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: 2000441825

Amendment Number: 6

Vendor: AMERIHEALTH CARITAS LA INC

Description: Managed Care Organizations - Emergency

Approved By: PAMELA RICE

Approval Date: 07/23/2021 13:50:24

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 6

LAGOV#: 2000441825

LDH #:

MVA

Medical Vendor Administration

(Regional/ Program/ Facility)

Bureau of Health Services Financing

AND

Amerihealth Caritas Louisiana, Inc.

Contractor Name

Original Contract Amount: 1,318,564,254

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: $3,111,205,718.00 Current Contract Term: 01/01/20-12/31/21

Attachment B - Statement of Work.
Attachment E - APM Strategic Plan Requirements and Report

Change Contract To: To Maximum Amount: Changed Contract Term:

Attachment B6 - Changes to Statement of Work.
Attachment E - APM Strategic Plan Requirements and Report 2.26.21

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 revisions to the Statement of Work in order to align with provisions of the SUPPORT Act, the DOJ Agreement, and other state and federal regulations. There is also a minor revision to Attachment E for clarification.

This Amendment Becomes Effective: 01-01-2021

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

Amerihealth Caritas Louisiana, Inc.

CONTRACTOR SIGNATURE Rebecca J. Engelman **DATE** 4/20/21

PRINT NAME: Rebecca J. Engelman

CONTRACTOR TITLE: President

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE Tara A LeBlanc Digitally signed by Tara A LeBlanc Date: 2021.04.26 15:07:45 -05'00' **DATE**

NAME: Tara LeBlanc

TITLE: Interim Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE **DATE**

NAME

Contract Amendment #6
Attachment B6

Changes to Statement of Work

Item	Change From:	Change To:	Justification
1	5.4.1.2.1 Physician Incentive Plans 5.4.1.2.1.1 In accordance with §422.208 and §422.210, the MCO 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 a member.	5.4.1.2.1 Physician Incentive Plans 5.4.1.2.1.1 In accordance with 42 C.F.R. §438.3(i), §422.208, and §422.210, the MCO 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 a member.	
2	5.4.1.2.2. Value-Based Payments … 5.4.1.2.3.1. Annually, by August 30 of the current contract year, 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 MCO incentive-based measures in Attachment C, or other Attachment C measures for non-primary care VBP arrangements. As part of its VBP agreements, the MCO shall not hold providers accountable for meeting a higher target for the incentive-based measure than the target to which LDH holds the MCO for the same measure unless the provider is already performing above the benchmark set by LDH for MCO performance on the IB measure. 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 in Attachment C in order for the MCO to report the primary care VBP in its Attachment E VBP 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 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	5.4.1.2.2. Value-Based Payments … 5.4.1.2.3.1. Annually, on or before ~~by~~ August 30 ~~of the current contract year~~, 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 MCO incentive-based measures in Attachment C, or other Attachment C measures for non-primary care VBP arrangements. As part of its VBP agreements, the MCO shall not hold providers accountable for meeting a higher target for the incentive-based measure than the target to which LDH holds the MCO for the same measure unless the provider is already performing above the benchmark set by LDH for MCO performance on the ~~IB~~ incentive-based measure. 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 in Attachment C in order for the MCO to report the primary care VBP in its Attachment E ~~VBP~~ 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 incentive-based measures in Attachment C, the	These revisions will allow LDH flexibilities regarding VBP withhold determinations and COVID-19 impacts. In addition, Attachment E has been revised to provide clarification to the MCOs and capture additional data that appears in the VBP Strategic Plan.

Item	Change From:	Change To:	Justification
	selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its Attachment E reporting. 5.4.1.2.3.1.3. To increase simplification and consistency in provider performance data reporting, the MCO must use performance measure specifications in its VBP arrangements that align with the LDH specifications for measures in Attachment C where the MCO is utilizing any measure included in Attachment C. … 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 in Attachment C in order for the MCO to report the primary care VBP in its Attachment E VBP reporting. 5.4.1.2.3.2. Annually, by March 15th submit to LDH a report on its VBP use for the prior Calendar Year as specified in Attachment E and a VBP year end report. In reporting its VBP use and provider payments, the MCO shall use a "date of payment" approach to complete Attachment E. 5.4.1.2.3.3. If LDH determines that the MCO use of recognized VBP models meets both of the following two VBP targets, 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 MCO performance measures in Attachment C as defined in 5.4.1.2.3.1 above. … 5.4.1.2.3.3.3. LDH will refund to the MCO half of the remaining amounts withheld for VBP during if the MCO meets either the VBP targets in 5.4.1.2.3.3.1 or 5.4.1.2.3.3.2.	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. 5.4.1.2.3.1.3. To increase simplification and consistency in provider performance data reporting, the MCO must use performance measure specifications in its VBP arrangements that align with the LDH specifications for measures in Attachment C ~~where~~ when the MCO is utilizing any measure included in Attachment C. … 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 ~~in~~ from Attachment C, one of which must be an incentive-based measure, in order for the MCO to report the primary care VBP in its Attachment E VBP reporting. … 5.4.1.2.3.2. Annually, ~~by~~ on or before March 15th submit to LDH a report on its VBP use for the prior Calendar Year as specified in Attachment E and a VBP year end report. In reporting its VBP use and provider payments, the MCO shall use a "date of payment" approach to complete Attachment E. If the MCO did not meet the VBP targets identified in 5.4.1.2.3.3 below, the MCO shall describe why the VBP targets were not met. 5.4.1.2.3.3. If LDH determines that the MCO's use of recognized VBP models meets both of the following two VBP targets, 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 MCO performance measures in Attachment C as defined in 5.4.1.2.3.1 above.	

