Rev 2010/08

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AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Amendment #: 3

CFMS #: 707861

DOA #: 305-200568

DHH #: 057718

(Regional/ Program/ Facility): Medical Vendor Administration — Bureau of Health Services Financing

Original Contract Amt: $68,031,170.00

Original Contract Begin Date: 02-01-2012

Original Contract End Date: 01-31-2015

AND

Community Health Solutions(CHS) of America, Inc. dba CHS of Lou

Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: $69,076,862.00

See Attachment A-3.

Change To: Maximum Amount: $69,076,862.00

See Attachment A-3.

Justification:

See Attachment A-3.

This Amendment Becomes Effective: 01-01-2013

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

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

CONTRACTOR

Community Health Solutions(CHS) of America, Inc. dba CHS

S. Kyle Moll 12/17/2013

CONTRACTOR SIGNATURE DATE

PRINT NAME: S. Kyle Moll

CONTRACTOR TITLE: Executive Vice President

APPROVED
Office of the Governor
Office of Contractual Review
JAN 27 2014
Pamela Bartfay Rice
DIRECTOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE 12/23/13

DATE

NAME: Jerry Phillips

TITLE: Undersecretary, DHH

OFFICE: Office of Management and Finance

PROGRAM SIGNATURE DATE

NAME: Mary TC Johnson

Bayou Health – Shared Savings Contract Amendment Attachment A-3

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**4.7. Savings Determination** 4.7.1. DHH will conduct periodic reconciliations to determine savings achieved or refunds due to DHH (from the enhanced primary care management fees). The reconciliation will compare the actual aggregate cost of authorized services as specified in this RFP, including the enhanced primary care management fee for dates of services in the reconciliation period, to the aggregate Per Capita Prepaid Benchmark (PCPB). • The PCPB will not include the PCP care management fees described in §4.3 above. • In the event a member transitions from CCN mandatory or voluntary status to excluded status before being discharged from the hospital, the cost of the entire admission will be included in the actual cost when performing the savings reconciliation. • Costs of DME and certain supplies, nursing home, dental, personal care services (EPSDT and LT), hospice, services provided by a school district and billed through the intermediate school district, EarlySteps services, targeted case management, non-emergency medical transportation, specific specialized behavioral health drugs, transplants, non-behavioral health drugs, and individual member total cost for the reconciliation year in excess of one hundred thousand dollars ($100,000), will not be included	**4.7. Savings Determination** **4.7.1.** DHH through its actuary will determine savings achieved or refunds due to DHH (from the enhanced primary care case management fee) on a periodic basis. The determination will calculate the difference between: • The actual aggregate cost of authorized services and • The aggregate Per Capita Prepaid Benchmark (PCPB), as described in Appendix F - CCN-S Benchmark Summary. The enhanced primary care case management fee will be included in the actual aggregate cost of authorized services. The PCP care management fee will be excluded from the actual aggregate cost of authorized services and the PCPB. The unit cost increase associated with the ACA 1202 Primary Care Increase will also be excluded from the actual aggregate cost of authorized services and the PCPB. The formula for the calculation will be: C = Actual aggregate cost of authorized services	To clarify savings determination methodology.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		in the determination of the PCPB nor will it be included in actual cost at the point of reconciliation so that outlier cost of certain individuals and/or services will not jeopardize the overall savings achieved by the CCN. •The PCPB benchmark for each CCN will be risk-adjusted, if applicable, according to the risk profiles of members enrolled with the CCN. • DHH will perform interim and final reconciliations as of June 30th and December 31st of each year with provisions for Incurred-But-Not-Reported (IBNR) claims included in the actual cost. DHH reserves the right to make interim payments of any savings for any Dates of Service with more than 6 months elapsed time. A final reconciliation will be performed for any periods for which there are Dates of Service with more than 12 months elapsed time, at which point there should be sufficient completion of paid claims to determine total medical cost incurred by the CCN without the need to consider additional claims that have been incurred but are still outstanding. Final reconciliations will not be for less than 12 months (of service) unless determined appropriate by the Department. • In the first year of a CCN's operations, DHH may exclude claims from the first 30 days of operations when calculating the reconciliation. • In the event the CCN exceeds the PCPB in the aggregate (for the entire CCN enrollment), as	B = Aggregate Per Capita Prepaid Benchmark D = Difference C – B = D If the difference calculated is less than zero, then the amount of the difference equals savings achieved. If the difference calculated is greater than zero, then the amount of the difference equals the refund due to DHH, not to exceed fifty percent (50%) of enhanced primary care case management fee paid to the CCN for the determination period. **4.7.2.