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: 16

Vendor: AETNA BETTER HEALTH INC (LA)

Description: Managed Care Organizations - Emergency

Approved By: PAMELA RICE

Approval Date: 09/15/2022 14:28:43

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 16

LAGOV#: 2000441824

LDH #:

MVA

Medical Vendor Administration

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

AND

Aetna Better Health, Inc.

Contractor Name

Original Contract Amount: 773109537

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

Attachment B - Statement of Work
Attachment C - Quality Performance Measures

Change Contract To: To Maximum Amount: $3,024,864,967.79 Changed Contract Term: N/A

Attachment B16 - Changes to Statement of Work
Attachment C16 - Changes to Quality Performance Measures
Attachment G - OIG Addendum

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: marketing and member education requirements related to event and activity approval, the Member Handbook, and Member ID Cards; and fraud, waste, and abuse provisions related to rights of review and recovery. It also updates Attachment C - Quality Performance Measures, including the retirement of two measures and edits to two other measures, and adds Attachment G - OIG Addendum.

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: 7/29/2022

PRINT NAME: Richard C. Born

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE: DocuSigned by: Tara A. Leblanc
338F7ABF393C405...

DATE: 8/1/2022

NAME: Tara A. LeBlanc

TITLE: Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE — DATE

NAME

Changes to Statement of Work

Item	Change From:	Change To:	Justification
1.	5.4.1.2.3.1.1. If an MCO implements a VBP arrangement with primary care providers, the VBP arrangement must include at least two measures from Attachment C in order for the MCO to report the primary care VBP in its Attachment E reporting. 5.4.1.2.3.1.2. If an MCO implements a VBP arrangement for services other than primary care, the MCO must include at least any two applicable incentive-based measures from Attachment C in the VBP arrangement, in order for the MCO to count the non-primary care VBP in its Attachment E reporting. If there are not at least two applicable measures in Attachment C, the MCO must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its Attachment E reporting.	5.4.1.2.3.1.1. If an MCO implements a VBP arrangement with primary care providers, the VBP arrangement must include at least two incentive-based measures from Attachment C in order for the MCO to report the primary care VBP in its Attachment E reporting. 5.4.1.2.3.1.2. If an MCO implements a VBP arrangement for services other than primary care, the MCO must include at least any two applicable ~~incentive-based~~ measures from Attachment C in the VBP arrangement, in order for the MCO to count the non-primary care VBP in its Attachment E reporting. If there are not at least two applicable measures in Attachment C, the MCO must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its Attachment E reporting.	These revisions restore the phrase "incentive-based" in Section 5.4.1.2.3.1.1 and remove it from Section 5.4.1.2.3.1.2. The deletion was incorrectly applied in Amendment 6.
2.	6.23.3.1. NEMT/NEAT transportation includes the following, when necessary to ensure the delivery of necessary medical services: • Transportation for the member and one attendant, by any means permitted by law, including but not limited to the requirements of La. R.S. 40:1203.1 et seq.; • The use of any service that utilizes drivers that have not met the requirements of La. R.S. 40:1203.1 et seq. is strictly prohibited; and • For trips requiring long distance travel, in accordance with Section 6.23.2.3, the cost of meals and lodging and other related travel expenses determined to be necessary to secure medical examinations and treatment for a member.	6.23.3.1. NEMT/NEAT transportation includes the following, when necessary to ensure the delivery of necessary medical services: • Transportation for the member and one attendant, by any means permitted by law, including but not limited to the requirements of La. R.S. 40:1203.1 et seq.; • The use of any service that utilizes drivers that have not met the requirements of La. R.S. 40:1203.1 et seq. is strictly prohibited; and • For trips requiring long distance travel, in accordance with Section 6.23.~~2.~~3.2, the cost of meals and lodging and other related travel expenses determined to be necessary to secure medical examinations and treatment for a member.	This revision corrects a reference error.
3.	12.6.2 The MCO must obtain prior written approval from LDH for any activities that include sponsorships. …	12.6.2 The MCO must obtain prior written approval from LDH for any activities that include sponsorships or grants. …	This revision aligns the contract with current practices. Historically, LDH has considered grants to be a form of sponsorship.

