Riverfront
LSU Alexandria
200 MSNS / 200 FMS
State Shelter
Lake Charles – McNeese
150
Recreation Complex
Lafayette
160
Heymann Center
Monroe – ULM
150
Ewing Coliseum
Baton Rouge–LSU (FMS)
500
Field House
Baton Rouge – LSU
300
Maravich Center
Hammond – SLU
200
Kinesiology Bldg.
Thibodeaux – Nicholls
200
Ayo Hall
Total:
1,450 MSNS
1,150 FMS
www.dcfs.louisiana.gov

AmeriHealth Caritas Louisiana shift schedule at the DHH EOC (template)

Bridge line between the DHH EOC and AmeriHealth Caritas Louisiana EOC
Toll-free: 1-866-244-8528
Host pass code: 9120937
Participant pass code: 912093

Bridge line for Philadelphia, South Carolina and AmeriHealth Caritas Louisiana
Toll-free: 1-800-201-2375
Host pass code: 6267556
Participant pass code: 626755

DHH EOC shifts			
Shifts (12 hours)	Day and date	Time	AmeriHealth Caritas Louisiana liaison name
Shift A	Day: ______ Date: ______	Start time: ______ End time: ______	Name: Contact number:
Shift B	Day: ______ Date: ______	Start time: ______ End time: ______	Name: Contact number:
Shift A	Day: ______ Date: ______	Start time: ______ End time: ______	Name: Contact number:
Shift B	Day: ______ Date: ______	Start time: ______ End time: ______	Name: Contact number:
Shift A	Day: ______ Date: ______	Start time: ______ End time: ______	Name: Contact number:
Shift B	Day: ______ Date: ______	Start time: ______ End time: ______	Name: Contact number:
Shift A	Day: ______ Date: ______	Start time: ______ End time: ______	Name: Contact number:

Exhibit 6

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
AMERIHEALTH CARITAS LOUISIANA, INC.	Business Corporation	BATON ROUGE	Active

Previous Names

AMERIHEALTH MERCY OF LOUISIANA, INC. (Changed: 6/20/2013)

Business: AMERIHEALTH CARITAS LOUISIANA, INC.
Charter Number: 40319429D
Registration Date: 10/5/2010
State Of Origin:

Domicile Address

CT CORPORATION SYSTEM
5615 CORPORATE BLVD., SUITE 400B
BATON ROUGE, LA 70808

Mailing Address

10000 PERKINS ROWE, SUITE 400
BATON ROUGE, LA 70801

Status

Status: **Active**
Annual Report Status: **In Good Standing**
File Date: 10/5/2010
Last Report Filed: 9/23/2014
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: 12/14/2012

Officer(s)

Additional Officers: No

Officer: STEVEN HARVEY BOHNER
Title: Director
Address 1: 200 STEVENS DR
City, State, Zip: PHILADELPHIA, PA 19113

Officer: JAMES MICHAEL JERNIGAN
Title: President, Officer
Address 1: 200 STEVENS DR
City, State, Zip: PHILADELPHIA, PA 19113

Officer:	ROBERT HOWARD GILMAN
Title:	Vice-President, Secretary
Address 1:	200 STEVENS DR
City, State, Zip:	PHILADELPHIA, PA 19113

Officer:	ANNE MAUREEN MORRISSEY
Title:	Director, Vice-President
Address 1:	200 STEVENS DR
City, State, Zip:	PHILADELPHIA, PA 19113

Officer:	ROBERT EDWARD TOOTLE
Title:	Secretary
Address 1:	200 STEVENS DR
City, State, Zip:	PHILADELPHIA, PA 19113

Officer:	REBECCA ENGLEMAN
Title:	Officer
Address 1:	200 STEVENS DR
City, State, Zip:	PHILADELPHIA, PA 19113

Officer:	PAUL TUFANO
Title:	Director
Address 1:	200 STEVENS DR
City, State, Zip:	PHILADELPHIA, PA 19113

Amendments on File (2)

Description	Date
Disclosure of Ownership	10/7/2010
Name Change	6/20/2013

Print