Item	Change From:	Change To:	Justification
	… [Add new section] … 5.4.1.2.4. LDH shall retain the amount of the VBP withhold not earned back from the MCO.	… 5.4.1.2.3.3.3. LDH will refund to the MCO half of the remaining amounts withheld for VBP during the calendar year if the MCO meets either the VBP targets in 5.4.1.2.3.3.1 or 5.4.1.2.3.3.2. … 5.4.1.2.3.3.5. LDH may refund to the MCO some of the remaining amounts withheld for VBP during the calendar year if the MCO partially meets one or both of the VBP targets in 5.4.1.2.3.3.1 and 5.4.1.2.3.3.2 and describes to LDH's satisfaction why the MCO did not fully meet the VBP targets. … 5.4.1.2.4. LDH shall retain the amount of the VBP withhold not earned back ~~from~~ by the MCO.	
3	5.7.1. LDH will develop cost-effective and actuarially sound rates according to all applicable CMS rules and regulations. LDH will not use a competitive bidding process to develop the MCO capitation. LDH will develop monthly capitation rates that will be offered to MCOs on a "take it or leave it" basis. 5.7.2. Rates will be set using fee-for-service claims data, Medicaid Managed Care Shared Savings claims experience, Medicaid Managed Care MCO encounter data, LBHP encounter data, and financial data and supplemental ad hoc data and analyses appropriate for determining actuarially sound rates. Fiscal periods of the base data will be determined based upon the data sources, rate periods and purposes for which the data is used with appropriate adjustments which include the following: …	5.7.1. LDH will develop cost-effective and actuarially sound rates ~~according to~~ in accordance with 42 CFR §438.4 through §438.7 and all applicable CMS rules and regulations. LDH will not use a competitive bidding process to develop the MCO capitation. LDH will develop monthly capitation rates that will be offered to MCOs on a "take it or leave it" basis. 5.7.2. Rates will be set using ~~fee-for-service claims data, Medicaid Managed Care Shared Savings claims experience, Medicaid Managed Care MCO encounter data, LBHP~~ encounter data, ~~and~~ financial data, and supplemental ad hoc data and analyses appropriate for determining actuarially sound rates. Fiscal periods of the base data will be determined based upon the data sources, rate periods and purposes for which the data is used with appropriate adjustments which include the following: …	These revisions provide flexibility to utilize the additional options related to rate development established by the managed care final rule published on November 13, 2020. Revisions also remove duplication and the use of obsolete data in rate setting.

Item	Change From:	Change To:	Justification
	5.7.4. Any adjusted rate must continue to be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c), and will require an amendment to the Contract that is mutually agreed upon by both parties. 5.7.5. Additional factors determining the rate for an individual member may include: 1) age; 2) gender; 3) Medicaid category of assistance; 4) the geographic location of the member's residence; and 5) Medicare enrollment. 5.7.6. As the MCO Program matures and FFS data and Shared Savings data are no longer available, there will be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments. 5.7.7. The MCO shall be paid in accordance with the monthly capitated rates specified in Contract Attachment D – Mercer Certification, Rate Development Methodology and Rates of this Contract. 5.7.8. The rates will be reviewed and may be periodically adjusted. Any adjusted rates shall be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c). 5.7.9. The MCO shall provide in writing any information requested by LDH to assist in the determination of MCO rates. LDH will give the MCO reasonable time to respond to the request and full cooperation by the MCO is required. LDH will make the final determination as to what is considered reasonable.	5.7.4. ~~Any adjusted rate must continue to be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c), and will require an amendment to the Contract that is mutually agreed upon by both parties.~~ ~~5.7.5.~~ Additional factors determining the rate for an individual member may include: 1) age; 2) gender; 3) Medicaid category of assistance; 4) the geographic location of the member's residence; and 5) Medicare enrollment. ~~5.7.6. As the MCO Program matures and FFS data and Shared Savings data are no longer available, there will be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments.~~ 5.7.5~~7~~. The MCO shall be paid in accordance with the monthly capitated rates specified in Contract Attachment D – Mercer Certification, Rate Development Methodology and Rates of this Contract. 5.7.6~~8~~. The rates will be reviewed and may be periodically adjusted. Any adjusted rates shall be actuarially sound, ~~and~~ consistent with requirements set forth in 42 CFR ~~§438.6(c)~~§438.4 through §438.7, and will require an amendment to the Contract. 5.7.7~~9~~. The MCO shall provide, in writing, any information requested by LDH to assist in the determination of MCO rates. LDH will give the MCO reasonable time to respond to the request, and full cooperation by the MCO is required. LDH will make the final determination as to what is considered reasonable.	
4	5.9.1. In accordance with the MCO Financial Reporting Guide published by LDH, the MCO shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year. 5.9.1.1. An MLR shall be reported in the aggregate, including all medical services covered under the contract.	5.9.1. In accordance with the MCO Financial Reporting Guide published by LDH and 42 CFR §438.8, the MCO shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year, which shall be a calendar year.	Under a provision of the SUPPORT Act, Louisiana would be entitled a larger share of any MLR rebate received from a contracted Managed Care Entity. CMS has allowed for the Federal share of MLR remittance attributable to Expansion populations to be calculated at regular Federal Medical

