



Office of State Procurement Contract Certification of Approval

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

Reference Number: 2000683487

Amendment Number: 10

Vendor: AETNA BETTER HEALTH INC (LA)

Description: Managed Care Organizations 3.0

Approved By: PAMELA RICE

Approval Date: 09/05/2025 15:03:51

AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 10

LAGOV#: 2000683487

LDH #:

Original Contract Amount \$3,569,491,194.00

Original Contract Begin Date 01-01-2023

Original Contract End Date 12-31-2025

RFP Number: 3000017417

(Regional/ Program/
Facility

Medical Vendor Administration

Bureau of Health Services Financing

AND

Aetna Better Health of Louisiana, Inc.

Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: \$3,874,496,959.00

Current Contract Term : 01/01/23-12/31/25

Attachment A - Model Contract
Attachment C - In Lieu of Services
Attachment D8 - Rate Certification effective 7/1/2024
Attachment D9 - Rate Certification effective 7/1/2024
Attachment E - APM Reporting Template
Attachment F - Provider Network Standards
Attachment G - Table of Monetary Penalties
Attachment H - Quality Performance Measures

Change Contract To: If Changed, Maximum Amount:

If Changed, Contract Term:

Amd 10 Attachment A10 - Changes to Attachment A - Model Contract; Amd 10 Attachment C10 - Changes to Attachment C - In Lieu of Services; Amd 8 Attachment D8 - Rate Certification effective 7/1/2024; Amd 9 Attachment D9 - Rate Amendment effective 7/1/2024; Amd 10 Attachment D10 - Rate Update Memorandum effective 7/1/2024; Amd 10 Attachment E10 - Changes to Attachment E - APM Reporting Template; Amd 10 Attachment F10 - Changes to Attachment F - Provider Network Standards; Amd 10 Attachment G10 - Changes to Attachment G - Table of Monetary Penalties; Amd 10 Attachment H10 - Changes to Attachment H - Quality Performance Measures

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 contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

This amendment also provides the Healthy Louisiana Capitation Rate Update for SFY2025 (July 1, 2024 through June 30, 2025). These rates are inclusive of directed payments and FMP. The rate adjustment is utilizing the de minimis flexibility provided under 438.7(c)(3).

This Amendment Becomes Effective: 07-01-2024

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

Signed by: Aetna Better Health of Louisiana, Inc.
Bridget Galatas 7/14/2025
2EE41ED8288D489...
CONTRACTOR SIGNATURE DATE

PRINT NAME Bridget Galatas

CONTRACTOR TITLE Chief Executive Officer

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

Signed by: 8/7/2025
Bruce D. Greenstein
8B69523F50424C5...
SIGNATURE DATE

NAME Bruce D. Greenstein

TITLE Secretary

OFFICE Louisiana Department of Health

DocuSigned by: 7/21/2025
Kimberly Sullivan
PROXY SIGNATURE DATE

NAME Kimberly Sullivan



MCO Amendment 10
Attachment A10 – Changes to Attachment A, Model Contract

Item	Change From	Change To	Justification
1	Acronyms ... [add new acronyms]	Acronyms ... <u>CPST – Community Psychiatric Support and Treatment</u> <u>DBT – Dialectical Behavior Therapy</u>	
2	Glossary ... [add new definition]	<u>Glossary</u> ... <u>Pass-through visits - the allowance of a certain number of visits to be provided without authorization.</u>	
3	2.2.6 Reports and Requests for Information ... 2.2.6.2.2 Requests that originate from the Office of the Governor, the LDH Office of the Secretary, or a Louisiana legislator shall be addressed within seventy-two (72) hours;	2.2.6 Reports and Requests for Information ... 2.2.6.2.2 Requests that originate from the Office of the Governor, the LDH Office of the Secretary, or a Louisiana legislator shall be addressed within seventy-two (72) twenty-four (24) hours <u>unless otherwise directed by LDH;</u>	This revision aligns the contract with current practice.
4	2.3.2 Voluntary MCO Populations The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all Applied Behavior Analysis (ABA), SBHS, NEMT, services, and NEAT services. ... 2.3.3 Mandatory MCO Populations for ABA, SBHS, and NEAT Services Only The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for	2.3.2 Voluntary MCO Populations The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for Applied Behavior Analysis (ABA), SBHS, NEMT, services, and <u>NEMT/NEAT to all Medicaid Covered S</u> services. ... 2.3.3 Mandatory MCO Populations for ABA, SBHS, and NEAT Services Only The <u>Contractor shall accept Enrollment of the</u> following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program <u>and provide</u> for ABA, SBHS, and NEAT <u>to all Medicaid Covered S</u> ervices only, and receive all other Medicaid Covered Services through FFS:	This revision is necessary to clarify the MCOs' obligation to provide NEMT/NEAT services to all Medicaid Covered Services.

Item	Change From	Change To	Justification
	<p>ABA, SBHS, and NEAT services only, and receive all other Medicaid Covered Services through FFS:</p> <p>...</p> <p>2.3.4 Mandatory MCO Populations for ABA, SBHS, and NEMT/NEAT Services Only</p> <p>The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for ABA, SBHS, and NEMT/NEAT to services only, and receive all other Medicaid Covered Services through FFS:</p>	<p>2.3.4 Mandatory MCO Populations for ABA, SBHS, and NEMT/NEAT Services Only</p> <p>The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program and provide for ABA, SBHS, and NEMT/ NEAT to all Medicaid Covered Sservices only, and receive all other Medicaid Covered Services through FFS:</p>	
5	<p>2.4.4 In Lieu of Services</p> <p>...</p> <p>[new provision]</p>	<p>2.4.4 In Lieu of Services</p> <p>...</p> <p><u>2.4.4.6 The Contractor shall identify In Lieu of Services in Encounter Data in accordance with the MCE System Companion Guide.</u></p>	<p>This revision facilitates the identification of In Lieu of Services in encounter data by utilizing the prefixes established in the MCE System Companion Guide.</p>
6	<p>2.4.5.4 The Contractor may propose to add to or expand upon the VAB(s) proposed in the Contractor’s RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval at least six (6) months in advance of the effective date of Enrollment resulting from the Enrollment Period. The Contractor shall submit requests in accordance with the MCO Manual.</p>	<p>2.4.5.4 The Contractor may propose to add to or expand upon the VAB(s) proposed in the Contractor’s RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval at least no later than six (6) months in advance of the effective date of Enrollment resulting from the Enrollment Period. The Contractor shall submit requests in accordance with the MCO Manual.</p>	<p>This revision allows for sufficient time to review and approve VAB submissions.</p>
7	<p>2.9.29 Network Provider Agreement Requirements</p> <p>...</p> <p>[new provision]</p>	<p>2.9.29 Network Provider Agreement Requirements</p> <p>...</p>	<p>This update is necessary to improve behavioral health-related follow-up rates. Research indicates that providing follow-up care to patients after psychiatric hospitalization can improve patient</p>



Item	Change From	Change To	Justification
		<p><u>2.9.29.17. All Network Provider Agreements with hospitals, shall include a requirement for the development of a discharge plan, with an aftercare appointment with a behavioral health provider as soon as clinically indicated but not later than ten (10) Calendar Days from the date of discharge, for Enrollees with behavioral health-related hospitalizations unless there is documented Enrollee refusal. This requirement shall be included in all present and future Network Provider Agreements and may be incorporated through a separate addendum to the agreement. In addition, the Network Provider Agreement shall specify the Contractor's responsibility as it pertains to discharge planning, including securing post-discharge appointments and linkages, and include information on the availability of a dedicated MCO e-mail address and telephone number for hospitals to utilize for Care Coordination activities.</u></p>	<p>outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.</p>

8	<p>2.10.3 Provider Relations</p> <p>The Contractor shall:</p> <p>[new provisions]</p>	<p>2.10.3 Provider Relations</p> <p>The Contractor shall:</p> <p>...</p> <p><u>2.10.3.12 Establish and maintain a process whereby hospitals may readily obtain assistance, including accurate contact information, regarding behavioral health Network Providers who may accept aftercare appointments within ten (10) Calendar Days of the discharge date for Enrollees presenting with behavioral health needs. This shall include, but is not limited to the following:</u></p> <p><u>2.10.3.12.1 Establishment of a dedicated MCO e-mail address and toll-free telephone number for hospitals to request assistance with locating behavioral health providers in the Enrollee’s area who will accept an aftercare appointment within ten (10) days of the Enrollee’s discharge date and other Care Coordination activities. The telephone number must be answered by a live voice and include immediate handoff to an MCO staff member with detailed knowledge regarding Louisiana Medicaid-funded behavioral health services and Network Providers with possible appointment availability within ten (10) Calendar Days of the Enrollee’s discharge date.</u></p>	<p>This update is necessary to improve behavioral health-related follow-up rates. Research indicates that providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.</p>
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Item	Change From	Change To	Justification
		<p><u>2.10.3.12.2. Development and maintenance of a listing of verified behavioral health Network Providers in each parish, if possible, or region, who may accept an aftercare appointment within ten (10) Calendar Days of the Enrollee's discharge date, which shall be provided to hospitals upon request.</u></p> <p><u>2.10.3.12.3 Documentation of all requests received through the dedicated e-mail address and telephone number including any instances in which an appointment could not be secured within ten (10) Calendar Days of the Enrollee's discharge date, and failed attempts by service type. This information shall be provided to LDH upon request, utilized by the Contractor to update provider files (e.g., provider closures, providers not accepting new appointments), assess network adequacy, and be integrated into the Contractor's Network Development and Management Plan Strategy.</u></p>	
9	<p>2.11.13 Payment for Hospital Services</p> <p>2.11.1.1 ...</p>	<p>2.11.13 Payment for Hospital Services</p> <p>2.11.1.1 ...</p>	<p>This revision specifies reporting requirements for directed payments for hospital services.</p>

Item	Change From	Change To	Justification
	<p>2.11.13.1</p> <p>....</p> <p>In accordance with Federal regulations, directed payments must be based on actual utilization and delivery of services. As such, within twelve (12) months of the end of the SFY, LDH will perform a reconciliation and provide the Contractor with a reconciliation report that will contain the adjustments to be made to each qualified hospital's next quarterly interim directed payment. If the Contractor fails to perform the reconciliation in accordance with the instructions or within the specified time period, LDH may penalize the Contractor using one (1) or more of the following:</p> <ul style="list-style-type: none"> • One (1) or more remedies in the Contract Non-Compliance section, including, but not limited to, Contract termination; • Attachment G, <i>Table of Monetary Penalties</i>; and • A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor. <p>[new provision]</p>	<p>2.11.13.1</p> <p>....</p> <p>In accordance with Federal regulations, directed payments must be based on actual utilization and delivery of services. As such, within twelve (12) months of the end of the SFY, LDH will perform a reconciliation and provide the Contractor with a reconciliation report that will contain the adjustments to be made to each qualified hospital's next quarterly interim directed payment. If the Contractor fails to perform the reconciliation in accordance with the instructions or within the specified time period, LDH may penalize the Contractor using one (1) or more of the following:</p> <ul style="list-style-type: none"> • One (1) or more remedies in the Contract Non-Compliance section, including, but not limited to, Contract termination; • Attachment G, <i>Table of Monetary Penalties</i>; and • A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor. <p><u>Annually, unless otherwise directed by LDH, the Contractor shall stratify and report on select performance measure results in Attachment H, Quality Performance Measures, using a template provided by LDH.</u></p>	
10	<p>2.11.14 Payment for Recruitment and Retention Incentives for psychiatrists and Licensed Mental Health Professionals</p> <p>....</p> <p>In accordance with 42 CFR §438.6(c), LDH will utilize a CMS-approved directed payment arrangement for specified Network Providers. The payment arrangement will utilize a series of uniform incentive payments dependent upon the</p>	<p>2.11.14 Payment for Recruitment and Retention Incentives for psychiatrists and Licensed Mental Health Professionals</p> <p>....</p> <p>In accordance with 42 CFR §438.6(c), LDH will utilize a CMS-approved directed payment arrangementss for specified Network Providers. The payment arrangementss will utilize a series of uniform incentive payments dependent upon the retention or recruitment category within which the eligible Network Provider</p>	<p>This addition is necessary to implement a directed payment arrangement, approved by CMS and funded through ARPA, to improve access to DBT.</p>

Item	Change From	Change To	Justification
	<p>retention or recruitment category within which the eligible Network Provider falls. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically.</p> <p>This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment.</p> <p>...</p> <p>2.11.14.4 This directed payment arrangement shall be detailed in Attachment D, <i>Actuarial Rate Certification Letter</i>.</p>	<p>falls. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically.</p> <p>These This directed payment arrangements will be made through a separate payment term outside of the monthly Capitation Payment. <u>Separate payment term(s) will be captured in the applicable rate certifications(s) but paid separately to the Contractor from the monthly base capitation rates paid to the Contractor based on the American Rescue Plan Act, 9817 funding.</u></p> <p>...</p> <p><u>2.11.14.4 For applicable dates of service within SFY 2024, unless a renewal is approved by CMS, and enacted by LDH, a State-directed payment arrangement will be utilized for a temporary, uniform rate increase for certain individual or group psychotherapy services over the Medicaid FFS fee schedule in effect as of July 1, 2023 for services provided by an enrolled qualified provider that utilizes Dialectical Behavior Therapy (DBT), an individual or group psychotherapy Evidence-Based Practice. The Contractor shall ensure compliance with the applicable CMS-approved State-directed payment preprint for DBT services.</u></p> <p><u>2.11.14.4.1 Eligible providers will be paid by the Contractor based on submission of eligible claims. The Contractor must ensure the accurate and timely processing of Claims and Encounters. The Contractor will be eligible to receive reimbursement from LDH for the DBT add-on portion of the total reimbursement paid for the applicable individual or group psychotherapy services. To receive reimbursement, the Contractor will invoice LDH on a quarterly basis for the portion of the claims attributable to the state directed payment. The initial invoice is due by the fifteenth (15th) of the month following the close of the first eligible calendar year quarter during which a</u></p>	



Item	Change	Change To	Justification
		<p><u>Contractor will be reimbursed by LDH within thirty (30) Calendar Days of invoice receipt.</u></p> <p>2.11.14.54 This directed payment arrangement shall be detailed in Attachment D, <i>Actuarial Rate Certification Letter</i>.</p>	
11	<p>2.11 Provider Reimbursement</p> <p>...</p> <p>[new provisions]</p>	<p>2.11 Provider Reimbursement</p> <p>...</p> <p><u>2.11.18 Payment for Recruitment and Retention Incentives for Nurses Providing Skilled Nursing Services in the Extended Home Health Program</u></p> <p><u>In accordance with 42 CFR §438.6(c), LDH will utilize a directed payment arrangement to disburse recruitment and retention bonuses for skilled nursing services provided under the extended home health program. The payment arrangement will be dependent upon the nurse meeting monthly service thresholds. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically.</u></p> <p><u>This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment.</u></p> <p><u>The Contractor shall make directed payments to qualified Network Providers as directed by LDH and in accordance with the written approval from CMS for the applicable rating period.</u></p> <p><u>2.11.18.1 LDH will provide a one-time recruitment lump sum payment contingent upon the nurse meeting service thresholds. Individual nurses are only eligible to receive to the recruitment lump sum bonus once.</u></p> <p><u>2.11.18.2 For each State Fiscal Year (SFY), pursuant to CMS approval, LDH will provide an additional recurring monthly retention payment to qualified</u></p>	<p>This addition is necessary to implement a directed payment arrangement, approved by CMS and funded through ARPA, to improve access to home health services.</p>

Item	Change From	Change To	Justification
		<p><u>thresholds. Additionally, the home health agency employing the nurse(s) will be eligible to receive a monthly administrative fee.</u></p> <p><u>2.11.18.3 This directed payment arrangement shall be detailed in Attachment D, Actuarial Rate Certification Letter.</u></p> <p>[subsequent provisions renumbered]</p>	
12	<p>2.12 Utilization Management</p> <p>2.12.1 General Requirements</p> <p>...</p> <p>2.12.1.2 The Contractor shall submit written policies and procedures to LDH or its designee for approval as part of Readiness Review and prior to any substantive changes. Policies and procedures shall include, but not be limited to:</p> <p>2.12.1.2.1 The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;</p> <p>2.12.1.2.2 Provisions for ensuring confidentiality of clinical information;</p> <p>2.12.1.2.3 The reporting of Fraud and Abuse information identified through the program to LDH in accordance with 42 CFR §455.1(a)(1);</p> <p>2.12.1.2.4 Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each Enrollee, in accordance with the MCO</p>	<p>2.12 Utilization Management</p> <p>2.12.1 General Requirements</p> <p>...</p> <p>2.12.1.2 The Contractor shall submit written policies and procedures to LDH or its designee for approval as part of Readiness Review and prior to any substantive changes. Policies and procedures shall include, but not be limited to:</p> <p>2.12.1.2.1 The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;</p> <p><u>2.12.1.2.1.1 For SBHS, as defined in Attachment B, MCO Covered Services, the Contractor shall provide the following for each unique service: _____</u></p> <p><u>2.12.1.2.1.1.1 Any Prior Authorization requirements;</u></p> <p><u>2.12.1.2.1.1.2 Number of pass-through visits or Encounters permitted as applicable;</u></p> <p><u>2.12.1.2.1.1.3 Detailed medical necessity criteria and source, and clinical documentation required for prior authorization and decision-making;</u></p>	<p>This revision is to ensure LDH’s awareness of the MCOs’ service authorization criteria for specialized behavioral health services and associated policies/procedures, and approve of such criteria/policies before implemented by the MCOs.</p>



