Office of State Procurement
Contract Certification of Approval

This certificate serves as a confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

Reference Number: 2000683511

Amendment Number: 2

Vendor: LOUISIANA HEALTHCARE CONNECTIONS INC

Description: Managed Care Organizations 3.0

Approved By: PAMELA RICE

Approval Date: 10/05/2023 11:34:39

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Medical Vendor Administration

(Regional/ Program/ Facility) Bureau of Health Services Financing

AND

Louisiana Healthcare Connections, Inc.

Contractor Name

Amendment #: 2
LAGOV#: 2000683511
LDH #:
Original Contract Amount $10,807,338,057.00
Original Contract Begin Date 01-01-2023
Original Contract End Date 12-31-2025
RFP Number: 3000017417

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $10,807,338,057.00 Current Contract Term: 01/01/23-12/31/25

Attachment A - Model Contract
Attachment B - MCO Covered Services
~~Attachment C - In Lieu of Services~~
Attachment E - APM Reporting Template
Attachment F - Provider Network Standards
Attachment G - Table of Monetary Penalties
Attachment H - Quality Performance Measures

DS JMS 9/22/2023
DS KLS 9/28/2023

Change Contract To: If Changed, Maximum Amount: $10,807,338,057.00 If Changed, Contract Term: N/A

Amd 2 Attachment A2 - Changes to Attachment A - Model Contract
Amd 2 Attachment B2 - Changes to Attachment B - MCO Covered Services
~~Amd 2 Attachment C2 - Changes to Attachment C - In Lieu of Services~~
Amd 2 Attachment E - APM Reporting Template
Amd 2 Attachment F2 - Changes to Attachment F - Provider Network Standards
Amd 2 Attachment G2 - Changes to Attachment G - Table of Monetary Penalties
Amd 2 Attachment H2 - Changes to Attachment H - Quality Performance Measures
Amd 2 Attachment K - Equity, Diversity, & Inclusion Statement

DS JMS 9/22/2023
DS KLS 9/28/2023

Justifications For Amendment:

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP.

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

This Amendment Becomes Effective: 01-01-2023

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

Louisiana Healthcare Connections, Inc.

DocuSigned by: Joseph M. Sullivan
AA305A3877394C7...

CONTRACTOR SIGNATURE — DATE 6/23/2023

PRINT NAME: Joseph M. Sullivan

CONTRACTOR TITLE: Chief Executive Officer

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

DocuSigned by: Tara A. LeBlanc
338F7ABF393C405...

SIGNATURE — DATE 6/28/2023

NAME: Tara A. LeBlanc

TITLE: Medicaid Executive Director

OFFICE: Louisiana Department of Health

DocuSigned by: Kimberly Sullivan
6F18D2F97367420...

DATE 9/28/2023

NAME

MCO Amendment 2

Attachment A2 – Changes to Attachment A, *Model Contract*

Item	Change From	Change To	Justification
1	**LIST OF CONTRACT ATTACHMENTS** … **Attachment E:** APM Strategic Plan Requirements and Reporting Template	**LIST OF CONTRACT ATTACHMENTS** … **Attachment E:** APM ~~Strategic Plan Requirements and~~ Reporting Template	The name of this attachment has been changed to more accurately reflect its content.
2	**Glossary** … **Adjudicate** – To deny or pay a Clean Claim.	**Glossary** … **Adjudicate** – To deny or pay a ~~Clean~~ Claim.	This revision expands the scope of the term to include any Claim and resolves conflicts with other provisions of the Contract.
3	**Glossary** … **[new terms]**	**Glossary** … **Alternative Payment Methodology** – A method of reimbursing a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) outside of the Prospective Payment System (PPS). The methodology must be agreed to by the State and the FQHC or RHC, result in a payment to the FQHC or RHC that is at least equal to the amount to which it is entitled under the PPS, and be described in the State Plan. **Alternative Payment Model (APM)** – A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. … **Prospective Payment System (PPS)** – A method of payment in which the Medicaid payment is made based on a predetermined, fixed amount.	This revision provides definitions to differentiate between similar payment-related terms.
4	**Glossary** …	Glossary …	This revision clarifies how time is to be computed.

Item	Change From	Change To	Justification
	Business Day –Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays. **…** **Calendar Days** – All seven (7) days of the week. Unless otherwise specified, the term "day" in the Contract refers to Calendar Days.	**Business Day** – Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays. In computing a period of time prescribed in Business Days, the date of the triggering act or event is not to be included. The last day of the period is to be included, unless it is a Saturday, a Sunday, or a State-designated holiday, in which event the period shall run until the end of the next day that falls on a Business Day. … **Calendar Days** – All seven (7) days of the week. Unless otherwise specified, the term "day" in the Contract refers to Calendar Days. In computing a period of time prescribed in Calendar Days, the date of the triggering act or event is not to be included, and the last day of the period is to be included.	
5	**Glossary** **…** **[new terms]**	**Glossary** **…** **Rural Area** – Any area outside an urban area. … **Urban Area** – A Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget and applied to Census Bureau data. The most recent delineation files and maps are located at https://www.census.gov.	This revision defines urban vs. rural areas to align with the Medicare program definition (42 CFR §412.62).
6	**Glossary** **…** **[new term]**	**Glossary** **…** **Experimental Procedure/Service** – A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be limited or inconclusive. The term applies only to the determination of eligibility for coverage or payment.	This revision adds the definition for "Experimental Procedure/Service" which is referenced in the Contract.

Item	Change From	Change To	Justification
7	**Acronyms** … **[new term]**	**Acronyms** … **ABA –** Applied Behavior Analysis	This revision adds an acronym that is referenced in this amendment.
8	2.2.2.2 Substitution of Personnel 2.2.2.2.1 The Contractor's personnel assigned to the Contract shall not be replaced without the prior written consent of the State. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to a project outside the Contract, outside of the Contractor's reasonable control, as the case may be, the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in completing tasks. The Contractor will make every reasonable attempt to assign the personnel listed in its proposal.	2.2.2.2 Substitution of Personnel 2.2.2.2.1 The Contractor's key personnel assigned to the Contract shall not be replaced without the prior written consent of the State. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to a project outside the Contract, outside of the Contractor's reasonable control, as the case may be, the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in completing tasks. The Contractor will make every reasonable attempt to assign the personnel listed in its proposal.	This revision reduces administrative burden by clarifying that only the substitution of key personnel requires prior written approval by LDH.
9	2.2.3.12.3.2 If the Contractor is a New Entrant, the Contractor shall have its pharmacy benefits carved into FFS. During this period, the Contractor will not be responsible for processing POS pharmacy Claims or Prior Authorizations for POS pharmacy Claims, but shall provide any required referrals and coordination for pharmacy services.	2.2.3.12.3.2 If the Contractor is a New Entrant, the Contractor shall have its pharmacy benefits carved into FFS. During this period, the following provisions apply: • The Contractor will not be responsible for processing POS pharmacy Claims or Prior Authorizations for POS pharmacy Claims, but shall provide any required referrals and coordination for pharmacy services.; and • The Contractor shall cover physician administered drugs listed on the Medicare Part B Drugs List as medical/professional outpatient Claims. LDH will supply the Contractor with a list each quarter identifying which physician administered drugs must be covered as medical/professional outpatient Claims. The list will also identify codes the Contractor must cover as a medical/professional benefit that could also be payable through FFS as a pharmacy benefit,	This revision is to clarify pharmacy benefits for the New Entrant, which has its pharmacy benefits carved into FFS until the Single PBM contract is operational.

Item	Change From	Change To	Justification
		depending upon how the Provider submits the Claim. If the drug could be covered as either a pharmacy or medical/professional benefit, the Claim shall be reimbursed as submitted (Provider choice of Claim type) and without site of care steerage. The Contractor shall not steer the Provider to submit such Claims to FFS and shall not provide any provider education that would result in utilization moving from the medical/professional benefit to the pharmacy benefit. The Contractor shall, at a minimum, set reimbursement for physician administered drugs using the current FFS reimbursement methodology in the State Plan. The Contractor shall be responsible for coverage of all drugs included in any high cost or gene therapy risk pool. In the event that the Contractor covers a risk pool drug, LDH or its Fiscal Intermediary will accept the Encounter through a manual process. The Contractor may apply edits for physician administered drugs that align with the manufacturer's package insert and FDA approved indications, but may not apply any edit that would indicate a drug is covered under the FFS pharmacy benefit.	
10	2.2.7.3 The Contractor shall require that all providers and all Subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a Material Subcontractor, the Contractor shall require that the Material Subcontractor complies with provisions of this Contract relating to mental health parity. The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. The Contractor shall require mental health parity disclosure on provider Enrollment forms as mandated by LDH.	2.2.7.3 The Contractor shall require that ~~all providers and~~ all Subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a Material Subcontractor, the Contractor shall require that the Material Subcontractor complies with provisions of this Contract relating to mental health parity. The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. ~~The Contractor shall require mental health parity disclosure on provider Enrollment forms as mandated by LDH.~~	This revision removes the specified obligation of Providers, as mental health parity is not impacted at the Provider level in such a way that would necessitate a disclosure on a Provider enrollment form.
11	2.3.2 Voluntary MCO Populations	2.3.2 Voluntary MCO Populations	This revision aligns the Contract with existing ABA coverage.