Item	Change From:	Change To:	Justification
	5.9.1.1.1. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the MCO shall refund LDH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher. 5.9.1.2. LDH may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health. 5.9.1.2.1. Neither the minimum MLR standard (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.	5.9.1.1. An MLR shall be reported in the aggregate, including all medical services covered under the contract, unless LDH requires separate reporting and separate MLR calculations for specific populations. 5.9.1.1.1. If the aggregate MLR (cost for health care benefits and services and specified quality expenditures) or the MLR for any specific population is less than eighty-five percent (85%), the MCO shall refund LDH the difference. Any unpaid balances after the refund is due shall be subject to interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher. 5.9.1.2. LDH may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health. ~~5.9.1.2.1. Neither the minimum MLR standard (85%) nor the refund applicable to the aggregate MLR shall apply to distinct MLRs reported.~~	Assistance Percentage (FMAP), as opposed to the enhanced Expansion FMAP for periods within Federal Fiscal Years 2020 – 2023.
5	5.13.2.2. The MCO shall "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement from the TPL insurer (within sixty days after the end of the month in which the payment was made) for any liable TPL of legal liability if: • The claim is for prenatal care for pregnant women as defined by HPA 16-17; • The claim is for preventive pediatric services as defined by HPA 16-17; or • The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.	5.13.2.2. The MCO shall "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement from the TPL insurer (within sixty days after the end of the month in which the payment was made) for any liable TPL of legal liability if the claim is for preventive pediatric services, as defined in the **MCO Manual**: • ~~The claim is for prenatal care for pregnant women as defined by HPA 16-17;~~ • ~~The claim is for preventive pediatric services as defined by HPA 16-17; or~~ • ~~The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.~~ 5.13.2.3. Effective April 1, 2021, the MCO shall "wait and see" on claims for a service that is provided to an individual on whose behalf child support	These revisions are to comply with the Bipartisan Budget Act of 2018 (Pub. L. 115-123) signed into law on February 9, 2018 which includes several provisions which modify third party liability (TPL) rules related to special treatment of certain types of care and payment and changes made to the Bipartisan Budget Act of 2013 made in April of 2019.

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		enforcement is being carried out by the state Title IV-D agency. "Wait and see" is defined as payment of a claim only after documentation is submitted to the MCO demonstrating that one hundred (100) calendar days have elapsed since the provider billed the responsible third party and the provider has not received payment for such services. [subsequent provisions renumbered]	
6	[Add new section]	6.19.3.5 Members of the DOJ Agreement Target Population, including those members who are transitioning/have transitioned from a nursing facility or diverted from nursing facility care, shall receive case management services through MCO-contracted community case management agencies upon implementation of the community case management program unless the member declines the service or no longer needs the service as determined through a standardized assessment.	This addition is needed to comply with the DOJ Agreement which requires ongoing community-based case management be provided to members of the target population.
7	6.39.4.6. When OBH determines that nursing facility services are not appropriate, the MCO shall assist eligible members to obtain appropriate alternative behavioral health services available under this contract.	6.39.4.6 When OBH determines that nursing facility services are not appropriate, the MCO shall assist eligible members ~~to obtain~~ with obtaining appropriate alternative behavioral health services available under this contract. The MCO shall make a referral to an MCO-contracted community case management agency under the DOJ Agreement within one (1) business day of referral from LDH.	This revision clarifies the timeframe for the MCO to make referrals for eligible members to community case management services, which is further addressed in new sections 6.19.3.5 and 6.39.8. This requirement will be effective once MCOs provide community case management services as early as July 2021 but no later than October 2021.
8	[Add new section]	6.39.8. Community Case Management Program The MCO shall develop a specialized community case management program consistent with the DOJ Agreement and LDH-issued guidance for the DOJ Target Population transitioning or diverted from nursing facility care, as defined or identified by LDH, using subcontracted community case managers who meet the qualifications established by LDH. The MCO shall maintain	This addition is needed to comply with DOJ Agreement which requires ongoing community-based case management be provided to members of the target population, tracking and monitoring of member outcomes across several domains, tracking and monitoring of member service