Item	Change From:	Change To:	Justification
	12.6.4 All proposed events and activities, including proposed sponsorships, must be submitted to LDH using the Event Submission Form. (See Appendix D)	12.6.4 All proposed events and activities, including proposed sponsorships or grants, must be submitted ~~to LDH using the Event Submission Form~~ via email to MMEReview@la.gov or online at www.ldh.la.gov/MME. ~~(See Appendix D)~~	
4.	12.6.5 Review Process for Events and Activities 12.6.5.1 LDH will review proposed sponsorship, press or media events and activities and either approve or deny within fourteen (14) business days from the date of submission. 12.6.5.2 In the case where a sponsorship, press, or media event or activity arises and approval within the seven (7) business day timeframe is not possible due to the proximity of the event or activity, the MCO may request an expedited approval. LDH reserves the right to deny such requests. … 12.6.5.4 Proposed sponsorships, press or media events and activities, except for those included in the original MCO marketing and member education plan, are deemed approved if a response from LDH is not returned within seven (7) business days following notice of event to LDH. 12.6.5.5 Any revisions to approved sponsorships, press or media events and activities must be resubmitted for approved by LDH prior to the event or activity using the **Event Submission Calendar**.	12.6.5 Review Process for Events and Activities 12.6.5.1 LDH will review proposed sponsorships, grants, press or media events and activities and either approve or deny within ~~fourteen (14) business~~ seven (7) calendar days from the date of submission. 12.6.5.2 In the case where a sponsorship, grant, press, or media event or activity arises and approval within the seven (7) calendar ~~business~~ day timeframe is not possible due to the proximity of the event or activity, the MCO may request an expedited approval. LDH reserves the right to deny such requests. … 12.6.5.4 Proposed sponsorships, grants, press or media events and activities, except for those included in the original MCO marketing and member education plan, are deemed approved if a response from LDH is not returned within seven (7) calendar ~~business~~ days following notice of event to LDH. 12.6.5.5 Any revisions to approved sponsorships, grants, press or media events and activities must be resubmitted for ~~approved~~ approval by LDH prior to the event or activity ~~using the **Event Submission Calendar**~~ via email **to MMEReview@la.gov**.	These revisions align the contract with current practices and corrects a conflict in the review timeline.
5.	12.11.2.2.3 All contents of the welcome packet are considered member materials and, as such, shall be reviewed and approved in writing by LDH prior to distribution according to the provisions described in this Contract. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:	12.11.2.2.3 All contents of the welcome packet are considered member materials and, as such, shall be reviewed and approved in writing by LDH prior to distribution according to the provisions described in this Contract. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:	This revision removes the requirement to include the Member Handbook and Provider Directory in the welcome packet, as instructions on how to obtain these materials is required in the Welcome Member Newsletter.

