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: 2000441824

Amendment Number: 13

Vendor: AETNA BETTER HEALTH INC (LA)

Description: Managed Care Organizations - Emergency

Approved By: KRISTI BONVILLAIN

Approval Date: 06/15/2022 10:16:36

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 13

LAGOV#: 2000441824

LDH #:

Medical Vendor Administration

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

AND

Aetna Better Health, Inc.

Contractor Name

Original Contract Amount: 773,109,537

Original Contract Begin Date: 01-01-2020

Original Contract End Date: 12-31-2020

RFP Number: N/A

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $3,024,864,967.79 Current Contract Term: 01/01/20-12/31/22

See Attachment B - Statement of Work
See Attachment C - Quality Performance Measures
See Attachment F - In Lieu of Services

Change Contract To: To Maximum Amount: Changed Contract Term: N/A

See Attachment B13 - Changes to Statement of Work
See Attachment C13 - Changes to Quality Performance Measures
See Attachment F13 - Changes to In Lieu of Services

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 incorporates numerous revisions to Attachment B - Statement of Work, including those related to DOJ Agreement requirements, updates to align with NCQA naming conventions, removal of HIPF Reimbursement due to its repeal, and pharmacy revisions to avoid a potential duplicate discount. It also updates Attachment C - Quality Performance Measures for measurement year 2022 and adds doula services to Attachment F - In Lieu of Services.

This Amendment Becomes Effective: 01-01-2022

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

Aetna Better Health, Inc.

DocuSigned by: Richard C. Born 191666E9A1D4445...

CONTRACTOR SIGNATURE — DATE: 5/3/2022

PRINT NAME: Richard C. Born

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

DocuSigned by: Patrick Gillies 7D2608CB02464F4...

SIGNATURE — DATE: 5/3/2022

NAME: Patrick Gillies

TITLE: Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE — DATE

NAME

Contract Amendment #13
Attachment B13

Changes to Statement of Work

Item	Change From:	Change To:	Justification
1	5.4.1.1.4. Targets for Healthcare Effectiveness Data and Information Set (HEDIS®) incentive-based measure scores will be equal to National Committee for Quality Assurance (NCQA) Quality Compass Medicaid National 50th percentile [All Lines of Business (LOBs) (Excluding Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs))] values for the prior measurement year. 5.4.1.1.5. Targets for HEDIS® incentive-based measure scores without NCQA Quality Compass Medicaid National 50th percentile [All Lines of Business (LOBs) (Excluding Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs))] values will be equal to the best performance reported to LDH by any MCO for the prior measurement year. 5.4.1.1.6. If NCQA makes changes to any of the measures selected by LDH, such that valid comparison to prior years will not be possible, or if it is determined that a measure is not reasonably attainable, LDH, at its sole discretion, may elect to eliminate the measure from incentive eligibility, change the affected measure to be reporting only, or replace it with another measure. 5.4.1.1.7. Targets for non-HEDIS incentive-based measures will be equal to the best performance reported to LDH by any MCO for the prior measurement year.	5.4.1.1.4. Targets for Healthcare Effectiveness Data and Information Set (HEDIS®) incentive-based measure scores will be equal to National Committee for Quality Assurance (NCQA) Quality Compass Medicaid National 50th percentile [All Lines of Business (LOBs) (Excluding Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs))] values for the prior Quality Compass product ~~measurement~~ year. 5.4.1.1.5. Targets for HEDIS® incentive-based measure scores without NCQA Quality Compass Medicaid National 50th percentile [All Lines of Business (LOBs) (Excluding Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs))] values will be equal to the best performance reported to LDH by any MCO for the measurement year that is two years prior to the current ~~prior~~ measurement year. 5.4.1.1.6. If NCQA makes changes to any of the measures selected by LDH, such that valid comparison to prior years will not be possible, or if it is determined that a measure is not reasonably attainable, LDH, at its sole discretion, may elect to eliminate the measure from incentive eligibility, change the affected measure to be reporting only, or replace it with another measure. 5.4.1.1.7. Targets for non-HEDIS incentive-based measures will be equal to the best performance reported to LDH by any MCO for the measurement year that is two years prior to the current measurement year.	This revision aligns with naming convention updates from NCQA.
2	5.16. Health Insurance Provider Fee (HIPF) Reimbursement If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee (“Annual Fee”) whose final calculation includes an applicable portion of the MCO’s net premiums written from LDH’s Medicaid/CHIP lines of business, LDH shall, upon the MCO	~~5.16. Health Insurance Provider Fee (HIPF) Reimbursement~~ ~~If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee (“Annual Fee”) whose final calculation includes an applicable portion of the MCO’s net premiums written from LDH’s Medicaid/CHIP lines of business, LDH shall, upon the MCO~~	This revision removes this section from the contract following the CY 2020 fee year. The Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502, signed into law on December 20, 2019, repealed the annual fee on health insurance providers for calendar years