** Savings achieved or refunds due will be determined for each CCN in the aggregate and not for separate enrollment types. **4.7.3.** The PCPB for each CCN will be risk-adjusted, if applicable, according to the risk profiles of the CCN's members. (See §4.8). **4.7.4.** If a member transitions from CCN mandatory or voluntary status to excluded status before being discharged from the hospital, the cost of the entire admission will be included in the actual aggregate cost of authorized services. **4.7.5.** Costs of DME and certain supplies, nursing home, dental, personal care services (EPSDT and LT), hospice, services provided by a school district	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		calculated in the final reconciliation, the CCN will be required to refund up to 50% of the total amount of the enhanced care case management fees (excluding the PCP care management fee specified in §4.3 above) paid to the CCN during the period being reconciled. • Such amounts shall be determined in the aggregate, and not for separate enrollment types. • CCN will be eligible for up to 60% of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees advanced, are less than the aggregate PCPB (for the entire CCN enrollment). The enhanced care management fee will be reduced by PCP PMPM during the reconciliation process. The PCP PMPM component of the enhanced care management fee will be in accordance with Appendix E –Mercer Certification, Rate Development Methodology and Rate. Due to limitations under the Medicaid State Plan, shared savings will be limited to 5% of the actual aggregate costs including the enhanced care management fees paid. Such amounts shall be determined in the aggregate, and not for separate enrollment types. • Distribution of any savings will be contingent upon the CCN meeting established contract reporting requirements, benchmarks for specified clinical performance measures and/or compliance with the Contract, as determined by DHH.	and billed through the intermediate school district, Early Steps services, targeted case management, non-emergency medical transportation, specific specialized behavioral health drugs, transplants, and individual member total cost for authorized services in the contract year in excess of one hundred thousand dollars ($100,000) will be excluded from the PCPB and the actual cost in the determination for that contract year so that outlier cost of certain individuals and/or services will not jeopardize the overall savings achieved by the CCN. **4.7.6.** The CCN may be eligible for up to sixty percent (60%) of savings determined for the determination period, consistent with the approved 1932 State Plan Amendment which limits savings distributions to the CCN to five percent (5%) of the actual aggregate cost of authorized services as defined in §4.7.1. **4.7.7.** Distribution of any savings payments will be contingent upon the CCN's compliance with the Contract, as determined by DHH. Plans will be notified of non-compliance through a written Notice of Action as defined in §18.1. Savings payments may be deferred pending resolution of any outstanding issues of non-compliance. Savings payments for the initial contract year shall be made only if the CCN has demonstrated the capacity to report on the five incentive-based measures and the 17 Level 1 HEDIS measures enumerated in Appendix H, as demonstrated by	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		• The CCN will be responsible for dividing the CCN's share of savings (if applicable) between the participating providers and itself, based upon any agreement established between the CCN and the providers.	the submission of a CCN-generated HEDIS report to DHH. Savings payments for the second and subsequent contract years shall be made only if the CCN has met the DHH established goals for the five incentive-based measures as reported through the NCQA process and validated by the External Quality Review Organization. **4.7.8.** The CCN will be responsible for distributing savings payments to participating providers based upon agreements made between the CCN and the providers. **4.7.9.** DHH through its actuary may make an interim determination and will make a final determination of savings achieved or refunds due to DHH (from the enhanced primary care case management fee) for each CCN for each contract year. **4.7.10.** DHH may exclude from determinations for the contract year claims from the first thirty (30) days of operations, specifically: • Claims for GSA A enrollees with dates of service during February 2012; • Claims for GSA B enrollees with dates of services during April 2012; and • Claims for GSA C enrollees with dates of services during June 2012.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			Determinations will be made in consideration of GSAs. The CCN's savings achieved or refund due is the sum of the CCN's savings achieved and/or refund due for each GSA. **4.7.11.** Interim determinations may be made for less than twelve (12) months of service during the contract year. For dates of service with less than 12 months of elapsed time after the end of the contract period an adjustment for Incurred But Not Reported (IBNR) claims will be made. DHH may make an interim payment to the CCN for savings achieved based on the interim determination. Interim payments shall not exceed seventy-five percent (75%) of the eligible amount as described in §4.7.6. **4.7.12.