Item	Change From:	Change To:	Justification
		ultimate responsibility for ensuring the case management needs of the DOJ Target Population are met by community case managers and community case managers satisfactorily complete required activities.	utilization, and reporting. LDH anticipates the MCOs will provide community case management services as early as July 2021 but no later than October 2021. Additional guidance about the community case management program will be provided in the DOJ Agreement Compliance Guide.
9	**7.3. Geographic Access Requirements** The MCO shall comply with the maximum travel time and/or distance requirements as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan. … **7.3.7. Specialized Behavioral Health Providers** 7.3.7.1. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members. 7.3.7.2. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or	**7.3. Geographic Access Requirements** The MCO shall comply with the maximum ~~travel time and/or~~ distance standards ~~requirements~~ as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan. … **7.3.7. Specialized Behavioral Health Providers** 7.3.7.1. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed thirty (30) miles ~~or 60 minutes~~ for ninety percent (90%) of such members. 7.3.7.2. Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not	These revisions remove the time standard from the geographic access requirements, as allowed by the managed care final rule published on November 13, 2020, which revised 42 CFR §438.68(b)(1) and (2) by deleting the requirements for states to set time and distance standards and adding a more flexible requirement that states set a quantitative network adequacy standard.

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	LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members. 7.3.7.3. Travel distance to psychiatric inpatient hospital services shall not exceed 90 miles or 90 minutes for 90% of members. Maximum time for admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary). 7.3.7.4. Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. 7.3.7.5. Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days. 7.3.7.6. Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days. 7.3.7.7. Travel distance to ASAM Level 3.7WM shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary. 7.3.7.8. Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles or 3.5 hours for 100% of members. Maximum time for admission shall not exceed 20 calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.	exceed fifteen (15) miles ~~or 30 minutes~~ for ninety percent (90%) of such members. 7.3.7.3. Travel distance to psychiatric inpatient hospital services shall not exceed ninety (90) miles ~~or 90 minutes~~ for ninety percent (90%) of members. Maximum time for admission shall not exceed four (4) hours (emergency involuntary), twenty-four (24) hours (involuntary), or twenty-four (24) hours (voluntary). 7.3.7.4. Travel distance to ASAM Level 3.3 shall not exceed thirty (30) miles ~~or 60 minutes~~ for ninety percent (90%) of adult members. Maximum time for admission or appointment shall not exceed ten (10) business days. 7.3.7.5. Travel distance to ASAM Level 3.5 shall not exceed thirty (30) miles ~~or 60 minutes~~ for ninety percent (90%) of adult members and shall not exceed sixty (60) miles ~~or 90 minutes~~ for ninety percent (90%) of adolescent members. Maximum time for admission or appointment shall not exceed ten (10) business days. 7.3.7.6. Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed sixty (60) miles ~~or 90 minutes~~ for ninety percent (90%) of adult members. Maximus time for admission or appointment shall not exceed ten (10) business days. 7.3.7.7. Travel distance to ASAM Level 3.7WM shall not exceed sixty (60) miles ~~or 90 minutes~~ for ninety percent (90%) of adult members. Maximum time for admission or appointment shall not exceed ten (10) business days. Withdrawal management shall be available within twenty-four (24) hours when medically necessary. 7.3.7.8. Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed two hundred (200) miles ~~or 3.5 hours~~ for one hundred percent (100%) of members. Maximum time for admission shall not exceed twenty (20)	

Item	Change From:	Change To:	Justification
	7.3.7.9. Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval. 7.3.7.10. There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member. 7.3.7.9. Request for exceptions as a result of prevailing community standards for ~~time and~~ distance accessibility standards must be submitted in writing to LDH for approval. 7.3.7.10. There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	
10	7.6.3.7. The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to each MCO member who received his or her care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years.	7.6.3.7. The MCO shall notify its enrollees of provider terminations in accordance with the Marketing and Member Education section of this Contract~~make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt of issuance of the termination notice, to each MCO member who received his or her care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years~~.	This revision removes duplication. Refer to Section 12.21.1 for notification requirements.