Item	Change From:	Change To:	Justification
	satisfying completion of the requirements below, make an annual payment to the MCO in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by LDH (and its contracted actuary) as an adjustment to each MCO's capitation rates, in accordance with the MCO Financial Reporting Guide, for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year. 5.16.1. The MCO shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements: 5.16.1.1. Provide LDH with a copy of the final Form 8963 submitted to the IRS by the deadline to be identified by LDH each year. The MCO shall provide LDH with any adjusted Form 8963 filings to the IRS within 5 business days of any amended filing. 5.16.1.2. Provide LDH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline to be identified by LDH each year (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing. 5.16.1.3. If the MCO's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the MCO's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the MCO pursuant to this Contract) was determined. The MCO will indicate for LDH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, if applicable, beginning with Data Year 2014.	~~satisfying completion of the requirements below, make an annual payment to the MCO in each calendar year payment is due to the IRS (the "Fee Year"). This annual payment will be calculated by LDH (and its contracted actuary) as an adjustment to each MCO's capitation rates, in accordance with the MCO Financial Reporting Guide, for the full amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.~~ ~~5.16.1. The MCO shall, at a minimum, be responsible for adhering to the following criteria and reporting requirements:~~ ~~5.16.1.1. Provide LDH with a copy of the final Form 8963 submitted to the IRS by the deadline to be identified by LDH each year. The MCO shall provide LDH with any adjusted Form 8963 filings to the IRS within 5 business days of any amended filing.~~ ~~5.16.1.2. Provide LDH Louisiana-specific Medicaid and CHIP-specific premiums included in the premiums reported on Form 8963 (including any adjusted filings) by the deadline to be identified by LDH each year (for the initial Form 8963 filing) of the Fee Year and within 5 business days of any amended filing.~~ ~~5.16.1.3. If the MCO's Louisiana-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, provide with its Form 8963 a supplemental delineation of Louisiana-specific Medicaid/CHIP premium revenue that was listed on the MCO's Form 8963 and a methodological description of how its Louisiana-specific Medicaid/CHIP premium revenue (payments to the MCO pursuant to this Contract) was determined. The MCO will indicate for LDH the portion of the Louisiana-specific Medicaid/CHIP premiums that were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, if applicable, beginning with Data Year 2014.~~	beginning after December 31, 2020 (fee years after the 2020 fee year). As a result of the repeal, 2020 is the last fee year.