Item	Change From	Change To	Justification
	<p>Manual. The Contractor shall collect and provide health records to LDH upon request;</p>	<p><u>2.12.1.2.1.1.4 Comprehensive Service Authorization criteria and source used by the Contractor’s staff to determine whether a service should be approved or partially denied; and</u></p> <p><u>2.12.1.2.1.1.5 Standard authorization period indicating how long a service is typically authorized by the MCO.</u></p> <p>2.12.1.2.2 Provisions for ensuring confidentiality of clinical information;</p> <p>2.12.1.2.3 The reporting of Fraud and Abuse information identified through the program to LDH in accordance with 42 CFR §455.1(a)(1);</p> <p>2.12.1.2.4 Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each Enrollee, in accordance with the MCO Manual. The Contractor shall collect and provide health records to LDH upon request; and</p>	
13	<p>2.12 Utilization Management</p> <p>2.12.1 General Requirements</p> <p>...</p> <p>2.12.1.3 All documentation and/or records maintained by the Contractor, its Material Subcontractors, and its Network Providers related to MCO Covered Services, charges, operations and agreements under this Contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an Enrollee or an authorized agent of the State or Federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the State or Federal government. Under no circumstances shall the Contractor or any of its Material Subcontractors</p>	<p>2.12 Utilization Management</p> <p>2.12.1 General Requirements</p> <p>...</p> <p>2.12.1.3 All documentation and/or records maintained by the Contractor, its Material Subcontractors, and its Network Providers related to MCO Covered Services, charges, operations and agreements under this Contract shall be maintained for at least ten (10) calendar years following termination of the Contract after the last good, service or supply has been provided to an Enrollee or an authorized agent of the State or Federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the State or Federal government. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the</p>	<p>This revision aligns the contract with the record retention requirements in 42 CFR §438.3(h).</p>

Item	Change From	Change To	Justification
	destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	
14	<p>2.12.3 General Service Authorization Requirements</p> <p>...</p> <p>2.12.3.6 The Contractor shall maintain written procedures including, but not limited to, the following:</p> <p>...</p> <p>2.12.3.6.4 A process to ensure that authorization requirements of the Contractor shall either be furnished to the healthcare provider within twenty-four (24) hours of a request for the requirements or posted in an easily searchable format, that includes the date of last review, on the Contractor’s website. The Contractor shall furnish these requirements to Providers in addition to the Prior Authorization information and training that must be furnished under the Provider Services and Support section;</p>	<p>2.12.3 General Service Authorization Requirements</p> <p>...</p> <p>2.12.3.6 The Contractor shall maintain develop and implement written procedures including, but not limited to, the following:</p> <p>...</p> <p>2.12.3.6.4 A process to ensure that authorization requirements of the Contractor shall either be furnished to the healthcare provider within twenty-four (24) hours of a request for the requirement. In addition, the Contractor shall post a list of all items and services that require prior authorization in an easily searchable format; that includes the date of last review, on the Contractor’s public website. The Contractor shall furnish these requirements to Providers in addition to the Prior Authorization information and training that must be furnished under the Provider Services and Support section;</p>	This revision is anticipation of Act 233, which requires MCOs to provide a publicly available website with a list of all items and services that require Prior Authorization.
15	2.12.3.6.5 A process to arrange for another level of care if appropriate when the Contractor denies a Service Authorization request.	2.12.3.6.5 A process to arrange for another level of care if appropriate when the Contractor denies a Service Authorization request. For SBHS, the Contractor shall have a process by which the Contractor’s staff may connect the Enrollee to another service or service provider (e.g., locating a provider, confirming the provider has availability, and/or securing an appointment), if appropriate, to ensure Enrollee continuity of care; and	This revision is meant to ensure and address Enrollee continuity of care, as needed, when an MCO denies a specialized behavioral health service.
16	2.12.4 Service Authorization Criteria	2.12.4 Service Authorization Criteria	This change is to standardize the authorization period for CPST and PSR services to reduce provider abrasion.

Item	Change From	Change To	Justification
	[new provision]	<u>2.12.4.5. The Contractor shall establish and implement a six (6) month Service Authorization period for CPST and PSR services unless otherwise approved by LDH based on justification provided by the Contractor.</u>	
17	2.12.5 Service Authorization Staffing Requirements ... [new provision]	2.12.5 Service Authorization Staffing Requirements ... <u>2.12.5.6. The Contractor shall ensure that all staff making Service Authorization decisions for SBHS participate in training and inter-rater reliability testing at least annually, or more frequently based on updates to the service definition or medical necessity criteria.</u>	This change is meant to ensure MCO staff making UM decisions are knowledgeable regarding SBHS and any updates to those services.
18	2.12.6 Service Authorization Determination Timing and Notices ... 2.12.6.4 Notices of Determinations ... 2.12.6.4.3 Informal Reconsideration ... 2.12.6.4.3.2 In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the Enrollee or a provider acting on behalf of the Enrollee and with the Enrollee’s written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 CFR §438.402(c)(1)(ii)].	2.12.6 Service Authorization Determination Timing and Notices ... 2.12.6.4 Notices of Determinations ... 2.12.6.4.3 Informal Reconsideration ... 2.12.6.4.3.2 In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the Enrollee or a provider acting on behalf of the Enrollee and with the Enrollee’s written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 CFR §438.402(c)(1)(ii)]. <u>For SBHS, the Contractor shall clearly identify the documentation to be submitted by the provider to obtain approval of SBHS or a more appropriate course of action or treatment based upon the approved Service Authorization criteria.</u>	These revisions address provider concerns regarding the informal reconsideration process.

Item	Change From	Change To	Justification
	<p>2.12.6.4.3.3 The informal reconsideration shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor’s physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.</p>	<p>2.12.6.4.3.3 <u>The Contractor shall offer the informal reconsideration at a mutually agreed upon time, which</u> The informal reconsideration shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor’s physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.</p>	
19	<p>2.16.8 Performance Measures</p> <p>...</p> <p>2.16.8.4 Reporting of quality measures shall include stratification of performance measure results across different populations with attention to geography, ethnicity, race, and disability status.</p>	<p>2.16.8 Performance Measures</p> <p>...</p> <p>2.16.8.4 Reporting of quality measures shall include stratification of performance measure results across different populations with attention to geography, ethnicity, race, and disability status as reasonably directed by LDH.</p>	<p>LDH doesn’t currently require the Contractor to stratify quality measures based on disability status. This revision is necessary to provide flexibility for future updates to stratification categories.</p>
20	<p>2.18.9.3 The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor’s process for the recycling of Denied Claims that are due to system update delays. The recycling of these Denied Claims shall be completed no later than fifteen (15) Calendar Days after the system update.</p> <p>2.18.9.4 Except as otherwise specified by LDH in writing, the Contractor shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. The Contractor shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or LDH.</p> <p>2.18.9.5 The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM,</p>	<p>2.18.9.3 The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor’s process for the recycling of Denied Claims that are due to system update delays. The recycling of these Denied Claims shall be completed no later than fifteen (15) Calendar Days after the system update. <u>The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification of inclusion on LDH fee schedule, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates.</u></p> <p>2.18.9.4 Except as otherwise specified by LDH in writing, the Contractor shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. The Contractor shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or LDH.</p>	<p>This revision clarifies that the 15-day timeline for recycling claims is applicable to system updates impacting code sets.</p> <p>Note: the two provisions were reordered for clarity. The new 2.18.9.3 has not changed, but the new 2.18.9.5 contains the following revisions:</p> <p>The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor’s process for the recycling of all impacted Claims, including Denied Claims, that are due to system update delays. The recycling of all impacted Denied Claims shall be completed no later than fifteen (15) Calendar Days after the system update.</p>

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	<p>and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates.</p>	<p>2.18.9.5 The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates. <u>The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor's process for the recycling of all impacted Claims, including Denied Claims, that are due to system updates. The recycling of all impacted Claims shall be completed no later than fifteen (15) Calendar Days after the system update.</u></p>	
21	<p>2.18.15 Encounter Data</p> <p>...</p> <p>2.18.15.3.2 Submit the Encounter Data 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 Contractor or its Subcontractor has a capitation arrangement with a provider. If the Contractor or its subcontracted vendor(s), excluding the Single PBM, individually or in aggregate, fails to submit complete Encounter Data as measured by a comparison of Encounters to cash disbursements within a one percent (1%) error threshold (i.e., Encounters are at least ninety-nine percent [99%] but no greater than one hundred percent [100%] of cash disbursements), LDH may impose Monetary Penalties in accordance with Attachment G, <i>Table of Monetary Penalties</i>. LDH, at its sole discretion, may waive the penalty if Encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) fall below the completion threshold during the transition to a new</p>	<p>2.18.15 Encounter Data</p> <p>...</p> <p>2.18.15.3.2 Submit the Encounter Data 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 Contractor or its Subcontractor has a capitation arrangement with a provider. If the Contractor or its subcontracted vendor(s), excluding the Single PBM, individually or in aggregate, fails to submit complete Encounter Data as measured by a comparison of Encounters to cash disbursements within a one two-percent (9921%) error threshold (i.e., Encounters are at least ninety-eight eight nine98%] but no greater than one hundred percent [100%] of cash disbursements), LDH may impose Monetary Penalties in accordance with Attachment G, <i>Table of Monetary Penalties</i>. LDH, at its sole discretion, may waive the penalty if Encounters processed by subcontracted vendors (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 ninety (90) Calendar Days for Encounters processed by either the exiting vendor or the new vendor.</p>	<p>This revision expands the non-pharmacy encounter reconciliation completeness threshold to 98-100% in order to align with current standards.</p>

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	vendor; however, this grace period shall not exceed ninety (90) Calendar Days for Encounters processed by either the exiting vendor or the new vendor.		
22	2.20.6 Rights of Review and Recovery by Contractor and LDH ... [new provisions]	2.20.6 Rights of Review and Recovery by Contractor and LDH ... <u>2.20.6.4.1 Before the Contractor executes a recoupment related to Fraud, Waste, or Abuse under investigation by the Contractor’s Special Investigation Unit (SIU), the provider shall have forty-five (45) Calendar Days from receipt of written notification addressed from the Contractor’s SIU of findings and/or recoupment to submit a written response to the Contractor as to why the findings and/or recoupment are not valid or should not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time period provided, the Contractor may execute the recoupment on the date specified in the notice. All Fraud, Waste, or Abuse recoupment notifications shall include the information listed in the <i>Payment Recoupments</i> section of this Contract.</u> [subsequent provisions renumbered]	This revision reinstates the timeframe from the previous contract to allow the Contractor to research potential fraud, waste, and abuse more efficiently while providing sufficient time to providers to respond to the request. This change will also allow the Contractor a better opportunity to meet the requirement in Section 2.20.6.4 of completing all complex reviews within ten (10) months (three hundred (300) Calendar Days) of the date the case was opened unless an extension is authorized by LDH.
23	4.4.1 MCO Performance Withhold Amount ... 4.4.1.7 - LDH will not withhold funds from the Contractor for MCO performance until July 2023.	4.4.1 MCO Performance Withhold Amount ... 4.4.1.7 - LDH will not withhold funds from the Contractor for MCO performance until July 2023 January 2024 .	This revision specifies that the 2% quality, VBP, and health equity withholds for the entirety of measurement year 2023 have been suspended.
24	4.4.1 MCO Performance Withhold Amount ...	4.4.1 MCO Performance Withhold Amount ...	This revision provides clarification regarding withhold provisions.

Item	Change From	Change To	Justification
	[new provision]	<u>4.4.1.8 LDH may, at its sole discretion, suspend the withhold for a specified period with written notification to the Contractor.</u>	
25	4.14 Post-Payment Recoveries ... [new provision]	4.14 Post-Payment Recoveries ... <u>4.14.1.17 The Contractor shall maintain a system to monitor cases where the Louisiana Patient's Compensation Fund (PCF) has assumed liability for future medical payments for Medicaid recipients. The Contractor shall bill the PCF on at least an annual basis for future medical payments related to medical malpractice lawsuits, as established by either a judgment or a settlement Agreement, pursuant to La R.S. 40:1231.3.</u> [subsequent provisions renumbered]	This revision aligns the contract with La. R.S. §40:1299.43.
26	5.4 Post-Turnover Services ... 5.4.4 The Contractor shall maintain all data and records related to Enrollees and providers for ten (10) years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	5.4 Post-Turnover Services ... 5.4.4 The Contractor shall maintain all data and records related to Enrollees and providers for ten (10) years <u>following termination of</u> after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	This revision aligns the contract with the record retention requirements in 42 CFR §438.3(h).
27	6.24.1 HIPAA Disclosure Process	6.24.1 HIPAA Disclosure Process	This revision aligns the HIPAA Disclosure Process with current practice.



Item	Change From	Change To	Justification
	<p>6.24.1.1 The Contractor shall protect confidential information and documents in accordance with 42 U.S.C. §671(a)(8), 42 U.S.C. §5106a, 42 U.S.C. §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La. R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable. The Contractor shall disclose in writing any use or disclosure of PHI other than as permitted by the Contract within three (3) Calendar Days of becoming aware of the use or disclosure.</p> <p>6.24.1.2 The Contractor is required to submit incident reports affecting Providers or Enrollees receiving services to LDH with a CAP and timelines for implementation of correction for approval by LDH within ten (10) Business Days of the Contractor’s discovery of any HIPAA breaches, as defined at 45 CFR §164.402. The incident report shall include, at a minimum:</p>	<p>6.24.1.1 The Contractor and its Subcontractors shall protect confidential information and documents in accordance with 42 U.S.C. §671(a)(8), 42 U.S.C. §5106a, 42 U.S.C. §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La. R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable. The Contractor shall disclose in writing any use or disclosure of PHI by the Contractor or any of its Subcontractors other than as permitted by the Contract within three (3) Calendar Days forty-eight (48) hours of becoming aware of the use or disclosure.</p> <p>6.24.1.2 The Contractor is required to submit incident reports affecting Providers or Enrollees receiving services to LDH with a CAP and timelines for implementation of correction for approval by LDH within ten (10) Business Days of the Contractor’s discovery of any HIPAA breaches, as defined at 45 CFR §164.402, that are committed by the Contractor or any of its Subcontractors. The incident report shall include, at a minimum:</p>	
28	<p>6.26 Security</p> <p>6.26.1 Contractor’s personnel shall comply with all security regulations in effect at the State’s premises and externally for materials and property belonging to the State or to the project. Where special security precautions are warranted (e.g., correctional facilities), the State shall provide such procedures to the Contractor, accordingly.</p> <p>6.26.2 The Contractor shall comply with the Office of Technology Services’ Information Security Policy at http://www.doa.la.gov/Pages/ots/InformationSecurity.aspx.</p> <p>[new provision]</p>	<p>6.26 Security</p> <p>6.26.1 Contractor’s personnel shall comply with all security regulations in effect at the State’s premises and externally for materials and property belonging to the State or to the project. Where special security precautions are warranted (e.g., correctional facilities), the State shall provide such procedures to the Contractor, accordingly.</p> <p>6.26.2 The Contractor shall comply with the Office of Technology Services’ (OTS) Information Security Policy at http://www.doa.la.gov/Pages/ots/InformationSecurity.aspx.</p> <p>6.26.3 The Contractor is responsible for reporting to the State any known Data Breach or Security Event, as defined in the OTS Information Security Policy, no later than forty-eight (48) hours after confirmation of the event. The Contractor shall notify the Information Security Team (“IST”) by calling</p>	This language is required by the Office of Technology Services (OTS) Information Security Team.

