Office of State Procurement
PROACT Contract Certification of Approval

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

Reference Number: 2000441827 (5)
Vendor: Community Care Health Plan of Louisiana, Inc. DBA Healthy Blue
Description: MCO EC amd 5 - SOW and performance measures, no change to time/money
Approved By: Pamela Rice
Approval Date: 3/31/2021

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 5

LAGOV#: 2000441827

LDH #:

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

AND

Community Care Health Plan of Louisiana DBA Healthy Blue
Contractor Name

Original Contract Amount: 1,676,850,203

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: $4,394,059,501.50 Current Contract Term: 01/01/20-12/31/21

See attachments:
Attachment B - Statement of Work
Attachment C: Performance Measures (Effective Measurement Year 2020)

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

See attachments:
Attachment B5 - Changes to Statement of Work
Attachment C: Quality Performance Measures (Effective Measurement Year 2021)

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 and the quality performance measures. This includes updated requirements specific to calendar year 2021, state and federal regulations, and other programmatic changes.

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	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
Community Care Health Plan of Louisiana DBA Healthy Blue	Secretary, Louisiana Department of Health or Designee
CONTRACTOR SIGNATURE [signature] DATE 3-3-21	SIGNATURE Tara A LeBlanc Digitally signed by Tara A LeBlanc Date: 2021.03.08 09:42:18 -06'00' DATE
PRINT NAME: Aaron Lambert	NAME: Tara LeBlanc
CONTRACTOR TITLE: CEO	TITLE: Interim Medicaid Executive Director
	OFFICE: Louisiana Department of Health
	PROGRAM SIGNATURE DATE
	NAME

Changes to Attachment B – Statement of Work

Item	Change From:	Change To:	Justification
1	4.7.4 The major subcontract shall: 4.7.4.1 Be written; 4.7.4.2 Specify, and require compliance with, all applicable requirements of this Contract and the activities and reporting responsibilities the major subcontractor is obligated to provide; 4.7.4.3 Provide for imposing penalties, including Contract termination, if the State or the Contractor determines that the major subcontractor's performance is inadequate or non-compliant; 4.7.4.4 Require the major subcontractor to comply with all applicable Medicaid laws, regulations, and applicable subregulatory guidance; and 4.7.4.5 Comply with the audit and inspection requirements set forth in 42 C.F.R. §438.230(c)(3) and 42 C.F.R. §438.3(k).	4.7.4 The major subcontract shall: 4.7.4.1 Be written; 4.7.4.2 Specify, and require compliance with, all applicable requirements of this Contract and the activities and reporting responsibilities the major subcontractor is obligated to provide; 4.7.4.3 Provide for imposing penalties, including Contract termination, if the State or the Contractor determines that the major subcontractor's performance is inadequate or non-compliant; 4.7.4.4 Require the major subcontractor to comply with all applicable Medicaid laws, regulations, applicable LDH policies and manuals, and applicable subregulatory guidance; and 4.7.4.5 Comply with the audit and inspection requirements set forth in 42 C.F.R. §438.230(c)(3) and 42 C.F.R. §438.3(k).	The MCO's contract with major subcontractors must stipulate that major subcontractors comply with applicable LDH policies and manuals, such as the MCO Manual.
2	5.4.1 A withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes, and value-based payments. The withhold amount will be equal to two percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments, payments under section 5.18, and the FMP component of the monthly capitated payment. In response to the COVID-19 pandemic, LDH shall suspend and refund the CY 2020 quality and VBP withholds. The suspension of the withholds is only in effect for CY 2020. The MCO shall continue to comply with quality and value-based payment reporting as required in the contract.	5.4.1 A withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes, and value-based payments. The withhold amount will be equal to two percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments, payments under section 5.18, and the FMP component of the monthly capitated payment. ~~In response to the COVID-19 pandemic, LDH shall suspend and refund the CY 2020 quality and VBP withholds. The suspension of the withholds is only in effect for CY 2020. The MCO shall continue to comply with quality and value-based payment reporting as required in the contract.~~	The revisions incorporate the updated performance measures for measurement year 2021 (Attachment C) and retire the suspension of quality and VBP withholds effective January 1, 2021.

Item	Change From:	Change To:	Justification
	… 5.4.1.1.13 LDH shall suspend and refund the MCO quality withhold for CY 2020 that is specific to CY 2020 data collection (CY 2021 reporting). Reporting activities and related deliverables for CY 2019 quality withhold and data collection (CY 2020 reporting) remain in effect; however, flexibilities may be afforded by LDH based on NCQA guidance to Medicaid plans.	… ~~5.4.1.1.13 LDH shall suspend and refund the MCO quality withhold for CY 2020 that is specific to CY 2020 data collection (CY 2021 reporting). Reporting activities and related deliverables for CY 2019 quality withhold and data collection (CY 2020 reporting) remain in effect; however, flexibilities may be afforded by LDH based on NCQA guidance to Medicaid plans.~~	
3	5.4.1.2. Value-Based Payments	5.4.1.2. Physician Incentive Plans and Value-Based Payments 5.4.1.2.1 Physician Incentive Plans 5.4.1.2.1.1 In accordance with 42 CFR §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. 5.4.1.2.1.2 The MCO's Physician Incentive Plans shall be in compliance with 42 C.F.R. §438.3(i), §422.208, and §422.210. Any sub-capitation arrangement with contracted physicians and physician groups is considered a Physician Incentive Plan and subject to federal requirements and requirements of this section. 5.4.1.2.1.3 The MCO shall report to LDH twice annually on all Physician Incentive Plans operated by MCO, and those Physician Incentive Plans that the MCO intends to operate within the next six months. The MCO's Physician Incentive Plan report is due on February 1, 2021 and August 30, 2021 and in accordance with LDH instructions and templates. In each of these reports, the MCO shall: 5.4.1.2.1.3.1 Provide a written assurance to LDH that either:	This revision relocates the physician incentive plan requirements to be alongside VBP and provides additional specificity in regards to reporting.

Item	Change From:	Change To:	Justification
		5.4.1.2.1.3.1.1 The MCO is not operating any Physician Incentive Plans that put physicians and physician groups at "substantial financial risk" as defined in 42 C.F.R. §422.208; or 5.4.1.2.1.3.1.2 The MCO is operating Physician Incentive Plans that put physicians and physician groups at "substantial financial risk" as defined in 42 C.F.R. §422.208 and those plans meet all applicable federal requirements. 5.4.1.2.1.3.2 Report to LDH the following information in sufficient detail to determine whether each existing and proposed Physician Incentive Plan complies with the regulatory requirements including: 5.4.1.2.1.3.2.1 Whether services not furnished by the physician or physician group are covered by the Physician Incentive Plan. No further disclosure is required if the Physician Incentive Plan does not cover services not furnished by the physician or physician group; 5.4.1.2.1.3.2.2 The type of incentive arrangement (e.g., withhold, bonus, capitation arrangement, etc.) and the percent of withhold or bonus, if applicable; 5.4.1.2.1.3.2.3 If the physician or physician group is at substantial financial risk, proof the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection; and If required to conduct member surveys in accordance with 42 C.F.R. §417.479, the survey results.	
4	5.4.1.2.1 Half of the total withhold amount, equal to one percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment, may be applied to incentivize Value-Based Payments (VBP).	5.4.1.2.2. Value-Based Payments ~~5.4.1.2.1~~ 5.4.1.2.2.1 Half of the total withhold amount, equal to one percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments, MFP and the FMP component of the monthly capitated payment, may be applied to incentivize Value-Based Payments (VBP).	The revisions provide instructions for earning back the value-based payment (VBP) and withhold in calendar year 2021.