Item	Change From:	Change To:	Justification
11	7.9.1. The MCO shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to LDH when significant changes occur and at least annually. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR §438. 68):	7.9.1. The MCO shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to LDH when significant changes occur and ~~at least annually~~ as directed by LDH. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR §438. 68):	This revision removes the annual submission of the Network Development and Management Plan. The Specialized Behavioral Health Network Development and Management Plan will remain an annual reporting requirement in accordance with section 7.9.8 and via report 053.
12	7.17.1.3. The MCO must keep an up-to-date pharmacy provider directory on its website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies: 7.17.1.3.1. Names, locations and telephone numbers. 7.17.1.3.2. Any non-English languages spoken. 7.17.1.3.3. Identification of hours of operation, including identification of providers that are open 24-hours per day. 7.17.1.3.4. Identification of pharmacies that provide vaccine services. 7.17.1.3.5. Identification of pharmacies that provide delivery services. 7.17.1.4. The MCO must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least annually. The online version should be updated in real time, but no less than weekly. …	7.17.1.3. The MCO must keep an up-to-date pharmacy provider directory on its website for public access. This directory must be web-based machine searchable, web-based machine readable, and mobile-enabled and include, but not be limited to, the following information on all contracted network pharmacies: 7.17.1.3.1. Names, locations and telephone numbers. 7.17.1.3.2. Any non-English languages spoken. 7.17.1.3.3. Identification of hours of operation, including identification of providers that are open 24-hours per day. 7.17.1.3.4. Identification of pharmacies that provide vaccine services. 7.17.1.3.5. Identification of pharmacies that provide delivery services. 7.17.1.4. The MCO must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least ~~annually~~ quarterly. The online version should be updated in real time, but no less than weekly.	These revisions to the pharmacy provider directory and general provider directory conform to the managed care final rule published on November 13, 2020 which revised information requirements in 42 CFR §438.10.

Item	Change From:	Change To:	Justification
	12.14. Provider Directory for Members 12.14.1. The MCO shall develop and maintain a Provider Directory in four (4) formats: 12.14.1.1. A hard copy directory, when requested, for members and potential members; 12.14.1.2. Web-based searchable, web-based machine readable, online directory for members and the public; 12.14.1.3. Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and 12.14.1.4. Hard copy, abbreviated version upon request by the Enrollment Broker. 12.14.2. The MCO shall utilize LDH-approved templates for its provider directory. 12.14.3. The hard copy directory for members shall be revised with updates at least monthly or no more than 30 days after the receipt of updated provider information. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by LDH.	… **12.14. Provider Directory for Members** 12.14.1. The MCO shall develop and maintain a Provider Directory in four (4) formats: 12.14.1.1. A hard copy directory, when requested, for members and potential members; 12.14.1.2. Web-based machine searchable, web-based machine readable, mobile-enabled, online directory for members and the public; 12.14.1.3. Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and 12.14.1.4. Hard copy, abbreviated version upon request by the Enrollment Broker. 12.14.2. The MCO shall utilize LDH-approved templates for its provider directory. 12.14.3. The hard copy directory for members shall be revised with updates at least quarterly~~monthly or no more than 30 days after the receipt of updated provider information~~. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by LDH.	

Item	Change From:	Change To:	Justification
13	**12.21. Notice to Members of Provider Termination** 12.21.1. The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider. 12.21.2. The MCO shall provide notice to a member, or the parent/legal guardian and the involved state agency as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	**12.21. Notice to Members of Provider Termination** 12.21.1. The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider, which shall be defined as one visit within the last eighteen (18) months. When timely notice from the provider is received or when the MCO initiates the termination, the notice to the member shall be provided by the later of thirty (30) calendar days prior to the effective date of the termination, or ~~within~~ fifteen (15) calendar days ~~of the~~ after receipt or issuance of the termination notice ~~from the provider~~. 12.21.2. The MCO shall provide notice to a member, or the parent/legal guardian and the involved state agency as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. ~~The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring.~~ Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	These revisions conform to the managed care final rule published on November 13, 2020 which revised information requirements in 42 CFR §438.10.
14	12.22.4. Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the	12.22.4. Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials critical to obtaining services must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral	These revisions conform to the managed care final rule published on November 13, 2020 which revised information requirements in 42 CFR §438.10.

Item	Change From:	Change To:	Justification
	information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.	interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a ~~font size no smaller than 18 point~~ conspicuously-visible font size as defined in 45 CFR §92.8(f)(1).	
15	13.2.4.2. The member may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution. … 13.4.2.1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. Unless the member requests an expedited appeal, the oral appeal shall be confirmed in writing.	13.2.4.2. The member may file an appeal either orally or in writing. ~~The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution.~~ … 13.4.2.1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. ~~Unless the member requests an expedited appeal, the oral appeal shall be confirmed in writing.~~	The managed care final rule published on November 13, 2020 eliminates the requirement for enrollees to submit a written, signed appeal after an oral appeal is submitted. [Refer to 42 CFR §438.402(c)(3)(ii) and §438.406(b)(3).]
16	16.15 CMS Interoperability and Patient Access The MCO shall be in compliance with the CMS Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (referred to as the "CMS Interoperability and Patient Access final rule") no later than July 1, 2021. The MCO shall: 16.15.1 Participate in development meetings as required by LDH.	16.15 CMS Interoperability and Patient Access The MCO shall ~~be in compliance~~ comply with the CMS Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (referred to as the "CMS Interoperability and Patient Access final rule") ~~no later than July 1, 2021~~ in accordance with timelines established by CMS and as directed by LDH through the **LDH MCE Interoperability Compliance Plan**. ~~The MCO shall:~~	This update provides flexibility for compliance with current and future interoperability and patient access rules and directs the MCOs to the LDH MCE Interoperability Compliance Plan for specific LDH direction on achieving compliance.