Item	Change From	Change To	Justification
		<p>Security Hotline at 1-844-692-8019 and emailing the security team at infosecteam@la.gov.</p>	
29	<p>PART 6: TERMS AND CONDITIONS</p> <p>...</p> <p>6.47 Record Retention</p> <p>6.47.1 The Contractor shall retain, and require Subcontractors to retain, as applicable, financial records, supporting documents, statistical records, and all other records pertinent to an award, including, but not limited to Enrollee Grievance and Appeal records in 42 CFR §438.416; base data in 42 CFR §438.5(c); MLR reports in 42 CFR §438.8(k); and the data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610, shall be retained for a period of ten (10) years from the date of submission of the final expenditure report. The only exceptions are the following:</p>	<p>PART 6: TERMS AND CONDITIONS</p> <p>...</p> <p>6.47 Record Retention</p> <p>6.47.1 The Contractor shall retain, and require Subcontractors to retain, as applicable, financial records, supporting documents, statistical records, and all other records pertinent to an award, including, but not limited to Enrollee Grievance and Appeal records in 42 CFR §438.416; base data in 42 CFR §438.5(c); MLR reports in 42 CFR §438.8(k); and the data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610, shall be retained for a period of ten (10) years following termination of the Contract from the date of submission of the final expenditure report. The only exceptions are the following:</p>	<p>This revision aligns the contract with the record retention requirements in 42 CFR §438.3(h).</p>



MCO Amendment 10
Attachment C10 – Changes to Attachment C, *In Lieu of Services*

Item	Changes	Justification
1	See redlined Attachment C.	These revisions add specific information about each ILOS, including descriptions, target populations, coding, and effective dates, as required by CMS.
2	Addition of “Visions of Hope Community Services.” See redlined Attachment C for further information.	This ILOS will provide comprehensive and intensive service bundling for high-risk, low-functioning individuals with severe and persistent mental illness, and should reduce psychiatric hospital visits and emergency room visits.
3	Addition of “Care at Home.” See redlined Attachment C for further information.	This ILOS will provide ordered treatment, at home, for enrollees who are physically unable to reach their provider and may otherwise necessitate emergency transport for care.



Medicaid Managed Care Organization Contract Attachment C: In Lieu of Services

The Contractor may, at its option, cover the approved services or settings for Enrollees in lieu of Medicaid State Plan services as provided in this Attachment. Requirements and policies for in lieu of services are provided in the Contract and the MCO Manual.

Physical Health

In Lieu of Service	Medicaid State Plan Service(s)	Effective Date
Chiropractic services for adults age 21 and older	Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners' services, laboratory and x ray services, prescribed drugs	1/1/2023
Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns	Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners' services	1/1/2023
Doula Services	Inpatient and outpatient hospital services	1/1/2023

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
<p><u>Chiropractic services for adults age 21 and older</u></p> <p><u>The purpose of this ILOS is to provide coverage of chiropractic services to diagnose and treat neuromusculoskeletal conditions associated with the functional integrity of the spine. Services include evaluation and management services, x-rays, spinal manipulation, and other treatments.</u></p>	<p><u>Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners'</u></p>	<p><u>Enrollees age 21 and older</u></p>	<p><u>99202 thru 99205 (E/M new pt); 99212 thru 99215 (E/M estab. pt); 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080,</u></p>	<p><u>1/1/2023</u></p>	<p><u>1/1/2022</u></p>

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
	<u>services, laboratory and x-ray services, prescribed drugs</u>		<u>72100, 72110, 72114, 72120, 72220 (X Rays); 98940, 98941, 98942 (spinal manipulation); 97012, 97014, 97022, 97035, 97032, 97110, 97112, 97116, 97124, 97140 (other treatments); 20560, 20561 (dry needling)</u>		
<p><u>Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns</u></p> <p><u>The purpose of this ILOS is to provide coverage of a comprehensive pregnancy medical home model of care to enrollees with substance use disorder (SUD) who are pregnant or postpartum. The model includes care coordination, health promotion, individual and family support, and linkages to community/support services, behavioral, and physical health services. The model does not include coverage of physical and behavioral health services otherwise covered under the Louisiana Medicaid State Plan (e.g., outpatient OB care, SUD treatment services). In addition, this ILOS is not duplicative of MCO case management services.</u></p>	<u>Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners' services</u>	<u>Enrollees with substance use disorder (SUD), who are pregnant and age 18 or older or up to 12 months postpartum, and their newborns</u>	<u>H0002(alcohol and drug screening); H0006(alcohol and drug tx services); H0023 (alcohol and drug tx outreach/BH services)</u>	<u>1/1/2023</u>	<u>1/1/2022</u>

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	<u>Effective Date under Current Contract</u>	<u>Original Effective Date</u>
<p><u>This ILOS will not serve as a substitute for medically necessary physical and behavioral health services such as obstetrical care or SUD care. Rather, the ILOS will help to ensure that enrollees receive comprehensive physical and behavioral health care services that meet their needs, while avoiding preventable use of acute care.</u></p>					
<p><u>Doula Services</u></p> <p><u>The purpose of this ILOS is to offer pregnant enrollees adjunctive services that encourage and support healthy childbirth experiences through support of pregnant persons before, during, and after childbirth. Support also may include birthing, lactation, and parenting classes. Reduction in adverse birth outcomes is the primary goal of this program by supporting birthing persons through the use of doulas that are trained and dedicated to providing physical, emotional, and informational support during the childbirth period. Doulas augment routine prenatal care by assuring that members receive safe, healthy, and equitable prenatal and postnatal health care.</u></p>	<p><u>Inpatient and outpatient hospital services</u></p>	<p><u>Pregnant and postpartum women</u></p>	<p><u>S9443: Lactation Class</u> <u>S9442: Birthing Class</u> <u>S9443: Lactation Class</u> <u>S9444: Parenting Class</u> <u>S9445: Pre/post-natal Doula visits</u> <u>99199: Attendance at Vaginal Delivery by Doula</u> <u>99404: Preventive Medicine Counseling/Post/Natal Nurse Advocacy</u></p> <p><u>(Billing provider type DL/1W and/or Rendering Provider Type DL/IV)</u></p>	<p><u>1/1/2023</u></p>	<p><u>1/1/2022</u></p>
<p>Remote Patient Monitoring Effective 7/1/2023</p>	<p>Physician services (office visits), emergency services,</p>	<p>Members with hypertensive disorders and/or diabetes, ages 18-75 (HEDIS), with the following characteristics:</p>	<p>99453 (setting up remote patient monitoring); 99454</p>	<p><u>7/1/2023</u></p>	<p><u>7/1/2023</u></p>

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
<p>Remote patient monitoring (RPM) means digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment, recommendations, and interventions. RPM devices include (1) non-invasive remote monitoring devices that measure or detect common physiological parameters, and (2) non-invasive monitoring devices that wirelessly transmit the beneficiary's medical information to their health care provider or other monitoring entity. The device must be reliable and valid, and the beneficiary must be trained or sufficiently knowledgeable in the proper use/wearing of the device to ensure appropriate recording of medical information. Medical information may include, but is not limited to, blood pressure and heart rate and rhythm monitoring for members with hypertension and blood glucose control for members with diabetes. Members enrolled should have smart phone or tablet access and connectivity for data reporting.</p>	<p>and inpatient hospitals</p>	<ul style="list-style-type: none"> Members with hypertension and a PPA/PPR/PPV* event within the last 18 months. Members with diabetes and a PPA/PPR/PPV events within last 18 months Poorly controlled hypertension (>140/90), at risk for PPA/PPR/PPV Poorly controlled diabetes (HbA1c >9.0%), at risk for PPA/PPR/PPV Smart phone or tablet access <p>Pregnant women with hypertensive disorders and/or diabetes, ages 16-50, with the following characteristics:</p> <ul style="list-style-type: none"> Poorly controlled hypertension (>140/90) Insulin dependent diabetes in pregnancy Smart phone or tablet access 	<p><u>(remote monitoring of physiologic parameters); 99199 (unlisted service) with appropriate modifiers: may be used as an alternative reimbursement CPT code for systems that have conflict with use of 99454)</u> 99453 99454 99199 —with appropriate modifiers</p>		
<p>Outpatient Lactation Support Effective 1/1/2024</p>	<p>Physician services, outpatient hospital services.</p>		<p><u>S9445, modifier 33</u> <u>S9443</u></p>	<p><u>1/1/2024</u></p>	<p><u>1/1/2024</u></p>
<p><u>Care at Home</u></p> <p><u>The purpose of this ILOS is to provide ordered treatment, at home, for enrollees with chronic disease who are experiencing an acute exacerbation of their illness. This is not intended as emergency care, but urgent care for enrollees who are physically unable to reach their provider and may otherwise necessitate</u></p>	<p><u>Emergency ambulance, emergency department</u></p>	<p><u>Medicaid-eligible members aged 13 and up, with chronic disease, with acute needs and unable to access office visit or virtual visit.</u></p>	<p><u>99342</u> <u>99344</u> <u>99345</u> <u>99348</u> <u>99349</u> <u>99350</u> <u>99417</u></p>	<p><u>7/1/2024</u></p>	<p><u>7/1/2024</u></p>

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	<u>Effective Date under Current Contract</u>	<u>Original Effective Date</u>
<u>emergency transport for care. Providers refer their patient for an at home scheduled visit when a virtual care or an in-office visit is not appropriate to address the enrollee's acute chronic health needs. An in-home care provider, either an EMT or paramedic, depending on need, is sent to the member's residence within 24 hours to facilitate treatment and symptom management, reducing unnecessary ED use and hospitalizations. Communication and coordination of care is arranged with the referring Provider.</u>			<u>E&M codes 99211-99215</u>		

Behavioral Health

In Lieu of Service	Medicaid State Plan Service(s)	Effective Date
23 Hour observation bed services for adults age 21 and older	Inpatient psychiatric hospitals	1/1/2023
Freestanding psychiatric hospitals for adults ages 21-64	General hospital psychiatric units	1/1/2023
Injection services provided by licensed nurses to adults age 21 and older	Physician services	1/1/2023
Mental Health Intensive Outpatient Programs	Inpatient psychiatric hospitals	1/1/2023
Population health management programs	Emergency services, inpatient hospitals	1/1/2023

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
<p><u>23-Hour observation bed services for adults age 21 and older</u></p> <p><u>23-hour observation offers an alternative to an unwarranted inpatient psychiatric hospitalization admission by providing 23-hour crisis respite and observation in a secure setting. This service is aimed for members who are voluntarily admitting for less than 24 hours due to sub-imminent crisis stabilization which is currently not available in every region. This service attempts to prevent psychiatric/psychologic impairments through rapid stabilization thus leading to the sooner return of functional independence.</u></p>	<p><u>Inpatient psychiatric hospitals</u></p>	<p><u>Medicaid-eligible adults 21+, presenting in a crisis.</u></p>	<p><u>G0379, 99218,99219,99220, 99234,99235,99236</u></p>	<p><u>1/1/2023</u></p>	<p><u>12/1/2015</u></p>
<p><u>Freestanding psychiatric hospitals for adults ages 21-64</u></p> <p><u>The purpose of this alternative service is to assist adult Medicaid members with significant behavioral health challenges. This population would be treated in more expensive general hospital psych units without this service. This creates access issues as beds in general hospitals are limited. Multiple downstream issues occur as a result. Consumers must remain in emergency departments while waiting for available beds. Costs increase to the healthcare system as members utilize those medical resources while awaiting beds in general hospitals. Use of free standing psych units reduces Emergency Department consumption, increases psychiatric bed capacity and provides a less costly alternative to general hospital beds.</u></p>	<p><u>General hospital psychiatric units</u></p>	<p><u>Medicaid-eligible adults, with significant behavioral health challenges, ages 21-64 years, with the following characteristics: Any adult that would have previously required treatment in general hospital psych units.</u></p>		<p><u>1/1/2023</u></p>	<p><u>12/1/2015</u></p>
<p><u>Injection services provided by licensed nurses to adults age 21 and older</u></p> <p><u>This service allows licensed nurses to provide injectable medications to adult Medicaid members. Many members are unable or unwilling to take oral psychotropics or their mental</u></p>	<p><u>Physician services</u></p>	<p><u>Medicaid-eligible adults ages 21 who have outpatient medication needs requiring injectable medications, as opposed to oral intake. Members who have tried and failed on oral psychotropics or their mental status</u></p>	<p><u>99201-99215, 96372, 96372, 99070, J0400, J1630, J1631, J2060, J2315, J2358, J2426,</u></p>	<p><u>1/1/2023</u></p>	<p><u>12/1/2015</u></p>

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
<p><u>status indicates a need for injectable meds to assure compliance and stability. The objective of adding Licensed Nurses is to fill in this services delivery method to aid members to receive medications in the most efficient and least costly manner possible, and at the same time increasing compliance, reducing subsequent office visits, and reducing hospitalizations resulting from decompensation.</u></p>		<p><u>indicates a need for injectable meds to assure compliance and stability.</u></p>	<p><u>J2794, J3310, J3360, J3486</u></p>		
<p><u>Mental Health (MH) Intensive Outpatient Programs (IOP)</u></p> <p><u>The purpose of this ILOS is to provide enrollees treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization or Assertive Community Treatment and providing a step-down option from inpatient hospitalization for enrollees at high risk for readmission.</u></p>	<p><u>Inpatient hospitalization or Assertive Community Treatment</u></p>	<p><u>Medicaid Eligible Members, Age 12+, who are at risk for inpatient hospitalization for a psychiatric condition, or members needing a step down from an inpatient hospitalization that is a higher level than standard outpatient services.</u></p>	<p><u>S9480, S9480HB, H0015</u></p>	<p><u>1/1/2023</u></p>	<p><u>9/14/2018</u></p>
<p><u>Population Health Management Program</u></p> <p><u>Mindoula Clinical Services, P.C.'s Population Health Management Program ("PHMP") is a precision solution that targets, engages, and serves members with Serious Mental Illness ("SMI"), Substance Use Disorder ("SUD") and/or members with Sickle Cell Disease ("SCD") and other comorbid medical conditions through team-based, tech-enabled, care extension services. This focused approach includes (1) identification of members for the PHMP using proprietary algorithms and member archetype data, (2) outreach and enrollment of members using an intake process specific to SMI, SUD and SCD populations, and (3) provision of tech-enabled programmatic interventions that include content and methods tailored to reducing total costs of care by addressing behavioral, medical, and social needs specific to SMI, SUD and SCD populations.</u></p>	<p><u>Emergency services, inpatient hospitals</u></p>	<p><u>Members with Serious Mental Illness (SMI), Substance Use Disorder (SUD) and/or Sickle Cell Disease (SCD) living in Louisiana, ages 18+, who have a diagnosis of Schizophrenia, Major Depressive Disorder, Bipolar Disorder, and other SMI, with or without substance use, and members with SCD who have not engaged with outpatient care and experience repeated behavioral health-related hospitalizations and/or visits to the emergency department because of poorly treated/controlled behavioral health symptoms. Most of these members have either refused case management services or cannot be contacted.</u></p>	<p><u>99490</u></p>	<p><u>1/1/2023</u></p>	<p><u>1/5/2022</u></p>

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	Effective Date under Current Contract	Original Effective Date
<p>Therapeutic Day Center for ages 5-20 Effective 7/1/2023</p> <p>The Center for Resilience is a therapeutic day center which provides educational and intensive mental health supports in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities. The leadership team is comprised of clinicians, educators, and medical doctors, and the therapeutic milieu is a result of this intentionally interdisciplinary collaboration. The goal of this ILOS is to reduce incidents of crisis hospitalization and residential psychiatric care.</p>	<p>Inpatient psychiatric hospitals, psychiatric residential treatment facility (PRTF)</p>	<p>Children and adolescents with behavioral health diagnoses, 5 to <21, with the following characteristics:</p> <ul style="list-style-type: none"> • PTSD, anger, depression, mood disorders, developmental disabilities, learning disabilities, psychosis • High risk behaviors & juvenile justice-involvement <p>Unresponsive to school and agency/MHR intervention</p>	<p>G0177 or H0035</p>	<p>7/1/2023</p>	<p>7/1/2023</p>
<p>Integrated Behavioral Health Homes Effective 7/1/2023</p> <p>Integrated Behavioral Health Homes (IBHH) is a value-based program that furthers alternative payment methodologies and integration by improving medical, behavioral, and social healthcare outcomes for participants while decreasing the overall total cost of care. MCOs who offer this ILOS will contract with qualified providers to deliver the six core services that are central to Medicaid health homes, as outlined by the ACA and endorsed by CMS, Substance Abuse and Mental Health Services</p>	<p>Inpatient psychiatric hospitals, psychiatric residential treatment facility (PRTF)</p>	<p>Medicaid and dual eligible beneficiaries, all ages, with the following characteristics: Members with SMI, SED and/or SUD diagnoses who have complex medical comorbidities and high utilization of ER/ED, Medical IP, or Behavioral IP/Residential care</p>	<p>G9002</p>	<p>7/1/2023</p>	<p>7/1/2023</p>