Item	Change From:	Change To:	Justification
	5.4.1.2.2 The MCO may earn back the VBP withhold amount for maintaining or increasing its reported use of VBP consistent with the MCO's VBP deliverables and its use of payment models that include categories 2A, 2C, 3 and 4 of the Learning Action Network (LAN) Alternative Payment Models Framework and aligned with the incentive-based measures specified in Attachment C (hereafter collectively referred to as "APM"). 5.4.1.2.3 The VBP withhold shall be suspended for CY2020; however, the MCO shall comply with VBP reporting requirements. The MCO shall: 5.4.1.2.3.1 Submit the following deliverables to LDH by August 30, 2020: 5.4.1.2.3.1.1 A written update to its VBP Strategic Plan describing the implementation and status of its VBP use for SFY2020. 5.4.1.2.3.1.2 A report on its SFY2020 VBP use as specified in Attachment E. 5.4.1.2.3.1.3 The MCO must report its SFY2020 VBP use using the same method as reported for its CY2017 baseline report and SFY2019 report ("date of payment" or "date of service" approach). 5.4.1.2.3.1.4 If the MCO chooses to report its SFY2020 VBP use using a "date of service" approach, it must submit a refreshed SFY2020 VBP use report by October 15, 2020. 5.4.1.2.3.1.5 The update to the VBP Strategic Plan and SFY2020 VBP use reported in Attachment E must demonstrate the MCO maintained or increased its SFY2019 reported use of APM consistent with categories 2A, 2C, 3, and 4 of the LAN APM Framework and aligned with the incentive-based measures specified in Attachment C. If the	~~5.4.1.2.2~~ 5.4.1.2.2.2 The MCO may earn back the VBP withhold amount for submitting VBP deliverables and meeting VBP targets specified by LDH as demonstrated within the MCO's ~~maintaining or increasing its~~ reported use of VBP consistent with ~~the MCO's VBP deliverables and its use of~~ payment models that include categories 2A, 2C, 3 and/or 4 of the Learning Action Network (LAN) Alternative Payment Models (APM) Framework and aligned with the incentive-based measures specified in Attachment C ~~(hereafter collectively referred to as "APM")~~. ~~5.4.1.2.3 The VBP withhold shall be suspended for CY2020; however, the MCO shall comply with VBP reporting requirements. The MCO shall:~~ ~~5.4.1.2.3.1 Submit the following deliverables to LDH by August 30, 2020:~~ ~~5.4.1.2.3.1.1 A written update to its VBP Strategic Plan describing the implementation and status of its VBP use for SFY2020.~~ ~~5.4.1.2.3.1.2 A report on its SFY2020 VBP use as specified in Attachment E.~~ ~~5.4.1.2.3.1.3 The MCO must report its SFY2020 VBP use using the same method as reported for its CY2017 baseline report and SFY2019 report ("date of payment" or "date of service" approach).~~ ~~5.4.1.2.3.1.4 If the MCO chooses to report its SFY2020 VBP use using a "date of service" approach, it must submit a refreshed SFY2020 VBP use report by October 15, 2020.~~ ~~5.4.1.2.3.1.5 The update to the VBP Strategic Plan and SFY2020 VBP use reported in Attachment E must demonstrate the MCO maintained or increased its SFY2019 reported use of APM consistent with categories 2A, 2C, 3, and 4 of the LAN APM Framework and aligned with the incentive-based measures specified in Attachment C. If the~~	

Item	Change From:	Change To:	Justification
	MCO did not meet this criteria, the MCO shall describe why the criteria were not met. 5.4.1.2.3.2 By November 30, 2020, schedule and complete a meeting with LDH to review its VBP Strategic Plan and FY2020 use report, as delivered in 5.4.1.2.3.1, in comparison to its VBP deliverables for SFY2019. 5.4.1.2.4 LDH shall refund any amounts withheld for the CY 2020 VBP incentive. In other years, if this contract is extended, LDH shall retain the amount withheld from any MCO for any unearned VBP incentive. 5.4.1.3. If, in the final determination of MCO performance relative to Quality and Health Outcomes and Value Based Payment incentives, the MCO's unearned withhold amount exceeds its withhold balance held in escrow by LDH, the MCO is responsible for remitting payment for the balance to LDH within thirty (30) calendar days following notification to the MCO by LDH unless otherwise authorized in writing by LDH. LDH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to LDH to future payments. 5.4.1.4. If the MCO is unable to achieve specified milestones required to earn back the withhold, solely due to an early termination for convenience, LDH shall refund the remainder of the amount withheld. 5.4.2. All MCOs contracted with LDH shall utilize the collectively agreed upon common format and frequency for provider-specific profile reports on the incentive-based quality measures identified in Attachment C. The profile format shall be reviewed annually by the MCOs. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.	~~MCO did not meet this criteria, the MCO shall describe why the criteria were not met.~~ ~~5.4.1.2.3.2 By November 30, 2020, schedule and complete a meeting with LDH to review its VBP Strategic Plan and FY2020 use report, as delivered in 5.4.1.2.3.1, in comparison to its VBP deliverables for SFY2019.~~ ~~5.4.1.2.4 LDH shall refund any amounts withheld for the CY 2020 VBP incentive. In other years, if this contract is extended, LDH shall retain the amount withheld from any MCO for any unearned VBP incentive.~~ 5.4.1.2.3. To earn back the full VBP withhold amount related to performance, the MCO shall: 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	

Item	Change From:	Change To:	Justification
	5.4.3. The MCO shall distribute provider-specific profile reports to providers using the LDH-approved common format and frequency effective the first quarter of calendar year 2020. 5.4.4. No interest shall be due to the MCO on any sums withheld or retained under this Section. 5.4.5. The withold arrangement is for a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied. Withhold arrangements are available to both public and private contractors under the same terms of performance. Participation in withhold arrangements is not conditioned on the MCO entering into or adhering to intergovernmental transfer agreements. 5.4.6. The withhold arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under 42 CFR § 438.340. 5.4.7. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract. LDH reserves the right to assess monetary penalties for failure to meet deliverables as required under this section.	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. 5.4.1.2.3.1.3. 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. 5.4.1.2.3.1.4. If LDH determines that the mid-year report demonstrates an increase in VBP use by the MCO, alignment with performance measures in Attachment C, and is consistent with LDH specifications, LDH will refund any VBP-related amounts withheld for the calendar year through June of that year. The VBP withhold amounts shall not be refunded for late submissions. 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.	