** Final determinations will not be made for less than twelve (12) months of service during the contract year. Final determinations will be made when all dates of service during the contract year have twelve (12) months of elapsed time from the last date of service. Final determinations will use data updated since the interim determinations for: • Actual aggregate cost of authorized services; • Enhanced primary care case management fee;	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			• PCP care management fee; and • PCPB. DHH will make a final payment to the CCN for savings achieved based on the final determination. The final payment amount will be up to the difference between the amount of the interim payment (if any) and the final amount eligible for distribution as defined in §4.7.6. **4.7.13.** The CCN will make payment to DHH for any refund due, up to fifty percent (50%) of enhanced primary care case management fee paid to the CCN during the period being reconciled. **4.7.14.** DHH will make payment to the CCN for savings achieved when either: the CCN provides to the CCN Program Director written concurrence with the determination; or, when relative to a written request for reconsideration of a savings determination, a decision has been made by the Medicaid Director as specified in §19.30. Written communication regarding concurrence or request for reconsideration must be provided to DHH within sixty (60) days of issuance of the determination to the CCN. Determinations that are neither agreed to nor disputed by the CCN within sixty (60) days shall be deemed final. **4.7.15** DHH will collect any refunds due from the CCN as specified in §4.10 when the determination	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			is deemed final as defined in §4.7.14.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**4.7.2. Health-Based Risk Adjustment Methodology** Health-based risk adjustment is a method that accounts for variation in health risks among participating CCNs when determining CCN-S shared savings. Risk adjustment provides a mechanism to better align the shared savings per capita prepaid benchmark (PCPB) to the expected costs based on the health risk of the enrolled population. The Adjusted Clinical Groups (ACGs) developed by Johns Hopkins University will initially be used to assess the health risk of each Medicaid/CHIP member and calculate the relative health risk of each CCN. Using diagnoses reported on FFS claims along with age and gender, the ACG model assigns members into approximately one hundred (100) mutually exclusive groups or risk categories with a similar level of expected resource utilization. For each risk category, the cost weight or relative health risk score denoting the average costs of members relative to the overall population will initially be calculated using historical Louisiana specific experience from the fee-for-service Medicaid population. The shared savings PCPB will be risk-adjusted by assessing the relative health risk of CCN	**4.8. Health-Based Risk Adjustment Methodology** **4.8.1.** Health-based risk adjustment is a method that accounts for variation in health risks among participating CCNs when determining CCN-S shared savings. Risk adjustment provides a mechanism to better align the shared savings PCPB to the expected costs based on the health risk of the enrolled population. **4.8.2.** The Adjusted Clinical Groups (ACGs) developed by Johns Hopkins University will initially be used to assess the health risk of each Medicaid/CHIP member and calculate the relative health risk of each CCN. **4.8.3.** Using diagnoses reported on FFS claims along with age and gender, the ACG model assigns members into approximately one hundred (100) mutually exclusive groups or risk categories with a similar level of expected resource utilization. For each risk category, the cost weight or relative health risk score denoting the average costs of members relative to the overall population will initially be calculated using historical Louisiana specific experience from the fee-for-service Medicaid population. **4.8.4.** The shared savings PCPB will be risk-adjusted by assessing the relative health risk of CCN members. The health risk will then be measured at the CCN level and will be used to	Clarification of contract language required renumbering of Section 4 of the contract.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		members. The health risk will then be measured at the CCN level and will be used to adjust the universal PCPBs to arrive at the CCN-specific risk-adjusted PCPB. The risk-adjusted PCPB, in turn, will be used to determine the shared savings between the CCN and DHH. This will be accomplished by comparing the CCN-specific PCPB (adjusted to reflect the health risk of member enrollment) with the actual FFS medical costs for the measurement period. Risk adjustment will begin three (3) months after initial program implementation. The PCPB for the initial three (3) months will be based entirely on the universal PMPM values. Starting in the fourth (4th) month of implementation in a geographic area, PCPBs will be risk-adjusted to applicable rate cells. Assessment of individual member risk scores will be based on the most recent twelve months of complete fee-for-service claims data. The health risk of the members and the CCN will be updated on a semi-annual basis to reflect changes in risk over time.	adjust the universal PCPBs to arrive at the CCN-specific risk-adjusted PCPB. The risk-adjusted PCPB, in turn, will be used to determine the shared savings between the CCN and DHH. This will be accomplished by comparing the CCN-specific PCPB (adjusted to reflect the health risk of member enrollment) with the actual FFS medical costs for the measurement period. **4.8.5.