Name and Description	Covered Medicaid State Plan Service or Setting for which each ILOS is a substitute	Clinically oriented definition(s) for the target population(s) for each ILOS	Specific coding for each ILOS to be used on claims and encounter data	<u>Effective Date under Current Contract</u>	<u>Original Effective Date</u>
<p>Administration (SAMHSA), and the National Council for Mental Wellbeing:</p> <ul style="list-style-type: none"> • Comprehensive care management; • Care coordination; • Health promotion; • Comprehensive transitional care and follow-up; • Patient and family support; and • Referrals to community and social support services. <p>The eligible population will be identified by the MCO and assigned to the participating providers within the eligible population’s geographical area. This is an opt-in model and does not require enrollees to change or adjust any of their existing provider relationships.</p>					
<p><u>Visions of Hope Community Services</u></p> <p><u>The Visions of Hope Community Services program is a comprehensive and intensive service bundling for high-risk, low-functioning individuals with severe and persistent mental illness. This model addresses whole person care that combines behavioral health while addressing social determinants of health and providing physical health coordination and support. The VOH-CS program serves individuals who would have difficulty navigating services across multiple, disconnected providers and thus are at greater risk of hospitalization, homelessness, substance use, victimization and incarceration. This model offers daily socialization opportunities for this population who might not interact socially with their peers in other settings.</u></p>	<p><u>Inpatient psychiatric hospitalization, Assertive Community Treatment Program, and Emergency Room Visits</u></p>	<p><u>Region 7 members 18 years or older who have a severe and persistent mental illness (SPMI) with or without a co-occurring disorder that is seriously impairing their functioning within the community as evidenced by a LOCUS of 3 or higher</u></p>	<p><u>H2022</u></p>	<p><u>7/1/2024</u></p>	<p><u>7/1/2024</u></p>

SFY 2025 Healthy Louisiana Medicaid Managed Care Rate Summary

July 1, 2024 through June 30, 2025

State of Louisiana Department of Health

July 7, 2025

[Anders Larson](#), FSA, MAAA, Principal and Consulting Actuary

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Introduction & Executive Summary

Milliman, Inc. (Milliman) has been retained by the State of Louisiana, Department of Health (LDH) to provide actuarial and consulting services related to the development of capitation rates for the Physical Health (PH) and Specialized Behavioral Health (SBH) programs within the Healthy Louisiana managed care program. This memorandum provides supporting documentation for capitation rates paid from July 1, 2024 through June 30, 2025.

Based on 42 CFR 438.7(c)(3), an amended capitation rate certification is not required if the State increases or decreases the capitation rate per rate cell up to 1.5%. The CFR notes: “CMS may require a State to provide documentation that modifications to the capitation rate comply with the requirements in §§ 438.3(c) and (e) and 438.4(b)(1).” LDH has elected to pay limited capitation rates that approximately 1.5% above the certified amended limited capitation rates for consideration outlined in the following documents:

- *State Fiscal Year 2025 Healthy Louisiana Medicaid Managed Care Capitation Rate Amendment* dated November 27, 2024

This memorandum serves as documentation of these capitation rate modifications.

Capitation Rate Update

The updated capitation rates for the Medicaid managed care populations are illustrated in Figure 1. Figure 1 provides the rates effective from July 1, 2024 through June 30, 2025, and includes a comparison to the amended effective capitation rates for July 1, 2024 through June 30, 2025. The rates are inclusive of Full Medicaid Pricing (FMP) and directed payment amounts. Because the FMP and directed payment amounts are not being adjusted, the aggregate increase to expected payments is less than 1.5%. The composite rates illustrated for July 1, 2024 through June 30, 2025 have been developed based on an estimate of projected enrollment during that time period.

FIGURE 1: EXPECTED PAYMENT COMPARISON WITH AMENDED SFY 2025 PMPM

POPULATION	ESTIMATED SFY 2025	COMPOSITE MCO EXPECTED PAYMENTS		% CHANGE
	AVERAGE MONTHLY ENROLLMENT	AMENDED SFY 2025	DE MINIMIS AMENDED RATE	
SSI	94,100	\$ 2,297.97	\$ 2,322.28	1.1%
F&C	769,300	410.51	414.72	1.0%
SBH	133,300	59.78	60.62	1.4%
Medicaid Expansion	575,500	829.01	838.87	1.2%
All Other Populations	29,000	1,343.02	1,358.90	1.2%
Medicaid Expansion - Kick	1,200	23,591.39	23,733.97	0.6%
Non-Expansion - Kick	1,700	20,812.16	20,933.15	0.6%
Composite	1,601,200	\$ 699.69	\$ 707.28	1.1%

- Notes:
1. Amended SFY 2025 and De Minimis amended composite rates were developed based on the SFY 2025 projected monthly enrollment.
 2. The estimated average monthly enrollment values are rounded to the nearest hundred.
 3. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

Figure 2 provides similar information as contained in Figure 1 with illustrated rate values reflecting the SFY 2025 De Minimis limited rate (the capitated amount excluding FMP and state directed payments).

FIGURE 2: LIMITED RATE COMPARISON WITH AMENDED SFY 2025 PMPM RATES

POPULATION	ESTIMATED SFY 2025	COMPOSITE LIMITED RATES		
	AVERAGE MONTHLY ENROLLMENT	AMENDED SFY 2025	DE MINIMIS AMENDED RATE	% CHANGE
SSI	94,100	\$ 1,621.17	\$ 1,645.49	1.5%
F&C	769,300	280.79	285.00	1.5%
SBH	133,300	56.23	57.08	1.5%
Medicaid Expansion	575,500	657.48	667.34	1.5%
All Other Populations	29,000	1,058.46	1,074.33	1.5%
Medicaid Expansion - Kick	1,200	9,505.46	9,648.04	1.5%
Non-Expansion - Kick	1,700	8,065.82	8,186.80	1.5%
Composite	1,601,200	\$ 506.17	\$ 513.76	1.5%

- Notes:
1. Amended SFY 2025 and De Minimis amended composite rates were developed based on the SFY 2025 projected monthly enrollment.
 2. The estimated average monthly enrollment values are rounded to the nearest hundred.
 3. All Other Populations includes HCBS, Act 421, Foster Care Children, Breast and Cervical Cancer, LaHIPP Affordable Plan, and non-SBH Chisholm Class Members rate cells.

The capitation rate impact by rate cell and region can be found in Appendix 1.

Please note that LDH has submitted a preprint for a physician state directed payment to replace the FMP payment that was included in the original SFY 2025 capitation rates. Because that preprint has not yet been approved as of the date of this letter, we have not reflected any changes to the FMP payment. When the preprint is approved, this will be documented in a separate capitation rate amendment.

Limitations and Data Reliance

The information contained in this report has been prepared for the State of Louisiana, Department of Health (LDH) to provide documentation of the development of a de minimis revision to the Healthy Louisiana Medicaid managed care program capitation rates effective July 1, 2024 through June 30, 2025. The data and information presented may not be appropriate for any other purpose.

The information contained in this report, including the appendices, has been prepared for LDH and their consultants and advisors. It is our understanding that the information contained in this report will be shared with Managed Care Organizations (MCOs) and the Centers for Medicaid and Medicare Services (CMS). Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for LDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by LDH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Appendix 1: Rate Change Summary (Provided in Excel)



Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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State of Louisiana
 Department of Health
 Louisiana Medicaid Managed Care Program
 SFY 2025 De Minimis Amendment
 Rate Change Summary

Region: Statewide	Projected Exposure	Current MCO Limited Rate	Prior MCO Limited Rate	% Change	FMP	Current MCO Capitation Rate	Prior MCO Capitation Rate	% Change	Directed Payments	Current Total Expected Payment PMPM	Prior Total Expected Payment PMPM	% Change
F&C												
F&C - 0-2 Months	122,148	\$ 2,740.55	\$ 2,700.05	1.5%	\$ 233.81	\$ 2,974.36	\$ 2,933.86	1.4%	\$ 4,879.43	\$ 7,853.79	\$ 7,813.29	0.5%
F&C - 3-11 Months	384,660	371.19	365.71	1.5%	38.27	409.46	403.97	1.4%	265.37	674.63	669.34	0.8%
F&C - Child 1-20 Years	7,769,908	211.04	207.92	1.5%	17.68	228.72	225.60	1.4%	26.23	254.95	251.83	1.2%
F&C - Adult 21+ Years	955,252	537.26	529.93	1.5%	44.26	582.14	574.26	1.4%	76.21	658.36	650.41	1.2%
Subtotal F&C	9,231,968	\$ 285.00	\$ 280.79	1.5%	\$ 24.16	\$ 309.15	\$ 304.93	1.4%	\$ 105.58	\$ 414.72	\$ 410.51	1.0%
SSI												
SSI - 0-2 Months	456	\$ 35,544.76	\$ 35,019.47	1.5%	\$ 3,035.66	\$ 38,580.42	\$ 38,055.12	1.4%	\$ 73,323.78	\$ 111,904.19	\$ 111,378.90	0.5%
SSI - 3-11 Months	4,260	9,112.83	8,978.16	1.5%	504.20	9,617.02	9,482.35	1.4%	14,431.72	24,048.74	23,914.07	0.6%
SSI - Child 1-20 Years	347,108	961.95	947.73	1.5%	32.08	994.02	979.81	1.5%	296.09	1,290.12	1,275.90	1.1%
SSI - Adult 21+ Years	776,988	1,890.02	1,862.09	1.5%	88.62	1,978.64	1,950.71	1.4%	821.32	2,589.96	2,572.03	1.1%
Subtotal SSI	1,129,812	\$ 1,846.48	\$ 1,821.17	1.5%	\$ 73.98	\$ 1,919.48	\$ 1,895.17	1.4%	\$ 602.80	\$ 2,322.29	\$ 2,307.97	1.1%
HCBS												
HCBS - Child 1-20 Years	21,648	\$ 3,845.10	\$ 3,788.27	1.5%	\$ 61.52	\$ 3,906.61	\$ 3,849.79	1.5%	\$ 969.80	\$ 4,906.41	\$ 4,849.59	1.2%
HCBS - Adult 21+ Years	34,584	2,009.43	1,979.73	1.5%	75.83	2,085.25	2,055.56	1.4%	720.66	2,805.91	2,776.21	1.1%
Subtotal HCBS	56,232	\$ 2,716.12	\$ 2,675.98	1.5%	\$ 70.32	\$ 2,786.43	\$ 2,746.29	1.5%	\$ 828.12	\$ 3,614.55	\$ 3,574.41	1.1%
SBH												
SBH - HCBS - Child 1-20 Years	15,708	\$ 318.10	\$ 313.40	1.5%	\$ 0.84	\$ 318.94	\$ 314.24	1.5%	\$ 8.52	\$ 327.46	\$ 322.76	1.5%
SBH - HCBS - Adult 21+ Years	32,736	134.34	132.35	1.5%	2.57	136.91	134.92	1.5%	6.63	143.54	141.55	1.4%
SBH - LaHIPP, All Ages	6,420	45.88	45.20	1.5%	0.13	46.01	45.33	1.5%	0.58	46.59	45.91	1.5%
SBH - CCM, All Ages	17,068	261.76	257.89	1.5%	0.98	262.72	258.85	1.5%	9.75	272.47	268.60	1.4%
SBH - Dual Eligible, All Ages	1,495,859	45.88	45.20	1.5%	0.19	46.07	45.40	1.5%	2.87	48.74	48.06	1.4%
SBH - Other - All Ages	31,656	268.47	264.50	1.5%	5.55	274.03	270.06	1.5%	18.44	292.46	288.49	1.4%
Subtotal SBH	1,609,467	\$ 67.98	\$ 65.23	1.5%	\$ 0.36	\$ 67.44	\$ 65.89	1.5%	\$ 3.19	\$ 68.62	\$ 67.98	1.4%
Other Populations												
Other Populations - FCC, All Ages Male & Female	175,932	\$ 484.36	\$ 487.06	1.5%	\$ 22.32	\$ 516.68	\$ 509.38	1.4%	\$ 97.42	\$ 614.11	\$ 606.80	1.2%
Other Populations - BCC, All Ages	3,588	2,979.96	2,935.02	1.5%	79.30	3,059.26	3,015.22	1.5%	291.14	3,350.43	3,306.89	1.3%
Other Populations - LAP, All Ages	26,028	213.16	210.01	1.5%	14.70	227.87	224.72	1.4%	12.09	239.96	236.81	1.3%
Other Populations - CCM, All Ages	60,108	1,616.94	1,593.05	1.5%	37.19	1,654.14	1,630.24	1.5%	308.98	1,963.11	1,939.22	1.2%
Subtotal Other Populations	265,656	\$ 754.38	\$ 743.23	1.5%	\$ 25.71	\$ 786.09	\$ 768.94	1.4%	\$ 139.55	\$ 919.64	\$ 908.49	1.2%
Act 421 - LaHIPP TPL												
Act 421 - LaHIPP TPL - 0-2 Months	4	\$ 317.27	\$ 312.58	1.5%	\$ 0.00	\$ 317.27	\$ 312.58	1.5%	\$ 0.00	\$ 317.27	\$ 312.58	1.5%
Act 421 - LaHIPP TPL - 3-11 Months	4	23.11	22.76	1.5%	-	23.11	22.76	1.5%	-	23.11	22.76	1.5%
Act 421 - LaHIPP TPL - Child 1-18 Years	4	210.64	207.53	1.5%	-	210.64	207.53	1.5%	-	210.64	207.53	1.5%
Subtotal Act 421 - LaHIPP TPL	12	\$ 183.67	\$ 180.96	1.5%	\$ 0.00	\$ 183.67	\$ 180.96	1.5%	\$ 0.00	\$ 183.67	\$ 180.96	1.5%
Act 421 - Non-TPL												
Act 421 - Non-TPL - 0-2 Months	97	\$ 12,822.55	\$ 12,633.05	1.5%	\$ 267.55	\$ 13,090.10	\$ 12,900.60	1.5%	\$ 2,288.43	\$ 15,358.53	\$ 15,169.03	1.2%
Act 421 - Non-TPL - 3-11 Months	360	3,491.34	3,429.89	1.5%	40.42	3,521.77	3,470.32	1.5%	1,615.74	5,337.50	5,286.06	1.0%
Act 421 - Non-TPL - Child 1-18 Years	14,042	873.39	860.48	1.5%	11.72	885.11	872.20	1.5%	231.37	1,116.48	1,103.57	1.2%
Subtotal Act 421 - Non-TPL	14,499	\$ 1,018.09	\$ 1,003.04	1.5%	\$ 14.14	\$ 1,032.23	\$ 1,017.18	1.5%	\$ 284.34	\$ 1,316.57	\$ 1,301.52	1.2%
Act 421 - Non-LaHIPP TPL												
Act 421 - Non-LaHIPP TPL - 0-2 Months	62	\$ 3,845.33	\$ 3,788.50	1.5%	\$ 49.93	\$ 3,895.26	\$ 3,838.43	1.5%	\$ 414.41	\$ 3,936.66	\$ 3,879.84	1.5%
Act 421 - Non-LaHIPP TPL - 3-11 Months	588	1,157.63	1,140.52	1.5%	13.83	1,171.46	1,154.35	1.5%	9.19	1,180.64	1,163.53	1.5%
Act 421 - Non-LaHIPP TPL - Child 1-18 Years	10,694	446.15	439.56	1.5%	8.75	455.90	449.31	1.5%	7.53	463.43	456.84	1.4%
Subtotal Act 421 - Non-LaHIPP TPL	11,344	\$ 591.61	\$ 494.19	1.5%	\$ 10.18	\$ 511.79	\$ 504.38	1.5%	\$ 7.80	\$ 519.59	\$ 512.18	1.4%
Medicaid Expansion												
Medicaid Expansion - Age 19-64	6,835,256	\$ 673.89	\$ 663.93	1.5%	\$ 42.89	\$ 716.78	\$ 706.82	1.4%	\$ 130.25	\$ 847.03	\$ 837.07	1.2%
Medicaid Expansion - High Needs	1,536	673.89	663.93	1.5%	86.16	760.04	750.08	1.3%	556.62	1,316.65	1,306.70	0.8%
Medicaid Expansion - SBH - CCM, All Ages	732	261.76	257.89	1.5%	-	261.76	257.89	1.5%	5.26	267.02	263.15	1.5%
Medicaid Expansion - SBH - Dual Eligible, All Ages	65,172	21.42	21.10	1.5%	1.90	23.32	23.01	1.4%	1.33	24.65	24.33	1.3%
Medicaid Expansion - SBH - LaHIPP, All Ages	3,444	21.42	21.10	1.5%	0.02	21.45	21.13	1.5%	0.14	21.58	21.27	1.5%
Medicaid Expansion - SBH - Other	372	268.47	264.50	1.5%	8.83	277.30	273.33	1.5%	2.48	279.77	275.81	1.4%
Subtotal Medicaid Expansion	6,906,512	\$ 667.34	\$ 657.48	1.5%	\$ 42.48	\$ 709.83	\$ 699.97	1.4%	\$ 129.05	\$ 838.87	\$ 829.01	1.2%
Medicaid Expansion - Kick												
Medicaid Expansion - Kick - Maternity Kick Payment	14,837	\$ 9,649.53	\$ 9,506.92	1.5%	\$ 1,622.25	\$ 11,271.77	\$ 11,129.17	1.3%	\$ 12,467.48	\$ 23,739.25	\$ 23,596.65	0.6%
Medicaid Expansion - Kick - EED Kick Payment	4	4,130.34	4,069.30	1.5%	-	4,130.34	4,069.30	1.5%	-	4,130.34	4,069.30	1.5%
Subtotal Medicaid Expansion - Kick	14,841	\$ 9,648.04	\$ 9,505.46	1.5%	\$ 1,621.81	\$ 11,269.85	\$ 11,127.27	1.3%	\$ 12,464.12	\$ 23,733.97	\$ 23,591.39	0.6%
Non-Expansion - Kick												
Non-Expansion - Kick - Maternity Kick Payment	20,273	\$ 8,187.80	\$ 8,068.80	1.5%	\$ 1,265.05	\$ 9,452.86	\$ 9,331.85	1.3%	\$ 11,483.81	\$ 20,936.66	\$ 20,815.66	0.6%
Non-Expansion - Kick - EED Kick Payment	4	3,122.79	3,076.64	1.5%	-	3,122.79	3,076.64	1.5%	-	3,122.79	3,076.64	1.5%
Subtotal Non-Expansion - Kick	20,277	\$ 8,186.80	\$ 8,065.82	1.5%	\$ 1,264.80	\$ 9,451.61	\$ 9,330.62	1.3%	\$ 11,481.81	\$ 20,933.15	\$ 20,812.16	0.6%
Total	19,214,502	\$ 513.76	\$ 506.17	1.5%	\$ 34.41	\$ 548.17	\$ 540.58	1.4%	\$ 159.10	\$ 707.28	\$ 699.69	1.1%