Item	Change From:	Change To:	Justification
		5.4.1.2.3.3.1. MCO contracts with recognized VBP models represent at least 40% of total provider payments or at least a 10% increase in the MCO's VBP percentage compared to the MCO VBP percentage as reported by the MCO in the prior calendar year. 5.4.1.2.3.3.1.1. This 10% increase applies regardless of whether the MCO was previously reporting on VBP arrangements using a date of service approach. 5.4.1.2.3.3.2. MCO provider VBP incentive payments represents at least 1.5% of total provider payments or at least $1 million higher than what the MCO reported as provider incentive payments in the prior calendar year. 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. 5.4.1.2.3.3.4. LDH shall refund to the MCO all of the remaining amounts withheld for VBP during the calendar year if the MCO meets the VBP targets in both 5.4.1.2.3.3.1 and 5.4.1.2.3.3.2. 5.4.1.2.4. LDH shall retain the amount of the VBP withhold not earned back from the MCO. 5.4.1.3. Other Requirements Related to Quality and VBP Withholds 5.4.1.3.1 If, in the final determination of MCO performance relative to Quality and Health Outcomes and Value Based Payment incentives, the MCO's unearned withhold amount exceeds its withhold balance held in escrow by LDH, the MCO is responsible for remitting payment for the balance to LDH within thirty (30) calendar days following notification to the MCO by LDH unless otherwise authorized in writing by LDH. LDH, at its discretion, reserves the right to collect amounts due	

Item	Change From:	Change To:	Justification
		by withholding and applying all balances due to LDH to future payments. ~~5.4.1.4.~~ 5.4.1.3.2 If the MCO is unable to achieve specified milestones required to earn back the withhold, solely due to an early termination for convenience, LDH shall refund the remainder of the amount withheld. ~~5.4.2.~~ 5.4.1.3.3 All MCOs contracted with LDH shall utilize the collectively agreed upon common format and frequency for provider-specific profile reports on the incentive-based quality measures identified in Attachment C. The profile format shall be reviewed annually by the MCOs. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation. ~~5.4.3.~~ 5.4.1.3.4 The MCO shall distribute provider-specific profile reports to providers using the LDH-approved common format and frequency effective the first quarter of calendar year ~~2020~~2021. ~~5.4.4.~~ 5.4.1.3.5 No interest shall be due to the MCO on any sums withheld or retained under this Section. ~~5.4.5.~~ 5.4.1.3.6 The withhold arrangement is for a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied. Withhold arrangements are available to both public and private contractors under the same terms of performance. Participation in withhold arrangements is not conditioned on the MCO entering into or adhering to intergovernmental transfer agreements. ~~5.4.6.~~ 5.4.1.3.7 The withhold arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under 42 CFR § 438.340.	

Item	Change From:	Change To:	Justification
		~~5.4.7.~~ 5.4.1.3.8 The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract. LDH reserves the right to assess monetary penalties for failure to meet deliverables as required under this section.	
5	5.6.4 Zolgensma Risk Pool Arrangement 5.6.4.1 The amount of the risk pool is determined by the projected Zolgensma costs incorporated into the CY 2020 rates. Maximum allowable cost per claim will be based on Fee for Service reimbursement (wholesale acquisition cost plus professional dispensing fee). LDH will redistribute funds among MCOs based on the actual Zolgensma costs, net of TPL. The MCO shall follow FFS clinical criteria for Zolgensma. The Zolgensma risk pool will be settled following the conclusion of the CY 2020 contract period.	5.6.4 Zolgensma Risk Pool Arrangement 5.6.4.1 The amount of the risk pool, if applicable, will be ~~is~~ determined by the projected Zolgensma costs incorporated into ~~the CY 2020~~ annual capitation rates as described in the rate certification. Maximum allowable cost per claim will be based on Fee for Service reimbursement (wholesale acquisition cost plus professional dispensing fee). LDH will redistribute funds among MCOs based on the actual Zolgensma costs, net of TPL. The MCO shall follow FFS clinical criteria for Zolgensma. The Zolgensma risk pool will be settled following the conclusion of the ~~CY 2020~~ annual contract period.	These revisions extend the Zolgensma risk pool arrangement into calendar year 2021 with the same parameters.
6	5.6.5. Due to potential utilization variances caused by the COVID-19 pandemic, LDH will maintain a risk corridor for all non-Hepatitis C-related medical expenses retroactive to January 1, 2020. The parameters of this risk corridor and process for reconciliation and payments will be specified in the Financial Reporting Guide. LDH may terminate the risk corridor described in this section at its sole discretion. 5.6.5.1. LDH will be fully at risk for actual MCO non-Hepatitis C-related medical expenses that are less than or equal to 2% above the benchmark. 5.6.5.2. LDH will fully retain any savings for actual MCO non-Hepatitis C-related medical expenses that are less than or equal to 2% below the benchmark.	~~5.6.5. Due to potential utilization variances caused by the COVID-19 pandemic, LDH will maintain a risk corridor for all non-Hepatitis C-related medical expenses retroactive to January 1, 2020. The parameters of this risk corridor and process for reconciliation and payments will be specified in the Financial Reporting Guide. LDH may terminate the risk corridor described in this section at its sole discretion.~~ ~~5.6.5.1. LDH will be fully at risk for actual MCO non-Hepatitis C-related medical expenses that are less than or equal to 2% above the benchmark.~~ ~~5.6.5.2. LDH will fully retain any savings for actual MCO non-Hepatitis C-related medical expenses that are less than or equal to 2% below the benchmark.~~	This revision terminates the COVID-19 risk corridor effective January 1, 2021.

Item	Change From:	Change To:	Justification
	5.6.5.3. LDH and the MCOs will equally share the risk and any savings for actual MCO non-Hepatitis C-related medical expenses that are between 2% and 5% above or below the benchmark. 5.6.5.4. LDH will be fully at risk for actual MCO non-Hepatitis C-related medical expenses that are greater than or equal to 5% above the benchmark. 5.6.5.5. LDH will fully retain any savings for actual MCO non-Hepatitis C-related medical expenses that are greater than or equal to 5% below the benchmark. 5.6.5.6. The MCO is prohibited from increasing reimbursement rates for in-network and out-of-network providers to such an extent that would generate material losses to LDH, unless the increase was for the purpose of meeting network adequacy standards or otherwise approved by LDH. LDH may assess monetary penalties if it, or its actuary, determines that the rate increase materially impacted the risk corridor and the MCO does not provide sufficient evidence to meet the aforementioned exceptions.	~~5.6.5.3. LDH and the MCOs will equally share the risk and any savings for actual MCO non-Hepatitis C-related medical expenses that are between 2% and 5% above or below the benchmark.~~ ~~5.6.5.4. LDH will be fully at risk for actual MCO non-Hepatitis C-related medical expenses that are greater than or equal to 5% above the benchmark.~~ ~~5.6.5.5. LDH will fully retain any savings for actual MCO non-Hepatitis C-related medical expenses that are greater than or equal to 5% below the benchmark.~~ ~~5.6.5.6. The MCO is prohibited from increasing reimbursement rates for in-network and out-of-network providers to such an extent that would generate material losses to LDH, unless the increase was for the purpose of meeting network adequacy standards or otherwise approved by LDH. LDH may assess monetary penalties if it, or its actuary, determines that the rate increase materially impacted the risk corridor and the MCO does not provide sufficient evidence to meet the aforementioned exceptions.~~	
7	6.3.3.5. LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid (drugs classified with PA Indicators 1 & 3) divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL (drugs classified with PA Indicators 1-4). The MCO shall achieve at least a 92% compliance rate. PDL compliance less than 92% may result in monetary penalties of $100,000 per quarter.	6.3.3.5. LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid (drugs classified with PA Indicators 1 & 3) divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL (drugs classified with PA Indicators 1-4). The MCO shall achieve at least a 92% overall compliance rate and at least a 92% compliance rate for each medication on the brand-over-generic list provided by LDH (calculated as brand/(brand + generic)). The PDL compliance rate shall be calculated at the sole determination of LDH. Failure to meet both of these standards may result in monetary penalties set forth in Section 20 of this contract. ~~PDL compliance less than 92% may result in monetary penalties of $100,000 per quarter.~~	LDH develops its PDL based on clinical and cost effectiveness. PDL non-compliance (other than limited exceptions for medically necessary reasons) results in members potentially getting inappropriate care in addition to excess expenditures. In particular, adherence on brand-over-generic drugs is important to reduce LDH program costs. The compliance provision is already addressed in the Table of Monetary Penalties.