** Risk adjustment will begin three (3) months after initial program implementation. The PCPB for the initial three (3) months will be based entirely on the universal PMPM values. Starting in the fourth (4th) month of implementation in a geographic area, PCPBs will be risk-adjusted to applicable rate cells. **4.8.6.** Assessment of individual member risk scores will be based on the most recent twelve months of complete fee-for-service claims data. The health risk of the members and the CCN will be updated on a semi-annual basis to reflect changes in risk over time.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**4.8. Primary Care Provider Services Reimbursements** Enrollment in the Louisiana Medicaid Program is mandatory for all CCN network providers. The CCN shall reimburse the PCP for PCP care management services. Claims payment for CCN	**4.9. Primary Care Provider Services Reimbursements** **4.9.1.** Enrollment in the Louisiana Medicaid Program is mandatory for all CCN network providers. **4.9.2.** The CCN may reimburse the PCP for PCP	Clarification of contract language required renumbering of Section 4 of the contract.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		members will continue to be paid by the FI through the fee-for-service system.	care management services. Claims payment for CCN members will continue to be paid by the FI through the fee-for-service system.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**4.9. Return of Funds** The CCN agrees that all amounts owed to DHH, as identified through routine or investigative reviews of records or audits conducted by DHH or other state or federal agency, are due no later than 30 calendar days following notification to the CCN by DHH unless otherwise authorized in writing by DHH. DHH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to DHH to future payments. DHH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR §30.13. This rate may be revised quarterly by the Secretary of the Treasury and shall be published by HHS in the Federal Register. The CCN shall reimburse all payments as a result of any federal disallowances or sanctions imposed on DHH as a result of the CCN's failure to abide by the terms of the Contract. The CCN shall be subject to any additional conditions or restrictions placed on DHH by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written	**4.10. Return of Funds** **4.10.1.** The CCN agrees that all amounts owed to DHH, as identified through routine or investigative reviews of records or audits conducted by DHH or other state or federal agency or as a result of monetary sanctions or final savings determinations, are due no later than thirty (30) calendar days following notification to the CCN by DHH unless otherwise specified in writing by DHH. In the event an appeal by the CCN results in a decision in favor of the CCN, any such funds collected by DHH will be returned to the CCN. DHH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to DHH to future payments. DHH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR §30.13. This rate may be revised quarterly by the Secretary of the Treasury and shall be published by HHS in the Federal Register. **4.10.2** The CCN shall reimburse all payments as a result of any federal disallowances or sanctions	Provide additional clarification of reason for payment of funds of Health Plan to DHH and clarification of contract language required renumbering of Section 4 of the contract.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		notice.	imposed on DHH as a result of the CCN's failure to abide by the terms of the Contract. The CCN shall be subject to any additional conditions or restrictions placed on DHH by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**4.10. Physician Incentive Plans** The CCN should develop incentive plans. All incentive plans for network providers shall be consistent with 42 CFR §422.208 and 422.210 Physician incentive plans: requirements and limitations. The CCN shall disclose to DHH the following: • Services that are furnished by a physician/group that are covered by any incentive plan; • Type of incentive arrangement, e.g. withhold, bonus, capitation; • Percent of withhold or bonus (if applicable); • Panel size, and if patients are pooled, the approved method used; and • If the physician/group is at substantial financial risk, the entity must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.	**4.11. Physician Incentive Plans** **4.11.1.** The CCN should develop incentive plans. All incentive plans for network providers shall be consistent with 42 CFR §422.208 and 422.210 Physician incentive plans: requirements and limitations. **4.11.2.** The CCN shall disclose to DHH the following: • Services that are furnished by a physician/group that are covered by any incentive plan; • Type of incentive arrangement, e.g. withhold, bonus, capitation; • Percent of withhold or bonus (if applicable); • Panel size, and if patients are pooled, the approved method used; and • If the physician/group is at substantial financial risk, the entity must report proof	Clarification of contract language required renumbering of Section 4 of the contract.