Item	Change From:	Change To:	Justification
	5.16.1.3.1. The MCO shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606. 5.16.1.3.2. If a portion of the Louisiana-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, the MCO shall submit the calculations and methodology for the amount excluded. 5.16.1.4. Provide LDH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline to be identified by LDH each year. 5.16.1.5. Provide LDH with the final calculation of the Annual Fee as determined by the IRS by the deadline to be identified by LDH each year. 5.16.1.6. Provide LDH with the corporate income tax rates – federal and state (if applicable) -- by the deadlines to be identified by LDH each year. and include a certification regarding the corporate income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606. 5.16.2. For covered entities subject to the HIPF, LDH will calculate the HIPF percentage in accordance with the steps outlined in the MCO Financial Reporting Guide and based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by LDH. 5.16.3. LDH (and its contract actuary) will compute the change in capitation revenue that is due to the higher capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the MCO. 5.16.4. In accordance with the schedule provided in the MCO Financial Reporting Guide, LDH will make a payment to the MCO that is based on the final Annual Fee amount provided by the IRS and calculated by LDH (and its	~~5.16.1.3.1. The MCO shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606.~~ ~~5.16.1.3.2. If a portion of the Louisiana-specific Medicaid/CHIP premiums were excluded from the Form 8963 premiums by the MCO as Medicaid long-term care, the MCO shall submit the calculations and methodology for the amount excluded.~~ ~~5.16.1.4. Provide LDH with the preliminary calculation of the Annual Fee as determined by the IRS by the deadline to be identified by LDH each year.~~ ~~5.16.1.5. Provide LDH with the final calculation of the Annual Fee as determined by the IRS by the deadline to be identified by LDH each year.~~ ~~5.16.1.6. Provide LDH with the corporate income tax rates – federal and state (if applicable) -- by the deadlines to be identified by LDH each year. and include a certification regarding the corporate income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606.~~ ~~5.16.2. For covered entities subject to the HIPF, LDH will calculate the HIPF percentage in accordance with the steps outlined in the MCO Financial Reporting Guide and based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963, and agreed reasonable by LDH.~~ ~~5.16.3. LDH (and its contract actuary) will compute the change in capitation revenue that is due to the higher capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the MCO.~~ ~~5.16.4. In accordance with the schedule provided in the MCO Financial Reporting Guide, LDH will make a payment to the MCO that is based on the final Annual Fee amount provided by the IRS and calculated by LDH (and its~~	

Item	Change From:	Change To:	Justification
	contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if LDH determines that that the reporting requirements under this section have been satisfied. 5.16.5. The MCO shall advise LDH if payment of the final fee payment is less than the amount invoiced by the IRS. 5.16.6. The MCO shall reimburse LDH for any amount applicable to Louisiana Medicaid/CHIP premiums that are not paid towards the fee and/or are reimbursed back to the MCO, at any time and for any reason, by the IRS. 5.16.7. LDH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee. In the event the calculation methodology or method or timing of payment for the Annual Fee as set forth in the MCO Financial Reporting Guide requires modification, LDH will obtain MCO input regarding the required modification(s) prior to implementation of the modification. 5.16.8. Payment by LDH is intended to put the MCO in the same position as the MCO would have been in had the MCO's health insurance providers fee tax rate (the final Annual Fee as a portion of the covered entity's premiums filed on Form 8963) and corporate tax rates been known in advance and used in the determination of the Data Year capitation rates. The obligation outlined in this section shall survive the termination of the contract.	~~contracted actuary) as an adjustment to the capitation rates in effect during the Data Year. This payment will only be made to the Contactor if LDH determines that that the reporting requirements under this section have been satisfied.~~ ~~5.16.5. The MCO shall advise LDH if payment of the final fee payment is less than the amount invoiced by the IRS.~~ ~~5.16.6. The MCO shall reimburse LDH for any amount applicable to Louisiana Medicaid/CHIP premiums that are not paid towards the fee and/or are reimbursed back to the MCO, at any time and for any reason, by the IRS.~~ ~~5.16.7. LDH reserves the right to update the calculation and method of payment for the Annual Fee based upon any new or revised requirements established by CMS in regards to this fee. In the event the calculation methodology or method or timing of payment for the Annual Fee as set forth in the MCO Financial Reporting Guide requires modification, LDH will obtain MCO input regarding the required modification(s) prior to implementation of the modification.~~ ~~5.16.8. Payment by LDH is intended to put the MCO in the same position as the MCO would have been in had the MCO's health insurance providers fee tax rate (the final Annual Fee as a portion of the covered entity's premiums filed on Form 8963) and corporate tax rates been known in advance and used in the determination of the Data Year capitation rates.~~ ~~The obligation outlined in this section shall survive the termination of the contract.~~	
3	14.6.1 The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Functional Family	14.6.1 The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Functional Family	This revision reflects the addition of Individual Placement and Support (IPS) as a Medicaid reimbursable service for the DOJ/My Choice Louisiana population, effective February 21, 2022,