Item	Change From:	Change To:	Justification
8	6.3.3.6 The MCO shall not enter into agreements with manufacturers to acquire discounts or rebates on drugs.	6.3.3.6 ~~The MCO shall not enter into agreements with manufacturers to acquire discounts or rebates on drugs.~~ Manufacturer-Derived Revenue 6.3.3.6.1 The MCO shall not negotiate, pursue collection of, or collect Manufacturer-Derived Revenue for prescribed drugs. 6.3.3.6.2 The MCO shall diligently and in good faith negotiate, maximize, and pursue collection of all Manufacturer-Derived Revenue for diabetic supplies on behalf of LDH. 6.3.3.6.3 The MCO shall report all Manufacturer-Derived Revenue the MCO receives, including any future Manufacturer-Derived Revenue, related to any covered drug or diabetic supply provided under this contract, according to the Financial Reporting Guide. This provision survives termination of the contract between LDH and the MCO. The MCO shall report all Manufacturer-Derived Revenue received on claims incurred prior to the termination of the contract until one hundred percent (100 percent) of earned Manufacturer-Derived Revenues specific to the contract between LDH and the MCO are paid. 6.3.3.6.4 Within ten (10) business days of LDH's request, the MCO shall provide LDH with unredacted copies of or access to all books, records, and Manufacturer-Derived Revenue agreements with pharmaceutical and diabetic supply manufacturers, intermediaries, subcontractors, wholesalers, or other third parties related to this contract. This provision applies to the MCO as well as all subcontractors. All such information shall be kept confidential by LDH and shall be exempt from disclosure under the Louisiana Public Records Law. 6.3.3.6.5 Within ten (10) business days of LDH's request, the MCO shall provide LDH an itemized report of all Manufacturer-Derived Revenue amounts received by the MCO and its subcontractors, if applicable, within a specified time period. This report must itemize Manufacturer-	These revisions are to ensure compliance with La. R.S. 46:450.7 and La. R.S. 39:1648 and to enhance transparency around manufacturer-derived revenue received by the PBM.

Item	Change From:	Change To:	Justification
		Derived Revenue by National Drug Code number and manufacturer, indicate amounts paid to the MCO, and indicate the time frames when the Manufacturer-Derived Revenue was received by the MCO or its subcontractors. The report must also indicate when the Manufacturer-Derived Revenue was paid to the MCO by the PBM, if applicable.	
9	(New provision)	6.3.4.1.21 The PBM or other subcontractor shall provide the MCO pharmacy staff real-time, unredacted, read access to view prior authorization records, at no cost to the MCO.	Access to prior authorization records is an essential business function so that the MCO can review and troubleshoot prior authorization issues with LDH.
10	(New Provision)	6.3.8 Emergencies 6.3.8.1 In the event of an emergency, as defined by LDH, LDH shall have the authority to require the MCOs to implement any necessary configuration modifications to pharmacy requirements within 72 hours of notification. Within 24 hours from LDH's request, the MCO shall alter or remove Point of Sale, prior authorization, or other pharmacy requirements as determined by LDH, in a manner that may be statewide or limited to certain ZIP codes or parishes. For an emergency, specific changes shall be determined by LDH and may include: 6.3.8.1.1 Point of Sale edits: This may include, but is not limited to, altering early refill and refill too soon edits to an educational alert (message to pharmacy only, no denial at Point of Sale) as well as altering early refill and refill too soon edits set to deny so that they return an override code to be utilized by the pharmacy if needed to bypass the edit, without the requirement of a phone call to the helpdesk. 6.3.8.1.2 Prior authorization requirements: This may include, but is not limited to, altering prior authorization denials to an educational alert (message to pharmacy only, no denial at Point of Sale) as well as	This addition is to clearly specify and delineate emergency operations relative to pharmacy, in alignment with current practices.

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		extending the expiration date of currently approved prior authorizations to a date requested by LDH. 6.3.8.1.3 Quantity limitations: This may include, but is not limited to, allowing dispensing of a 90 day supply for medications specified by LDH. 6.3.8.1.4 Copays: This may include, but is not limited to, waiving member copays for pharmacy claims, which shall be added back to the pharmacy reimbursement. 6.3.8.1.5 Signatures: This may include, but is not limited to, removing the requirement of a signature for pick-up or delivery. 6.3.8.1.6 Lock-in restrictions: This may include, but is not limited to, removing pharmacy lock-in restrictions or both pharmacy and prescriber lock-in restrictions including on a case-by-case basis. 6.3.8.1.7 Any other change deemed necessary by LDH to respond to the emergency and protect member health.	
11	6.6.4. The MCO is required to fulfill the medical, vision, and hearing screening components and immunizations as specified in the LDH periodicity schedule. … 6.6.7. Some EPSDT preventive screening claims should be submitted sooner than within twelve (12) months from date of service due to the fact that the screenings periodicity can range from every two months and up. See periodicity schedule at: http://www.lamedicaid.com/provweb1/ProviderTraining/packets/2018ProviderTraining/2018_EPSDT_Periodicity_Schedule.pdf.	6.6.4. The MCO is required to fulfill the medical, vision, and hearing screening components and immunizations as specified in the ~~LDH periodicity schedule~~ MCO Manual. … ~~6.6.7. Some EPSDT preventive screening claims should be submitted sooner than within twelve (12) months from date of service due to the fact that the screenings periodicity can range from every two months and up. See periodicity schedule at: http://www.lamedicaid.com/provweb1/ProviderTraining/packets/2018ProviderTraining/2018_EPSDT_Periodicity_Schedule.pdf.~~	Louisiana Medicaid has adopted the "Recommendations for Preventive Pediatric Health Care" periodicity schedule promulgated by the American Academy of Pediatrics (AAP)/Bright Futures with exceptions as specified in the MCO Manual.