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		The CCN shall provide information on its incentive plans to any Medicaid member upon request (this includes the right to adequate and timely information on the plan.	the physician/group has adequate stop loss coverage, including amount and type of stop-loss. **4.11.3.** The CCN shall provide information on its incentive plans to any Medicaid member upon request (this includes the right to adequate and timely information on the plan).	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**6.9.2.1.** By the end of the first year of operations in the region: • Total of 20% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited. **6.9.2.2.** By the end of the second year of operation under the Contract: • Total of 30% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; and • Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited. **6.9.2.3.** By the end of the third year of operation under the Contract: • Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; • Total of 40% of practices shall be NCQA PPC®-	**6.9.2.1.** Twelve (12) months post statewide implementation, June 1, 2013: • Total of 20% of members linked to practices that are NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited. **6.9.2.2.** By the end of the second year of statewide operations, June 1, 2014: • Total of 30% of members linked to practices that are NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; and • Total of 10% of members linked to practices that are NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited. **6.9.2.3.** By the end of the third (3rd) year of statewide operations, June 1, 2015: • Total of 10% of members linked to practices that are NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; • Total of 40% of members linked to practices	Revised timeframe requirement for meeting Patient-Centered Medical Home recognition or accreditation and denominator for measure.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		PCMH Level 2 recognized or JCAHO PCH accredited; and • Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	that are NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited; and • Total of 10% of members linked to practices that are NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**7.1.8.1.5** The QAPI Committee shall meet on a quarterly basis. Its responsibilities shall include: • Direct and review quality improvement (QI) activities; • Assure that QAPI activities take place throughout the CCN; • Review and suggest new and/or improved QI activities; • Direct task forces/committees to review areas of concern in the provision of healthcare services to members; • Designate evaluation and study design procedures; • Conduct individual PCP and practice quality performance measure profiling; • Report findings to appropriate executive authority, staff, and departments within the CCN; • Direct and analyze periodic reviews of members' service utilization patterns; and • Maintain minutes of all committee and sub-committee meetings. Submit	**7.1.8.1.5** The QAPI Committee shall meet on a quarterly basis. Its responsibilities shall include: • Direct and review quality improvement (QI) activities; • Assure that QAPI activities take place throughout the CCN; • Review and suggest new and/or improved QI activities; • Direct task forces/committees to review areas of concern in the provision of healthcare services to members; • Designate evaluation and study design procedures; • Conduct individual PCP and practice quality performance measure profiling; • Report findings to appropriate executive authority, staff, and departments within the CCN; • Direct and analyze periodic reviews of members' service utilization patterns; • Maintain minutes of all committee and sub-committee meetings; • Report to DHH an evaluation of the	Removal of 5-day requirement for submission of minutes and correction of typographical errors.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		meeting minutes to DHH within 5 working days of the meetings. • Report to DHH an evaluation of the impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, all care management services. • Ensure that a QAPI committee designee attends DHH's quality meetings.	impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, all care management services; and • Ensure that a QAPI committee designee attends DHH's quality meetings.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**7.1.2.3.2** The UM Committee shall provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less than quarterly and shall submit meeting minutes to DHH within five (5) business days of each meeting. UM Committee responsibilities include: • Monitoring providers' requests for rendering healthcare services to its members; • Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling; • Reviewing the effectiveness of the utilization review process and making changes to the process as needed; • Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing	**7.1.2.3.2** The UM Committee shall provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less than quarterly. UM Committee responsibilities include: • Monitoring providers' requests for rendering healthcare services to its member; • Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling; • Reviewing the effectiveness of the utilization review process and making changes to the process as needed; • Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task; • Monitoring consistent application of	Removal of 5-day requirement for submission of minutes

