Contract Amendment #2
Attachment B2

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment D Rate Certification	Mercer rate certification; Attachment D.	New rate certification effective 7/1/2020.	These revised certifications support the implementation of: • COVID-19 lab testing fee schedule changes • COVID-19 risk corridor
2	Attachment B Statement of Work	5.5.6 For enrollees dis-enrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover claim payments under the retroactively dis-enrolled enrollee's ID if the remaining valid ID is linked to another MCO or FFS. The MCO shall subrogate to the MCO that is responsible for the claim(s) for the dates of service.	5.5.6 For enrollees dis-enrolled due to the invalidation of a duplicate Medicaid ID, the Contractor shall not recover claim payments under the retroactively dis-enrolled enrollee's ID if the remaining valid ID is linked to another MCO ~~or FFS~~. The MCO shall subrogate the amount of the paid claim(s) to the MCO that is responsible for the claim(s) for the dates of service.	Inclusion of FFS is not applicable in this instance. Duplicate member IDs are for members enrolled with the same MCO or another MCO.
3	Attachment B Statement of Work	[end of section]	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.	Establishes a risk corridor to address uncertainty around expenditures during the COVID-19 event.

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			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. 5.6.5.3 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.	
4	Attachment B Statement of Work	6.1.16. The MCO shall comply with the terms of the Louisiana Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana) as directed by LDH.	6.1.16. The MCO shall comply with the terms of the Louisiana Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana), subsequent implementation plans, and other activities required in order to implement this agreement	Provides further instruction for compliance with DOJ Agreement.

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			in accordance with the DOJ Agreement Compliance Guide or as directed by LDH. LDH reserves the right to assess monetary penalties for failure to meet this requirement.	
5	Attachment B Statement of Work	6.3.1.1. The MCO may follow the FFS limit of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than the Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber.	6.3.1.1. The MCO shall notify LDH prior to implementing or changing any prescription limits. The MCO may follow the FFS limit of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than the Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber.	Requires notification of prescription limits for LDH awareness.
6	Attachment B Statement of Work	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 divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL. The MCO shall seek to achieve a 90 percent compliance rate.	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 ~~seek to~~ achieve at least a 92%~~0 percent~~ compliance rate. PDL compliance less than 92% may result in monetary penalties of up to $100,000 per quarter.	Increases PDL compliance rate.
7	Attachment B Statement of Work	6.3.4.1 LDH intends to align FFS and MCO prior authorization (PA) criteria for drugs on the single PDL over time through the Drug Utilization Review (DUR) board. The MCOs shall have input on PA criteria development and representation on the DUR board. Prior to alignment, the MCOs shall maintain PA criteria that is not more restrictive than FFS. The MCO shall have a Prior Authorization (PA) process that complies with 42 CFR § 438.3(s)(6) and the following requirements.	6.3.4.1 MCO prior authorization (PA) criteria shall align with FFS for drugs on the Single PDL that were filled in an outpatient pharmacy setting. LDH intends to align FFS and MCO ~~prior authorization (~~PA~~)~~ criteria for drugs not on the single PDL over time through the Drug Utilization Review (DUR) board. The MCOs shall have input on PA criteria development and representation on the DUR board. Prior to alignment, the MCOs shall maintain PA criteria that is not more restrictive than FFS. The MCO shall have a Prior Authorization (PA)	Aligns contract verbiage with current practice.