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12	6.19.2. The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). LDH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.	6.19.2. The MCO shall identify at least ninety percent (90%) of members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). LDH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess at least ninety percent (90%) of those members that the MCO is able to contact and are willing to engage, within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.	This revision establishes a minimum completion rate for assessments conducted for enrollees with special health care needs.
13	6.23.2. The MCO or the MCO's Transportation Broker shall establish and maintain a call center. The call center shall be responsible for scheduling all Non-Emergency Medical Transportation (NEMT)/Non-Emergency Ambulance Transportation (NEAT) reservations and dispatching of trips during the business hours of 7:00 am to 7:00 pm Monday through Friday, with the exception of recognized state holidays. The call center shall adhere to the call center performance standards specified in Section 12.	6.23.2. The MCO or the MCO's Transportation Broker shall establish and maintain a call center. Effective January 1, 2022, the call center must be located in Louisiana. The call center shall be responsible for scheduling all Non-Emergency Medical Transportation (NEMT)/Non-Emergency Ambulance Transportation (NEAT) reservations and dispatching of trips during the business hours of 7:00 am to 7:00 pm Monday through Friday, with the exception of recognized state holidays. The call center shall adhere to the call center performance standards specified in Section 12.	This revision requires the transportation call center to be based in Louisiana in accordance with House Resolution 68 of the 2020 Regular Session.
14	7.8.9.2. For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the MCO shall schedule the transportation and require its NEMT/NEAT provider to arrive and provide services with sufficient time to ensure that the member arrives at least fifteen (15) minutes, but no more than one (1) hour, before the appointment; does not have to wait more than one hour after the conclusion of the treatment for transportation; is	7.8.9.2. For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the MCO shall schedule the transportation and require its NEMT/NEAT provider to ~~arrive and provide services with sufficient time to ensure that the member arrives at least fifteen (15) minutes, but no more than one (1) hour, before the appointment; does not have to wait more than one hour after the conclusion of the treatment for transportation; is~~	This revision provides updated travel and wait time standards.

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	not picked up prior to the completion of treatment; and is not in the vehicle for more than one (1) hour in excess of the estimated travel time, as calculated by a mapping application, for each leg of the trip.	~~not picked up prior to the completion of treatment; and is not in the vehicle for more than one (1) hour in excess of the estimated travel time, as calculated by a mapping application, for each leg of the trip.~~meet the following standards: 7.8.9.2.1. Ensure that members arrive at least 15 minutes, but no more than two hours, prior to their appointments; 7.8.9.2.2. Ensure that members are picked up no more than two hours after the appointment has concluded; and 7.8.9.2.3. Ensure that members shall not be in the vehicle for more than one hour beyond the estimated travel time.	
15	(New provision)	7.13.14 The MCO shall not include in its provider agreements an all-products clause, requiring providers to participate in all products offered by the MCO or its parent organization. This provision is applicable to all provider agreements created or amended on or after January 1, 2021.	This addition prohibits the inclusion of all-products clauses in provider agreements. These clauses are often overly restrictive to providers and impact enrollee access to care. Existing provider agreements are exempt from this requirement until the agreements are extended or otherwise amended.
16	7.18.4. The MCO shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.	7.18.4. The MCO shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings, includes the raw data in the format provided by LDH, and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.	LDH will provide a template for aggregating survey data to ensure that data is reported consistently across MCOs.
17	9.10. Physician Incentive Plans 9.10.1. In accordance with 42 CFR §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 an individual.	~~9.10. Physician Incentive Plans~~ ~~9.10.1. In accordance with 42 CFR §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 an individual.~~	Physician incentive plan requirements are relocated to be alongside VBP requirements.

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	9.10.2. The MCO's Physician Incentive Plans shall be in compliance with 42 CFR §438.3(i), §422.208 and §422.210. 9.10.3. Any sub-capitation arrangement with contracted providers is considered a provider incentive plan and subject to appropriate requirements of 9.10. 9.10.4. The MCO shall provide an annual written assurance to LDH that either: 9.10.4.1. The MCO is not operating any Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 CFR §422.208; or 9.10.4.2. The MCO is operating Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 CFR §422.208 and those plans meet all applicable federal requirements. 9.10.5. The MCO shall provide written notification to LDH within thirty (30) days upon implementation of any new plan or when an existing plan is modified. The written notification must include a list of participating providers and specify that all terms and conditions of the plans are compliant with all applicable federal regulations. LDH reserves the right to request additional documentation, including but not limited to the actual incentive plans. 9.10.6. The MCO shall provide the information specified in 42 CFR §422.210(b) regarding its physician incentive plans to any Medicaid member upon request. 9.10.7. The proposed monetary value of Physician Incentive Plans outlined in the MCO's proposal and any subsequent additional under Section 9.10 will be considered a binding contract deliverable. If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM	~~9.10.2. The MCO's Physician Incentive Plans shall be in compliance with 42 CFR §438.3(i), §422.208 and §422.210.~~ ~~9.10.3. Any sub-capitation arrangement with contracted providers is considered a provider incentive plan and subject to appropriate requirements of 9.10.~~ ~~9.10.4. The MCO shall provide an annual written assurance to LDH that either:~~ ~~9.10.4.1. The MCO is not operating any Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 CFR §422.208; or~~ ~~9.10.4.2. The MCO is operating Physician Incentive Plans that put providers at "substantial financial risk" as defined in 42 CFR §422.208 and those plans meet all applicable federal requirements.~~ ~~9.10.5. The MCO shall provide written notification to LDH within thirty (30) days upon implementation of any new plan or when an existing plan is modified. The written notification must include a list of participating providers and specify that all terms and conditions of the plans are compliant with all applicable federal regulations. LDH reserves the right to request additional documentation, including but not limited to the actual incentive plans.~~ ~~9.10.6. The MCO shall provide the information specified in 42 CFR §422.210(b) regarding its physician incentive plans to any Medicaid member upon request.~~ ~~9.10.7. The proposed monetary value of Physician Incentive Plans outlined in the MCO's proposal and any subsequent additional under Section 9.10 will be considered a binding contract deliverable. If for some reason, including but not limited to lack of provider participation or performance, the aggregated annual per member per month PMPM~~	

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	proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended. 9.10.8. Non-Payment for Specified Services 9.10.8.1. The MCO shall deny payment to providers for deliveries occurring before 39 weeks without a medical indication. MCO will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks. 9.10.9. Provider Preventable Conditions 9.10.9.1. The MCO shall deny payment to providers for Provider Preventable Conditions (PPCs) as defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual. 9.10.9.2. The MCO shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. PPCs should be identified on the encounter file via the Present on Admission (POA) indicators.	~~proposed is not expended the department reserves the right to require the MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.~~ 9.10.~~8.~~ Non-Payment for Specified Services 9.10.~~8.~~1. The MCO shall deny payment to providers for deliveries occurring before 39 weeks without a medical indication. MCO will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks. 9.10.~~9~~2. Provider Preventable Conditions 9.10.~~9~~2.1. The MCO shall deny payment to providers for Provider Preventable Conditions (PPCs) as defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual. 9.10.~~9~~2.2. The MCO shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. PPCs should be identified on the encounter file via the Present on Admission (POA) indicators.	
18	(New Provision)	10.5.5.1 The MCO must obtain prior written approval from LDH for all provider materials related to the pharmacy benefit, unless exempted by LDH. Provider (pharmacy and prescribing) materials must be submitted to LDH for approval at least thirty (30) days before implementation, unless the MCO can demonstrate to LDH's satisfaction that just cause for an abbreviated timeframe exists.	Approval of provider education materials is necessary to prevent dissemination of materials that contain inaccurate information about Medicaid benefits.
19	12.22.2. The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for	12.22.2. The MCO must make ~~real-time oral~~ interpretation services, including real-time oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language, available free of charge to each potential enrollee and enrollee. This applies to all non-English	These revisions clarify the interpretation services which must be offered to enrollees and potential enrollees and extend the services to providers.