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		each task; • Monitoring consistent application of "medical necessity" criteria; • Application of clinical practice guidelines; • Monitoring over- and under-utilization; • Review of outliers; and • Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.	"medical necessity" criteria; • Application of clinical practice guidelines; • Monitoring over- and under-utilization; • Review of outliers; and • Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**7.1.2.2.8.1.** The CCN shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the CCN can provide the service through an in-network or out-of-network provider for a lower level of care.	**Delete in its entirety**	Health Plan does not have authority to contract with inpatient services, therefore cannot meet this requirement.
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**7.1.2.6.3.2.** The CCN may request to be notified by the provider, but shall not deny claims for payment based solely on lack of notification, for the following: • Inpatient emergency admissions within one (1) business day of admission (Failure of admission notification after one business day may result in claim denial); • Obstetrical care (at first visit); and • Obstetrical admissions exceeding forty-eight	**7.1.2.6.3.2.** The CCN may request to be notified by the provider of obstetrical care at the time of the first visit of the pregnancy. The CCN shall not deny a claim for payment based solely on lack of notification of obstetrical care at the time of the first visit of the pregnancy. **7.1.2.6.3.3.** The CCN may request to be notified by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. The CCN is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical	Allows the Shared Health Plan to deny portion of service if the provider does not notify the Health Plan timely.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		(48) hours after vaginal delivery and ninety-six (96) hours after Caesarean section.	admission exceeding forty-eight (48) hours after vaginal delivery. In this case, the CCN is allowed to deny only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours. **7.1.2.6.3.4.** The CCN may request to be notified by the provider of obstetrical admissions exceeding ninety-six (96) hours after caesarean section. The CCN is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of Obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, the CCN is allowed to deny only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours. **7.1.2.6.3.5.** The CCN may request to be notified by the provider of inpatient emergency admissions within one (1) business day of admission. The CCN is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify the CCN of inpatient emergency admission within one (1) business day of admission.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**7.1.10 Early Warning System Performance Measures** The CCN shall collect and report monthly on the Early Warning System Performance Measure outcomes, as specified by DHH in this RFP (Appendix H), in order to monitor and evaluate	**7.1.10 Early Warning System Performance Measures** The CCN shall collect and report quarterly on the Early Warning System Performance Measure outcomes, as specified by DHH in this RFP (Appendix H), in order to monitor and evaluate	To clarify requirement for early warning system.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		the successful implementation of the CCN program. During a CCN's first two years of operations, distribution of any savings will be contingent upon the CCN meeting the established "Early Warning System" performance measures and compliance under this Contract. After the second year of operations, distribution of any savings will be contingent upon the CCN meeting established performance measures and compliance with this Contract.	the successful implementation of the CCN program.	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**13.19 Audit Requirements** The CCN shall ensure that their System facilitates the auditing of individual claims. Adequate audit trails shall be provided throughout the System. To facilitate claims auditing, the CCN shall ensure that the System follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, *The Auditor's Study and Evaluation of Internal Control in EDP Systems.* The CCN shall maintain and adhere to an internal EDP Policy and Procedures manual, available for DHH review upon request, which at a minimum shall contain and assure all accessible screens used throughout the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The	**13.19 State Audit Requirements** The CCN shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The CCN shall provide information necessary to assist the state auditor in processing or utilizing the files. If the auditor's findings point to discrepancies or errors, the CCN shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual.	To remove systems audit requirements that are not applicable to PCCM networks.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		manual is subject to yearly audit, by both state and independent auditors. **13.19.1 State Audit** The CCN shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The CCN shall provide information necessary to assist the state auditor in processing or utilizing the files. If the auditor's findings point to discrepancies or errors, the CCN shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual. **13.19.2 Independent Audit** **13.19.2.1** The CCN shall be required to subcontract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's		