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			process that complies with 42 CFR § 438.3(s)(6) and the following requirements.	
8	Attachment B Statement of Work	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents, Synagis, Respiratory monoclonal antibody agents (benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), omalizumab (Xolair®), and reslizumab (Cinqair®), Growth Hormones, Multiple Sclerosis drugs, and Hemophilia agents.	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents (as directed by LDH) Spinraza and~~,~~ Synagis, ~~Respiratory monoclonal antibody agents (benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), omalizumab (Xolair®), and reslizumab (Cinqair®), Growth Hormones, Multiple Sclerosis drugs, and Hemophilia agents~~. MCOs shall utilize the LDH form and criteria for these specialty classes filled in an outpatient pharmacy setting.	Aligns PA criteria and forms for provider simplification.
9	Attachment B Statement of Work	6.3.7.3 The MCO shall provide for a DUR program that contains the following components: • Prospective DUR program • Retrospective DUR program • Educational DUR program	6.3.7.3 The MCO shall provide for a DUR program that contains the following components: • Prospective DUR program • Retrospective DUR program • Educational DUR program DUR initiatives directed by LDH shall be implemented as directed or with written LDH approval of alternative programming reaching the same outcomes. DUR initiatives not or incorrectly implemented may result in monetary penalties of $250 per claim until identified, then $5,000 daily until programming is corrected and implemented.	Establishes a monetary penalty for DUR initiatives.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
10	Attachment B Statement of Work	**6.3.7.3.1 Prospective DUR Program** 6.3.7.3.1.1 The MCO shall provide for a review of drug therapy at Point of Sale (POS) before each prescription is given to the recipient. Screening should be performed for potential drug problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, duration of therapy, and clinical misuse. The following parameters should be screened at POS. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. Reporting capabilities shall exist for these denial codes. The MCOs will need to report data on edits to the Department on a semi-annual basis prior to the submission date requirement of the DUR Annual Report. 6.3.7.3.1.2 Pharmacy claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the adjudication process at POS. Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code.	**6.3.7.3.1 Prospective DUR Program** 6.3.7.3.1.1 The MCO shall provide for a review of drug therapy at Point of Sale (POS) before each prescription is given to the recipient. Screening should be performed for potential drug problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, duration of therapy, and clinical misuse. The following parameters should be screened at POS. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. Reporting capabilities shall exist for these denial codes. ~~The MCOs will need to report data on edits to the Department on a semi-annual basis prior to the submission date requirement of the DUR Annual Report.~~ The MCOs shall align their coding of NCPDP compliant POS edits and overrides with LDH. Prior authorization is not an acceptable method to override certain POS edits. 6.3.7.3.1.2 Pharmacy claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the adjudication process at POS. Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code. The MCO shall allow pharmacist overrides on selected POS denials as instructed by LDH. Pharmacist overrides shall utilize NCPDP established standards.	Aligns contract verbiage with current practice.

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11	Attachment B Statement of Work	6.3.7.3.2.2 Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. At a minimum, the MCO shall incorporate all of LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.	6.3.7.3.2.2 Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. Each MCO shall follow retrospective criteria approved at the DUR Board meeting. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy. LDH approved enrollee profiles shall be sent to providers with the retrospective letters. Additional retrospective DUR initiatives may be implemented by the MCO when previously approved by LDH. ~~At a minimum, the MCO shall incorporate all of LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.~~	Aligns contract verbiage with current practice.
12	Attachment B Statement of Work	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives and submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date.	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, ~~DUR utilization review process/procedure and~~ the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives and submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date.	Aligns contract verbiage with current practice.
13	Attachment B Statement of Work	6.4.11. Coordinated System of Care (CSoC) Implementation Plan Development In anticipation of the potential for inclusion of CSoC services within Medicaid Managed Care, the MCO shall develop a plan of implementation to be submitted to LDH no later than July 1, 2016. Elements to be addressed in the plan include but are not limited to: 6.4.11.1. Demonstration of the MCOs knowledge on System of Care values and Wraparound Process;	~~6.4.11. Coordinated System of Care (CSoC) Implementation Plan Development~~ ~~In anticipation of the potential for inclusion of CSoC services within Medicaid Managed Care, the MCO shall develop a plan of implementation to be submitted to LDH no later than July 1, 2016. Elements to be addressed in the plan include but are not limited to:~~ ~~6.4.11.1. Demonstration of the MCOs knowledge on System of Care values and Wraparound Process;~~	Removes outdated information that is no longer applicable.