State of Louisiana
 Department of Health
 Healthy Louisiana Medicaid Managed Care Program
 SFY 2025 De Minimis Amendment
 Rate Change Summary

Region: Capital	Projected Exposure	Current MCO Limited Rate	Prior MCO Limited Rate	% Change	FMP	Current MCO Capitation Rate	Prior MCO Capitation Rate	% Change	Directed Payments	Current Total Expected PMPM	Prior Total Expected Payment PMPM	% Change
F&C												
F&C - 0-2 Months	32,628	\$ 2,839.30	\$ 2,797.34	1.5%	\$ 623.94	\$ 3,463.24	\$ 3,421.28	1.2%	\$ 5,395.85	\$ 8,859.09	\$ 8,817.13	0.5%
F&C - 3-11 Months	100,428	351.60	346.40	1.5%	49.23	400.82	395.63	1.3%	282.55	683.38	678.18	0.8%
F&C - Child 1-20 Years	2,029,521	209.81	206.71	1.5%	19.10	228.91	226.30	1.4%	33.30	262.21	259.10	1.2%
F&C - Adult 21+ Years	245,887	557.04	548.91	1.5%	47.60	604.64	596.41	1.4%	76.47	681.11	672.88	1.2%
Subtotal F&C	2,408,434	\$ 286.79	\$ 282.55	1.5%	\$ 31.46	\$ 318.25	\$ 314.01	1.3%	\$ 120.76	\$ 439.00	\$ 434.76	1.0%
SSI												
SSI - 0-2 Months	120	\$ 35,544.76	\$ 35,019.47	1.5%	\$ 6,435.24	\$ 41,980.00	\$ 41,454.70	1.3%	\$ 54,589.92	\$ 96,569.92	\$ 96,044.63	0.5%
SSI - 3-11 Months	1,164	9,112.83	8,978.16	1.5%	465.99	9,578.82	9,444.15	1.4%	16,131.97	16,131.97	15,997.30	0.8%
SSI - Child 1-20 Years	81,509	1,048.91	1,033.41	1.5%	36.62	1,085.52	1,070.02	1.4%	301.73	1,387.26	1,371.76	1.1%
SSI - Adult 21+ Years	185,063	2,052.89	2,022.55	1.5%	99.04	2,151.93	2,121.89	1.4%	729.53	2,881.46	2,851.12	1.1%
Subtotal SSI	247,856	\$ 1,772.10	\$ 1,745.91	1.5%	\$ 83.30	\$ 1,835.40	\$ 1,829.21	1.4%	\$ 642.27	\$ 2,497.67	\$ 2,471.48	1.1%
HCBS												
HCBS - Child 1-20 Years	6,984	\$ 3,845.10	\$ 3,788.27	1.5%	\$ 73.57	\$ 3,918.67	\$ 3,861.85	1.5%	\$ 1,225.42	\$ 5,144.09	\$ 5,087.27	1.1%
HCBS - Adult 21+ Years	9,144	2,062.08	2,031.61	1.5%	92.30	2,154.38	2,123.90	1.4%	900.30	3,054.67	3,024.20	1.0%
Subtotal HCBS	16,128	\$ 2,834.19	\$ 2,792.31	1.5%	\$ 84.19	\$ 2,918.38	\$ 2,876.50	1.5%	\$ 1,041.09	\$ 3,959.47	\$ 3,917.58	1.1%
SBH												
SBH - HCBS - Child 1-20 Years	5,352	\$ 318.10	\$ 313.40	1.5%	\$ 1.22	\$ 319.32	\$ 314.62	1.5%	\$ 3.26	\$ 322.58	\$ 317.88	1.5%
SBH - HCBS - Adult 21+ Years	8,976	161.40	159.01	1.5%	3.22	164.62	162.23	1.5%	7.13	171.75	169.36	1.4%
SBH - LaHIPP, All Ages	2,652	41.07	40.46	1.5%	0.30	41.37	40.76	1.5%	0.38	41.74	41.14	1.5%
SBH - CCM, All Ages	4,464	244.46	240.84	1.5%	1.41	245.86	242.25	1.5%	8.13	254.00	250.38	1.4%
SBH - Dual Eligible, All Ages	346,376	41.07	40.46	1.5%	0.18	41.25	40.65	1.5%	2.43	43.68	43.08	1.4%
SBH - Other - All Ages	8,124	268.47	264.50	1.5%	5.78	274.25	270.29	1.5%	16.07	290.32	286.35	1.4%
Subtotal SBH	375,944	\$ 66.22	\$ 64.40	1.5%	\$ 0.41	\$ 66.62	\$ 64.81	1.5%	\$ 2.90	\$ 68.52	\$ 67.71	1.4%
Other Populations												
Other Populations - FCC, All Ages Male & Female	50,244	\$ 516.19	\$ 508.56	1.5%	\$ 25.76	\$ 541.94	\$ 534.31	1.4%	\$ 97.68	\$ 639.62	\$ 631.99	1.2%
Other Populations - BCC, All Ages	1,272	2,979.96	2,935.52	1.5%	107.22	3,087.18	3,043.14	1.4%	406.27	3,493.45	3,449.41	1.3%
Other Populations - LAP, All Ages	7,908	213.16	210.01	1.5%	14.21	227.38	224.23	1.4%	5.22	232.60	229.45	1.4%
Other Populations - CCM, All Ages	13,404	1,770.41	1,744.25	1.5%	44.97	1,815.39	1,789.22	1.5%	333.90	2,149.29	2,123.12	1.2%
Subtotal Other Populations	72,828	\$ 757.16	\$ 745.97	1.5%	\$ 29.46	\$ 786.62	\$ 775.43	1.4%	\$ 136.51	\$ 923.12	\$ 911.93	1.2%
Act 421 - LaHIPP TPL												
Act 421 - LaHIPP TPL - 0-2 Months	1	\$ 243.21	\$ 239.62	1.5%	\$ 0.00	\$ 243.21	\$ 239.62	1.5%	\$ 0.00	\$ 243.21	\$ 239.62	1.5%
Act 421 - LaHIPP TPL - 3-11 Months	1	13.79	13.58	1.5%	-	13.79	13.58	1.5%	-	13.79	13.58	1.5%
Act 421 - LaHIPP TPL - Child 1-18 Years	1	229.96	226.56	1.5%	-	229.96	226.56	1.5%	-	229.96	226.56	1.5%
Subtotal Act 421 - LaHIPP TPL	3	\$ 162.32	\$ 159.92	1.5%	\$ 0.00	\$ 162.32	\$ 159.92	1.5%	\$ 0.00	\$ 162.32	\$ 159.92	1.5%
Act 421 - Non-TPL												
Act 421 - Non-TPL - 0-2 Months	48	\$ 9,868.84	\$ 9,722.99	1.5%	\$ 465.05	\$ 10,333.89	\$ 10,188.05	1.4%	\$ 4,584.11	\$ 14,918.00	\$ 14,772.16	1.0%
Act 421 - Non-TPL - 3-11 Months	108	2,046.91	2,016.66	1.5%	44.86	2,091.76	2,061.51	1.5%	125.49	2,217.26	2,187.01	1.4%
Act 421 - Non-TPL - Child 1-18 Years	4,899	873.39	860.48	1.5%	12.25	885.64	872.73	1.5%	915.97	1,501.21	1,488.30	0.9%
Subtotal Act 421 - Non-TPL	5,055	\$ 983.88	\$ 969.34	1.5%	\$ 17.25	\$ 1,001.13	\$ 986.59	1.5%	\$ 642.78	\$ 1,643.91	\$ 1,629.37	0.9%
Act 421 - Non-LaHIPP TPL												
Act 421 - Non-LaHIPP TPL - 0-2 Months	48	\$ 3,279.11	\$ 3,230.65	1.5%	\$ 82.89	\$ 3,332.00	\$ 3,283.54	1.5%	\$ 53.48	\$ 3,385.49	\$ 3,337.03	1.5%
Act 421 - Non-LaHIPP TPL - 3-11 Months	228	742.67	731.69	1.5%	14.08	756.74	745.77	1.5%	23.29	780.03	769.06	1.4%
Act 421 - Non-LaHIPP TPL - Child 1-18 Years	3,990	446.15	439.56	1.5%	12.11	458.27	451.67	1.5%	16.34	474.61	468.02	1.4%
Subtotal Act 421 - Non-LaHIPP TPL	4,266	\$ 493.87	\$ 485.58	1.5%	\$ 12.68	\$ 506.55	\$ 499.25	1.5%	\$ 17.13	\$ 523.69	\$ 516.39	1.4%
Medicaid Expansion												
Medicaid Expansion - Age 19-64	1,723,232	\$ 711.17	\$ 700.66	1.5%	\$ 46.97	\$ 758.14	\$ 747.63	1.4%	\$ 147.30	\$ 905.44	\$ 894.93	1.2%
Medicaid Expansion - High Needs	456	711.17	700.66	1.5%	101.83	813.00	802.49	1.3%	320.10	1,133.10	1,122.59	0.9%
Medicaid Expansion - SBH - CCM, All Ages	108	244.46	240.84	1.5%	-	244.46	240.84	1.5%	7.73	252.19	248.58	1.5%
Medicaid Expansion - SBH - Dual Eligible, All Ages	15,229	19.70	19.41	1.5%	2.96	22.66	22.37	1.3%	1.19	23.85	23.56	1.2%
Medicaid Expansion - SBH - LaHIPP, All Ages	1,360	19.70	19.41	1.5%	0.04	19.74	19.45	1.5%	0.12	19.86	19.57	1.5%
Medicaid Expansion - SBH - Other	132	268.47	264.50	1.5%	0.93	269.40	265.43	1.5%	16.07	269.40	265.43	1.5%
Subtotal Medicaid Expansion	1,740,537	\$ 704.51	\$ 694.10	1.5%	\$ 46.55	\$ 751.06	\$ 740.65	1.4%	\$ 145.93	\$ 897.00	\$ 886.59	1.2%
Medicaid Expansion - Kick												
Medicaid Expansion - Kick - Maternity Kick Payment	3,958	\$ 9,407.82	\$ 9,268.79	1.5%	\$ 1,915.52	\$ 11,323.35	\$ 11,184.32	1.2%	\$ 11,590.87	\$ 22,914.22	\$ 22,775.19	0.6%
Medicaid Expansion - Kick - EED Kick Payment	1	3,984.70	3,925.82	1.5%	-	3,984.70	3,925.82	1.5%	-	3,984.70	3,925.82	1.5%
Subtotal Medicaid Expansion - Kick	3,959	\$ 9,406.45	\$ 9,267.44	1.5%	\$ 1,915.04	\$ 11,321.49	\$ 11,182.48	1.2%	\$ 11,587.94	\$ 22,909.44	\$ 22,770.43	0.6%
Non-Expansion - Kick												
Non-Expansion - Kick - Maternity Kick Payment	5,459	\$ 7,727.49	\$ 7,613.29	1.5%	\$ 1,453.95	\$ 9,181.44	\$ 9,067.24	1.3%	\$ 10,314.80	\$ 19,496.24	\$ 19,382.04	0.6%
Non-Expansion - Kick - EED Kick Payment	1	2,908.42	2,865.44	1.5%	-	2,908.42	2,865.44	1.5%	-	2,908.42	2,865.44	1.5%
Subtotal Non-Expansion - Kick	5,460	\$ 7,726.61	\$ 7,612.42	1.5%	\$ 1,453.88	\$ 9,180.29	\$ 9,066.10	1.3%	\$ 10,312.91	\$ 19,493.20	\$ 19,379.02	0.6%
Total	4,871,051	\$ 526.44	\$ 518.66	1.5%	\$ 40.39	\$ 566.83	\$ 559.05	1.4%	\$ 171.90	\$ 738.73	\$ 730.95	1.1%

State of Louisiana
 Department of Health
 Louisiana Medicaid Managed Care Program
 SFY 2025 De Minimis Amendment
 Rate Change Summary