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	interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and how to access those services. On materials where this information is provided, the notation should be written in Spanish.	languages not just those that Louisiana specifically requires (Spanish). ~~The enrollee is not to be charged for interpretation services.~~ The MCO must notify its enrollees that oral interpretation is available for any language and how to access those services. On materials where this information is provided, the notation should be written in Spanish. These interpretation services shall be made available to network providers treating non-English speaking enrollees at no charge by March 31, 2021. The MCO may coordinate with Louisiana Commission for the Deaf for American Sign Language interpretation services.	
20	15.1.1 The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. … 15.1.12 The MCO, as well as its subcontractors and providers, shall comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request. …	15.1.1 The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.608, 42 C.F.R. §438.611-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. Compliance with 42 C.F.R. §438.610 is also required until the state has implemented its own screening of MCO-only providers and has notified the MCO that it has assumed this function. … 15.1.12 Until the state implements its own screening of MCO-only providers and has notified the MCO that it has assumed this function, t~~T~~he MCO, as well as its subcontractors and providers, shall comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	LDH will no longer require MCOs to perform their own ownership disclosure collection and screening once LDH assumes these functions for MCO-only providers. This eliminates duplicative screening and will increase provider satisfaction by eliminating an onerous part of the MCO credentialing process while not introducing risk for the state. LDH will notify the MCOs prior to assuming this function, currently estimated for March 1, 2021.

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	15.3.4 The MCO and its subcontractors shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The MCO and its subcontractors shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436.	… 15.3.4 The MCO and its subcontractors shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The MCO and its subcontractors shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436. This section does not require ownership disclosure collection and screening once the state has implemented its own MCO-only provider screening and has notified the MCO that it has assumed this function.	
21	17.2.4.1 If the MCO or LDH or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within thirty (30) calendar days of discovery, or if circumstances exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.	17.2.4.1 If the MCO or LDH or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within thirty (30) calendar days of discovery, or if circumstances exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond either the thirty (30) day claims reprocessing deadline or the specified deadline approved by LDH, whichever is later. The MCO shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.	This revision clarifies that the 12% per annum interest is applicable for claims that are reprocessed due to erroneous denials or other MCO errors.
22	17.2.7.7 The MCO shall perform all National Correct Coding Initiative (NCCI) edits (or its successors) to applicable claims processed in their system. Updates shall be implemented quarterly as directed by CMS and adhere to CMS/LDH timelines for the updates.	17.2.7.7 ~~The MCO shall perform all National Correct Coding Initiative (NCCI) edits (or its successors) to applicable claims processed in their system. Updates shall be implemented quarterly as directed by CMS and adhere to CMS/LDH timelines for the updates.~~The MCO shall	These revisions provide additional specificity in regards to federally mandated claims edits and nationally recognized clinical editing standards.

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		employ CMS mandated edits for Medicaid and nationally recognized clinical editing standards as outlined below: 17.2.7.7.1 At a minimum, these edits shall be maintained and updated annually unless otherwise appropriate and apply to practitioners, outpatient hospitals, and DME services. 17.2.7.7.2 Edits shall be based on current industry benchmarks and best practices including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Medicaid, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successors. 17.2.7.7.3 Clinical edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. Editing shall include the ability to apply edits to the current claim as well as paid history claims when applicable. 17.2.7.7.4 NCCI edits shall be updated quarterly as directed by CMS and adhere to CMS/LDH timelines. 17.2.7.7.5 The MCO shall apply edits for physician-administered drugs, updated quarterly, based on the CMS NDC-HCPCS Crosswalk file. 17.2.7.7.6 The MCO shall attest annually, or as otherwise directed, that they are adhering to these requirements and are subject to periodic requests from LDH for validation of the edits.	
23	17.4.4 The MCO shall submit a sample of remittance advices that were sent to independent, chain and specialty pharmacies by the PBM to LDH pharmacy staff quarterly. This sample shall include at least 10 RAs from each pharmacy type (independent, chain, and specialty).	17.4.4 Pharmacy Remittance Advice from the PBM must be issued as a standalone RA, specific to Louisiana Medicaid and separate from other lines of business at the request of the pharmacy, effective April 1, 2021.	This revision requires pharmacy RAs to be specific to Medicaid in order to reduce confusion and simplify the process for providers.

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		17.4.5 The MCO shall submit a sample of remittance advices that were sent to independent, chain and specialty pharmacies by the PBM to LDH pharmacy staff quarterly. This sample shall include at least 10 RAs from each pharmacy type (independent, chain, and specialty).	
24	(New provision)	17.11.1.9 The PBM or other subcontractor shall provide the MCO pharmacy staff real-time, unredacted, read access to view the pharmacy claims processing system, at no cost to the MCO.	Access to the claims processing system is an essential business function so that the MCO can review and troubleshoot claims payment issues with LDH.
25	17.11.5.4 Any contract for pharmacy benefit manager services shall: 17.11.5.4.1 Be limited to a transaction fee, not to exceed $1.25 per processed claim. The transaction fee covers non-claims costs, exclusive of amounts paid to a pharmacy for a prescription, including the ingredient cost, dispensing fee and provider fee; 17.11.5.4.2 Exclude any rebates or discounts, direct or indirect, from any pharmaceutical manufacturer; and, 17.11.5.4.3 Exclude "spread pricing," defined as any amount charged or claimed by a pharmacy benefit manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.	17.11.5.4 Any contract for pharmacy benefit manager services shall be a direct contract with the MCO and shall provide for the following: ~~17.11.5.4.1 Be limited to a transaction fee, not to exceed $1.25 per processed claim. The transaction fee covers non-claims costs, exclusive of amounts paid to a pharmacy for a prescription, including the ingredient cost, dispensing fee and provider fee;~~ ~~17.11.5.4.2 Exclude any rebates or discounts, direct or indirect, from any pharmaceutical manufacturer; and,~~ ~~17.11.5.4.3 Exclude "spread pricing," defined as any amount charged or claimed by a pharmacy benefit manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.~~ 17.11.5.4.1 As payment-in-full for the services performed under the contract, the MCO shall pay the PBM an all-inclusive administrative fee, calculated by multiplying the number of processed claims by a transaction fee, which shall not exceed $1.25 per pharmacy claim processed. 17.11.5.4.2 In accordance with La. R.S. 46:450.7, the contract shall prohibit "spread pricing," defined as any amount charged or claimed by a PBM to the MCO that is in excess of the amount paid to the	Overall, the purpose of these provisions is to ensure compliance with La. R.S. 46:450.7 and La. R.S. 39:1648, to enhance accountability of the PBM to the MCO (and to LDH), and to ensure that PBMs return all manufacturer-derived revenue to the MCOs. In addition, these updated provisions provide more operational detail to the definition of "spread pricing" and incorporate other provisions to ensure that MCO-PBM contracts support MCO compliance with all pharmacy requirements.