Item	Change From:	Change To:	Justification
	• A Member Handbook and/or Welcome Member Newsletter; • The MCO Member ID Card (if not mailed under a separate mailing); • If the Member ID Card is mailed separately, a welcome letter highlighting major program features, details that a card specific to the MCO's Medicaid Managed Care Plan will be sent via mail separately and contact information for the MCO's Medicaid Managed Care Plan; and • A current Provider Directory when specifically requested by the member (also must be available in searchable format online).	• ~~A Member Handbook and/or~~ Welcome Member Newsletter; • The MCO Member ID Card (if not mailed under a separate mailing); and • If the MCO Member ID Card is mailed separately, a ~~welcome letter~~ the Welcome Letter highlighting major program features, details that the MCO Member ID Card ~~a card specific to the MCO's Medicaid Managed Care Plan~~ will be sent via mail separately and MCO contact information ~~for the MCO's Medicaid Managed Care Plan; and~~. • ~~A current Provider Directory when specifically requested by the member (also must be available in searchable format online).~~	This complies with 42 CFR § 438.10(g)(3) and (h)(1). A model Welcome Newsletter and model Welcome Letter are located in the Marketing and Member Education Companion Guide.
6.	12.12.1.40.1. Should the MCO elect not to provide a Member Handbook hard copy at the time of sending the welcome packet for new members, the MCO shall develop and maintain a welcome newsletter that adheres to the requirements in 42 CFR §438.10.	12.12.1.40.1. ~~Should the MCO elect not to provide a Member Handbook hard copy at the time of sending the welcome packet for new members, the~~ The MCO shall develop and maintain a welcome newsletter that adheres to the requirements in 42 CFR §438.10.	This revision coincides with removal of the requirement include the Member Handbook in the welcome packet.
7.	12.13. Member Identification (ID) Cards 12.13.1. MCO members will be issued at a minimum two (2) different member identification cards related to their enrollment in the Louisiana Medicaid managed care delivery system. The MCO may opt to provide members with a third ID card, if the MCO elects to issue a separate pharmacy-related ID card. 12.13.2 A LDH issued ID card will be issued to all Medicaid eligibles, including MCO members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by MCO providers. These systems will contain the most current information available to LDH, including specific information regarding MCO enrollment. There will be no MCO specific information printed on the card. The MCO member may need to show this card to access Medicaid services not included in the MCO core benefits and services.	12.13. Member Identification (ID) Cards 12.13.1. Enrollees will be issued up to three (3) different ID cards related to their enrollment in the Louisiana Medicaid managed care program. ~~MCO members will be issued at a minimum two (2) different member identification cards related to their enrollment in the Louisiana Medicaid managed care delivery system. The MCO may opt to provide members with a third ID card, if the MCO elects to issue a separate pharmacy-related ID card.~~ 12.13.1.1 An LDH issued ID card will be issued to all Medicaid eligibles, including MCO members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by MCO providers. These systems will contain the most current information available to LDH, including specific information regarding MCO enrollment. There will be	These revisions address the addition of a DBPM card, consolidating the MCO and PBM member ID cards into one MCO Member ID Card for improved manageability, and incorporating the standards and requirements of the National Council for Prescription Drug Programs. The revisions also prohibit the inclusion of the member's date of birth on the MCO Member ID Card to allow for the date of birth to be utilized as one of the authentication factors.

<table>
<tr><th>Item</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td></td><td>12.13.3 An MCO-issued member ID card that contains information specific to the MCO. The member's ID card shall at a minimum include, but not be limited to, the following information as it applies to the covered populations as specified in section 3.3.3:
• The member's name and date of birth;
• The MCO's name and address;
• Instructions for emergencies;
• The PCP's name and telephone numbers (including after-hours number, if different from business hours number);
• The toll-free number(s) for:
○ 24-hour Nurse Line
○ The Member Services Line
○ and Filing Grievances
○ 24-hour behavioral health crisis line
○ Provider Services and Prior Authorization and
○ Reporting Medicaid Fraud (1-800-488-2917); and
• The member's Unique Identifying number encoded into a standard 2D, QR machine-readable barcode and printed with a minimum 3/4" height and width. The MCO shall convert all ID cards to include this barcode by June 30, 2021.</td><td>no MCO specific information printed on the card. The MCO member may need to show this card to access Medicaid services not included in the MCO core benefits and services.

12.13.1.2 A Dental Benefit Program Manager (DBPM) issued ID card will be issued to all eligible enrollees. It will be used by enrollees to access dental benefits provided through the DBPM.

12.13.1.3 The MCO shall issue an MCO Member ID Card to its members. The MCO Member ID Card must be clearly legible with a minimum font size of six (6) points, preferably eight (8) points, and shall comply with guidance from the Workgroup for Electronic Data Interchange (WEDI) Health Identification Card Implementation Guide. Exceptions due to space constraints may be considered on case by case basis and must be approved, in writing, by LDH.