Reason: Gulf	Projected Exposure	Current MCO Limited Rate	Prior MCO Limited Rate	% Change	FMP	Current MCO Capitation Rate	Prior MCO Capitation Rate	% Change	Directed Payments	Current Total Expected PMPM	Prior Total Expected Payment PMPM	% Change
F&C												
F&C - 0-2 Months	32,088	\$ 2,815.72	\$ 2,774.11	1.5%	\$ 121.23	\$ 2,936.95	\$ 2,896.34	1.4%	\$ 4,822.48	\$ 7,759.43	\$ 7,717.81	0.5%
F&C - 3-11 Months	104,088	366.47	361.06	1.5%	34.78	401.25	395.83	1.4%	240.15	641.40	635.99	0.9%
F&C - Child 1-20 Years	2,061,192	210.54	207.43	1.5%	20.39	230.93	227.82	1.4%	23.92	254.85	251.74	1.2%
F&C - Adult 21+ Years	252,518	536.61	530.68	1.5%	55.93	592.54	586.61	1.4%	79.86	672.41	664.46	1.2%
Subtotal F&C	2,449,886	\$ 284.90	\$ 280.69	1.5%	\$ 25.99	\$ 310.88	\$ 306.67	1.4%	\$ 101.72	\$ 412.60	\$ 408.39	1.0%
SSI												
SSI - 0-2 Months	132	\$ 35,544.76	\$ 35,019.47	1.5%	\$ 2,719.43	\$ 38,264.19	\$ 37,738.90	1.4%	\$ 103,376.91	\$ 141,641.09	\$ 141,115.80	0.4%
SSI - 3-11 Months	1,224	9,112.83	8,978.16	1.5%	688.50	9,801.32	9,666.65	1.4%	20,281.61	30,082.68	29,948.01	0.4%
SSI - Child 1-20 Years	91,732	961.76	947.54	1.5%	36.60	998.36	984.14	1.4%	312.59	1,310.95	1,296.73	1.1%
SSI - Adult 21+ Years	222,741	1,961.79	1,932.80	1.5%	102.33	2,064.13	2,035.13	1.4%	940.59	2,704.72	2,675.73	1.1%
Subtotal SSI	315,809	\$ 1,715.08	\$ 1,687.77	1.5%	\$ 86.66	\$ 1,799.69	\$ 1,774.37	1.4%	\$ 664.38	\$ 2,464.07	\$ 2,438.76	1.0%
HCBS												
HCBS - Child 1-20 Years	5,844	\$ 3,845.10	\$ 3,788.27	1.5%	\$ 68.36	\$ 3,913.46	\$ 3,856.64	1.5%	\$ 1,204.84	\$ 5,118.30	\$ 5,061.48	1.1%
HCBS - Adult 21+ Years	8,040	1,742.83	1,717.08	1.5%	74.90	1,817.73	1,791.98	1.4%	403.38	2,221.11	2,195.36	1.2%
Subtotal HCBS	13,884	\$ 2,627.71	\$ 2,588.88	1.5%	\$ 72.15	\$ 2,699.86	\$ 2,661.03	1.5%	\$ 740.73	\$ 3,440.59	\$ 3,401.76	1.1%
SBH												
SBH - HCBS - Child 1-20 Years	4,440	\$ 318.10	\$ 313.40	1.5%	\$ 0.92	\$ 319.03	\$ 314.33	1.5%	\$ 7.25	\$ 326.27	\$ 321.57	1.5%
SBH - HCBS - Adult 21+ Years	8,604	82.15	80.93	1.5%	2.82	84.96	83.75	1.4%	4.21	89.17	87.96	1.4%
SBH - LaHIPP, All Ages	1,164	43.28	42.64	1.5%	0.02	43.30	42.66	1.5%	1.16	44.45	43.81	1.5%
SBH - CCM, All Ages	4,080	215.63	212.45	1.5%	1.72	217.36	214.17	1.5%	4.59	221.95	218.76	1.5%
SBH - Dual Eligible, All Ages	424,458	43.28	42.64	1.5%	0.29	43.57	42.93	1.5%	2.71	46.28	45.64	1.4%
SBH - Other - All Ages	4,178	268.47	264.50	1.5%	7.00	275.47	271.51	1.5%	15.24	290.71	286.74	1.4%
Subtotal SBH	446,922	\$ 66.44	\$ 64.69	1.5%	\$ 0.42	\$ 66.96	\$ 65.11	1.5%	\$ 2.91	\$ 63.77	\$ 63.02	1.4%
Other Populations												
Other Populations - FCC, All Ages Male & Female	28,860	\$ 479.44	\$ 472.35	1.5%	\$ 28.11	\$ 507.54	\$ 500.46	1.4%	\$ 142.59	\$ 650.14	\$ 643.05	1.1%
Other Populations - BCC, All Ages	780	2,979.96	2,935.02	1.5%	59.62	3,039.58	2,995.54	1.5%	116.82	3,156.40	3,114.36	1.4%
Other Populations - LAP, All Ages	7,068	213.16	210.01	1.5%	17.55	230.71	227.56	1.4%	15.84	246.55	243.40	1.3%
Other Populations - CCM, All Ages	17,112	1,479.01	1,457.16	1.5%	44.08	1,523.09	1,501.23	1.5%	268.29	1,791.38	1,769.52	1.2%
Subtotal Other Populations	53,620	\$ 796.52	\$ 786.72	1.5%	\$ 32.26	\$ 830.78	\$ 818.98	1.4%	\$ 166.67	\$ 996.35	\$ 984.54	1.2%
Act 421 - LaHIPP TPL												
Act 421 - LaHIPP TPL - 0-2 Months	1	\$ 453.18	\$ 446.46	1.5%	\$ 0.00	\$ 453.18	\$ 446.46	1.5%	\$ 0.00	\$ 453.18	\$ 446.46	1.5%
Act 421 - LaHIPP TPL - 3-11 Months	1	28.63	28.21	1.5%	-	28.63	28.21	1.5%	-	28.63	28.21	1.5%
Act 421 - LaHIPP TPL - Child 1-18 Years	1	210.16	207.06	1.5%	-	210.16	207.06	1.5%	-	210.16	207.06	1.5%
Subtotal Act 421 - LaHIPP TPL	3	\$ 230.65	\$ 227.24	1.5%	\$ 0.00	\$ 230.65	\$ 227.24	1.5%	\$ 0.00	\$ 230.65	\$ 227.24	1.5%
Act 421 - Non-TPL												
Act 421 - Non-TPL - 0-2 Months	24	\$ 18,203.63	\$ 17,934.61	1.5%	\$ 136.18	\$ 18,339.81	\$ 18,070.79	1.5%	\$ 0.00	\$ 18,339.81	\$ 18,070.79	1.5%
Act 421 - Non-TPL - 3-11 Months	156	4,335.94	4,271.87	1.5%	33.42	4,369.36	4,305.29	1.5%	4,103.28	8,472.65	8,408.57	0.8%
Act 421 - Non-TPL - Child 1-18 Years	2,795	873.39	860.48	1.5%	14.11	897.50	874.59	1.5%	6.90	894.40	881.50	1.5%
Subtotal Act 421 - Non-TPL	2,875	\$ 1,194.76	\$ 1,177.11	1.5%	\$ 16.11	\$ 1,210.87	\$ 1,193.21	1.5%	\$ 1,432.52	\$ 1,432.52	\$ 1,414.86	1.2%
Act 421 - Non-LaHIPP TPL												
Act 421 - Non-LaHIPP TPL - 0-2 Months	12	\$ 6,107.82	\$ 6,017.56	1.5%	\$ 43.76	\$ 6,151.59	\$ 6,061.32	1.5%	\$ 0.00	\$ 6,151.59	\$ 6,061.32	1.5%
Act 421 - Non-LaHIPP TPL - 3-11 Months	156	1,541.17	1,518.40	1.5%	13.48	1,554.65	1,531.87	1.5%	0.07	1,554.72	1,531.95	1.5%
Act 421 - Non-LaHIPP TPL - Child 1-18 Years	2,496	446.15	439.56	1.5%	10.05	456.21	449.61	1.5%	1.02	457.22	450.63	1.5%
Subtotal Act 421 - Non-LaHIPP TPL	2,664	\$ 535.78	\$ 527.86	1.5%	\$ 10.41	\$ 546.18	\$ 538.27	1.5%	\$ 0.96	\$ 547.14	\$ 539.22	1.5%
Medicaid Expansion												
Medicaid Expansion - Age 19-64	1,938,031	\$ 692.59	\$ 672.50	1.5%	\$ 48.12	\$ 731.71	\$ 721.62	1.4%	\$ 127.59	\$ 659.30	\$ 649.21	1.2%
Medicaid Expansion - High Needs	564	682.59	672.50	1.5%	83.66	766.27	756.18	1.3%	967.11	1,723.39	1,713.30	0.6%
Medicaid Expansion - SBH - CCM, All Ages	216	215.63	212.45	1.5%	-	215.63	212.45	1.5%	5.55	221.19	218.00	1.5%
Medicaid Expansion - SBH - Dual Eligible, All Ages	18,995	17.51	17.25	1.5%	2.23	19.75	19.49	1.3%	1.11	20.86	20.60	1.3%
Medicaid Expansion - SBH - LaHIPP, All Ages	516	17.51	17.25	1.5%	0.05	17.56	17.30	1.5%	0.14	17.71	17.45	1.5%
Medicaid Expansion - SBH - Other	36	268.47	264.50	1.5%	-	268.47	264.50	1.5%	-	268.47	264.50	1.5%
Subtotal Medicaid Expansion	1,958,298	\$ 675.92	\$ 665.93	1.5%	\$ 48.66	\$ 724.58	\$ 714.69	1.4%	\$ 126.56	\$ 651.14	\$ 641.15	1.2%
Medicaid Expansion - Kick												
Medicaid Expansion - Kick - Maternity Kick Payment	3,850	\$ 10,629.30	\$ 10,472.22	1.5%	\$ 2,300.15	\$ 12,929.46	\$ 12,772.37	1.2%	\$ 13,079.61	\$ 26,009.07	\$ 25,851.99	0.6%
Medicaid Expansion - Kick - EED Kick Payment	1	4,502.06	4,435.53	1.5%	-	4,502.06	4,435.53	1.5%	-	4,502.06	4,435.53	1.5%
Subtotal Medicaid Expansion - Kick	3,851	\$ 10,627.71	\$ 10,470.65	1.5%	\$ 2,299.56	\$ 12,927.27	\$ 12,770.21	1.2%	\$ 13,079.61	\$ 26,003.48	\$ 25,846.42	0.6%
Non-Expansion - Kick												
Non-Expansion - Kick - Maternity Kick Payment	5,705	\$ 8,825.37	\$ 8,694.85	1.5%	\$ 1,768.73	\$ 10,594.10	\$ 10,463.68	1.2%	\$ 12,329.44	\$ 22,923.54	\$ 22,793.12	0.6%
Non-Expansion - Kick - EED Kick Payment	1	3,321.63	3,272.54	1.5%	-	3,321.63	3,272.54	1.5%	-	3,321.63	3,272.54	1.5%
Subtotal Non-Expansion - Kick	5,706	\$ 8,824.41	\$ 8,694.00	1.5%	\$ 1,768.42	\$ 10,592.83	\$ 10,462.42	1.2%	\$ 12,327.28	\$ 22,920.11	\$ 22,789.70	0.6%
Total	5,244,281	\$ 526.46	\$ 518.66	1.5%	\$ 39.71	\$ 566.17	\$ 558.39	1.4%	\$ 161.84	\$ 728.01	\$ 720.23	1.1%

State of Louisiana
 Department of Health
 Louisiana Medicaid Managed Care Program
 SFY 2025 De Minimis Amendment
 Rate Change Summary

Region: North	Projected Exposure	Current MCO Limited Rate	Prior MCO Limited Rate	% Change	FMP	Current MCO Capitation Rate	Prior MCO Capitation Rate	% Change	Directed Payments	Current Total Expected PMPM	Prior Total Expected Payment PMPM	% Change
F&C												
F&C - 0-2 Months	23,988	\$ 2,496.71	\$ 2,449.96	1.5%	\$ 88.05	\$ 2,574.76	\$ 2,538.01	1.4%		\$ 4,154.86	\$ 6,692.67	0.5%
F&C - 3-11 Months	73,932	342.60	337.54	1.5%	32.20	374.79	369.73	1.4%	\$ 186.50	561.29	565.23	0.9%
F&C - Child 1-20 Years	1,553,309	214.32	211.15	1.5%	13.89	228.21	225.04	1.4%	23.44	251.66	248.49	1.3%
F&C - Adult 21+ Years	185,748	516.21	509.59	1.5%	27.82	544.04	536.41	1.4%	78.65	622.69	615.06	1.2%
Subtotal F&C	1,839,977	\$ 290.07	\$ 275.93	1.5%	\$ 17.02	\$ 297.09	\$ 292.95	1.4%	\$ 89.82	\$ 386.61	\$ 382.47	1.1%
SSI												
SSI - 0-2 Months	72	\$ 35,544.76	\$ 35,019.47	1.5%	\$ 1,217.45	\$ 36,762.21	\$ 36,236.91	1.4%	\$ 50,717.19	\$ 87,479.40	\$ 86,954.11	0.6%
SSI - 3-11 Months	960	9,112.83	8,978.16	1.5%	437.10	9,549.93	9,415.26	1.4%	17,138.04	26,687.97	26,553.30	0.5%
SSI - Child 1-20 Years	89,646	863.96	851.19	1.5%	22.27	886.23	873.47	1.5%	257.26	1,143.50	1,130.73	1.1%
SSI - Adult 21+ Years	187,355	1,695.25	1,670.20	1.5%	56.48	1,751.73	1,726.68	1.5%	990.63	2,342.96	2,317.31	1.1%
Subtotal SSI	279,033	\$ 1,461.60	\$ 1,440.00	1.5%	\$ 47.07	\$ 1,508.66	\$ 1,487.06	1.5%	\$ 653.28	\$ 2,061.92	\$ 2,040.32	1.1%
HCBS												
HCBS - Child 1-20 Years	3,312	\$ 3,845.10	\$ 3,788.27	1.5%	\$ 47.23	\$ 3,892.33	\$ 3,835.51	1.5%	\$ 526.91	\$ 4,419.24	\$ 4,362.41	1.3%
HCBS - Adult 21+ Years	7,212	2,195.72	2,163.27	1.5%	59.02	2,254.74	2,222.29	1.5%	910.91	3,165.64	3,133.19	1.0%
Subtotal HCBS	10,524	\$ 2,714.79	\$ 2,674.67	1.5%	\$ 55.31	\$ 2,770.10	\$ 2,729.98	1.5%	\$ 790.06	\$ 3,560.16	\$ 3,520.04	1.1%
SBH												
SBH - HCBS - Child 1-20 Years	2,184	\$ 318.10	\$ 313.40	1.5%	\$ 0.37	\$ 318.48	\$ 313.77	1.5%	\$ 29.52	\$ 347.99	\$ 343.29	1.4%
SBH - HCBS - Adult 21+ Years	6,276	127.18	125.30	1.5%	1.49	128.67	126.79	1.5%	7.16	135.83	133.95	1.4%
SBH - LaHIPP, All Ages	756	50.88	50.13	1.5%	50.88	50.13	50.13	1.5%	0.65	51.53	50.78	1.5%
SBH - CCM, All Ages	3,888	230.01	226.61	1.5%	0.31	230.32	226.92	1.5%	17.24	247.56	244.16	1.4%
SBH - Dual Eligible, All Ages	328,142	50.88	50.13	1.5%	0.14	51.02	50.26	1.5%	2.90	53.91	53.16	1.4%
SBH - Other - All Ages	9,828	268.47	264.50	1.5%	4.39	272.86	268.90	1.5%	16.70	289.57	285.60	1.4%
Subtotal SBH	351,074	\$ 611.98	\$ 610.07	1.5%	\$ 0.28	\$ 622.26	\$ 613.35	1.5%	\$ 33.68	\$ 659.94	\$ 656.03	1.4%
Other Populations												
Other Populations - FCC, All Ages Male & Female	39,516	\$ 555.69	\$ 557.33	1.5%	\$ 16.40	\$ 502.09	\$ 573.73	1.5%	\$ 99.05	\$ 681.14	\$ 672.70	1.2%
Other Populations - BCC, All Ages	780	2,979.96	2,935.52	1.5%	60.64	3,040.59	2,996.56	1.5%	434.27	3,474.87	3,430.83	1.3%
Other Populations - LAP, All Ages	4,512	213.16	210.01	1.5%	11.37	224.53	221.38	1.4%	10.90	235.44	232.29	1.4%
Other Populations - CCM, All Ages	12,936	1,654.27	1,629.83	1.5%	28.77	1,683.05	1,658.60	1.5%	367.60	2,050.65	2,026.20	1.2%
Subtotal Other Populations	57,744	\$ 914.62	\$ 902.59	1.5%	\$ 19.37	\$ 834.00	\$ 821.96	1.5%	\$ 156.86	\$ 990.85	\$ 978.82	1.2%
Act 421 - LaHIPP TPL												
Act 421 - LaHIPP TPL - 0-2 Months	1	\$ 236.87	\$ 233.47	1.5%	\$ 0.00	\$ 236.87	\$ 233.47	1.5%	\$ 0.00	\$ 236.87	\$ 233.47	1.5%
Act 421 - LaHIPP TPL - 3-11 Months	1	26.88	26.48	1.5%	-	26.88	26.48	1.5%	-	26.88	26.48	1.5%
Act 421 - LaHIPP TPL - Child 1-18 Years	1	188.16	185.38	1.5%	-	188.16	185.38	1.5%	-	188.16	185.38	1.5%
Subtotal Act 421 - LaHIPP TPL	3	\$ 150.67	\$ 148.44	1.5%	\$ 0.00	\$ 150.67	\$ 148.44	1.5%	\$ 0.00	\$ 150.67	\$ 148.44	1.5%
Act 421 - Non-TPL												
Act 421 - Non-TPL - 0-2 Months	1	\$ 9,518.76	\$ 9,378.09	1.5%	\$ 194.77	\$ 9,713.54	\$ 9,572.87	1.5%	\$ 0.00	\$ 9,713.54	\$ 9,572.87	1.5%
Act 421 - Non-TPL - 3-11 Months	48	3,984.03	3,925.15	1.5%	89.46	4,073.49	4,014.61	1.5%	-	4,073.49	4,014.61	1.5%
Act 421 - Non-TPL - Child 1-18 Years	2,464	873.39	860.48	1.5%	18.70	890.09	877.19	1.5%	44.23	934.32	921.42	1.4%
Subtotal Act 421 - Non-TPL	2,533	\$ 935.76	\$ 921.92	1.5%	\$ 18.15	\$ 953.90	\$ 940.07	1.5%	\$ 43.37	\$ 997.28	\$ 983.45	1.4%
Act 421 - Non-LaHIPP TPL												
Act 421 - Non-LaHIPP TPL - 0-2 Months	1	\$ 3,193.81	\$ 3,146.61	1.5%	\$ 0.00	\$ 3,193.81	\$ 3,146.61	1.5%	\$ 0.00	\$ 3,193.81	\$ 3,146.61	1.5%
Act 421 - Non-LaHIPP TPL - 3-11 Months	84	1,446.72	1,425.34	1.5%	8.10	1,454.83	1,433.45	1.5%	0.97	1,455.79	1,434.41	1.4%
Act 421 - Non-LaHIPP TPL - Child 1-18 Years	1,421	446.15	439.56	1.5%	12.22	458.37	451.78	1.5%	5.91	464.28	457.69	1.5%
Subtotal Act 421 - Non-LaHIPP TPL	1,506	\$ 903.78	\$ 895.34	1.5%	\$ 11.98	\$ 915.77	\$ 903.32	1.5%	\$ 6.63	\$ 921.40	\$ 913.95	1.4%
Medicaid Expansion												
Medicaid Expansion - Age 19-64	1,385,017	\$ 640.17	\$ 630.71	1.5%	\$ 27.41	\$ 667.57	\$ 658.11	1.4%	\$ 130.59	\$ 798.16	\$ 788.70	1.2%
Medicaid Expansion - High Needs	228	640.17	630.71	1.5%	33.10	673.26	663.80	1.4%	353.96	1,027.22	1,017.76	0.9%
Medicaid Expansion - SBH - CCM, All Ages	228	230.01	226.61	1.5%	-	230.01	226.61	1.5%	5.67	235.69	232.29	1.5%
Medicaid Expansion - SBH - Dual Eligible, All Ages	12,059	22.31	21.98	1.5%	0.54	22.86	22.53	1.5%	1.54	24.39	24.07	1.4%
Medicaid Expansion - SBH - LaHIPP, All Ages	576	22.31	21.98	1.5%	-	22.31	21.98	1.5%	0.12	22.44	22.11	1.5%
Medicaid Expansion - SBH - Other	84	268.47	264.50	1.5%	-	268.47	264.50	1.5%	4.78	273.26	269.29	1.5%
Subtotal Medicaid Expansion	1,398,192	\$ 634.49	\$ 625.12	1.5%	\$ 27.16	\$ 661.65	\$ 652.28	1.4%	\$ 129.43	\$ 791.08	\$ 781.70	1.2%
Medicaid Expansion - Kick												
Medicaid Expansion - Kick - Maternity Kick Payment	2,855	\$ 10,741.23	\$ 10,582.49	1.5%	\$ 988.86	\$ 11,730.09	\$ 11,571.35	1.4%	\$ 12,876.44	\$ 24,606.52	\$ 24,447.79	0.6%
Medicaid Expansion - Kick - EED Kick Payment	1	4,549.47	4,482.24	1.5%	-	4,549.47	4,482.24	1.5%	-	4,549.47	4,482.24	1.5%
Subtotal Medicaid Expansion - Kick	2,856	\$ 10,739.06	\$ 10,580.36	1.5%	\$ 988.51	\$ 11,727.57	\$ 11,568.87	1.4%	\$ 12,871.93	\$ 24,599.50	\$ 24,440.79	0.6%
Non-Expansion - Kick												
Non-Expansion - Kick - Maternity Kick Payment	3,617	\$ 9,548.61	\$ 9,407.50	1.5%	\$ 748.92	\$ 10,297.54	\$ 10,156.42	1.4%	\$ 12,113.63	\$ 22,411.17	\$ 22,270.05	0.6%
Non-Expansion - Kick - EED Kick Payment	1	3,593.84	3,540.73	1.5%	-	3,593.84	3,540.73	1.5%	-	3,593.84	3,540.73	1.5%
Subtotal Non-Expansion - Kick	3,618	\$ 9,546.97	\$ 9,405.88	1.5%	\$ 748.72	\$ 10,295.68	\$ 10,154.60	1.4%	\$ 12,113.63	\$ 22,405.97	\$ 22,264.88	0.6%
Total	3,939,586	\$ 501.21	\$ 493.80	1.5%	\$ 22.79	\$ 524.00	\$ 516.59	1.4%	\$ 152.01	\$ 676.01	\$ 668.60	1.1%