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		System application. The independent firm shall: ○ Perform limited scope EDP audits on an ongoing and annual basis for contract compliance at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the Contract is in force with DHH and at the conclusion of the Contract; and ○ Perform a comprehensive audit on an annual basis for controls placed in operation and operation effectiveness, to determine the CCN's compliance with the obligations specified in this RFP. **13.19.2.2** The auditing firm shall deliver to the CCN and to DHH a report of findings and recommendations within thirty (30) calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews. **13.19.2.3.** DHH shall use the findings and recommendations of each report as part of its monitoring process. **13.19.2.4.** The CCN shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the		

<table>
<tr><th>Exhibit/ Attachment</th><th>Document</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td></td><td></td><td>independent auditing firm. These findings are reviewed by DHH and shall become a part of the CCN's EDP manual.

13.19.2.5. Audits shall include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).</td><td></td><td></td></tr>
<tr><td>Exhibit E</td><td>RFP 305 PUR-DHHRFP-CCN-S-MVA</td><td>This row of table in 16.12. Report Submissions Timeframes:
<table><tr><td>CC</td><td>Quality Assurance (QA)

E. Early Warning System Performance Measures</td><td>E. Monthly</td><td>Quality Companion Guide

TBE</td><td>DHH – Coordinated Care Section</td></tr></table></td><td>This row of table in 16.12. Report Submissions Timeframes:
<table><tr><td>CC</td><td>Quality Assurance (QA)

E. Early Warning System Performance Measures</td><td>E. Quarterly</td><td>Quality Companion Guide

TBE</td><td>DHH – Coordinated Care Section</td></tr></table></td><td>Corrects reporting requirement.</td></tr>
<tr><td>Exhibit E</td><td>RFP 305 PUR-DHHRFP-CCN-S-MVA</td><td>19.4 ...Second Sentence

The Contract may be amended at any time as provided in this paragraph. The Contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions provided however that rates must be certified as actuarially sound.
...</td><td>19.4 Amendments
...
The Contract may be amended at any time as provided in this paragraph. The Contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions provided however that shared savings benchmarks are calculated in a manner that is in accordance with generally accepted actuarial practices and principles.</td><td>Clarifies language applicable to PCCM contract.</td></tr>
</table>

Bayou Health – Shared Savings Contract Amendment Attachment A-3

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			...	
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**19.17.1.2.** Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.	**19.17.1.2.** Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable state and federal laws regarding employment of personnel.	To clarify that requirement is applicable to all state and federal laws.
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**Table of Monetary Penalties** **Ad Hoc Reports -** As required by this Contract or upon request by DHH and mutually agreed upon by the CCN. Two thousand dollars ($2,000.00) per calendar day for each business day that a report is late or incorrect	**Table of Monetary Penalties** **Ad Hoc Reports -** As required by this Contract or upon request by DHH and mutually agreed upon by the CCN. Two thousand dollars ($2,000.00) per calendar day that a report is late or incorrect	Correction
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**(Glossary Item)** **Actuarially Sound PMPM rates** - PMPM rates that (1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the contract; and (3) have been certified, as meeting the requirements of this definition, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.	**Delete in its entirety**	Deletes language not applicable to PCCM contract.

Bayou Health – Shared Savings Contract Amendment Attachment A-3

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit E	RFP 305 PUR-DHHRFP-CCN-S-MVA	**N/A**	**(Glossary Item)** **Enhanced Primary Care Management PMPM Fee** - Fee paid on a per member per month basis to provide enhanced primary care case management services.	To add definition.
Exhibit E, Appendix F	RFP 305 PUR-DHHRFP-CCN-S-MVA	Mercer Letter dated "August 22, 2012" and entitled "BAYOU HEALTH – Shared Savings Model Benchmark Development for Contract Period August 1 through December 31, 2012."	**Revise Appendix F to add the following:** Mercer Letter dated "April 30, 2013" and entitled "BAYOU HEALTH – Shared Savings Model Benchmark Development for Contract Period January 1 through January 31, 2013." (See attached.)	To update benchmarks.
Exhibit E, Appendix F	RFP 305 PUR-DHHRFP-CCN-S-MVA	Mercer Letter dated "August 22, 2012" and entitled "BAYOU HEALTH – Shared Savings Model Benchmark Development for Contract Period August 1 through December 31, 2012."	**Revise Appendix F to add the following:** Mercer Letter dated "June 20, 2013" and entitled "BAYOU HEALTH – Shared Savings Model Benchmark Development for Contract Period February 1 through June 30, 2013." (See attached.)	To update benchmarks.
Exhibit E, Appendix H	RFP 305 PUR-DHHRFP-CCN-S-MVA	**Appendix H Shared-Savings Administrative Measures**	Replace with new version of **Appendix H Shared-Savings Administrative Measures.** (See attached.)	To match requirements in chart with reporting requirements.