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	16.15.2 Implement and maintain a standards-based Patient Access application programming interface (API) to make certain health information about Medicaid and CHIP beneficiaries, as defined by CMS, accessible through the API, enabling enrollees to access their health data on their Internet-enabled devices. 16.15.3 Establish a Payer-to-Payer Data Exchange, to comply with enrollee requests to have their health data transferred from payer to payer, no later than January 1, 2022. 16.15.4 Make standardized information about provider networks available via a Fast Healthcare Interoperability Resources (FHIR) based Provider Directory API. The MCO shall provide current provider directory information via an API no later than July 1, 2021. 16.15.5 Make available required data in the United States Core Data for Interoperability (USCDI) residing in health information exchanges or public health agencies as described in 45 CFR 170.213. 16.16.6 Provide members free access to the MCO's API for purposes of the Patient Access and Provider Directory APIs.	~~16.15.1 Participate in development meetings as required by LDH.~~ ~~16.15.2 Implement and maintain a standards-based Patient Access application programming interface (API) to make certain health information about Medicaid and CHIP beneficiaries, as defined by CMS, accessible through the API, enabling enrollees to access their health data on their Internet-enabled devices.~~ ~~16.15.3 Establish a Payer-to-Payer Data Exchange, to comply with enrollee requests to have their health data transferred from payer to payer, no later than January 1, 2022.~~ ~~16.15.4 Make standardized information about provider networks available via a Fast Healthcare Interoperability Resources (FHIR) based Provider Directory API. The MCO shall provide current provider directory information via an API no later than July 1, 2021.~~ ~~16.15.5 Make available required data in the United States Core Data for Interoperability (USCDI) residing in health information exchanges or public health agencies as described in 45 CFR 170.213.~~ ~~16.16.6 Provide members free access to the MCO's API for purposes of the Patient Access and Provider Directory APIs.~~	
17	18.5.1 The MCO shall comply with the required format provided by LDH. Encounter data includes claims paid or denied by the MCO or the MCO's subcontractors for services delivered to enrollees through the MCO during a specified reporting period. LDH collects and uses this data for many reasons such as: federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care, LDH hospital rate setting and research studies.	18.5.1 The MCO shall comply with the required format provided by LDH. Encounter data includes claims paid or denied by the MCO or the MCO's subcontractors for services delivered to enrollees through the MCO during a specified reporting period. Submissions must include, at a minimum, all enrollee encounter data, including allowed amount and paid amount, that the State is required to report to CMS. LDH collects and uses this data for many reasons such as: federal reporting, rate setting, risk adjustment, service	This revision is to comply with the managed care final rule published on November 13, 2020 which requires MCOs to submit to the state the same encounter data that is submitted in T-MSIS submissions to CMS, including allowed amount and paid amount. [Refer to 42 CFR § 438.242(c)(3).]

<table>
<tr><th>Item</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td></td><td></td><td>verification, managed care quality improvement program, utilization patterns and access to care, LDH hospital rate setting and research studies.</td><td></td></tr>
<tr><td>18</td><td>18.9.3.3 Annual reports and files, and other deliverables due annually, shall be submitted within thirty (30) calendar days following the twelfth (12th) month of the contract year; except those annual reports that have an explicit deadline provided on the LDH website [link] or are specifically exempted from this 30-calendar-day deadline by this Contract. This Contract will specify the due date of any annual report it exempts from this 30-calendar-day deadline. If the Contract is terminated early, prior to 12/31/2020, the Contractor shall submit reports and other deliverables as specified by LDH in the notice of termination, or as otherwise provided in this contract; and</td><td>18.9.3.3 Annual reports and files, and other deliverables due annually, shall be submitted within thirty (30) calendar days following the twelfth (12th) month of the contract year; except those annual reports that have an explicit deadline provided on the LDH website [link] or are specifically exempted from this thirty (30) -calendar- day deadline by this Contract. This Contract will specify the due date of any annual report it exempts from this thirty (30) -calendar- day deadline. If the Contract is terminated early~~, prior to 12/31/2020~~, the Contractor shall submit reports and other deliverables as specified by LDH in the notice of termination, or as otherwise provided in this ~~contract~~Contract; and</td><td>This revision removes the reference to a specific contract end date to account for extensions of the contract via amendments.</td></tr>
<tr><td>19</td><td>Table of Monetary Penalties
<table>
<tr><th>Failed Deliverable</th><th>Penalty</th></tr>
<tr><td>Prompt Pay
Ninety percent (90%) of all clean claims must be paid within fifteen (15) business days of the date of receipt.
Ninety-nine percent (99%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt.
The MCO shall pay providers interest at 12% per annum, calculated</td><td>Five thousand dollars ($5,000.00) for the each month that an MCO’s claims performance percentages by claim type fall below the performance standard.