Item	Change From:	Change To:	Justification
	Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment Act (ACT) as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports. 14.6.2 The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH-specified ACT Monitoring tool. The MCO shall ensure their staff are properly trained on utilization of the identified ACT Monitoring tool.	Therapy (FFT), Multisystemic Therapy (MST), ~~and~~ Homebuilders and Assertive Community Treatment Act (ACT), and Individual Placement and Support (IPS) as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports. 14.6.2 The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) and Individual Placement and Support (IPS) providers to ensure minimum fidelity standards utilizing the LDH-specified ACT Monitoring tool and the IPS Fidelity Scale. The MCO shall ensure their staff are properly trained on utilization of the identified and IPS ACT Monitoring tools.	in alignment with compliance expectations of the DOJ Agreement.
4	17.7.8 Providers shall have the right to an independent review of claims that are the subject of an adverse determination by the MCO. The review shall be provided and conducted in accordance with R.S. 46:460.31 through 460.89.	17.7.8 Providers shall have the right to an independent review of claims that are the subject of an adverse determination by the MCO. The review shall be provided and conducted in accordance with R.S. 46:460.~~38~~1 through 460.89.	This revision corrects a citation error.
5	17.9.2 Each MCO shall create a unique Processor Control Number (PCN) or Group number for Louisiana Medicaid. The health plan shall submit the PCN or group number and the Bank Identification Number with the encounter claims data submission. … 17.11.3.4 The MCO shall utilize a unique Processor Control Number (PCN) or Group Number for Louisiana Medicaid. This unique PCN or group number shall be submitted to LDH before processing any pharmacy claims.	17.9.2 Each MCO shall create a unique Processor Control Number (PCN) ~~or~~ and unique Group number (if a group number is utilized) for Louisiana Medicaid. The health plan shall submit the PCN, ~~or~~ group number (if a group number is utilized), and the Bank Identification Number with the encounter claims data submission. … 17.11.3.4 The MCO shall utilize a unique Processor Control Number (PCN) ~~or~~ and unique Group Number (if a group number is utilized) for Louisiana Medicaid. This ~~unique~~ PCN ~~or~~ and group number (if a group number is utilized) shall be submitted to LDH before processing any pharmacy claims.	This revision is to avoid creating a potential duplicate discount. Contract pharmacies need a unique PCN and a unique group number to prevent 340B stock accumulation for Medicaid claims. The contract pharmacies code their system to block the Medicaid BINs, PCNs, and group numbers so that 340B stock is not utilized. LDH posts the MCO PBMs BIN/PCN and group numbers for providers. When MCOs allow a separate PCN to process Medicaid claims, there is a possibility that LDH will seek rebate on 340B claims therefore creating a potential duplicate discount.