<table>
<tr><th>Item</th><th>Change From</th><th>Change To</th><th>Justification</th></tr>
<tr><td></td><td>The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all SBHS, NEMT services, and NEAT services.

…

2.3.2.2 Voluntary MCO Populations may elect to receive all Medicaid Covered Services through the Managed Care Program at any time, effective the earliest possible month that the administrative action can be taken.

2.3.2.3 Voluntary MCO Populations may return to FFS for all Medicaid Covered Services other than SBHS and NEMT/NEAT services at any time, effective the earliest possible month that the administrative action can be taken.</td><td>The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all Applied Behavior Analysis (ABA), SBHS, NEMT services, and NEAT services.

…

2.3.2.2 Voluntary MCO Populations may elect to receive all Medicaid Covered Services through the Managed Care Program at any time, effective the earliest possible month that the administrative action can be taken.

2.3.2.3 Voluntary MCO Populations may return to FFS for all Medicaid Covered Services other than ABA, SBHS and NEMT/NEAT services at any time, effective the earliest possible month that the administrative action can be taken.

…

2.3.3 Mandatory MCO Populations for ABA, SBHS and NEAT Services Only

The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for ABA, SBHS and NEAT services only, and receive all other Medicaid Covered Services through FFS:

2.3.3.1 Beneficiaries residing in Nursing Facilities (NF); and

2.3.3.2 Beneficiaries under the age of twenty-one (21) residing in ICF/IIDs.

2.3.4 Mandatory MCO Populations for ABA, SBHS and NEMT/NEAT Services Only

The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for ABA, SBHS and NEMT/NEAT services only, and receive all other Medicaid Covered Services through FFS:</td><td></td></tr>
</table>

Item	Change From	Change To	Justification
		2.3.4.1 Beneficiaries who are enrolled in both the Louisiana Medicaid Program and Medicare (Medicaid dual eligible), except those residing in an institution as specified in this section. 2.3.4.2 LaHIPP Beneficiaries except those residing in an institution as specified in this section.	
12	2.7.2.4 The Contractor's HNA shall: … 2.7.2.4.4 Identify individuals for referral to Case Management, with more in-depth assessment to occur as part of the POC; … 2.7.3 Enrollees with Special Health Care Needs (SHCN) 2.7.3.1 The Contractor shall implement mechanisms to provide each Enrollee identified as having SHCN with a comprehensive assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. 2.7.3.2 The Contractor shall complete this comprehensive assessment for at least ninety percent (90%) of those Enrollees that the Contractor is able to contact and are willing to engage within ninety (90) Calendar Days of being identified as having SHCN. 2.7.3.3 The Contractor shall offer Case Management to all Enrollees with SHCN regardless of information gathered through this comprehensive assessment or the HNA.	2.7.2.4 The Contractor's HNA shall: … 2.7.2.4.4 Identify individuals for referral to Case Management~~, with more in-depth assessment to occur as part of the POC~~; … 2.7.3 ~~Enrollees with Special Health Care Needs (SHCN)~~ Case Management Assessment 2.7.3.1 The Contractor shall use Claims data and other available data to identify Enrollees who meet the SHCN criteria on at least a monthly basis. The Contractor shall implement mechanisms to provide each Enrollee identified as having SHCN with a comprehensive Case Management assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. 2.7.3.2 The Contractor shall implement mechanisms to provide other Enrollees referred to Case Management with a Case Management assessment to identify any needs or conditions of the Enrollee that require intervention by the MCO, a course of treatment, or regular care monitoring. 2.7.3.3 The Contractor shall complete ~~this comprehensive~~ the required assessment for at least ninety percent (90%) of those Enrollees that the Contractor is able to contact and are willing to engage within ninety (90)	The revision is to distinguish between the assessments given to Enrollees with SHCN and other Enrollees referred to case management. It also establishes a timeframe for Contractors to identify existing Enrollees who may have a SHCN and to align with current practice.

Item	Change From	Change To	Justification
		Calendar Days of being identified as having SHCN or of being referred to Case Management. 2.7.3.~~3~~4 The Contractor shall offer Case Management to all Enrollees with SHCN regardless of information gathered through this comprehensive assessment or the HNA.	
13	2.7.5.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of identification and shall include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC, with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.2 Case Management (Medium) (Tier 2) Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of identification and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health*	2.7.5.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of the Case Management assessment being completed~~identification~~ and shall include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.2 Case Management (Medium) (Tier 2)	This revision is to clarify that the Plan of Care is to be completed following the completion of the Case Management assessment, and that it is the Contractors' responsibility to coordinate transitions of care for Enrollees enrolled in Case Management.

Item	Change From	Change To	Justification
	section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.3 Case Management (Low) (Tier 1) Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of identification and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC, with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.	Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of the Case Management assessment being completed~~identification~~ and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i) and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.3 Case Management (Low) (Tier 1) Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of the Case Management assessment being completed ~~identification~~ and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate	

Item	Change From	Change To	Justification
		discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.	
14	2.7.5.4 Transitional Case Management The Contractor shall implement procedures to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing.	2.7.5.4 Transitional Case Management The Contractor shall implement procedures to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees not already enrolled in Case Management Tiers 1, 2, or 3 to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing.	This revision is to clarify that Transitional Case Management is for Enrollees not already enrolled in tiered Case Management.
15	2.11.2.1 The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 U.S.C. §1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount LDH would pay for such services through FFS as defined by the Prospective Payment System (PPS) rate in effect on the date of service for each Encounter or an alternative payment methodology approved by LDH in writing.	2.11.2.1 The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 U.S.C. §1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount LDH would pay for such services through FFS as defined by the Prospective Payment System (PPS) rate or the Alternative Payment Methodology rate in effect on the date of service for each Encounter~~ or an alternative payment methodology approved by LDH in writing~~.	This revision aligns the Contract with the Louisiana Administrative Code.

Item	Change From	Change To	Justification
16	2.12.3.4 The Contractor shall not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a Service Authorization determination, for that particular item or service. 2.12.3.4.1 When the provider fails to provide requested medical information, the Contractor may at its discretion, or shall as directed by LDH, impose financial penalties against the provider as appropriate.	2.12.3.4 The Contractor shall not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a Service Authorization determination, for that particular item or service. ~~2.12.3.4.1 When the provider fails to provide requested medical information, the Contractor may at its discretion, or shall as directed by LDH, impose financial penalties against the provider as appropriate.~~	This revision removes the imposition of an unnecessary penalty, as Providers are not reimbursed for services when they fail to provide the requested medical information for Service Authorization determinations.
17	2.12.6.1.1.3 The MCO shall make all determinations for behavioral health crisis response services that require Prior Authorization as expeditiously as the enrollee’s condition requires, but no later than one (1) Calendar Day after obtaining appropriate clinical documentation.	2.12.6.1.1.3 The MCO shall make all determinations for any behavioral health crisis ~~response~~ services that require Prior Authorization as expeditiously as the E~~e~~nrollee’s condition requires, but no later than one (1) Calendar Day after obtaining appropriate clinical documentation.	This revision applies this standard to any behavioral health crisis service, as it is in the best interest of the Enrollee to have a short turnaround time for crisis services.
18	2.13.8.7.1 Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, PCPs, specialists, hospital PCP groups, pharmacies, behavioral health providers, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving Provider list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified. Provider types shall be delineated by parish and zip code;	2.13.8.7.1 Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, PCPs, specialists, hospital PCP groups, pharmacies, behavioral health providers, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving Provider list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified. Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders shall be clearly identified. Provider types shall be delineated by parish and zip code;	This revision is to comply with the requirements of La. R.S. 40:1125.4, as revised by HB 784 of the 2022 Regular Legislative Session, to identify providers who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders, which are searchable by location.
19	2.16.22 Quality Monitoring Reviews	2.16.22 Quality Monitoring Reviews	This revision is to align with MCO Manual.

Item	Change From	Change To	Justification
	The Contractor shall collaborate with the other MCOs to develop and implement a plan for monitoring a statistically significant of specialized behavioral health providers and facilities across service categories, which incorporates onsite reviews and member interviews, on a quarterly basis. The Contractor shall submit the plan to LDH for approval no later than sixty (60) Calendar Days after the Operational Start Date of the Contract and at least sixty (60) Calendar Days prior to any Material Change. The Contractor's monitoring plan, monitoring process, and sampling approach shall comply with the requirements as specified by LDH in the MCO Manual.	The Contractor shall collaborate with the other MCOs to develop and implement a plan for monitoring a ~~statistically significant~~representative sample of specialized behavioral health providers and facilities across ~~service categories~~levels of care, which incorporates onsite reviews and member interviews, on a quarterly basis. The Contractor shall submit the plan to LDH for approval no later than sixty (60) Calendar Days after the Operational Start Date of the Contract and at least sixty (60) Calendar Days prior to any Material Change. The Contractor's monitoring plan, monitoring process, and sampling approach shall comply with the requirements as specified by LDH in the MCO Manual.	
20	2.17.1 Value-Based Payment (VBP) Overview The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in the MCO Manual and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of populations (better health), enhance the experience of care for individuals (better care), effectively manage Louisiana Medicaid Program per capita care costs (lower costs), and be designed to meet or exceed the VBP withhold requirements in this Contract. … 2.17.2 Minimum VBP Threshold and Qualifying VBP Arrangements A portion of the Contractor's annual VBP withhold described in the Financial Incentives for MCO Performance section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract and the MCO Manual. Unless otherwise modified by LDH, the minimum VBP threshold for each Measurement Year is as follows: 2.17.2.1 Calendar Year 2023	2.17.1 Value-Based Payment (VBP) Overview The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in this Contract ~~the MCO Manual~~ and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of populations (better health), enhance the experience of care for individuals (better care), effectively manage Louisiana Medicaid Program per capita care costs (lower costs), and be designed to meet or exceed the VBP withhold requirements in this Contract. … 2.17.2 Minimum VBP Threshold and Qualifying VBP Arrangements A portion of the Contractor's annual VBP withhold described in the Financial Incentives for MCO Performance section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract ~~and the MCO Manual~~. Unless otherwise modified by LDH, the minimum VBP threshold for each Measurement Year is as ~~follows:~~ described in the *Financial Incentives for MCO Performance* section.	This revision aligns this section with the updates being made to the *Financial Incentives for MCO Performance* section of the Contract.