Twenty-five thousand dollars ($25,000.00) for each additional month that the claims performance percentages by claim type, by</td></tr>
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Twenty-five thousand dollars ($25,000.00) for each additional month that the claims performance percentages by claim type~~, by~~</td></tr>
</table></td><td>This revision corrects the monetary penalty associated to align with the prompt pay revision in Amendment 3.</td></tr>
</table>

Item	Change From:	Change To:	Justification
	daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is paid. MCO fall below the performance standards. One thousand dollars ($1,000.00) per claim if the MCO fails to timely pay interest.	• The MCO shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the thirty (30) calendar -day claims processing deadline. Interest owed the provider must be paid the same date that the claim is paid. ~~MCO~~ fall below the performance standards. One thousand dollars ($1,000.00) per claim if the MCO fails to timely pay interest.	
20	**25.0 TERMS AND CONDITIONS** The Contract effective date is anticipated to be January 1, 2020. LDH reserves the right to revise the anticipated effective date and/or dates of the enrollment phases to a later date. The term of the contract shall be twelve (12) months from the effective date or unless terminated prior to that date in accordance with state or federal law or terms of the Contract.	**25.0 TERMS AND CONDITIONS** The Contract effective date is anticipated to be January 1, 2020. LDH reserves the right to revise the anticipated effective date and/or dates of the enrollment phases to a later date. The term of the contract shall be twelve (12) months from the effective date or as otherwise extended if mutually agreed to in accordance with Section 25.1, unless terminated prior to that date in accordance with state or federal law or terms of the Contract.	This revision corrects the term of the contract to incorporate extensions of the contract via amendments.
21	[Glossary] **Adverse Benefit Determination** – Means any of the following: • The denial or limited authorization of a requested service, including determinations based on the type or level of service,	[Glossary] **Adverse Benefit Determination** – Means any of the following: • The denial or limited authorization of a requested service, including determinations based on the type or level of service,	This revision is to comply with the managed care final rule published on November 13, 2020 which clarifies that a denial due solely to not meeting the definition of a clean claim is not an adverse benefit determination and is therefore not subject to the notice

Item	Change From:	Change To:	Justification
	requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. • The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.	requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' in accordance with 42 CFR §447.45(b) is not an adverse benefit determination. • The failure to provide services in a timely manner, as defined by the State. • The failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.	requirements of 42 CFR §438.404. [Refer to 42 CFR §438.400(b)(3).]
22	**LIST OF MCO COMPANION GUIDES** **…** **13. MCO Manual**	**LIST OF MCO COMPANION GUIDES** **…** **13. MCO Manual** **14. LDH MCE Interoperability Compliance Plan**	The LDH MCE Interoperability Compliance Plan provides operational guidance on current and future interoperability and patient access rules.

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 (note reporting time period and if you are using an incurred/date of service approach)	

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**		Foundational payments for infrastructure and operations	
	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	

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 only (Foundational Payments for Infrastructure & Operations)	**Category 2A APMs ONLY** - Total dollars paid to providers for foundational spending to improve care , e.g. care coordination payments, PCMH payments, infrastructure payments, during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is for foundational spending to improve care.	$0	% of Total provider payments that are paid under Category 2A APMs ONLY	#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** 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 (Pay for Reporting)	**Category 2B APMs ONLY** - Total dollars paid to providers for pay for reporting , e.g. payments for reporting on HEDIS measures ('pay-per-click') during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is linked to pay for reporting.	$0	% of Total provider payments that are paid under Category 2B APMs ONLY	#DIV/0!
Contracts that include Category 2B APMs	**Provider Payments under Contracts that include Category 2B APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** pay for reporting.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2B APM	#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.		
	For Provider Contracts with Category 2B APMs - % of provider payments that are linked to pay for reporting	#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.				
Category 2C <u>Incentives only</u> (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. <u>Do not include FFS or base payments to providers. Do not include payments to providers for reporting HEDIS or other measures.</u>	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Category 2C <u>Penalties only</u> (Penalties for Performance)	**Category 2C APMs ONLY** - Total dollars for any penalties applied to providers based on performance to quality measures. <u>Do not include FFS or base payments to providers. Do not include penalties for non-reporting.</u>	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Contracts that include Category 2C APMs	Total dollars paid under provider contracts that include <u>FFS/base payment</u> **<u>plus (or minus)</u>** <u>any P4P payments or penalties, as applicable,</u> (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!