12.13.2 Effective September 1, 2022 for new and reissued MCO Member ID Cards, the card shall include, at a minimum ~~An MCO-issued member ID card that contains information specific to the MCO. The member's ID card shall at a minimum include, but not be limited to~~, the following information as it applies to the covered populations as specified in section 3.3.3:
• The MCO's name, or identifying trademark, address, and identifier (plan ID);
• The member's name;
• The Member ID Number, which shall be a unique identifying number assigned by the MCO;
• The PCP's name, address, and telephone number(s) (including after-hours number, if different from business hours number);
• The PBM's name, or identifying trademark, and address;
• RxBIN and other electronic transaction routing information and other numbers required by the MCO or the benefit administrator to process</td><td></td></tr>
</table>

Item	Change From:	Change To:	Justification
		a prescription claim electronically, including, but not limited to, the RxPCN, RxGRP, or RXID, including FFS information for members enrolled for Specialized Behavioral Health and NEMT and/or NEAT services only; • The Member ID Number encoded into a standard 2D, QR machine-readable barcode and printed with a minimum ¾" height and width; • Instructions for emergencies; and • The toll-free number(s) for: o The 24-hour Nurse Line; o The Member Services Line; o The 24-hour behavioral health crisis line; o Filing appeals and grievances; o Provider services and prior authorization and; o Pharmacy benefit assistance; o Pharmacy services and prior authorization; and o Reporting Medicaid Fraud (1-800-488-2917). • The member's name and date of birth; • The MCO's name and address; • Instructions for emergencies; • The PCP's name and telephone numbers (including after-hours number, if different from business hours number); • The toll-free number(s) for: o 24-hour Nurse Line o The Member Services Line o and Filing Grievances o 24-hour behavioral health crisis line o Provider Services and Prior Authorization and o Reporting Medicaid Fraud (1-800-488-2917); and • The member's Unique Identifying number encoded into a standard 2D, QR machine-readable barcode and printed with a minimum 3/4" height and	

Item	Change From:	Change To:	Justification
		~~width. The MCO shall convert all ID cards to include this barcode by June 30, 2021.~~ 12.13.2.1 LDH may grant exceptions to the required content of the MCO Member ID Card due to space constraints on case by case basis. Exceptions must be approved in writing by LDH. 12.13.2.2 MCOs shall not include the member's date of birth on new and reissued MCO Member ID Cards effective September 1, 2022. All MCO Member ID Cards shall meet this standard by September 1, 2023. 12.13.2.2.1 MCOs shall utilize two-factor and dynamic knowledge-based authentication before details about the member are discussed over the phone. Information used to authenticate the member shall not include information that can be readily found on their MCO Member ID Card. [Subsequent provisions renumbered]	
8.	**12.13.4. Pharmacy-Related ID Card Requirements** 12.13.4.1. The MCO shall provide on the member's identification card, or on a separate prescription benefit card, or through other technology, prescription billing information that: 12.13.4.1.1. Complies with the standards set forth in the National Council for Prescription Drug Programs pharmacy ID card prescription benefit card implementation guide at the time of issuance of the card or other technology; or	~~**12.13.4. Pharmacy-Related ID Card Requirements**~~ ~~12.13.4.1. The MCO shall provide on the member's identification card, or on a separate prescription benefit card, or through other technology, prescription billing information that:~~ ~~12.13.4.1.1. Complies with the standards set forth in the National Council for Prescription Drug Programs pharmacy ID card prescription benefit card implementation guide at the time of issuance of the card or other technology; or~~	This deletion is due to the incorporation of pharmacy-specific requirements into the MCO Member ID Card requirements.