Item	Change From	Change To	Justification
	2.17.2.1.1 Contractual arrangements linked to a VBP model that includes one or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed six (6) million dollars in total provider payments; or 2.17.2.1.2 The Contractor's total potential provider incentive payments exceed twelve (12) million dollars in total provider payments. 2.17.2.1.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, category 3B APM or category 4 APM that is effective no later than December 2023. 2.17.2.1.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures and provide initial data-based assessments to determine the extent to which providers participated in specific VBP models may be performing differently on targeted quality measures than providers not participating in such VBP models. 2.17.2.2 Calendar Year 2024 2.17.2.2.1 Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed seven (7) million dollars in total provider payments; or 2.17.2.2.2 The Contractor's total potential provider incentive payments exceed fourteen (14) million dollars in total provider payments. 2.17.2.2.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, and one new Network Provider	~~2.17.2.1 Calendar Year 2023~~ ~~2.17.2.1.1 Contractual arrangements linked to a VBP model that includes one or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed six (6) million dollars in total provider payments; or~~ ~~2.17.2.1.2 The Contractor's total potential provider incentive payments exceed twelve (12) million dollars in total provider payments.~~ ~~2.17.2.1.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, category 3B APM or category 4 APM that is effective no later than December 2023.~~ ~~2.17.2.1.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures and provide initial data-based assessments to determine the extent to which providers participated in specific VBP models may be performing differently on targeted quality measures than providers not participating in such VBP models.~~ ~~2.17.2.2 Calendar Year 2024~~ ~~2.17.2.2.1 Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed seven (7) million dollars in total provider payments; or~~ ~~2.17.2.2.2 The Contractor's total potential provider incentive payments exceed fourteen (14) million dollars in total provider payments.~~ ~~2.17.2.2.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, and one new Network~~	

LOUISIANA DEPARTMENT OF HEALTH

Item	Change From	Change To	Justification
	Agreement with a category 3B APM or category 4 APM that is effective no later than December 2024. 2.17.2.2.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years. 2.17.2.3 Calendar Year 2025 and Future Calendar Years 2.17.2.3.1 Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total potential provider incentive payments exceed eight (8) million dollars in total provider payments, or 2.17.2.3.2 The Contractor's total potential provider incentive payments exceed sixteen (16) million dollars in total provider payments. 2.17.2.3.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, one new Network Provider Agreement with a category 3B APM, and one new Network Provider Agreement with a category 4 APM that is effective no later than the end of the applicable calendar year. 2.17.2.3.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will	~~Provider Agreement with a category 3B APM or category 4 APM that is effective no later than December 2024.~~ ~~2.17.2.2.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years.~~ ~~2.17.2.3 Calendar Year 2025 and Future Calendar Years~~ ~~2.17.2.3.1 Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total potential provider incentive payments exceed eight (8) million dollars in total provider payments, or~~ ~~2.17.2.3.2 The Contractor's total potential provider incentive payments exceed sixteen (16) million dollars in total provider payments.~~ ~~2.17.2.3.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, one new Network Provider Agreement with a category 3B APM, and one new Network Provider Agreement with a category 4 APM that is effective no later than the end of the applicable calendar year.~~ ~~2.17.2.3.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate~~	

Item	Change From	Change To	Justification
	use the results of this data analysis to improve it VBP models and provider support for calendar year 2026 and future calendar years.	~~how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2026 and future calendar years.~~	
21	2.17.3 Qualifying VBP Arrangements The Contractor may only report a provider payment model as a VBP arrangement if the following conditions are met: 2.17.3.1 The payment model includes a Category 2A foundational payment or Category 2B pay for reporting as one component of a broader payment model that includes Category 2C or 3 APMs for the same provider(s); and/or 2.17.3.2 The payment model falls within Categories 2C, 3 or 4 of the LAN Alternative Payment Model Framework; and 2.17.3.3 The payment model is linked to applicable incentive-based measures from Attachment H, *Quality Performance Measures*. 2.17.3.4 VBP models focused on PCPs must include at least two incentive-based measure from Attachment H, *Quality Performance Measures*. VBP arrangements focused on services other than primary care must utilize at least two applicable measures in Attachment H, *Quality Performance Measures*, and these measures do not need to be identified as incentive-based measures.	2.17.3 Qualifying VBP Arrangements The Contractor may only report a provider payment model as a VBP arrangement if the following conditions are met: 2.17.3.1 The payment model includes a Category 2A foundational payment or Category 2B pay for reporting as one component of a broader payment model that includes Category 2C, ~~or~~ 3, or 4 APMs for the same provider(s); and/or 2.17.3.2 The payment model falls within Categories 2C, 3 or 4 of the HCP-LAN ~~Alternative Payment Model~~ APM Framework; and 2.17.3.3 The payment model is linked to at least two (2) applicable ~~incentive-based~~ measures from Attachment H, *Quality Performance Measures*. 2.17.3.4 VBP models focused on PCPs must include at least two incentive-based measure from Attachment H, *Quality Performance Measures*. VBP arrangements focused on services other than primary care must utilize at least two applicable measures in Attachment H, *Quality Performance Measures*, and these measures do not need to be identified as incentive-based measures. If there are not at least two applicable measures in Attachment H, *Quality Performance Measures*, the Contractor must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its submission of Attachment E, *APM Reporting Template*.	This revision is to align the Contract with the MCO 3.0 withhold strategy: 1. The performance Measurement Year will be a calendar year basis. 2. LDH will suspend the withholds for the first six months of the Contract (1/1/2023 - 6/30/2023) to allow the New Entrant to gain experience and mitigate reporting and Enrollment concerns of the MCOs. 3. For rating period 7/1/2023 – 6/30/2024 (SFY 24) and subsequent fiscal years, LDH will begin the Quality, VBP, and Health Equity withholds. The performance measurement period will remain on a calendar year basis. The reporting and associated deliverables specified in the Contract will also be on a calendar year basis, but will take the rating period and withholds into account.

LOUISIANA DEPARTMENT OF HEALTH

Item	Change From	Change To	Justification
22	2.17.4 Physician Incentive Plans 2.17.4.1 In accordance with 42 CFR §422.208 and §422.210, the Contractor may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. 2.17.4.2 The Contractor's Physician Incentive Plans shall be in compliance with 42 CFR §438.3(i), §422.208, and §422.210 and the MCO Manual.	2.17.4 Physician Incentive Plans 2.17.4.1 In accordance with 42 CFR §422.208 and §422.210, the Contractor may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. 2.17.4.2 The Contractor's Physician Incentive Plans shall be in compliance with 42 CFR §438.3(i), §422.208, and §422.210 and ~~the MCO Manual~~ this Contract.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
23	2.17.6 Preferred VBP Arrangements 2.17.6.1 Preferred VBP arrangements are priorities for LDH based on the potential to improve health care and cost-efficiency. The Contractor shall indicate in its VBP Strategic Plan and subsequent updates to the Plan which of the following preferred VBP arrangements it intends to implement and when it will implement such arrangements during the Contract period: 2.17.6.1.1 Maternity-focused VBP arrangements; 2.17.6.1.2 Models supporting physical and behavioral health integration; 2.17.6.1.3 Patient-centered medical home models that are part of a broader payment model that includes Category 2C or 3 APMs and which support the integration of behavioral health, SDOH, and/or populations with special health care needs;	2.17.6 Preferred VBP Arrangements 2.17.6.1 Preferred VBP arrangements are priorities for LDH based on the potential to improve health care and cost-efficiency. The Contractor shall indicate in its VBP Strategic Plan and subsequent updates to the Plan which of the following preferred VBP arrangements it intends to implement and when it will implement such arrangements during the Contract period: 2.17.6.1.1 Maternity-focused VBP arrangements; 2.17.6.1.2 Models supporting physical and behavioral health integration; 2.17.6.1.3 Patient-centered medical home models that are part of a broader payment model that includes Category 2C, ~~or~~ 3, or 4 APMs and which support the integration of behavioral health, SDOH, and/or populations with special health care needs;	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
24	2.18.6 Claims Reprocessing If the Contractor or LDH or its Subcontractors or Providers discover errors made by the Contractor when a Claim was Adjudicated, the Contractor shall make corrections and reprocess the Claim within fifteen (15) Calendar Days of discovery or notification, or if circumstances exist that prevent the Contractor from meeting this time frame, by a specified date subject to LDH written	2.18.6 Claims Reprocessing If the Contractor or LDH or its Subcontractors or Providers discover errors made by the Contractor when a Claim was Adjudicated, the Contractor shall make corrections and reprocess the Claim within fifteen (15) Calendar Days of discovery or notification, or if circumstances exist that prevent the Contractor from meeting this time frame, by a specified date subject to LDH written	This revision is to clarify that the interest is to be calculated from the original processing deadline and that the 15 Calendar Day deadline applies only to the deadline for paying (and not calculating) the interest.