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		dispensing pharmacy, including the ingredient cost, provider fee and dispensing fee. 17.11.5.4.3 The PBM or other subcontractor shall provide the MCO pharmacy staff real-time, unredacted, read access to view the pharmacy claims processing system and prior authorization records, at no cost to the MCO." 17.11.5.4.4 The PBM shall coordinate with the MCO the dissemination of materials to members and providers such that the MCO can obtain the appropriate prior approvals from LDH, when necessary. 17.11.5.4.5 If the PBM contracts with a subcontractor, the MCO shall request prior approval of the subcontract and any amendment thereto. To obtain such approval, the MCO shall submit a written request and a copy of the proposed subcontract. The request shall also describe how the MCO and PBM will oversee the subcontractor. The MCO shall provide LDH with any additional information requested by LDH. LDH shall review and approve or deny the subcontractor contract.	
26	18.8 Errors 18.8.1 The MCO agrees to prepare complete and accurate reports for submission to LDH. If after preparation and submission, an MCO error is discovered either by the MCO or LDH; the MCO shall correct the error(s) and submit accurate reports as follows: 18.8.1.1 For encounters – In accordance with the timeframes specified in the Contract Monitoring and Sanctions Sections of this Contract. 18.8.1.2 For all reports – Fifteen (15) calendar days from the date of discovery by the MCO or date of written notification by LDH (whichever is earlier). LDH may at its discretion extend the due date if an acceptable plan of correction has been submitted and the MCO can	18.8 Errors 18.8.1 The MCO agrees to prepare complete and accurate reports for submission to LDH. If after preparation and submission, an MCO error is discovered either by the MCO or LDH; the MCO shall correct the error(s) and submit accurate reports as follows: 18.8.1.1 For encounters – In accordance with the timeframes specified in the Contract Monitoring and Sanctions Sections of this Contract. 18.8.1.2 For all reports and data submissions – ~~Fifteen (15)~~ Seven (7) calendar days from the date of discovery by the MCO or date of written notification by LDH (whichever is earlier). LDH may at its discretion extend the due date if an acceptable plan of correction has been	This revision reduces the allotted time to correct reports and data submissions to facilitate timely resolution of all errors.

<table>
<tr><th>Item</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td></td><td>demonstrate to LDH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.</td><td>submitted and the MCO can demonstrate to LDH's satisfaction the problem cannot be corrected within ~~fifteen (15)~~ seven (7) calendar days.</td><td></td></tr>
<tr><td>27</td><td>Table of Monetary Penalties<table><tr><th>Failed Deliverable</th><th>Penalty</th></tr><tr><td>Preferred Drug List (PDL)</td><td>One hundred thousand dollars ($100,000.00) per quarter in which the PDL compliance rate is less than 92%.</td></tr></table></td><td>Table of Monetary Penalties<table><tr><th>Failed Deliverable</th><th>Penalty</th></tr><tr><td>Preferred Drug List (PDL)</td><td>One hundred thousand dollars ($100,000.00) per quarter in which the overall PDL compliance rate is less than 92%.

One hundred thousand dollars ($100,000.00) per quarter in which the brand-over-generic PDL compliance rate is less than 92%.</td></tr></table></td><td>Establishes a penalty for brand-over-generic PDL compliance, which is separate from the existing penalty for overall PDL compliance.</td></tr>
<tr><td>28</td><td>Table of Monetary Penalties

(New Provision)</td><td>Table of Monetary Penalties<table><tr><th>Failed Deliverable</th><th>Penalty</th></tr><tr><td>Conflict of Interest</td><td>$10,000.00 per occurrence plus an additional $5,000.00 per calendar day after notification by LDH that the MCO remains in violation of the conflict of interest requirements.</td></tr></table></td><td>This addition ties a specific monetary penalty to the violation of the conflict of interest prohibition (Sections 2.1.1.8 or 25.62).</td></tr>
<tr><td>29</td><td>GLOSSARY
…
(New Provision)</td><td>Manufacturer-Derived Revenue(s) – Refers to rebates and other manufacturer revenues specific to the contract between LDH and MCO.</td><td>The purpose of this provision is to ensure compliance with La. R.S. 46:450.7 and La. R.S. 39:1648 and to ensure that PBMs return all manufacturer-derived revenue to the MCOs.</td></tr>
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Item	Change From:	Change To:	Justification
30	**GLOSSARY** **…** (New Provision)	**Money Follows the Patient (MFP) -** Supplemental hospital reimbursement distributed based on each hospital's volume of services delivered to Louisiana Medicaid managed care enrollees. The MFP program is designed such that payments will follow the patient, so that hospitals who see more Medicaid patients receive more reimbursement.	This revision defines Money Follows the Patient, which is referenced in section 5.4.1.2.2. Value-Based Payments.
31	**GLOSSARY** **…** (New Provision)	**Other Manufacturer Revenue(s)** – Refers to, without limitation, compensation or remuneration received or recovered, directly or indirectly, from a pharmaceutical or diabetic supply manufacturer for administrative, educational, research, clinical program, or other services, product selection switching incentives, charge-back fees, market share incentives, drug pull-through programs, or any payment amounts related to the number of covered lives, preferred drug lists, formularies, or the MCO's relationship with its Subcontractor(s) or with the State.	The purpose of this provision is to ensure compliance with La. R.S. 46:450.7 and La. R.S. 39:1648 and to ensure that PBMs return all manufacturer-derived revenue to the MCOs.
32	**GLOSSARY** **…** (New Provision)	**Rebate(s)** – Refers to all price concessions paid by a manufacturer or any other third-party, including rebates, discounts, credits, fees, manufacturer administrative fees, or other payments that are based on actual or estimated utilization of a covered drug or diabetic supply, or price concessions based on the effectiveness of a covered drug or diabetic supply.	The purpose of this provision is to ensure compliance with La. R.S. 46:450.7 and La. R.S. 39:1648 and to ensure that PBMs return all manufacturer-derived revenue to the MCOs.
33	**GLOSSARY** **…** **Specialized Behavioral Health Services (BHS)** – Mental health services and substance abuse services that include, but are not limited to, services specifically defined in the state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider.	**Specialized Behavioral Health Services (BHS)** – Mental health services and substance use disorder treatment ~~abuse~~ services that include~~, but are not limited to,~~ services specifically defined in the state plan such as outpatient, inpatient, and residential services ~~and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider~~.	The revision is to encompass the totality of behavioral health services offered by Medicaid.
34	**ACRONYMS** **…**	**ACRONYMS** **…** **MFP** – Money Follows the Patient	This revision defines Money Follows the Patient, which is referenced in section 5.4.1.2.2. Value-Based Payments.

Item	Change From:	Change To:	Justification
35	**LIST OF MCO COMPANION GUIDES** **…** **12. Marketing and Member Education Companion Guide**	**LIST OF MCO COMPANION GUIDES** **…** **12. Marketing and Member Education Companion Guide** **13. MCO Manual**	The MCO Manual provides additional clarification to contractual requirements and operational guidelines.