State of Louisiana
 Department of Health
 Healthy Louisiana Medicaid Managed Care Program
 SFY 2025 De Minimis Amendment
 Rate Change Summary

Region: South Central	Projected Exposure	Current MCO Limited Rate	Prior MCO Limited Rate	% Change	FMP	Current MCO Capitation Rate	Prior MCO Capitation Rate	% Change	Directed Payments	Current Total Expected Payment PMPM	Prior Total Expected Payment PMPM	% Change
F&C												
F&C - 0-2 Months	33,444	\$ 2,754.17	\$ 2,713.46	1.5%	\$ 65.76	\$ 2,819.92	\$ 2,779.22	1.5%	\$ 4,949.94	\$ 7,759.86	\$ 7,729.16	0.5%
F&C - 3-11 Months	106,212	414.25	408.13	1.5%	35.55	449.80	443.68	1.4%	328.73	778.53	772.41	0.8%
F&C - Child 1-20 Years	2,125,886	210.29	207.19	1.5%	16.46	226.76	223.65	1.4%	23.76	250.51	247.40	1.3%
F&C - Adult 21+ Years	208,139	536.76	530.83	1.5%	41.79	570.62	570.55	1.4%	70.81	649.36	641.43	1.2%
Subtotal F&C	2,533,671	\$ 286.97	\$ 282.73	1.5%	\$ 20.99	\$ 307.56	\$ 303.32	1.4%	\$ 106.55	\$ 414.11	\$ 409.87	1.0%
SSI												
SSI - 0-2 Months	132	\$ 35,544.76	\$ 35,019.47	1.5%	\$ 1,253.10	\$ 36,797.86	\$ 36,272.57	1.4%	\$ 72,632.30	\$ 109,430.16	\$ 108,904.87	0.5%
SSI - 3-11 Months	912	9,112.83	8,978.16	1.5%	376.23	9,489.06	9,354.39	1.4%	13,787.67	23,276.73	23,142.06	0.6%
SSI - Child 1-20 Years	84,221	982.29	967.78	1.5%	33.19	1,015.49	1,000.97	1.5%	314.00	1,329.48	1,314.97	1.1%
SSI - Adult 21+ Years	201,859	1,858.40	1,830.93	1.5%	94.81	1,953.20	1,925.74	1.4%	940.03	2,483.24	2,465.77	1.1%
Subtotal SSI	207,094	\$ 1,838.92	\$ 1,815.69	1.5%	\$ 75.16	\$ 1,716.08	\$ 1,693.84	1.4%	\$ 546.96	\$ 2,287.63	\$ 2,242.89	1.1%
HCBS												
HCBS - Child 1-20 Years	5,508	\$ 3,845.10	\$ 3,788.27	1.5%	\$ 47.55	\$ 3,892.65	\$ 3,835.83	1.5%	\$ 780.50	\$ 4,673.15	\$ 4,616.33	1.2%
HCBS - Adult 21+ Years	10,188	2,040.69	2,010.53	1.5%	73.67	2,114.36	2,084.20	1.4%	675.13	2,789.49	2,759.33	1.1%
Subtotal HCBS	15,696	\$ 2,673.88	\$ 2,634.37	1.5%	\$ 64.51	\$ 2,738.39	\$ 2,698.87	1.5%	\$ 712.11	\$ 3,450.50	\$ 3,410.98	1.2%
SBH												
SBH - HCBS - Child 1-20 Years	3,732	\$ 318.10	\$ 313.40	1.5%	\$ 0.46	\$ 318.56	\$ 313.86	1.5%	\$ 5.31	\$ 323.87	\$ 319.17	1.5%
SBH - HCBS - Adult 21+ Years	8,890	162.61	160.21	1.5%	2.43	165.04	162.64	1.5%	8.10	173.15	170.75	1.4%
SBH - LaHIPP, All Ages	1,848	48.74	48.02	1.5%	-	48.74	48.02	1.5%	0.49	49.23	48.51	1.5%
SBH - CCM, All Ages	4,656	346.10	340.99	1.5%	0.41	346.52	341.40	1.5%	9.57	356.09	350.97	1.5%
SBH - Dual Eligible, All Ages	396,883	48.74	48.02	1.5%	0.14	48.89	48.17	1.5%	2.84	51.53	50.81	1.4%
SBH - Other - All Ages	9,528	268.47	264.50	1.5%	5.92	274.39	270.43	1.5%	23.85	298.04	294.07	1.3%
Subtotal SBH	425,527	\$ 61.66	\$ 60.74	1.5%	\$ 0.32	\$ 61.98	\$ 61.07	1.5%	\$ 3.32	\$ 65.30	\$ 64.39	1.4%
Other Populations												
Other Populations - FCC, All Ages Male & Female	57,312	\$ 433.57	\$ 427.16	1.5%	\$ 20.47	\$ 454.04	\$ 447.64	1.4%	\$ 73.33	\$ 527.37	\$ 520.96	1.2%
Other Populations - BCC, All Ages	756	2,979.96	2,935.02	1.5%	71.86	3,051.84	3,007.80	1.5%	127.71	3,179.54	3,135.50	1.4%
Other Populations - LAP, All Ages	6,540	213.16	210.01	1.5%	14.51	227.68	224.53	1.4%	17.17	244.84	241.69	1.3%
Other Populations - CCM, All Ages	16,656	1,806.15	1,582.41	1.5%	30.39	1,836.54	1,612.81	1.5%	285.20	1,921.74	1,898.01	1.3%
Subtotal Other Populations	81,264	\$ 679.86	\$ 669.81	1.5%	\$ 22.90	\$ 702.36	\$ 692.31	1.5%	\$ 112.74	\$ 615.10	\$ 605.05	1.2%
Act 421 - LaHIPP TPL												
Act 421 - LaHIPP TPL - 0-2 Months	1	\$ 335.75	\$ 330.79	1.5%	\$ 0.00	\$ 335.75	\$ 330.79	1.5%	\$ 0.00	\$ 335.75	\$ 330.79	1.5%
Act 421 - LaHIPP TPL - 3-11 Months	1	23.13	22.79	1.5%	-	23.13	22.79	1.5%	-	23.13	22.79	1.5%
Act 421 - LaHIPP TPL - Child 1-18 Years	1	214.28	211.11	1.5%	-	214.28	211.11	1.5%	-	214.28	211.11	1.5%
Subtotal Act 421 - LaHIPP TPL	3	\$ 191.05	\$ 188.23	1.5%	\$ 0.00	\$ 191.05	\$ 188.23	1.5%	\$ 0.00	\$ 191.05	\$ 188.23	1.5%
Act 421 - Non-TPL												
Act 421 - Non-TPL - 0-2 Months	24	\$ 13,486.55	\$ 13,287.24	1.5%	\$ 6.94	\$ 13,493.49	\$ 13,294.18	1.5%	\$ 0.00	\$ 13,493.49	\$ 13,294.18	1.5%
Act 421 - Non-TPL - 3-11 Months	48	3,428.69	3,376.02	1.5%	4.16	3,432.85	3,382.18	1.5%	-	3,432.85	3,382.18	1.5%
Act 421 - Non-TPL - Child 1-18 Years	3,864	873.39	860.48	1.5%	61.01	879.40	866.58	1.5%	26.94	906.43	893.52	1.4%
Subtotal Act 421 - Non-TPL	3,836	\$ 981.46	\$ 966.96	1.5%	\$ 6.08	\$ 987.54	\$ 973.04	1.5%	\$ 26.45	\$ 1,013.99	\$ 999.49	1.5%
Act 421 - Non-LaHIPP TPL												
Act 421 - Non-LaHIPP TPL - 0-2 Months	1	\$ 4,525.11	\$ 4,458.24	1.5%	\$ 31.82	\$ 4,556.93	\$ 4,490.06	1.5%	\$ 0.00	\$ 4,556.93	\$ 4,490.06	1.5%
Act 421 - Non-LaHIPP TPL - 3-11 Months	120	1,245.06	1,226.66	1.5%	17.83	1,262.89	1,244.49	1.5%	-	1,262.89	1,244.49	1.5%
Act 421 - Non-LaHIPP TPL - Child 1-18 Years	2,787	446.15	439.56	1.5%	4.84	450.99	444.40	1.5%	1.58	452.57	445.97	1.5%
Subtotal Act 421 - Non-LaHIPP TPL	2,908	\$ 486.52	\$ 473.42	1.5%	\$ 5.36	\$ 485.90	\$ 478.89	1.5%	\$ 1.51	\$ 487.42	\$ 480.32	1.5%
Medicaid Expansion												
Medicaid Expansion - Age 19-64	1,768,976	\$ 654.66	\$ 644.99	1.5%	\$ 44.20	\$ 698.87	\$ 689.19	1.4%	\$ 116.45	\$ 615.32	\$ 605.64	1.2%
Medicaid Expansion - High Needs	288	654.66	644.99	1.5%	108.13	762.80	753.12	1.3%	307.24	1,070.04	1,060.36	0.9%
Medicaid Expansion - SBH - CCM, All Ages	180	346.10	340.99	1.5%	-	346.10	340.99	1.5%	2.91	349.01	343.90	1.5%
Medicaid Expansion - SBH - Dual Eligible, All Ages	18,949	26.10	25.72	1.5%	1.59	27.70	27.31	1.4%	1.52	29.22	28.83	1.3%
Medicaid Expansion - SBH - LaHIPP, All Ages	972	26.10	25.72	1.5%	0.00	26.11	25.72	1.5%	0.17	26.28	25.89	1.5%
Medicaid Expansion - SBH - Other	120	268.47	264.50	1.5%	26.34	294.81	290.85	1.4%	4.33	299.14	295.17	1.3%
Subtotal Medicaid Expansion	1,809,485	\$ 647.69	\$ 638.12	1.5%	\$ 43.74	\$ 681.42	\$ 681.85	1.4%	\$ 115.20	\$ 606.62	\$ 597.05	1.2%
Medicaid Expansion - Kick												
Medicaid Expansion - Kick - Maternity Kick Payment	4,174	\$ 8,228.28	\$ 8,106.68	1.5%	\$ 1,152.10	\$ 9,380.38	\$ 9,258.78	1.3%	\$ 12,454.38	\$ 21,834.76	\$ 21,713.16	0.6%
Medicaid Expansion - Kick - EED Kick Payment	1	3,485.11	3,433.60	1.5%	-	3,485.11	3,433.60	1.5%	-	3,485.11	3,433.60	1.5%
Subtotal Medicaid Expansion - Kick	4,175	\$ 8,227.15	\$ 8,105.96	1.5%	\$ 1,151.82	\$ 9,376.97	\$ 9,262.39	1.3%	\$ 12,454.38	\$ 21,830.36	\$ 21,708.78	0.6%
Non-Expansion - Kick												
Non-Expansion - Kick - Maternity Kick Payment	5,492	\$ 7,086.83	\$ 6,982.09	1.5%	\$ 894.00	\$ 7,880.83	\$ 7,876.10	1.3%	\$ 11,352.57	\$ 19,333.40	\$ 19,228.67	0.5%
Non-Expansion - Kick - EED Kick Payment	1	2,687.29	2,627.87	1.5%	-	2,687.29	2,627.87	1.5%	-	2,687.29	2,627.87	1.5%
Subtotal Non-Expansion - Kick	5,493	\$ 7,086.02	\$ 6,981.30	1.5%	\$ 893.84	\$ 7,878.12	\$ 7,873.97	1.3%	\$ 11,352.57	\$ 19,330.36	\$ 19,225.65	0.5%
Total	5,159,584	\$ 498.46	\$ 491.10	1.5%	\$ 32.27	\$ 530.73	\$ 523.37	1.4%	\$ 149.66	\$ 680.40	\$ 673.03	1.1%



MCO Amendment 10
Attachment E10 – Changes to Attachment E, *APM Reporting Template*

Item	Changes	Justification
1	See Attachment E.	Tab 2, “VBP Reporting,” line 26: this revision adds more concise language for the payment approach and corrected a typo. Tab 3, “Definitions,” line 22: this revision updates the definition of “Population-based payment for conditions” with emphasis on APM Framework Category 4 if there is a link to quality.