Item	Change From	Change To	Justification
	approval. The Contractor shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean Claim remains unpaid beyond either the fifteen (15) Calendar Day Claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later. The Contractor shall automatically recycle all impacted Claims for all providers and shall not require the provider to resubmit the impacted Claims.	approval. The Contractor shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable C~~c~~lean Claim remains unpaid beyond the thirty (30) Calendar Day Clean Claims processing deadline. Interest owed to the provider shall be paid on the same date that the Claim is Adjudicated and by either the fifteen (15) Calendar Day Claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later. The Contractor shall automatically recycle all impacted Claims for all providers and shall not require the provider to resubmit the impacted Claims.	
25	2.20.2.4 Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, Contractor employees and the public on the Contractor's website required under this Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted. The Contractor shall submit to LDH or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) Calendar Days in advance of making them effective. LDH, at its sole discretion, may require that the Contractor modify its compliance plan.	2.20.2.4 Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, Contractor employees and the public on the Contractor's website required under this Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted. 2.20.2.5 The Contractor shall submit to LDH or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) Calendar Days in advance of making them effective. LDH, at its sole discretion, may require that the Contractor modify its compliance plan.	This revision clarifies the language as two separate requirements.
26	2.20.6.10 LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network via "complex" or "automated" review. LDH may recover from the Contractor, via a deduction from the Contractor's Capitation Payment, all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not:	2.20.6.10 LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network via "complex" or "automated" review for a five (5) year period from the date of service of a Claim. LDH may recover from the Contractor, via a deduction from the Contractor's Capitation Payment, all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not:	This revision is to align the contract with the MCO lookback period provided in the "General Information and Administration Provider Manual" chapter of the **Medicaid Services Manual**.

Item	Change From	Change To	Justification
27	[new provision]	4.4.1.7 LDH will not withhold funds from the Contractor for MCO performance until July 2023.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
28	4.4.2 Earning the Quality and Health Outcomes Withhold 4.4.2.1 For each Measurement Year, the Contractor may earn back the quality withhold for the Measurement Year based on its performance relative to incentive-based measures and targets as established by LDH.	4.4.2 Earning the Quality and Health Outcomes Withhold 4.4.2.1 For each Measurement Year, the Contractor may earn back the applicable quality withhold ~~for the Measurement Year~~ based on its performance relative to incentive-based measures and targets as established by LDH for that Measurement Year.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
29	4.4.3 Earning the VBP Withhold For each Contract year, the Contractor may earn back the VBP withhold based on meeting the VBP reporting and performance requirements and targets as established by this Contract and as described in the *Value-Based Payment* section. 4.4.3.1 The Contractor may earn back the VBP withhold amount for submitting VBP deliverables and meeting VBP targets specified by LDH as demonstrated within the Contractor's reported use of VBP consistent with payment models that include categories 2A, 2C, 3 and/or 4 of the Learning Action Network (LAN) Alternative Payment Models (APM) Framework and aligned with the incentive-based measures specified in Attachment H, *Quality Performance Measures*. 4.4.3.2 To earn back the full VBP withhold amount related to performance, the Contractor shall: 4.4.3.2.1 Annually, on or before August 30, submit to LDH a written VBP mid-year report describing the implementation and status of its VBP use and evidence that each VBP model includes financial incentives for providers linked to at least two of the Contractor's incentive-based measures in Attachment H, *Quality Performance Measures*, or other Attachment H, *Quality Performance Measures*, measures for non-primary care VBP arrangements. As part of its VBP agreements, the Contractor shall not hold providers accountable for meeting a	4.4.3 Earning the VBP Withhold For each ~~Contract~~ Measurement ~~y~~Year, the Contractor may earn back the applicable VBP withhold based on meeting the VBP reporting and performance requirements and targets for that Measurement Year as established by this Contract including ~~and~~ as described in the *Value-Based Payment* section. 4.4.3.1 The Contractor may earn back the VBP withhold amount for submitting VBP deliverables and meeting VBP targets specified by LDH as demonstrated within the Contractor's reported use of VBP consistent with the HCP-LAN APM Framework and VBP requirements of this Contract~~payment models that include categories 2A, 2C, 3 and/or 4 of the Learning Action Network (LAN) Alternative Payment Models (APM) Framework and aligned with the incentive-based measures specified in Attachment H, *Quality Performance Measures*~~. 4.4.3.2 The VBP Measurement Year is the calendar year. To earn back the full VBP withhold amount related to performance for each Measurement Year, the Contractor shall: 4.4.3.2.1 Annually, on or before August 30, submit to LDH a written VBP mid-year report describing the implementation and status of its VBP use and evidence that each VBP model includes financial incentives for providers linked to at least two of the Contractor's incentive-based measures in Attachment H,	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.

Item	Change From	Change To	Justification
	higher target for the incentive-based measure than the target to which LDH holds the Contractor for the same measure unless the provider is already performing above the benchmark set by LDH for Contractor performance on the incentive-based measure. 4.4.3.2.1.1 If the Contractor implements a VBP arrangement with primary care providers, the VBP arrangement must include at least two incentive-based measures from Attachment H, *Quality Performance Measures*, one of which must be an incentive-based measure, in order for the MCO to report the primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template reporting*. 4.4.3.2.1.2 If the Contractor implements a VBP arrangement for services other than primary care, the Contractor must include at least any two (2) applicable measures from Attachment H, *Quality Performance Measures*, in the VBP arrangement, in order for the Contractor to count the non-primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template* reporting. If there are not at least two (2) applicable measures in Attachment H, *Quality Performance Measures*, the Contractor must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its Attachment E, *APM Strategic Plan Requirements and Reporting Template*, reporting. 4.4.3.2.1.3 To increase simplification and consistency in provider performance data reporting, the Contractor must use performance measure specifications in its VBP arrangements that align with the LDH specifications for measures in Attachment H, *Quality Performance Measures* when the Contractor is utilizing any measure included in Attachment H, *Quality Performance Measures*. 4.4.3.2.1.4 If LDH determines that the mid-year report demonstrates an increase in VBP use by the Contractor, alignment with performance measures in Attachment H, *Quality Performance Measures*, and is consistent with LDH	*Quality Performance Measures*, or other Attachment H, *Quality Performance Measures*, measures for non-primary care VBP arrangements. ~~As part of its VBP agreements, the Contractor shall not hold providers accountable for meeting a higher target for the incentive-based measure than the target to which LDH holds the Contractor for the same measure unless the provider is already performing above the benchmark set by LDH for Contractor performance on the incentive-based measure.~~ ~~4.4.3.2.1.1 If the Contractor implements a VBP arrangement with primary care providers, the VBP arrangement must include at least two incentive-based measures from Attachment H, *Quality Performance Measures*, one of which must be an incentive-based measure, in order for the MCO to report the primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template* reporting.~~ ~~4.4.3.2.1.2 If the Contractor implements a VBP arrangement for services other than primary care, the Contractor must include at least any two (2) applicable measures from Attachment H, *Quality Performance Measures*, in the VBP arrangement, in order for the Contractor to count the non-primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template* reporting. If there are not at least two (2) applicable measures in Attachment H, *Quality Performance Measures*, the Contractor must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its Attachment E, *APM Strategic Plan Requirements and Reporting Template*, reporting.~~ 4.4.3.2.1.1~~3~~ To increase simplification and consistency in provider performance data reporting, the Contractor must use performance measure specifications in its VBP arrangements that align with the LDH specifications for measures in Attachment H, *Quality Performance Measures* when the Contractor is utilizing any measure included in Attachment H, *Quality Performance Measures*.	