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		6.4.11.2. Processes and protocols for screening and referral; 6.4.11.3. Network Development for services and supports; 6.4.11.4. Technical assistance and training for the CSoC providers inclusive of the WAAs, the Family Support Organization (FSO) and other contracted providers; 6.4.11.5. Coordination and communications with key agencies, i.e. OJJ, DCFS, OBH, etc.; 6.4.11.6. Transition and coordination of care out of CSoC level of care. 6.4.11.7. Program monitoring and quality improvement; and 6.4.11.8. Timelines required for implementation.	~~6.4.11.2. Processes and protocols for screening and referral;~~ ~~6.4.11.3. Network Development for services and supports;~~ ~~6.4.11.4. Technical assistance and training for the CSoC providers inclusive of the WAAs, the Family Support Organization (FSO) and other contracted providers;~~ ~~6.4.11.5. Coordination and communications with key agencies, i.e. OJJ, DCFS, OBH, etc.;~~ ~~6.4.11.6. Transition and coordination of care out of CSoC level of care.~~ ~~6.4.11.7. Program monitoring and quality improvement; and~~ ~~6.4.11.8. Timelines required for implementation.~~	
14	Attachment B Statement of Work	6.6.5. The MCO shall accurately report, via encounter data submissions all EPSDT and well-child services, blood lead screening access to preventive services, and any other services as required for LDH to comply with federally mandated CMS 416 reporting requirements. Instructions on how to complete the CMS 416 report may be found on CMS's website at: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html. See **MCO Systems Companion Guide** for format and timetable for reporting of EPSDT data.	6.6.5. The MCO shall accurately report, via encounter data submissions all EPSDT and well-child services, blood lead screening access to preventive services, and any other services as required for LDH to comply with federally mandated CMS 416 reporting requirements. ~~Instructions on how to complete the CMS 416 report may be found on CMS's website at: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.~~ ~~See **MCO Systems Companion Guide** for format and timetable for reporting of EPSDT data.~~	MCOs are not required to submit the CMS 416 report; however, they are required to report accurately the data referenced in this provision for LDH to complete the CMS 416 report.
15	Attachment B Statement of Work	6.19.1.6. Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination;	6.19.1.6. Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination and members of the DOJ Agreement Target	Expands the special health care needs population to include members of the DOJ Agreement Target Population and those at high risk of entering that population.

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		6.19.1.7. Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed and have declined to enter or are transitioning out of the CSoC program; 6.19.1.8. Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months; 6.19.1.9. Individuals with co-occurring behavioral health and developmental disabilities; 6.19.1.10. Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis; 6.19.1.11. Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and 6.19.1.12. Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.	Population who meet the diversion definition set forth by the Department; 6.19.1.7. Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed and have declined to enter or are transitioning out of the CSoC program; 6.19.1.8. Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months; 6.19.1.9. Individuals with co-occurring behavioral health and developmental disabilities; 6.19.1.10. Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis; 6.19.1.11. Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; ~~and~~ 6.19.1.12. Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services~~.~~; and 6.19.1.13. Persons with serious mental illness who have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments and who are at high risk of inpatient admission or Emergency Department visits, including	

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			enrollees transitioning across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting.	
16	Attachment B Statement of Work	6.39.6. Case Management for Members Receiving Nursing Facility Care	6.39.6. Case Management for Members Receiving Nursing Facility Care or otherwise within the DOJ Agreement Target Population	Extends the requirement to those within the DOJ Agreement Target Population.
17	Attachment B Statement of Work	7.9.5.9 Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from LDH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	7.9.5.9 Ensure that provider complaints are acknowledged within three (3) business days of receipt; resolve and/or state the result communicated to the provider within thirty (30) business days of receipt (this includes referrals from LDH). ~~If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.~~	Provider complaints are to be resolved within 30 days.
18	Attachment B Statement of Work	7.13.8. Notification of amendments or changes to any provider agreement which, in accordance with Section 7.11 of this Contract, materially affects this Contract, shall be provided to LDH prior to the execution of the amendment in accordance with Section 23.1 of this Contract.	7.13.8. Notification of amendments or changes to any provider agreement which, in accordance with Section 7.11 of this Contract, materially affects this Contract, shall be provided to LDH prior to the execution of the amendment ~~in accordance with Section 23.1 of this Contract~~.	Removes an incorrect reference.
19	Attachment B Statement of Work	7.17.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • Reimburse the FFS (legacy) to all "local pharmacies" as defined in Act 301 of the 2017 Regular Session of the Louisiana Legislature; • Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by LDH;	7.17.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • Reimburse the FFS (legacy) to all "local pharmacies" as defined in Act 301 of the 2017 Regular Session of the Louisiana Legislature; • Add any state imposed provider fees for pharmacy services, on top of the ~~minimum~~ professional dispensing fee and ingredient cost reimbursement ~~required by LDH~~;	Clarifies that the provider fee should be an additional reimbursement to ingredient cost and the professional dispensing fee.