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	
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 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 under Category 3 shared risk arrangements	#DIV/0!
Contracts that include Category 3 APMs	Total dollars paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality), include FFS/base payment **plus** any shared savings **or minus** downside risk applied during payment period, as applicable.	$0	% of Total provider payments that are paid under 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 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)				

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.					
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: C8, C15, C21 or C23, 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 C8, C15, C21, or C23.	$0			
VBP BENCHMARK (Contracts with one or more APMs in category 2A, 2C, 3 or 4)					
Total Provider Incentive Payment Payments in Category 2A, 2C, 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 2A, 2C, 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 C25. 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

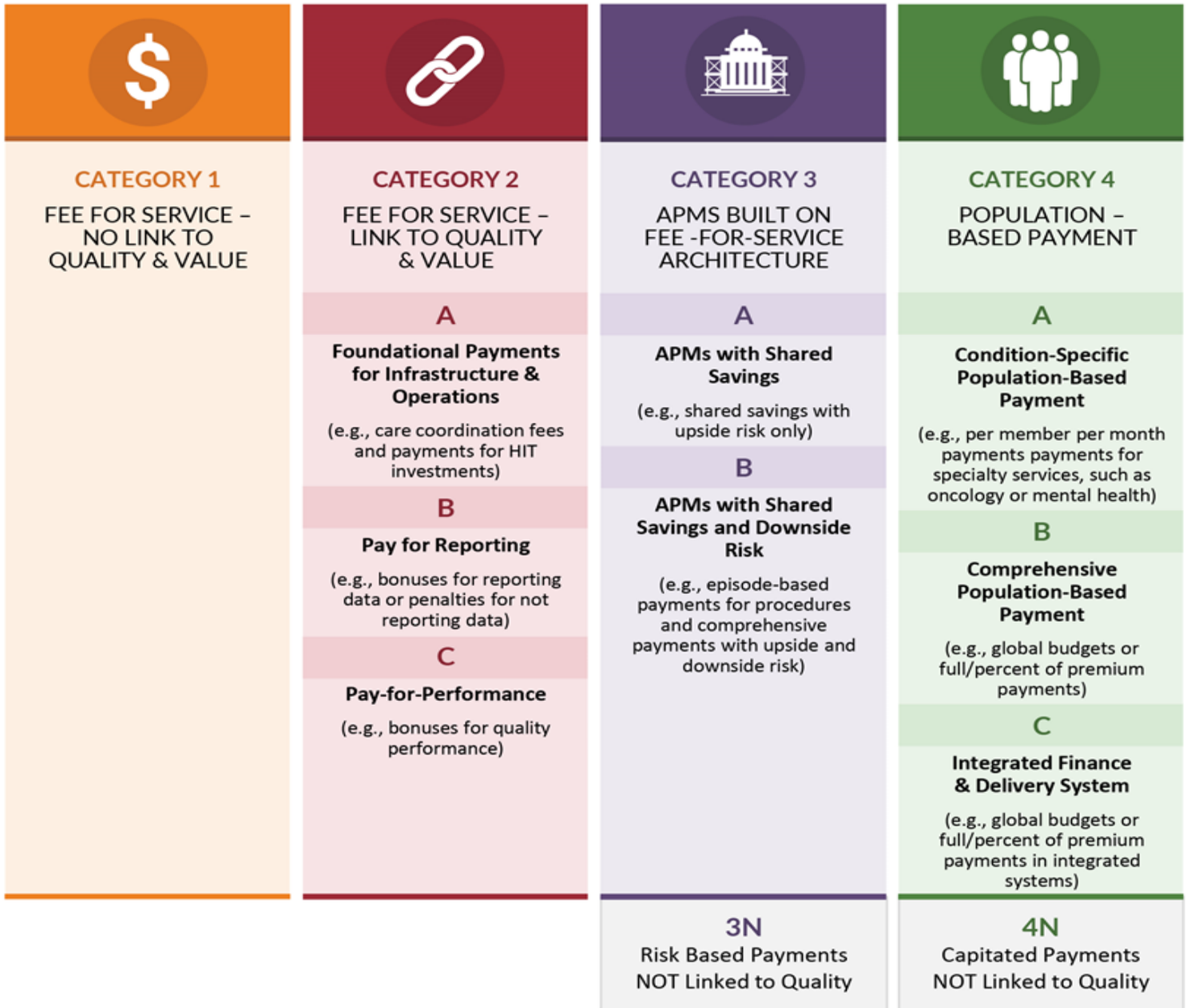
Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment 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/
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 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 outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, 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.

Definitions

Terms	Definitions
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].
Payment Period	The twelve month period, applicable to the specified MCO reporting requirements.
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 be, for example, primary care services or professional services that are 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 meet quality targets and 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.



Note - This is a draft refreshed framework. The comment period has closed. The LAN may issue clarifications or changes.