Item	Change From	Change To	Justification
	specifications, LDH will refund any VBP-related amounts withheld for the calendar year through June of that year. The VBP withhold amounts shall not be refunded for late submissions. 4.4.3.2.2 Annually, on or before March 15 submit to LDH a report on its VBP use for the prior calendar year as specified in Attachment E, *APM Strategic Plan Requirements and Reporting Template*, and a VBP year-end report. In reporting its VBP use and provider payments, the Contractor shall use a "date of payment" approach to complete Attachment E, *APM Strategic Plan Requirements and Reporting Template*. If the Contractor did not meet the VBP targets identified in 4.4.3.2.4, 4.4.3.2.5, 4.4.3.2.6 below, if applicable, the Contractor shall describe why the VBP targets were not met. 4.4.3.2.3 If LDH determines that the Contractor's use of recognized VBP models meets the following VBP targets in each specific calendar year as described below, LDH will refund any remaining amounts withheld for VBP. Recognized VBP arrangements exclude LAN APM category 2B (pay for reporting) models and VBP models that do not have a link to at least two of the applicable Contractor performance measures in Attachment H, *Quality Performance Measures*, as defined in 4.4.3.2.1 above. 4.4.3.2.4 Calendar Year 2023 4.4.3.2.4.1 Contractual arrangements linked to a VBP model that includes one (1) or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed six (6) million dollars in total provider payments, OR the Contractor's total potential provider incentive payments exceed twelve (12) million dollars in total provider payments. … 4.4.3.2.5 Calendar Year 2024	4.4.3.2.1.24 If LDH determines that the mid-year report demonstrates ~~an increase in~~ VBP use by the Contractor that~~, alignment with~~ includes applicable performance measures in Attachment H, *Quality Performance Measures*, and is consistent with LDH specifications in this Contract, LDH will refund ~~any~~a portion of the VBP-related amounts withheld for the calendar year prior to the end of the calendar year~~through June of that year~~. The VBP withhold amounts shall not be refunded for late submissions. 4.4.3.2.2 Annually, on or before March 15, submit to LDH a report on its VBP use for the prior calendar year as specified in Attachment E, *APM ~~Strategic Plan Requirements and~~ Reporting Template*, and a VBP year-end report. In reporting its VBP use and provider payments, the Contractor shall use a "date of payment" approach to Attachment E, *APM ~~Strategic Plan Requirements and~~ Reporting Template*. If the Contractor did not meet the VBP targets identified in 4.4.3.2.4~~, 4.4.3.2.5, 4.4.3.2.6 below~~, if applicable, the Contractor shall describe why the VBP targets were not met. 4.4.3.2.3 If LDH determines that the Contractor's use of recognized VBP models meets the following VBP targets in each specific calendar year as described below, LDH will refund any remaining amounts withheld for VBP. Recognized VBP arrangements exclude certain LAN APM category 2A and 2B ~~(pay for reporting)~~ models and VBP models that do not have a link to at least two of the applicable Contractor performance measures in Attachment H, *Quality Performance Measures*, as defined in the *Value-Based Payment* sections of this Contract ~~4.4.3.2.1 above~~. 4.4.3.2.4 Unless otherwise modified by LDH, the minimum VBP thresholds for each Measurement Year are as follows: 4.4.3.2.4.1 Calendar Year 2023 • ~~4.4.3.2.4.1~~Contractual arrangements linked to a VBP model that includes one (1) or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in	

Item	Change From	Change To	Justification
	4.4.3.2.5.1 Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed seven (7) million dollars in total provider payments, or the Contractor's total potential provider incentive payments exceed fourteen (14) million dollars in total provider payments. … 4.4.3.2.5.4 The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years. 4.4.3.2.6 Calendar Year 2025 and Future Calendar Years 4.4.3.2.6.1 Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total potential provider incentive payments exceed eight (8) million dollars in total provider payments, or the Contractor's total potential provider incentive payments exceed sixteen (16) million dollars in total provider payments. … 4.4.3.2.6.4 The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years. 4.4.3.2.7 LDH may refund to the Contractor some of the remaining amounts withheld for VBP during the calendar year if the Contractor partially	the Measurement Year and the Contractor's total ~~potential~~ provider incentive payments related to this Measurement Year exceed six (6) million ~~dollars in total provider payments~~, OR the Contractor's total ~~potential~~ provider incentive payments exceed twelve (12) million dollars ~~in total provider payments~~. *[subsequent provisions renumbered]* 4.4.3.2.4.2~~5~~ Calendar Year 2024 • ~~4.4.3.2.5.1~~ Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total ~~potential~~ provider incentive payments related to this Measurement Year exceed seven (7) million dollars ~~in total provider payments~~, or the Contractor's total ~~potential~~ provider incentive payments exceed fourteen (14) million dollars ~~in total provider payments~~. *[subsequent provisions renumbered]* • ~~4.4.3.2.5.4~~ The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for ~~calendar year 2025 and~~ future calendar years. 4.4.3.2.4.3~~6~~ Calendar Year 2025 and Future Calendar Years • ~~4.4.3.2.6.1~~ Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total ~~potential~~ provider incentive payments exceed eight (8) million dollars ~~in total provider payments~~, or the Contractor's total	

Item	Change From	Change To	Justification
	meets the VBP targets in 4.4.3.2.4, 4.4.3.2.5, 4.4.3.2.6, if applicable and describes to LDH's satisfaction why the Contractor did not fully meet the VBP targets. 4.4.3.2.8 LDH shall retain the amount of the VBP withhold not earned back by the Contractor.	~~potential~~ provider incentive payments exceed sixteen (16) million dollars ~~in total provider payments~~. *[subsequent provisions renumbered]* • ~~4.4.3.2.6.4~~ The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve ~~it~~ VBP models and provider support for ~~calendar year 2025 and~~ future calendar years. • ~~4.4.3.2.7~~ LDH may refund to the Contractor some of the remaining amounts withheld for VBP ~~during the calendar year~~ if the Contractor partially meets the applicable VBP targets in 4.4.3.2.4~~, 4.4.3.2.5, 4.4.3.2.6, if applicable~~ and describes to LDH's satisfaction why the Contractor did not fully meet the VBP targets. • ~~4.4.3.2.8~~ LDH shall retain the amount of the VBP withhold not earned back by the Contractor.	
30	4.4.4 Earning Health Equity Withhold For each Contract year, the Contractor may earn back the Health Equity withhold based on its reporting and performance relative to health equity requirements as established by this Contract and LDH as described in the *Health Equity* section. … 4.4.4.1.2.2 The annual report submitted to LDH by December 31 must demonstrate progress on meeting Health Equity milestones and goals as outlined in Section 2.7 of the Contract.	4.4.4 Earning Health Equity Withhold For each ~~Contract~~ Measurement Y~~y~~ear, the Contractor may earn back the applicable Health Equity withhold based on its reporting and performance relative to H~~h~~ealth E~~e~~quity requirements for that Measurement Year as established by this Contract and LDH as described in the *Health Equity* section. … 4.4.4.1.2.2 The annual report submitted to LDH by December 31 must demonstrate progress on meeting Health Equity milestones and goals as outlined in Section 2.6~~7~~ of the Contract.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #21 and corrects a section reference.

Item	Change From	Change To	Justification
31	4.4.5.4 The Contractor shall distribute provider-specific profile reports to providers using the common format and frequency effective the first quarter of calendar year X, as approved by LDH in writing.	4.4.5.4 The Contractor shall distribute provider-specific profile reports to providers using the common format and frequency effective the first quarter of calendar year 2023~~X~~, as approved by LDH in writing.	This revision corrects a previous omission.
32	4.14.3.5 The Contractor shall submit an annual report of all health insurance collections for Enrollees plus copies of any Form 1099s received from health insurance companies for that period of time.	4.14.3.5 The Contractor shall submit an annual report of all health insurance collections~~ for Enrollees plus copies of any Form 1099s received from health insurance companies for that period of time~~.	This revision is to align with current practice. The reporting of this information is associated with the 022 Third Party Liability Report.
33	4.19 Reimbursement for COVID-19 Vaccine Incentive Distribution 4.19.1 LDH will pay the Contractor, on a monthly, non-risk basis, for the costs of COVID-19 vaccine incentive distribution to its Enrollees in accordance with the Louisiana Medicaid COVID-19 “Shot Per 100,000” COVID vaccine administration member incentive program. The Enrollee incentive amount paid shall be determined by LDH. The Contractor is entitled to a nine percent (9%) administration fee in addition to the amount of the incentive distributed through the “Shot Per 100,000” program. All payments associated with this program shall be paid on an administrative cost basis, separately from the monthly Capitation Payments. LDH will identify eligible Enrollees by leveraging existing data extraction processes and weekly COVID vaccine administration reports and by utilizing the Contractor’s internal resources. The Contractor will use various data sources and internal databases to confirm Enrollee eligibility for the incentive. 4.19.2 The Contractor shall submit all data related to the COVID-19 vaccine incentive in accordance with the terms and conditions of this Contract and the reporting template developed for the “Shot Per 100,000” program. 4.19.3 The Contractor shall report expenditures for COVID-19 vaccine incentives on a date of service basis.	4.19 Reimbursement for COVID-19 Vaccine Incentive Distribution 4.19.1 LDH will pay the Contractor, on a monthly, non-risk basis, for the costs of COVID-19 vaccine incentive distribution to its Enrollees in accordance with the Louisiana Medicaid COVID-19 “Shot Per 100,000” COVID vaccine administration member incentive program. The Enrollee incentive amount paid shall be determined by LDH. The Contractor is entitled to a nine percent (9%) administration fee in addition to the amount of the incentive distributed through the “Shot Per 100,000” program. All payments associated with this program shall be paid on an administrative cost basis, separately from the monthly Capitation Payments. ~~LDH~~ The Contractor will identify eligible Enrollees by leveraging LDH’s existing data extraction processes and weekly COVID vaccine administration reports and by utilizing the Contractor’s internal resources. The Contractor will use various data sources and internal databases to confirm Enrollee eligibility for the incentive. 4.19.2 The Contractor shall submit all data related to the COVID-19 vaccine incentive in accordance with the terms and conditions of this Contract and the reporting template developed for the “Shot Per 100,000” program. 4.19.3 The Contractor shall report expenditures for COVID-19 vaccine incentives on a date of service basis.	This revision is to align with current practice.

Item	Change From	Change To	Justification
	4.19.4 The Contractor shall distribute the COVID-19 vaccine incentive to Enrollees within five (5) Business Days of LDH validating the Enrollee's eligibility to receive the COVID-19 vaccine incentive.	4.19.4 The Contractor shall distribute the COVID-19 vaccine incentive to Enrollees within five (5) Business Days of ~~LDH~~ the Contractor validating the Enrollee's eligibility to receive the COVID-19 vaccine incentive.	