Attachment C: Quality Performance Measures (Effective Measurement Year 2021)

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
Better Care. Make health care more person-centered, coordinated, and accessible so that enrollees get the right care at the right time in the right place.	Ensure access to care to meet enrollee needs	Ensure timely and approximate access to primary and specialty care		1. Child and Adolescent Well-Care Visits	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA
				2. Well-Child Visits in the First 30 Months of Life	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	
				3. Adult Access to Preventive/Ambulatory Services	The percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported: • 20-44 years • 45-64 years • 65 years and older • Total	
	Improve coordination and transitions of care	Ensure appropriate follow-up after emergency department visits and hospitalizations through effective care coordination and case management		4. Ambulatory Care: Emergency Department Visits	This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months. *Note: A lower rate indicates better performance.*	NCQA
			$$	5. Follow-Up After Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • $$: The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within 7 days after discharge.	
			$$	6. Follow-Up After Emergency Department Visit for Mental Illness	The percentage of emergency department (ED) visits for members 6 years of age and older with a diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: • $$: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).	

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
					• The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	
			$$	7. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: • $$: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	
				8. Plan All-Cause Readmissions	For members 18 -64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	
	Facilitate patient-centered, whole person care	Engage and partner with enrollees to improve enrollee experience and outcomes		9. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version (Medicaid)	This measure provides information on parents' experience with their child's Medicaid organization.	NCQA
				10. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid)	This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.	
		Integrate behavioral and physical health		11. Depression Screening and Follow-Up for Adolescents and Adults (*Note: This is a pilot measure and LDH will work with the MCO on strategies to collect this information. This measure is not required for reporting*).	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • *Depression Screening*. The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen*. The percentage of members who received follow-up care within 30 days of screening positive for depression.	NCQA
				12. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	
				13. Diabetes Monitoring for People with Diabetes and Schizophrenia	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	
				14. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
				15. Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year	
Healthier People, Healthier Communities. Improve the health of enrollees through evidence-based prevention and treatment interventions that address physical and behavioral health needs.	Promote wellness and prevention	Improve overall health		16. Self-Reported Overall Health (Adult and Child) *Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data.*	The percentage of members reporting overall excellent or very good health.	AHRQ
				17. Self-Reported Overall Mental or Emotional Health (Adult and Child) *Note: This measure is from the CAHPS survey. Reporting will be dependent on availability and validity of data.*	The percentage of members reporting overall excellent or very good mental or emotional health.	
		Ensure maternal safety and appropriate care during childbirth and postpartum		18. Prenatal and Postpartum Care: Timeliness of Prenatal Care	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	NCQA
				19. Elective Delivery or Early Induction Without Medical Indication	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed	TJC
			$$	20. Cesarean Rate for Low-Risk First Birth Women	$$: The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions). *Note: A lower rate indicates better performance.*	
				21. Prenatal and Postpartum Care: Postpartum Care	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.	NCQA
		Prevent prematurity and reduce infant mortality		22. Initiation of Injectable Progesterone for Preterm Birth Prevention	The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.	State
				23. Percentage of Low Birthweight Births	Percentage of live births that weighted less than 2,500 grams in the state during the reporting period.	AHRQ

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
		Promote healthy development and wellness in children and adolescents		24. Developmental Screening in the First Three Years of Life	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	CMS
				25. Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	NCQA
		Promote oral health in children		26. Percentage of Eligibles Who Received Preventive Dental Services (*Note: CMS will calculate this measure and MCOs will not be required to report).*	The percentage of individuals ages 1 to 20 who are enrolled for at least 90 continuous days, are eligible EPSDT services, and who received at least one preventive dental service during the reporting period.	CMS
		Improve immunization rates	$$	27. Childhood Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. ($$: Combo 3)	NCQA
			$$	28. Immunizations for Adolescents	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday. Report all individual vaccine numerators and combinations. ($$: Combo 2)	
				29. Flu Vaccinations for Adults Ages 18 to 64	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.	
		Prevent obesity and address physical activity and nutrition in children and adults		30. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity	NCQA
		Promote reproductive health		31. Contraceptive Care – All Women Ages 21–44	The percentage of women ages 21-44 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.	OPA
				32. Contraceptive Care – Postpartum Women Ages 21–44	The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery or were provided a LARC within 3 and 60 days of delivery. Four rates are reported.	

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
				33. Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	NCQA
		Improve cancer screening	$$	34. Cervical Cancer Screening	$$: Percentage of women 21–64 years of age who were screened for cervical cancer: • Women 21-64 who had cervical cytology performed every 3 years. • Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years.	NCQA
				35. Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	
			$$	36. Colorectal Cancer Screening	$$: The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	
		Improve hepatitis C virus infection screening		37. Hepatitis C Virus Screening	Percentage of eligible individuals screened for hepatitis C virus infection.	State
		Promote use of evidence-based tobacco cessation treatments		38. Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies	NCQA
	Improve chronic disease management and control	Improve hypertension, diabetes, and cardiovascular disease management and control	$$	39. Controlling High Blood Pressure	$$: The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	NCQA
				40. Diabetes Short-Term Complications Admission Rate	Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older. *Note: A lower rate indicates better performance.*	AHRQ
				41. Statin Therapy for Patients with Cardiovascular Disease	• The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy (were dispensed at least one high or moderate-intensity statin medication during the measurement year.) • The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who had statin adherence of at least 80% (who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.)	NCQA

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
				42. Heart Failure Admission Rate	Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish).	AHRQ
			$$	43. Comprehensive Diabetes Care	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing • $$: HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • HbA1c control (<7.0%) for a selected population • Eye exam (retinal) performed • BP control (<140/90 mm Hg) *Note: For some measures, a lower rate indicates better performance.*	NCQA
		Improve respiratory disease management and control		44. Asthma in Younger Adults Admission Rate	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39. *Note: A lower rate indicates better performance.*	AHRQ
				45. Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older. *Note: A lower rate indicates better performance.*	
		Improve HIV control	$$	46. HIV Viral Load Suppression	$$: Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200.	HRSA
		Improve quality of mental health and substance use disorder care		47. Pharmacotherapy for Opioid Use Disorder	The percentage of new opioid use disorder (OUD) pharmacotherapy episodes that resulted in 180 or more covered treatment days among members 16 years of age and older with a diagnosis of OUD	NCQA
				48. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD	

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
					services or medication treatment within 34 days of the initiation visit.	
				49. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.	
				50. Adherence to Antipsychotic Medications for Individuals with Schizophrenia	The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	
				51. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	
				52. Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.	
	Improve population health and address health disparities	Stratify key quality measures by race/ethnicity and rural/urban status and narrow health disparities		53. Measures for stratified data: a. Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44 b. Child: Well Child Visits in the First 30 Months of Life, Childhood Immunizations (Combo 3), Immunizations for Adolescents (Combo 2) c. Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Cervical Cancer Screening	*Refer to individual measures	Various

Aims	Goals	Objectives	$$	Measures	Measure Description	Steward
				d. Behavioral Health: Follow-Up After Emergency Department Visit for Mental Illness (within 30 days), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (within 30 days), Follow-Up After Hospitalization for Mental Illness		
Smarter Spending. Advance high-value, efficient care.	Minimize wasteful spending	Reduce low value care		54. Appropriate Treatment for Children With Upper Respiratory Infection	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	NCQA
				55. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	
				56. Use of Imaging Studies for Low Back Pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	
				57. Non-recommended Cervical Cancer Screening in Adolescent Females	The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. *Note: A lower rate indicates better performance.*	