Contract Amendment #13
Attachment C13

Changes to Attachment C: Quality Performance Measures (Effective Measurement Year ~~2021~~ 2022)

Justification (for all items): These revisions align with NCQA Measurement Year 2022 technical specification updates

Item	Change From:		Change To:	
1	4. Ambulatory Care: Emergency Department Visits	This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months. *Note: A lower rate indicates better performance.*	4. Ambulatory Care~~:~~ ~~Emergency Department Visits~~	This measure summarizes utilization of ambulatory care ~~ED Visits per 1,000 member months.~~ in the following categories: • Outpatient Visits Including Telehealth. • ED Visits *Note: A lower rate indicates better performance for ED visits.*
2	7. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: • $$: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	7. Follow-Up After Emergency Department Visit for ~~Alcohol and Other Drug Abuse or Dependence~~ Substance Use	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of ~~alcohol or other drug (AOD) abuse or dependence,~~ substance use disorder (SUD), or any diagnosis of drug overdose, for which there was ~~who had~~ a follow-up ~~visit for AOD~~. Two rates are reported: • $$: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
3	9. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version (Medicaid)	This measure provides information on parents' experience with their child's Medicaid organization.	9. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.~~0~~1H – Child Version (Medicaid)	This measure provides information on parents' experience with their child's Medicaid organization.
	10. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid)	This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.	10. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.~~0~~1H, Adult Version (Medicaid)	This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.

Item	Change From:		Change To:		
4	(new provision; subsequent revisions renumbered)		$$ 43. Hemoglobin A1c Control for Patients With Diabetes	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c control (<8.0%). • $$ HbA1c poor control (>9.0%) *Note: A lower rate indicates better performance for HbA1c poor contol (i.e., low rates of poor control indicate better care).*	NCQA
			44. Blood Pressure Control for Patients With Diabetes	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year	NCQA
			45. Eye Exam for Patients With Diabetes	The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam	NCQA
5	43. Comprehensive Diabetes Care	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing • $$: HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) for a selected population • Eye exam (retinal) performed • BP control (<140/90 mm Hg) *Note: For some measures, a lower rate indicates better performance.*	~~43. Comprehensive Diabetes Care~~	~~The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:~~ ~~• Hemoglobin A1c (HbA1c) testing~~ ~~• $$: HbA1c poor control (>9.0%)~~ ~~• HbA1c control (<8.0%)~~ ~~• HbA1c control (<7.0%) for a selected population~~ ~~• Eye exam (retinal) performed~~ ~~• BP control (<140/90 mm Hg)~~ ~~*Note: For some measures, a lower rate indicates better performance.*~~	
6	48. Initiation and Engagement of Alcohol and	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.	~~48.~~ 50. Initiation and Engagement of ~~Alcohol and Other Drug Abuse or~~	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.	

Item	Change From:		Change To:	
	Other Drug Abuse or Dependence Treatment	• Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.	~~Dependence~~ Substance Use Disorder Treatment	• Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.
7	53. Measures for stratified data: a. Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44 b. Child: Well Child Visits in the First 30 Months of Life, Childhood Immunizations (Combo 3), Immunizations for Adolescents (Combo 2) c. Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening d. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (within 30 days), Follow-Up After Hospitalization for Mental Illness	*Refer to individual measures	~~53.~~ 55. Measures for stratified data: a. Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44 b. Child: Well Child Visits in the First 30 Months of Life, Childhood Immunizations (Combo 3), Immunizations for Adolescents (Combo 2) c. Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening d. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for ~~Alcohol and Other Drug Abuse or Dependence~~ Substance Use (within 30 days), Follow-Up After Hospitalization for Mental Illness (within 30 days)	*Refer to individual measures

Contract Amendment #13
Attachment F13

Changes to Attachment F: In Lieu of Services

Justification: This revision authorizes MCOs to provide doula services as a cost effective alternative to inpatient and outpatient hospital state plan services.

<table>
<tr><th>Item</th><th>Change From:</th><th>Change To:</th></tr>
<tr><td>1</td><td>(new provision)</td><td>
<table>
<tr><th>In Lieu of Service</th><th>Medicaid State Plan Service(s)</th><th>Effective Date</th></tr>
<tr><td>Doula services</td><td>Inpatient and outpatient hospital services</td><td>1/1/2022</td></tr>
</table>
</td></tr>
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