MCO Amendment 2
Attachment B2 – Changes to Attachment B, *MCO Covered Services*

Item	Change From	Change To	Justification
1	**Physical Health Services** … • Applied Behavioral Analysis Therapy (age 0 – 20)	**Physical Health Services** … • ~~Applied Behavioral Analysis Therapy (age 0 – 20)~~ … **Behavioral Health Services** … **Applied Behavior Analysis Therapy (age 0 – 20)**	This revision moves Applied Behavioral Analysis (ABA) Therapy as a separate category at the end of the list of covered services.

~~MCO Amendment 2~~

~~Attachment C2 – Changes to Attachment C, *In Lieu of Services*~~

Item	Change From	Change To	Justification
~~1~~	~~*[new ILOS]*~~	~~**Physical Health**~~ ~~**In Lieu of Service**: Remote Patient Monitoring~~ ~~**Medicaid State Plan Service(s)**: Physician services (office visits), emergency services, and inpatient hospitals~~ ~~**Effective Date**: 2/9/2023~~	~~This addition seeks to improve enrollee outcomes and reduce preventable hospitalizations.~~
~~2~~	~~*[new ILOS]*~~	~~**Behavioral Health**~~ ~~**In Lieu of Service**: Therapeutic Day Center for age 5-20~~ ~~**Medicaid State Plan Service(s)**: Inpatient psychiatric hospitals, psychiatric residential treatment facility (PRTF)~~ ~~**Effective Date**: 1/1/2023~~	~~This addition seeks to reduce incidents of crisis hospitalization and residential psychiatric care.~~
~~3~~	~~*[new ILOS]*~~	~~**Behavioral Health**~~ ~~**In Lieu of Service**: Integrated Behavioral Health Homes~~ ~~**Medicaid State Plan Service(s)**: Emergency services, inpatient psychiatric hospitals, PRTF~~ ~~**Effective Date**: 1/1/2023~~	~~This addition seeks to improve the health and recovery of Enrollees with Serious Mental Illness (SMI), Substance Use Disorder (SUD) and Serious Emotional Disturbance (SED) by allowing for different methods of payment and furthering behavioral health integration.~~

DS JMS 9/22/2023 DS KLS 9/28/2023

Instructions: Fill in the cells that are shaded yellow in this worksheet and in the APM reporting template. For questions on terms see the Definitions tab.

MCO Name	
Contact Person/e-mail for questions on APM Report	
Measurement Year	

Alternative Payment Models are health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper (https://hcp-lan.org/groups/apm-refresh-white-paper/). See 'refreshed' APM Framework tab for a summary graphic.

Types of APMs (Subcategories)

Question	LAN APM Category	APM Types - Subcategories Select all that apply by putting an X in column C in each applicable row		**Brief description of type of providers/services involved** (e.g. primary care, hospitals, maternity providers, etc.). May include additional APM detail such as noting provider payment arrangements that include multiple APMs or shared savings approaches that have not yet been reconciled.
Which types of APM payment models were in effect during any portion of the payment period.	**2A Care Management**		Payments for care management	
	2A Other		Foundational payments for infrastructure and operations (non-care management)	
	2B*		Pay for Reporting	
	2C		Pay for Performance	
	3A		APMs with Shared Savings	
	3B		APMs with Shared Savings and Downside Risk	
	4A		Condition-specific population-based payment	
	4B		Comprehensive population-based payment	
	4C		Integrated Finance & Delivery System	

* Consistent with the MCO 3.0 Contract, and the definitions and instructions within this Excel file, MCOs should only report on 2B VBP models that are recognized by LDH.

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
1. Total Annual Provider Payments				
All provider payments	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified payment period. Managed Care Incentive Program (MCIP) payments should be excluded from any calculations in this report.	$0	Percentage of Total Provider Payments	#DIV/0!
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**	
2. Alternative Payment Model Framework - Category 2 (All methods below are linked to quality).				
Category 2A Incentive Payments: Care Management Only	Total dollars paid to providers for care management related to VBP agreements during the payment period.	$0	% of Total provider payments for 2A **Care Management** incentive payments	#DIV/0!
Category 2A Incentive Payments (Other)	Total dollars paid to providers for foundational spending to improve care, e.g. infrastructure payments, during payment period, **except those for care management payments included in cell C7 above.** Do not include FFS/base payments.	$0	% of Total provider payments for **Other** Category 2A Incentive Payments	#DIV/0!
Contracts that include Category 2A APMs	**Provider Payments under Contracts that include Category 2A APMs** - Total dollars paid under provider contracts that include FFS/base payments plus care management/foundational spending to improve care.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A APM	#DIV/0!
	For Provider Contracts with Category 2A APMs - % of provider payments that are linked to foundational payments			#DIV/0!
Category 2B Incentive Payments only for LDH Recognized APMs (Pay for Reporting)	**Category 2B APMs ONLY** - Total dollars paid to providers for pay for reporting during payment period for APMs recognized by LDH. Only include 2B incentive payments if component of a VBP model that includes Category 2C or 3 APMs for the same provider(s). Do not include FFS/base payments, just report the provider incentive payment linked to pay for reporting. Do not include 2B provider incentive payments earned for provider APMs that do not include a 2C or 3 APM component.	$0	% of Total provider payments that are incentives paid under Category 2B APMs ONLY	#DIV/0!
Category 2C Incentives only (Rewards for Performance)	**Category 2C APMs ONLY** - Total dollars paid to providers for pay for performance (P4P) rewards to improve care, such as provider performance to population-based target for quality such as a target HEDIS rate. Do not include FFS or base payments to providers. Do not include payments to providers for reporting HEDIS or other measures.	$0	% of Total provider payments that are incentives paid under Category 2C APMs ONLY	#DIV/0!
Category 2C Penalties only (Penalties for Performance)	**Category 2C APMs ONLY** - Total dollars for any penalties applied to providers based on performance to quality measures. Do not include FFS or base payments to providers. Do not include penalties for non-reporting.	$0	% of Total provider payments that are penalties collected under Category 2C APMs ONLY	#DIV/0!
Contracts that include Category 2C APMs	Total dollars paid under provider contracts that include FFS/base payment **plus (or minus)** any P4P payments or penalties, as applicable, (linked to quality) during payment period	$0	% of Total provider payments that are paid under contracts that include at least one Category 2C APM	#DIV/0!
	For Provider Contracts with Category 2C APMs - % of provider payments that are linked to P4P			#DIV/0!
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**	
Alternative Payment Model Framework - Category 3 (All methods below are linked to quality)				
Category 3 - Only **Shared Savings** Payments to providers	Total **shared savings** dollars ONLY paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are paid out as incentive payments under Category 3 shared savings arrangements	#DIV/0!
Category 3 - Only **Downside Risk** 'recoupments' applied to providers	Total **downside risk** collections or recoupments applied to providers under contracts that include Category 3 APMs and paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are collected or applied to providers as penalties under Category 3 shared risk arrangements	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.					
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**		
Contracts that include Category 3 APMs (and related TCOC targets)	Total dollars paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality), plus any shared savings or minus downside risk based on a budget target or shared savings. In total cost of care (TCOC) models, all provider payments associated with attributed members for services included in the TCOC target for the accountable provider entity should be included in the amount reported here.	$0	% of Total provider payments that are paid under or related to contracts that include at least one Category 3 APM		#DIV/0!
Alternative Payment Model Framework - Category 4 (All methods below are linked to quality)					
Category 4 - Population Based Payments to providers	Total dollars paid to providers for **population-based payments** as part of prospective payment/capitation. For example, PMPM primary care capitaton payments, prospective payments for specialty services, global budgets, and other payments made within prospective capitated arrangements.	$0	% of Total provider payments that are paid as capitation payments under Category 4 APMs		#DIV/0!
Contracts with Category 4 APMs	Total dollars paid to providers under contracts that include **Population-based APMs** (Category 4). Population-based payments include prospective primary care, condition-specific population-based payments, comprehensive population-based payments, and payments made within integrated finance and delivery systems.	$0	% of Total provider payments that are paid under contracts that include Category 4 APMs		#DIV/0!
For calculation only - Contracts with one or more APMs in category 2A, 2C, 3 or 4 (excludes contracts with only Category 2B APMs)					
Automated calculation of payments under provider contract with one or more APMs in categories 2A, 2C, 3 and 4	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs as reported above. If an MCO reported a contract(s) with more than one APM Categories (e.g., Category 2 and 3) in more than one of the following cells: C9, C16, C22 or C25, this total it will be "**overstated."**	$0			
Overstated provider payments in contracts with multiple APMs	In cases of provider contracts that include mulitple APM categories, enter total amount of the overstated provider contract(s) so that no provider contract is counted more than once in cells C9, C16, C22, or C25.	$0			
VBP BENCHMARK (Contracts with one or more APMs in category 2A, 2C, 3 or 4)					
Total Provider Incentive Payment Payments in Category 2, 3 and 4	Total dollars paid to providers during the payment period within Categories 2A, 2C, 3 and 4, counting downside risk and penalties as positive numbers.	$0	% of Total provider incentive payments paid under Category 2A, 2C, 3 or 4 APMs		**#DIV/0!**
Contracts that include Category 2, 3, or 4 APMs (unduplicated)	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs (all with links to quality). This may be less than the combination of provider contract payments reported under each applicable LAN category as calculated in cell C28. If a contract includes more than one type of APM, it should only be counted once in the VBP benchmark.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A, 2C, 3 or 4 APM		**#DIV/0!**