Definitions

Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper and the graphic included on the 'refreshed' APM Framework tab. https://hcp-lan.org/groups/apm-refresh-white-paper/
Care Management	Includes payments to improve care delivery such as outreach and care coordination/management and after-hour availability; May come in the form of care/case management fees or medical home payments. [APM Framework Category 2A]
Category 2 APM (must be linked to quality)	Fee-for-service linked to quality. These payments utilize traditional FFS payments, but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics. Examples are described in more detail in other definitions and include: 2A: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems 2C: Rewards and Penalties for Performance: Bonus payments/rewards and/or penalties for quality performance on specified measures, including those in DRG systems.
Category 2A APMs recognized by LDH	Category 2A VBP models where the 2A arrangement is one component of a broader VBP model that includes Category 2C, 3 or 4 APMs for the same provider(s). This does not include provider contracts or VBP models that only include Category 2A APMs.
Category 2B APMs recognized by LDH	Category 2B pay for reporting where the 2B arrangement is one component of a broader VBP model that includes Category 2C, 3, or 4 APMs for the same provider(s). This does not include provider contracts or VBP models that only include Category 2B APMs. LDH considers "pay per click" arrangements related to HEDIS measures as a 2B arrangement. Unlike category 2C arrangements, in 2B "pay-per-click" arrangements providers receive additional payment for each applicable HEDIS screen/service, regardless of whether the provider achieves an overall target HEDIS performance related to their attributed/assigned MCO members.
Category 3 APM (excludes risk-based payment models that are NOT linked to quality)	Alternative payment methods (APMs) built on fee-for-service architecture while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost performance against a target , irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are retrospectively eligible for shared savings, and those that do not may be held financially accountable. Examples include: 3A: APMs with upside gain sharing based on a budget target/shared savings: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); Oncology COE with retrospective shared savings (no shared risk). 3B: APMs with upside gain sharing and downside risk: retrospective bundled payments with up and downside risk, retrospective episode-based payments with shared savings and losses; PCMH with retrospective shared savings and losses; Oncology COE with retrospective shared savings and losses.

Definitions

Terms	Definitions
Category 4 APM (excludes capitated payment models that are NOT linked to quality)	<p>Prospective population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined or overall budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Examples include:</p> <p>4A: Condition-specific population-based payments, e.g. via an ACO, PCMH or Center of Excellence (COE), partial population-based payments for primary care, and episode-based payments for clinical conditions such as diabetes.</p> <p>4B: Comprehensive population-based payments - full or % of premium population-based payment, e.g. via an ACO, PCMH or Center of Excellence (COE), integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care.</p> <p>4C: Integrated Finance & Delivery Systems - global budgets or full/percent of premium payments in integrated systems</p>
Condition-specific bundled/episode payments	<p>A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category 4A]</p>
Diagnosis-related groups (DRGs)	<p>A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.</p>
Fee-for-service	<p>Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category 1]</p>
Foundational spending	<p>Includes but is not limited to payments to improve care delivery such as health IT infrastructure use. May come in the form of infrastructure payments, meaningful use payments and/or per-episode fees for specialists. [APM Framework Category 2A]</p>
Full or percent of premium population-based payments	<p>A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category 4B if there is a link to quality]</p>
Legacy payments	<p>Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs) and per diems. [APM Framework Category 1].</p>
Link to quality	<p>Payments that are set or adjusted based on evidence that providers meet a quality standard(s) or improve care or clinical services, including for providers who report quality data, or providers who meet thresholds on cost and quality metrics.</p>
Pay for performance	<p>The use of financial incentives to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. [APM Framework Category 2C if there is a link to quality].</p>

Definitions

Terms	Definitions
Payment Period	The twelve month Measurement Year period, applicable to the specified MCO reporting requirements, for example Calendar Year 2023.
Population-based payment for conditions	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period including inpatient care and facility fees. [APM Framework Category 3B 4A if there is a link to quality].
Population-based payment not condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could cover primary, acute and post-acute care that is not specific to any particular condition. [APM Framework Category 4 if there is a link to quality].
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories 3A & 3B].
Provider	For the purposes of this report, provider includes all providers for which there is MCO health care spending. For the purposes of reporting APMs, this definition of provider includes medical, behavioral, pharmacy, DME, PCMH/FCMH, dental, vision, transportation, and local health departments (e.g., lead screening) etc. as applicable.
Shared risk/losses	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the applicable payment period. Reported in cell C4 of the VBP Reporting tab under 1.Total Annual Provider Payments.



MCO Amendment 10
Attachment F10 – Changes to Attachment F, Provider Network Standards

Item	Change From	Change To				Justification																
1	[add new standards]	<table border="1"> <thead> <tr> <th data-bbox="1166 393 1400 532">Type¹</th> <th data-bbox="1400 393 1615 532">Network Ratio² (Provider: Member)</th> <th data-bbox="1615 393 1822 532">Rural Parishes³ (miles)</th> <th data-bbox="1822 393 2029 532">Urban Parishes³ (miles)</th> </tr> </thead> <tbody> <tr> <td colspan="4" data-bbox="1166 532 2029 570">Ancillary</td> </tr> <tr> <td data-bbox="1166 570 1400 643"><u>Primary Dental Services¹⁰</u></td> <td data-bbox="1400 570 1615 643"></td> <td data-bbox="1615 570 1822 643"><u>30</u></td> <td data-bbox="1822 570 2029 643"><u>10</u></td> </tr> <tr> <td data-bbox="1166 643 1400 846"><u>Specialty Dental Services¹⁰</u></td> <td data-bbox="1400 643 1615 846"></td> <td colspan="2" data-bbox="1615 643 2029 846"><u>75</u></td> </tr> </tbody> </table>				Type ¹	Network Ratio ² (Provider: Member)	Rural Parishes ³ (miles)	Urban Parishes ³ (miles)	Ancillary				<u>Primary Dental Services¹⁰</u>		<u>30</u>	<u>10</u>	<u>Specialty Dental Services¹⁰</u>		<u>75</u>		These revisions provide standards for dental service areas for transportation providers.
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2	<u>Notes:</u> ... [add new footnote]	<u>Notes:</u> ... ¹⁰ <u>Coverage of these dental services is provided by the Dental Benefit Program Manager (DBPM). Distance standards for these dental services are provided for the sole purpose of establishing a service area for transportation providers, to be used by the Contractor and its Transportation Broker.</u>																				



MCO Amendment 10
Attachment G10 – Changes to Attachment G, *Table of Monetary Penalties*

Item	Change From	Change To		Justification
1	[new monetary penalty]	Failed Deliverable or Deficiency Services	Penalty <u>Two thousand five hundred dollars (\$2,500) per Calendar Day for each incident of failure to provide, or provide timely, a Non-Emergency Medical Transportation (NEMT) or Non-Emergency Ambulance Transportation (NEAT) service that is reported to LDH by an Enrollee, provider, or other third party. Effective 7/1/2024.</u>	This penalty is to address transportation no-shows and untimeliness.



MCO Amendment 10
Attachment H10– Changes to Attachment H, Quality Performance Measures

Note: All measures are renumbered based on changes made.

Item	Change From		Change To		Justification								
1.	[new measure]		<table border="1"> <thead> <tr> <th data-bbox="1155 451 1540 488">Measures</th> <th data-bbox="1540 451 2061 488">Measure Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="1155 488 1540 677"><u>3. Antibiotic Utilization for Respiratory Conditions (AXR)</u></td> <td data-bbox="1540 488 2061 677"><u>The percentage of episodes for members three (3) months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.</u></td> </tr> </tbody> </table>		Measures	Measure Description	<u>3. Antibiotic Utilization for Respiratory Conditions (AXR)</u>	<u>The percentage of episodes for members three (3) months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.</u>	This revision is an NCQA requirement.				
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Item	Change From	Change To		Justification				
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5.	21. Cesarean Rate for Low-Risk First Birth Women	21. <u>Low-Risk Cesarean Delivery</u> Rate for Low-Risk First Birth Women		This revision is an update from NCQA. This revision is a name change from TJC as the measure steward.				

Item	Change From		Change To		Justification						
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Item	Change From		Change To		Justification								
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Item	Change From		Change To		Justification
			<p><u>were screened for cervical cancer using any of the following criteria:</u></p> <ul style="list-style-type: none"> • <u>Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three (3) years.</u> • <u>Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five (5) years.</u> • <u>Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five (5) years.</u> 		
10.	Measures	Measure Description	Measures	Measure Description	This revision is an NCQA requirement.

Item	Change From		Change To		Justification
	<p>44. Hemoglobin A1c Control for Patients With Diabetes</p>	<p>The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:</p> <ul style="list-style-type: none"> • HbA1c control (<8.0%). • \$\$ HbA1c poor control (>9.0%) <p><i>Note: A lower rate indicates better performance for HbA1c poor control (i.e., low rates of poor control indicate better care).</i></p>	<p>44. Hemoglobin A1c Control for Patients With Diabetes</p> <p><u>44. Glycemic Status Assessment for Patients With Diabetes (GSD)</u></p>	<p>The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:</p> <ul style="list-style-type: none"> • HbA1c control (<8.0%). • \$\$ HbA1c poor control (>9.0%) <p><i>Note: A lower rate indicates better performance for HbA1c poor control (i.e., low rates of poor control indicate better care).</i></p> <p><u>The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:</u></p> <ul style="list-style-type: none"> • <u>Glycemic Status <8.0%.</u> • <u>Glycemic Status >9.0%.</u> <p><u>Note: Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators</u></p>	

Item	Change From		Change To		Justification															
11.	<table border="1"> <thead> <tr> <th data-bbox="233 272 610 310">Measures</th> <th data-bbox="620 272 1123 310">Measure Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="233 310 610 506">64. Non-recommended Cervical Cancer Screening in Adolescent Females</td> <td data-bbox="620 310 1123 506">The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. <i>Note: A lower rate indicates better performance.</i></td> </tr> </tbody> </table>	Measures	Measure Description	64. 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. <i>Note: A lower rate indicates better performance.</i>		<table border="1"> <thead> <tr> <th data-bbox="1155 272 1532 310">Measures</th> <th data-bbox="1542 272 2045 310">Measure Description</th> </tr> </thead> <tbody> <tr> <td data-bbox="1155 310 1532 506">64. Non-recommended Cervical Cancer Screening in Adolescent Females</td> <td data-bbox="1542 310 2045 506">The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. <i>Note: A lower rate indicates better performance.</i></td> </tr> </tbody> </table>	Measures	Measure Description	64. 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. <i>Note: A lower rate indicates better performance.</i>		NCQA retired this measure.							
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12.	[abbreviation added to certain measures]		<table border="1"> <thead> <tr> <th data-bbox="1155 568 2045 605">Measures</th> </tr> </thead> <tbody> <tr> <td data-bbox="1155 605 2045 643">1. Child and Adolescent Well-Care Visits (WCV)</td> </tr> <tr> <td data-bbox="1155 643 2045 680">2. Well-Child Visits in the First 30 Months of Life (W30)</td> </tr> <tr> <td data-bbox="1155 680 2045 717">3. Antibiotic Utilization for Respiratory Conditions (AXR)</td> </tr> <tr> <td data-bbox="1155 717 2045 755">4. Adult Access to Preventive/Ambulatory Services (AAP)</td> </tr> <tr> <td data-bbox="1155 755 2045 792">5. Follow-Up After Hospitalization for Mental Illness (FUH)</td> </tr> <tr> <td data-bbox="1155 792 2045 862">6. Follow-Up After Emergency Department Visit for Mental Illness (FUM)</td> </tr> <tr> <td data-bbox="1155 862 2045 932">7. Follow-Up After Emergency Department Visit for Substance Use (FUA)</td> </tr> <tr> <td data-bbox="1155 932 2045 1002">8. Follow-Up After High Intensity Care for Substance Use Disorder (FUI)</td> </tr> <tr> <td data-bbox="1155 1002 2045 1039">9. Plan All-Cause Readmissions (PCR)</td> </tr> <tr> <td data-bbox="1155 1039 2045 1109">10. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version (Medicaid) (CPC)</td> </tr> <tr> <td data-bbox="1155 1109 2045 1179">11. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA)</td> </tr> <tr> <td data-bbox="1155 1179 2045 1216">12. Children with Chronic Conditions (CCC)</td> </tr> <tr> <td data-bbox="1155 1216 2045 1286">13. Depression Screening and Follow-Up for Adolescents and Adults (DSF)</td> </tr> <tr> <td data-bbox="1155 1286 2045 1356">14. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</td> </tr> </tbody> </table>		Measures	1. Child and Adolescent Well-Care Visits (WCV)	2. Well-Child Visits in the First 30 Months of Life (W30)	3. Antibiotic Utilization for Respiratory Conditions (AXR)	4. Adult Access to Preventive/Ambulatory Services (AAP)	5. Follow-Up After Hospitalization for Mental Illness (FUH)	6. Follow-Up After Emergency Department Visit for Mental Illness (FUM)	7. Follow-Up After Emergency Department Visit for Substance Use (FUA)	8. Follow-Up After High Intensity Care for Substance Use Disorder (FUI)	9. Plan All-Cause Readmissions (PCR)	10. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version (Medicaid) (CPC)	11. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA)	12. Children with Chronic Conditions (CCC)	13. Depression Screening and Follow-Up for Adolescents and Adults (DSF)	14. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	These revisions provide abbreviations to most measures for ease of reference.
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Item	Change From	Change To	Justification
		15. Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	
		16. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	
		17. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
		18. Self-Reported Overall Health (Adult and Child)	
		19. Self-Reported Overall Mental or Emotional Health (Adult and Child)	
		20. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC)	
		21. Low-Risk Cesarean Delivery	
		22. Prenatal and Postpartum Care: Postpartum Care (PPC)	
		23. Percentage of Low Birthweight Births	
		24. Developmental Screening in the First Three Years of Life	
		25. Lead Screening in Children (LSC)	
		26. Topical Fluoride for Children (TFC)	
		27. Appropriate Testing for Pharyngitis (CWP)	
		28. Childhood Immunization Status (CIS)	
		29. Immunizations for Adolescents (IMA)	
		30. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)	
		31. Contraceptive Care – All Women Ages 15 - 20	
		32. Contraceptive Care – Postpartum Women Ages 15-20	
		33. Contraceptive Care – All Women Ages 21–44	
		34. Contraceptive Care – Postpartum Women Ages 21–44	
		35. Chlamydia Screening in Women (CHL)	
		36. Cervical Cancer Screening (CCS)	
		37. Colorectal Cancer Screening (COL)	
		38. Hepatitis C Virus Screening	
		39. Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	

Item	Change From	Change To	Justification
		40. Controlling High Blood Pressure (CBP)	
		41. Diabetes Short-Term Complications Admission Rate	
		42. Statin Therapy for Patients with Cardiovascular Disease (SPC)	
		43. Heart Failure Admission Rate	
		44. Glycemic Status Assessment for Patients With Diabetes (GSD)	
		45. Blood Pressure Control for Patients With Diabetes (BPD)	
		46. Eye Exam for Patients With Diabetes (EED)	
		47. Asthma in Younger Adults Admission Rate	
		48. Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate	
		49. Asthma Medication Ratio	
		50. HIV Viral Load Suppression	
		51. Pharmacotherapy for Opioid Use Disorder (POD)	
		52. Initiation and Engagement of Substance Use Disorder Treatment (IET)	
		53. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	
		54. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	
		55. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication (ADD)	
		56. Antidepressant Medication Management (AMM)	
		57. Measures for stratified data:	
		58. Enrollment by Product Line (ENP)	
		59. Language Diversity of Membership (LDM)	
		60. Race/Ethnicity Diversity of Membership (RDM)	
		61. Appropriate Treatment for Children With Upper Respiratory Infection (URI)	
		62. Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	

Item	Change From	Change To		Justification				
		63. Use of Imaging Studies for Low Back Pain (LBP)						
13.	[correction of steward]	<table border="1"> <thead> <tr> <th data-bbox="1145 568 1542 607">Measures</th> <th data-bbox="1542 568 2045 607">Steward</th> </tr> </thead> <tbody> <tr> <td data-bbox="1145 607 1542 721">13. Depression Screening and Follow-Up for Adolescents and Adults (DSF)</td> <td data-bbox="1542 607 2045 721">NCQA-CMS</td> </tr> </tbody> </table>	Measures	Steward	13. Depression Screening and Follow-Up for Adolescents and Adults (DSF)	NCQA- CMS		This revision corrects an error.
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