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		• Update the ingredient costs of medications at least weekly and within three (3) business days of new rates being posted from the source of choice; • Base Maximum Allowable Cost (MAC) price lists on generic drugs with a FDA rating beginning with an "A"; • Make drug pricing list available to pharmacies for review; and • Afford individual pharmacies a chance to appeal inadequate reimbursement	• Update the ingredient costs of medications at least weekly and within three (3) business days of new rates being posted from the source of choice; • Base Maximum Allowable Cost (MAC) price lists on generic drugs with a FDA rating beginning with an "A"; • Make drug pricing list available to pharmacies for review; and • Afford individual pharmacies a chance to appeal inadequate reimbursement	
20	Attachment B Statement of Work	7.17.4.1.1 A specialty drug is defined as a prescription drug which meets all of the following criteria:	7.17.4.1.1 A specialty drug is defined as a prescription drug which meets two or more ~~all~~ of the following criteria:	Aligns contract verbiage with current practice.
21	Attachment B Statement of Work	9.7.7. In addition to the specific Web site requirements outlined above, the MCOs Web site shall be functionally equivalent to the Web site maintained by the LDH FI.	~~9.7.7. In addition to the specific Web site requirements outlined above, the MCOs Web site shall be functionally equivalent to the Web site maintained by the LDH FI.~~	Removes ambiguous requirement.
22	Attachment B Statement of Work	14.2.5.9 The MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).	14.2.5.9 The MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year). 14.2.5.9.1. LDH has the sole discretion to determine whether the MCOs will be granted an exception from obtaining a HEDIS audit and/or from submitting the results of the HEDIS audit to NCQA for either some or all of the quality and health outcome measurements. If such an exception is granted, the MCO shall comply with all instructions and deadlines provided by LDH.	Allows MCOs to submit supplemental results after the NCQA deadline, at LDH's discretion.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
23	Attachment B Statement of Work	17.3.4 The MCO shall pay pharmacy providers no less than the LDH specified dispensing fee. In addition, any state imposed provider fees for pharmacy services, shall be added on top of the minimum dispensing fee required by LDH.	~~17.3.4 The MCO shall pay pharmacy providers no less than the LDH specified dispensing fee. In addition, any state imposed provider fees for pharmacy services, shall be added on top of the minimum dispensing fee required by LDH.~~	The contents of this provision are covered in another section.
24	Attachment B Statement of Work	17.7.1.1.2 Date of birth of Medicaid identification number;	17.7.1.1.2 Date of birth ~~of~~ and Medicaid identification number;	Corrects a grammatical error.
25	Attachment B Statement of Work	17.9.3.2 Due in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the MCO or its subcontractor has a capitation arrangement with a provider. If the MCO fails to submit complete encounter data, including encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) as measured by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in Section 20 of the Contract.	17.9.3.2 Due in accordance with the encounter reconciliation schedule published by LDH or its contracted review organization, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the MCO or its subcontractor has a capitation arrangement with a provider. ~~If the MCO fails to submit complete encounter data, including encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) as measured by a comparison of encounters to cash disbursements within a five (5) percent error threshold (at least ninety-five (95) percent complete), the plan may be penalized as outlined in Section 20 of the Contract.~~ If the MCO or its subcontracted vendor(s), individually or in aggregate, fails to submit complete encounter data as measured by a comparison of encounters to cash disbursements within a three percent (3%) error threshold (i.e., encounters are at least ninety-seven percent (97%) but no greater than one hundred percent (100%) of cash disbursements), LDH may impose monetary penalties as outlined in Section 20 of the Contract. LDH, at its sole discretion, may waive the penalty if encounters processed by subcontracted vendors	Clarifies that the completion percentage applies to encounters processed by the MCO and its subcontracted vendors, separately or in aggregate. Allows for a grace period during transition periods.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			(e.g., pharmacy, non-emergency transportation, vision) fall below the completion threshold during the transition to a new vendor; however, this grace period shall not exceed 90 calendar days for encounters processed by either the exiting vendor or the new vendor.	
26	Attachment B Statement of Work	**LIST OF MCO COMPANION GUIDES** **…** **10. Wells Compliance Guide**	**LIST OF MCO COMPANION GUIDES** **…** **10. Wells Compliance Guide** **11. DOJ Agreement Compliance Guide**	Incorporates compliance guide specific to the DOJ Agreement.