Definitions

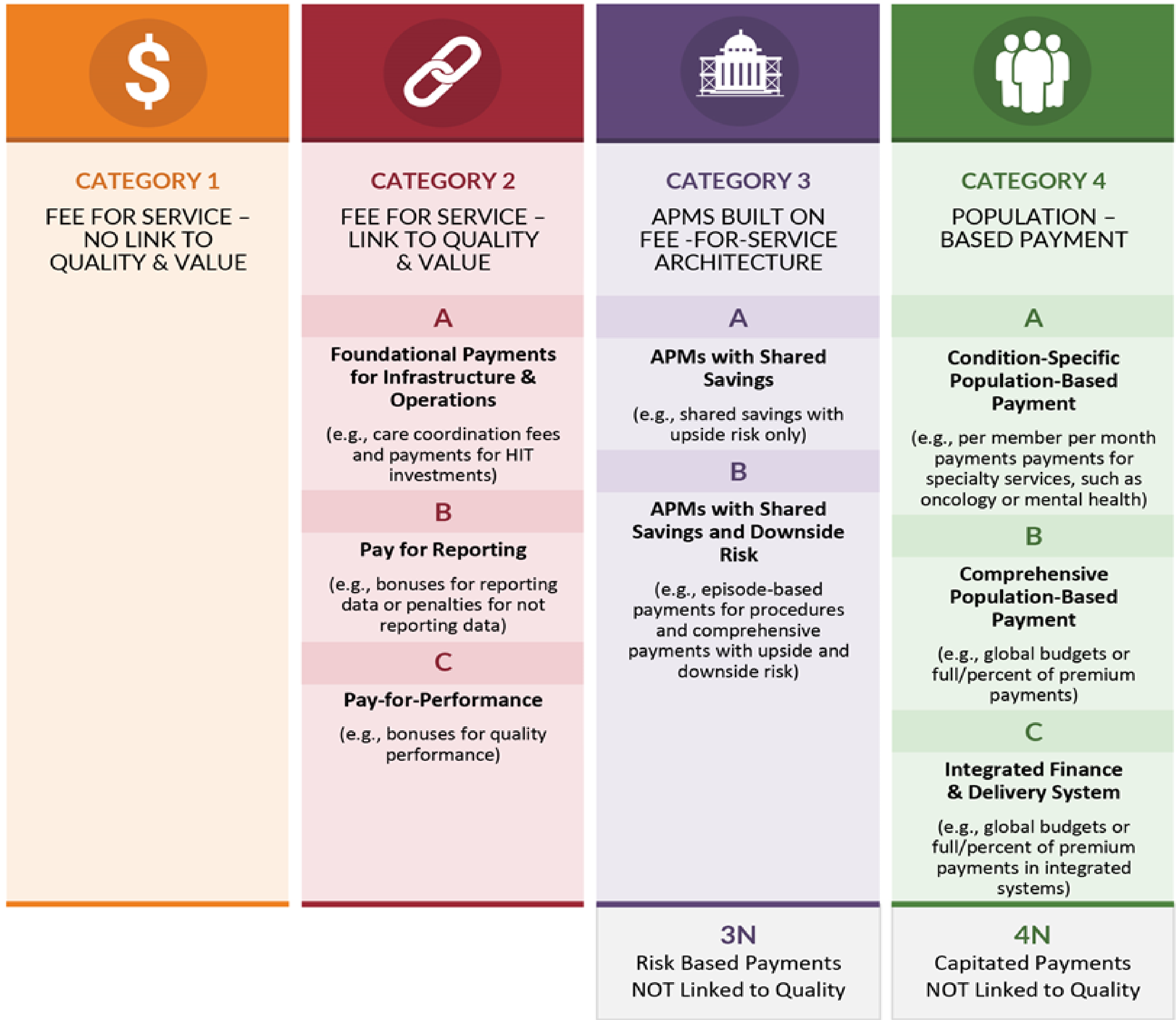
Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper and the graphic included on the 'refreshed' APM Framework tab. https://hcp-lan.org/groups/apm-refresh-white-paper/
Care Management	Includes payments to improve care delivery such as outreach and care coordination/management and after-hour availability; May come in the form of care/case management fees or medical home payments. [APM Framework Category 2A]
Category 2 APM (must be linked to quality)	Fee-for-service linked to quality. These payments utilize traditional FFS payments, but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics. Examples are described in more detail in other definitions and include: 2A: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems 2C: Rewards and Penalties for Performance: Bonus payments/rewards and/or penalties for quality performance on specified measures, including those in DRG systems.
Category 2B APMs recognized by LDH	Category 2B pay for reporting where the 2B arrangement is one component of a broader VBP model that includes Category 2C or 3 APMs for the same provider(s). LDH considers "pay per click" arrangements related to HEDIS measures as a 2B arrangement. Unlike category 2C arrangements, in 2B "pay-per-click" arrangements providers receive additional payment for each applicable HEDIS screen/service, regardless of whether the provider achieves an overall target HEDIS performance related to their attributed/assigned MCO members.
Category 3 APM (excludes risk-based payment models that are NOT linked to quality)	Alternative payment methods (APMs) built on **fee-for-service architecture** while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are **based on cost performance against a target**, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are retrospectively eligible for shared savings, and those that do not may be held financially accountable. Examples include: 3A: APMs with upside gain sharing based on a budget target/shared savings: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); Oncology COE with retrospective shared savings (no shared risk). 3B: APMs with upside gain sharing and downside risk: retrospective bundled payments with up and downside risk, retrospective episode-based payments with shared savings and losses; PCMH with retrospective shared savings and losses; Oncology COE with retrospective shared savings and losses.

Definitions

Terms	Definitions
Category 4 APM (excludes capitated payment models that are NOT linked to quality)	**Prospective population-based payment**. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined or overall budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Examples include: 4A: Condition-specific population-based payments, e.g. via an ACO, PCMH or Center of Excellence (COE), partial population-based payments for primary care, and episode-based payments for clinical conditions such as diabetes. 4B: Comprehensive population-based payments - full or % of premium population-based payment, e.g. via an ACO, PCMH or Center of Excellence (COE), integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care. 4C: Integrated Finance & Delivery Systems - global budgets or full/percent of premium payments in integrated systems
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A]**
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category **1**]
Foundational spending	Includes but is not limited to payments to improve care delivery such as health IT infrastructure use. May come in the form of infrastructure payments, meaningful use payments and/or per-episode fees for specialists. [APM Framework Category **2A**]
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B** if there is a link to quality**]**
Legacy payments	Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs) and per diems. [APM Framework Category **1**].
Linked to quality	Payments that are set or adjusted based on evidence that providers meet a quality standard(s) or improve care or clinical services, including for providers who report quality data, or providers who meet thresholds on cost and quality metrics.
Pay for performance	The use of financial incentives to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. [APM Framework Category **2C** if there is a link to quality].

Definitions

Terms	Definitions
Payment Period	The twelve month Measurement Year period, applicable to the specified MCO reporting requirements, for example Calendar Year 2023.
Population-based payment for conditions	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period including inpatient care and facility fees. [APM Framework Category **4A** if there is a link to quality].
Population-based payment not condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could cover primary, acute and post-acute care that is not specific to any particular condition. [APM Framework Category **3B** if there is a link to quality].
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **3B**].
Provider	For the purposes of this report, provider includes all providers for which there is MCO health care spending. For the purposes of reporting APMs, this definition of provider includes medical, behavioral, pharmacy, DME, PCMH/FCMH, dental, vision, transportation, and local health departments (e.g., lead screening) etc. as applicable.
Shared risk/losses	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the applicable payment period.


CATEGORY 1
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE
CATEGORY 2
FEE FOR SERVICE – LINK TO QUALITY & VALUE
A
Foundational Payments for Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)
B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)
C
Pay-for-Performance
(e.g., bonuses for quality performance)
CATEGORY 3
APMS BUILT ON FEE -FOR-SERVICE ARCHITECTURE
A
APMs with Shared Savings
(e.g., shared savings with upside risk only)
B
APMs with Shared Savings and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
3N
Risk Based Payments NOT Linked to Quality
CATEGORY 4
POPULATION – BASED PAYMENT
A
Condition-Specific Population-Based Payment
(e.g., per member per month payments payments for specialty services, such as oncology or mental health)
B
Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)
C
Integrated Finance & Delivery System
(e.g., global budgets or full/percent of premium payments in integrated systems)
4N
Capitated Payments NOT Linked to Quality

MCO Amendment 2
Attachment F2 – Changes to Attachment F, *Provider Network Standards*