Item	Change From:	Change To:	Justification
	12.13.4.1.2. Includes, at a minimum, the following data elements: 12.13.4.1.2.1. The name or identifying trademark of the MCO and the prescription benefit manager (see co-branding restrictions in Section 12.20.3); 12.13.4.1.2.2. The name and MCO member identification number of the recipient; 12.13.4.1.2.3. The telephone number that providers may call for: • Pharmacy benefit assistance; • 24-hour member services and filing grievances; • Provider services and prior authorization; and • Reporting Medicaid Fraud (1-800-488-2917) 12.13.4.1.3. All electronic transaction routing information and other numbers required by the MCO or its benefit administrator to process a prescription claim electronically. 12.13.4.1.4. If the MCO chooses to include the prescription benefit information on the Medicaid Managed Care Plan card, the MCO must ensure all members have a card that includes all necessary prescription benefit information, as outlined above. 12.13.4.1.5. If the MCO chooses to provide a separate prescription benefit card, the card mailer that accompanies the card must include language that explains the purpose of the card, how to use the card and how to use it in tandem with the LDH-issued Medicaid Card and the MCO-issued card.	~~12.13.4.1.2. Includes, at a minimum, the following data elements:~~ ~~12.13.4.1.2.1. The name or identifying trademark of the MCO and the prescription benefit manager (see co-branding restrictions in Section 12.20.3);~~ ~~12.13.4.1.2.2. The name and MCO member identification number of the recipient;~~ ~~12.13.4.1.2.3. The telephone number that providers may call for:~~ ~~• Pharmacy benefit assistance;~~ ~~• 24-hour member services and filing grievances;~~ ~~• Provider services and prior authorization; and~~ ~~• Reporting Medicaid Fraud (1-800-488-2917)~~ ~~12.13.4.1.3. All electronic transaction routing information and other numbers required by the MCO or its benefit administrator to process a prescription claim electronically.~~ ~~12.13.4.1.4. If the MCO chooses to include the prescription benefit information on the Medicaid Managed Care Plan card, the MCO must ensure all members have a card that includes all necessary prescription benefit information, as outlined above.~~ ~~12.13.4.1.5. If the MCO chooses to provide a separate prescription benefit card, the card mailer that accompanies the card must include language that explains the purpose of the card, how to use the card and how to use it in tandem with the LDH-issued Medicaid Card and the MCO-issued card.~~	

Item	Change From:	Change To:	Justification
9.	12.23.1.1 A summary report of all marketing and member education efforts must be submitted to LDH within thirty (30) days of the end of the calendar year using a **Marketing Plan Annual Review** format guidance provided by LDH.	12.23.1.1 A ~~summary report of all~~ Marketing and Member Education Plan detailing planned marketing and member education efforts must be submitted to LDH via e-mail at MMEReview@la.gov using the template and guidance in the **Marketing and Member Education Companion Guide** at the following times: ~~within thirty (30) days of the end of the calendar year using a **Marketing Plan Annual Review** format guidance provided by LDH.~~ 12.23.1.1.1 Within thirty (30) calendar days of the signed contract; 12.23.1.1.2 Before a new marketing or member education goal or strategy is implemented; and 12.23.1.1.3 Within thirty (30) calendar days of the end of the calendar year, unless a plan has been submitted within the previous six (6) months. 12.23.1.2 The MCO shall submit a quarterly report of all marketing and member education efforts to LDH in accordance with the **Marketing and Member Education Companion Guide**.	These revisions align the deliverables with current practices and clarifies expectations on the frequency of submissions.
10.	14.5.6 LDH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	14.5.6 LDH shall be included in all correspondence to the Council, including the distribution of council meeting agendas and ~~Council~~ minutes. Additionally, all council meeting agendas and ~~Council~~ minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted. 14.5.6.1 Council meeting minutes shall be submitted to **MMEReview@la.gov** within thirty (30) calendar days after the council meeting and posted to the MCO website within thirty (30) calendar days after LDH approval.	These revisions clarify that the council meeting minutes must be approved by LDH and establishes a deadline for posting.
11.	15.7.8 LDH or its agent shall have the right to audit and investigate providers and members within the MCO'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 MCO via a deduction from the MCO's capitation payment, any overpayments identified by LDH or its agent, and said recovered funds will be	15.7.8 LDH or its agent shall have the right to audit and investigate providers and members within the MCO'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 MCO via a deduction from the MCO's capitation payment, ~~any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State. The MCO may pursue recovery from the provider as a~~	This revision is to explicitly state LDH's intent to capture overpayments, overpayments identified through statistical sampling, and monetary penalties from the MCO capitation payments.