Shared Savings Appendix H – Performance Measures

Louisiana Administrative Performance Measurement Set

Measure	Minimum Performance Standard
Percent of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact.	≥95%
Percent of Expedited Service Authorization requests processed within 72 hours.	100%
Percent of Standard Pre-Certification requests processed within two days.	100%
Percent of calls to Health Plan's Member Services answered by a live person or directed to an automated call pickup system with IVR options within 30 seconds.	≥90%
Average hold time for calls to Members Services.	≤ 3.0 minutes
Percent of calls to Member Services that are abandoned (Callers who call then hang up before a representative answers.)	≤ 5%
Percent of calls to Health Plan's Provider Services answered by a live person or directed to an automated call pickup system with IVR options within 30 seconds.	≥90%
Average hold time for calls to Provider Services	≤ 3.0 minutes
Percent of calls to Provider Services that are abandoned (Callers who call then hang up before a representative answers.)	≤ 5%
Percent of Member grievances received by the Health Plan and resolved within 30 days.	100%
Percent of Member Requests for State Fair Hearings received during the previous 12 months that are reversed.	>90%
Percent of all Clean Claims that are pre-processed and submitted to the Fiscal Intermediary (FI) within no more than four (4) business days.	≥99%
Denied claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%

Louisiana Performance Measurement Set for Adult/Pediatric Networks

Incentive Based Measures

ACCESS AND AVAILABILITY OF CARE	EFFECTIVENESS OF CARE		USE OF SERVICES
$$ Adults' Access to Preventive/ Ambulatory Health Services ** *HEDIS*	$$ Comprehensive Diabetes Care HgbA1C ***HEDIS*	$$ Chlamydia Screening in Women ***HEDIS/CHIPRA*	$$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life ***HEDIS/CHIPRA*
			$$ Adolescent Well-Care Visits ***HEDIS/CHIPRA*

Revised 12/10/2013

Louisiana Performance Measurement Set for Adult/Pediatric Networks

(Continued)

Level I Measures

ACCESS AND AVAILABILITY OF CARE	EFFECTIVENESS OF CARE		PREVENTION QUALITY INDICATORS	USE OF SERVICES
Children and Adolescents Access to PCP ** *HEDIS/CHIPRA*	Childhood Immunization Status ***HEDIS/CHIPRA*	Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents ***HEDIS/CHIPRA*	Adult Asthma Admission Rate ***AHRQ*	Well-Child Visits in the First 15 Months of Life ***HEDIS/CHIPRA*
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) ***HEDIS/CHIPRA*	Immunizations for Adolescents ***HEDIS/CHIPRA*	Use of Medication for people with Asthma ***HEDIS/CHIPRA*	CHF Admission Rate ***AHRQ*	Ambulatory Care (ER Utilization) ***HEDIS*
	Cholesterol Management for Patients with cardiovascular conditions ***HEDIS*	Comprehensive Diabetes Care ***HEDIS*	Uncontrolled Diabetes Admission Rate ***AHRQ*	
	Cervical CA Screening ***HEDIS*	Breast CA Screening ***HEDIS/CHIPRA*	Plan All-Cause Readmissions ** *HEDIS-Adapted for Medicaid*	
	EPSDT Screening Rate ***CMS 416*			

Louisiana Performance Measurement Set for Adult/Pediatric Networks

(Continued)

Level II Measures

Effectiveness of Care		Use of Services	Satisfaction and Outcomes
Follow-Up Care for Children Prescribed ADHD Medication ***HEDIS/CHIPRA*	Cesarean Rate for Low-Risk First Birth Women ***CHIPRA*	Emergency Utilization-Avg # of ED visits per member per reporting period ***CHIPRA*	CAHPS Health Plan Survey 4.0, Adult Version ***HEDIS*
Otitis Media Effusion ***CHIPRA*	Appropriate Testing for Children With Pharyngitis ***HEDIS/CHIPRA*	Annual # of asthma patients (1yr old) with 1 asthma related ER visit ***CHIPRA*	CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions ***HEDIS/CHIPRA*
Controlling High Blood Pressure ***HEDIS*	% of Pregnant Women who are screened for tobacco usage and secondhand smoke exposure and are offered an appropriate and individualized intervention *** State*	Frequency of Ongoing Prenatal care ***HEDIS/CHIPRA*	Provider Satisfaction ***State*
Pediatric Central-Line Associated Bloodstream Infections ***CHIPRA*	Total number of eligible women who receive 17-OH progesterone during pregnancy, and % of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients *** State*		
Percent of live births weighing less than 2,500 grams ***CHIPRA*			