<table>
<tr><th>Item</th><th>Change From</th><th>Change To</th><th>Justification</th></tr>
<tr><td>1</td><td>[new standard]</td><td>
<table>
<tr><th>Type[1]</th><th>Rural Parishes[3] (miles)</th><th>Urban Parishes[3] (miles)</th></tr>
<tr><th colspan="3">Ancillary</th></tr>
<tr><td>Home Health</td><td>60</td><td>60</td></tr>
</table>
</td><td>This revision formalizes a network adequacy distance standard specifically for home health providers.</td></tr>
<tr><td>2</td><td>
<table>
<tr><th>Type[1]</th><th>Rural Parishes[3] (miles)</th><th>Urban Parishes[3] (miles)</th></tr>
<tr><th colspan="3">Psychiatric Inpatient Hospital Services[9]</th></tr>
<tr><td>Hospital, Free Standing Psychiatric Unit</td><td>75</td><td>60</td></tr>
<tr><td>Hospital, Distinct Part Psychiatric Unit</td><td>75</td><td>60</td></tr>
</table>
</td><td>
<table>
<tr><th>Type[1]</th><th>Rural Parishes[3] (miles)</th><th>Urban Parishes[3] (miles)</th></tr>
<tr><th colspan="3">Psychiatric Inpatient Hospital Services[9]</th></tr>
<tr><td>Hospital, Free Standing Psychiatric Unit</td><td>~~75~~90</td><td>~~60~~90</td></tr>
<tr><td>Hospital, Distinct Part Psychiatric Unit</td><td>~~75~~90</td><td>~~60~~90</td></tr>
</table>
</td><td rowspan="2">This revision reverts to previous standards for these services, as the implementation of the crisis response system alleviates the need for greater access to these services.</td></tr>
<tr><td>3</td><td>
<table>
<tr><th>Type of Visit/Admission/ Appointment</th><th>Access/Timeliness Standard</th></tr>
<tr><td>Urgent non-emergency behavioral health care</td><td>24 hours</td></tr>
</table>
</td><td>
<table>
<tr><th>Type of Visit/Admission/ Appointment</th><th>Access/Timeliness Standard</th></tr>
<tr><td>Urgent non-emergency behavioral health care</td><td>~~24~~ 48 hours</td></tr>
</table>
</td></tr>
</table>

MCO Amendment 2
Attachment G2 – Changes to Attachment G, *Table of Monetary Penalties*

<table>
<tr><th>Item</th><th>Change From</th><th>Change To</th><th>Justification</th></tr>
<tr><td>1</td><td><table><tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr><tr><th colspan="2">Care Management</th></tr><tr><td>Pre-Admission Screening and Resident Review (PASRR)</td><td>Five thousand dollars ($5,000) per month that less than ninety-five percent (95%) of PASRR Level II evaluations were submitted to OBH within four (4) Business Days of the receipt of referral.</td></tr></table></td><td><table><tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr><tr><th colspan="2">Care Management</th></tr><tr><td>Pre-Admission Screening and Resident Review (PASRR)</td><td>Five thousand dollars ($5,000) per month that less than ninety-five percent (95%) of PASRR Level II evaluations were submitted to OBH within four (4) ~~Business~~ Calendar Days of the receipt of referral.</td></tr></table></td><td>This update aligns the monetary penalty with section 2.7.7.4 of Attachment A, Model Contract.</td></tr>
<tr><td>2</td><td><table><tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr><tr><th colspan="2">Enrollee Services, Marketing, Grievances</th></tr><tr><td>Member ID Card</td><td>Five hundred dollars ($500) per incident of a justice-involved pre-release Enrollee's MCO Member ID card not arriving at the DOC facility specified on the lock-in file or supplied by LDH, or DOC headquarters in absence of a location code, within fifteen (15) Calendar Days from receipt of the file from LDH or the Enrollment Broker identifying the new Enrollee.</td></tr></table></td><td><table><tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr><tr><th colspan="2">Enrollee Services, Marketing, Grievances</th></tr><tr><td>Member ID Card</td><td>Five hundred dollars ($500) per incident of a justice-involved pre-release Enrollee's MCO Member ID card not arriving at the DOC facility specified on the lock-in file or supplied by LDH, or DOC headquarters in absence of a location code, within fifteen (15) ~~Calendar~~ Business Days from receipt of the file from LDH or the Enrollment Broker identifying the new Enrollee.</td></tr></table></td><td>This revision corrects the deadline to business days to align with current practice.</td></tr>
</table>

Louisiana Department of Health

MCO Amendment 2

Attachment H2 – Changes to Attachment H, *Quality Performance Measures*

Item	Change From	Change To	Justification
1	***[new performance measure]***	3. Inpatient Utilization – General Hospital/Acute Care (IPU) | This measure summarizes utilization of acute inpatient care and services in the following categories: • Maternity • Surgery • Medicine • Total inpatient (the sum of Maternity, Surgery and Medicine) | NCQA *(Subsequent items renumbered)*	This is a new performance measure from the Measurement Year (MY) 2023 technical specifications from NCQA.
2	***[new performance measure]***	12. Children with Chronic Conditions | This measure provides information on parents' experience with their child's Medicaid organization for the population of children with chronic conditions. | NCQA *(Subsequent items renumbered)*	This is a new performance measure from the MY2023 technical specifications from NCQA.
3	21. Cesarean Rate for Low-Risk First Birth Women | $$: The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions). *Note: A lower rate indicates better performance.* \| NCQA	21. Cesarean Rate for Low-Risk First Birth Women \| $$: 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). *Note: A lower rate indicates better performance.* | ~~NCQA~~ TJC	This performance measure is from The Joint Commission (TJC).
4	***[new performance measure]***	Objectives: Promote oral health in children 27. Topical Fluoride for Children (TFC) | The percentage of members 1-4 years of age who received at least two fluoride varnish applications during the measurement year. Report two age stratifications and a total rate: | NCQA	This is a new performance measure from the MY2023 technical specifications from NCQA.

Item	Change From		Change To			Justification
				• 1-2 years • 3-4 years • Total		
			28. Oral evaluation, Dental Services (OED)	The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year. Report four age stratifications and a total rate: • 0-2 years • 3-5 years • 6-14 years • 15-20 years • Total	NCQA	
			(Subsequent items renumbered)			
5	27. Flu Vaccinations for Adults Ages 18 to 64	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.	~~27. Flu Vaccinations for Adults Ages 18 to 64~~	~~The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.~~		This measure has been retired by NCQA.
6	33. Contraceptive Care – Postpartum Women Ages 15-20	The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery or were provided a LARC within 3 and 60 days of delivery. Four rates are reported.	33. Contraceptive Care – Postpartum Women Ages 15-20	The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and ~~60~~90 days of delivery or were provided a LARC within 3 and ~~60~~90 days of delivery. Four rates are reported.		CMS has updated the specifications for this measure effective MY2023.
7	35. Contraceptive Care – Postpartum Women Ages 21-44	The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery or were provided a LARC within 3 and 60 days of delivery. Four rates are reported.	35. Contraceptive Care – Postpartum Women Ages 21-44	The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and ~~60~~90days of delivery or were provided a LARC within 3 and ~~60~~90 days of delivery. Four rates are reported.		CMS has updated the specifications for this measure effective MY2023.
8	35. Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	~~35. Breast Cancer Screening~~	~~Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.~~		This measure has been retired by NCQA.

Item	Change From	Change To	Justification
9	***[new performance measure]***	50. Asthma Medication Ratio (AMR) The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Ages 5-64 as of December 31 of the measurement year. Report the following age stratifications and a total rate: • 5-11 years • 12-18 years • 19-50 years • 51-64 years • Total NCQA *(Subsequent items renumbered)*	This is a performance measure from the MY2023 technical specifications from NCQA.
10	***[new performance measure]***	59. Enrollment by Product Line The total number of members enrolled in the product line, stratified by age. NCQA *(Subsequent items renumbered)*	This is a new performance measure from the MY2023 technical specifications from NCQA.
11	***[new performance measure]***	60. Language Diversity of Membership An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials. NCQA *(Subsequent items renumbered)*	This is a new performance measure from the MY2023 technical specifications from NCQA.
12	***[new performance measure]***	61. Race/Ethnicity Diversity of Membership An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity. NCQA *(Subsequent items renumbered)*	This is a new performance measure from the MY2023 technical specifications from NCQA.

Medicaid Managed Care Organization Contract
Attachment K: Equity, Diversity, and Inclusion Statement

The Louisiana Department of Health (LDH) characterizes equity, diversity, and inclusion as representing the differences and similarities of all individuals while creating a work environment in which those same individuals are treated fairly and respectfully, have equal access to opportunities and resources, and can contribute fully to the work of LDH in a safe and welcoming environment.

LDH values diversity in its workplace, vendor network, customers, and communities. As a state agency, LDH believes that diversity contributes to the success of Louisiana and society. LDH values the unique contributions of individuals with wide ranging backgrounds and experiences, and believes an inclusive culture allows our employees to contribute their best. Because of this, LDH is committed to equal opportunity and fair treatment for all.

LDH prohibits discrimination on the basis of age, race, color, gender, religion, ethnicity, disability, marital or family status, national origin, sexual orientation, veteran status, genetic information, medical condition, or any other non-merit factor. LDH is fully committed to being a model for equity, diversity, inclusion, belonging, and accessibility, where all team members are treated with dignity and respect. This principle extends to all decisions relating to recruitment, hiring, contracting, training, placement, advancement, compensation, benefits, and termination. By signing this contract, contractor acknowledges the following:

a. That LDH values diversity in the workplace and that contractor agrees to value diversity in its workplace, further;
b. That the Contractor is subject to uphold this Equity, Diversity, and Inclusion Statement in actions related to the execution and/or fulfillment of this contract; and
c. That subject to federal and/or state laws, the Contractor agrees not to discriminate on the basis of age, race, color, gender, religion, ethnicity, disability, marital or family status, national origin, sexual orientation, veteran status, genetic information, or medical condition, in any action related to the execution and/or fulfillment of this contract.