Item	Change From:	Change To:	Justification
	retained by the State. The MCO may pursue recovery from the provider as a result of the State-identified overpayment.	~~result of the State-identified overpayment.~~ 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: • Monetary penalties assessed in accordance with the SURS Rule (Louisiana Administrative Code 50:I.4161.A.18); • State-identified improper payments and overpayments; • Overpayments determined through statistical sampling (extrapolation); and • Investigation costs. Any ~~any~~ overpayments identified by LDH or its agent, and said recovered funds will be retained by the State. The MCO may pursue recovery from the provider as a result of the State-identified overpayment. However, the MCO is prohibited from recouping a State-identified overpayment from a provider when the MCO is responsible for the overpayment, unless approved in writing by LDH.	
12.	15.7.14 In the event LDH or its agent recovers funds from the MCO due to a provider overpayment, the MCO may recover from the provider. If the MCO recovers State-identified improper payments, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH.	15.7.14 In the event LDH or its agent recovers ~~funds~~ any amounts assessed to a provider as a result of an LDH audit as provided for within this Section from the ~~MCO due to a provider overpayment,~~ MCO's capitation payment or any other method, the MCO may pursue recovery from the provider. However, the MCO is prohibited from recouping a State-identified overpayment from a provider when the MCO is responsible for the overpayment, unless approved in writing by LDH. If the MCO recovers State-identified improper payments, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH.	This revision is to explicitly state LDH's intent to capture overpayments, overpayments identified through statistical sampling, and monetary penalties from the MCO capitation payments.
13.	[new acronym]	[Acronyms] **DBPM** – Dental Benefit Program Manager	This revision corresponds with the addition of a provision referencing DBPM issued ID cards.

Item	Change From:	Change To:	Justification
14.	[List of Appendices] Appendix D – LDH Event Submission Form	[List of Appendices] Appendix D – ~~LDH Event Submission Form~~ Reserved	This revision removes the LDH Event Submission Form as an appendix as it is no longer used.

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

Justification for items 1-2: Revisions are being made to retire two quality measures.

Justification for items 3-4: These measures are already reported as part of the CMS Child Core Set, and are being added to the list of required reported measures for consistency, as the other contraception measures were already included.

Item	Change From:	Change To:
1	19. Elective Delivery or Early Induction Without Medical Indication | This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed	~~19. Elective Delivery or Early Induction Without Medical Indication~~ | ~~This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed~~ *[subsequent provisions renumbered]*
2	26. Percentage of Eligibles Who Received Preventive Dental Services *(Note: CMS will calculate this measure and MCOs will not be required to report).* | The percentage of individuals ages 1 to 20 who are enrolled for at least 90 continuous days, are eligible EPSDT services, and who received at least one preventive dental service during the reporting period. | CMS	~~26. Percentage of Eligibles Who Received Preventive Dental Services~~ ~~*(Note: CMS will calculate this measure and MCOs will not be required to report).*~~ | ~~The percentage of individuals ages 1 to 20 who are enrolled for at least 90 continuous days, are eligible EPSDT services, and who received at least one preventive dental service during the reporting period.~~ | ~~CMS~~ *[subsequent provisions renumbered]*
3	*(new item added)*	29. Contraceptive Care – All Women Ages 15-20 | The percentage of women ages 15-20 who are at risk of unintended pregnancy and were provided a most or moderately effective method of contraception or were provided a LARC. Two rates are reported.