20.3.3 Table of Monetary Penalties

		Justification
Risk Corridor (COVID-19)	The total value of the increase: (1) over the previously contracted rate for existing providers, or (2) over the FFS rate for new providers, plus the difference in the losses that would have been realized if the increase had not been in effect for each occurrence that the MCO increased provider reimbursement rates to such an extent that materially impacted the risk corridor without meeting a specified exception as determined by LDH at its sole discretion.	Establishes a monetary penalty corresponding to the COVID-19 risk corridor requirements.
Preferred Drug List (PDL)	One hundred thousand dollars ($100,000.00) per quarter in which the PDL compliance rate is less than 92%.	Establishes monetary penalties corresponding to revisions for PDL compliance rate and DUR initiatives.
Drug Utilization Review (DUR) Program	Two hundred fifty dollars ($250.00) per claim upon identification of DUR initiatives not or incorrectly implemented, plus five thousand dollars ($5,000.00) per day until programming is corrected and implemented.	Establishes monetary penalties corresponding to revisions for PDL compliance rate and DUR initiatives.
Encounter Data	Ten thousand dollars ($10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the Contract. ~~Ten thousand dollars ($10,000.00) per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the MCO for correction because submission data was in excess of the five (5) percent error rate threshold, until acceptance of the data by the fiscal intermediary.~~ ~~Ten thousand dollars ($10,000.00) per return by the fiscal intermediary of re-submission of encounter data that was returned to the MCO, as submission data was in excess of the five (5) percent error rate threshold, for correction and was rejected for the second time.~~ Fifty thousand dollars ($50,000) per occurrence in each bimonthly reconciliation in which LDH or its designee determines that the MCO or its subcontracted vendor(s), individually or in aggregate, failed to submit complete encounter data within a three percent (3%) error threshold. Ten thousand dollars ($10,000.00) per occurrence of medical record review by LDH or its designee where the MCO or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.	Clarifies when the monetary penalty will be assessed when the completion threshold is not met. Updates the completion threshold percentage and reduces the amount of the monetary penalty for each instance of non-compliance.

	Penalties specified above shall not apply for encounter data for the first three months after direct services to MCO members have begun to permit time for development and implementation of a system for exchanging data and training of staff and health care providers.	

Attachment C – Performance Measures

From:

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
MPM	Annual Monitoring for Patients on Persistent Medications	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the two rates separately and as a total rate.	NCQA	MEDICAID ADULT	Chronic Disease	Prevention	HEDIS

To:

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
~~MPM~~	~~Annual Monitoring for Patients on Persistent Medications~~	~~The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the two rates separately and as a total rate.~~	~~NCQA~~	~~MEDICAID ADULT~~	~~Chronic Disease~~	~~Prevention~~	~~HEDIS~~

Justification:

NCQA has retired Annual Monitoring for Patients on Persistent Medications (MPM) measure for HEDIS 2020.