<table>
<tr><th>Item</th><th>Change From:</th><th>Change To:</th></tr>
<tr><td>4</td><td>(new item added)</td><td><table><tr><td>30. Contraceptive Care – Postpartum Women Ages 15-20</td><td>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.</td></tr></table>[subsequent provisions renumbered]</td></tr>
</table>

Attachment G

ADDENDUM TO CONTRACT:

ADDITIONAL REQUIREMENTS FOR OIG COMPLIANCE

The Louisiana Department of Health ("LDH") has entered into a State Agency Compliance Agreement ("Compliance Agreement") with the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). The Compliance Agreement includes requirements that are applicable to LDH and to certain of its contractors and subcontractors who meet the definition of "Covered Person" as provided below, and this Addendum is attached to all LDH contracts with such "Covered Person" contractors.

1. *Definitions*. For purposes of this Addendum:

   a. "Covered Person" shall include any contractor, subcontractor, agent, or other person who furnishes patient care items or services or who performs billing or coding functions on behalf of LDH, excluding vendors whose sole connection with LDH is selling or otherwise providing medical supplies or equipment to LDH.

      i. "Individual Covered Person" means a Covered Person who is a natural person and includes any individual who is an officer, employee, member, or partner of a Corporate Covered Person, as defined below, and who participates in the performance of any work or services under the contract.

      ii. "Corporate Covered Person" means any Covered Person that is not an Individual Covered Person, including but not limited to a corporation, limited liability company (LLC), partnership, or other legal entity.

   b. "Ineligible Person" shall include an individual or entity who:

      i. is currently excluded from participation in any Federal health care program; or

      ii. has been convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7(a), but has not yet been excluded.

   c. "Exclusion List" means the HHS/OIG List of Excluded Individuals/Entities (LEIE) (available through the Internet at http://www.oig.hhs.gov).

2. *Training Requirements*. In accordance with the written Training Plan developed by LDH, Covered Persons must receive at least annual training regarding LDH's Compliance Agreement requirements and the applicable Federal health care program requirements, including the requirements of the Anti-Kickback Statute and the Stark Law. A Corporate Covered Person shall

be responsible for ensuring that all Individual Covered Persons within its organization receive the required training.

3. *Screening and Disclosure Requirements.*

   a. Before LDH enters into a contract with a prospective Covered Person, it will screen that prospective Covered Person against the Exclusion List, and a Corporate Covered Person shall be responsible for screening all Individual Covered Persons within its organization against the Exclusion List. Thereafter, LDH and all current Corporate Covered Persons shall continue to perform such screening on a monthly basis.

   b. Both during and after the contracting process, all prospective and current Covered Persons shall immediately disclose in writing to LDH as soon as they discover that that they are, or have become, an Ineligible Person. A Corporate Covered Person shall be responsible for facilitating and expediting such disclosures to LDH with regard to any Individual Covered Person within its organization who is an Ineligible Person.

4. *Removal Requirements.*

   a. If LDH receives actual notice that a Covered Person has become an Ineligible Person, it shall remove such Covered Person from responsibility for, or involvement with, LDH's business operations related to the Federal health care program(s) from which such Covered Person has been excluded and shall remove such Covered Person from any position for which the Covered Person's compensation or the items or services furnished, ordered, or prescribed by the Covered Person are paid in whole or part, directly or indirectly, by any Federal health care program(s) from which the Covered Person has been excluded at least until such time as the Covered Person is reinstated into participation in such Federal health care program(s).

   b. If LDH receives actual notice that a Covered Person is charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a), 1320a-7(b)(1)-(3), or is proposed for exclusion during the Covered Person's employment or contract term, LDH shall take all appropriate actions to ensure that the responsibilities of that Covered Person have not and shall not adversely affect the quality of care rendered to any beneficiary or the accuracy of any claims submitted to any Federal health care program.

   c. A Corporate Covered Person shall be responsible for facilitating and expediting the removal of any Individual Covered Person within its organization who is an Ineligible Person.

5. *Flowdown of Requirements.* A Covered Person shall be responsible for ensuring that any subcontractor, agent, or other person to whom it delegates the performance of any work or services under the contract shall comply with all requirements contained in this Addendum that are applicable to the subcontractor, agent, or other person as a Covered Person.