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: 4

Vendor: AETNA BETTER HEALTH INC (LA)

Description: Managed Care Organizations 3.0

Approved By: PAMELA RICE

Approval Date: 01/10/2024 15:01:23

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Medical Vendor Administration

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

AND

Aetna Better Health of Louisiana, Inc.
Contractor Name

Amendment #: 4
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

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 F - Provider Network Standards
Attachment G - Table of Monetary Penalties
Attachment H - Quality Performance Measures

Change Contract To: If Changed, Maximum Amount: $3,874,496,959.00 If Changed, Contract Term: N/A

Amd 4 Attachment A4 - Changes to Attachment A - Model Contract
Amd 4 Attachment F4 - Changes to Attachment F - Provider Network Standards
Amd 4 Attachment G4 - Changes to Attachment G - Table of Monetary Penalties
Amd 4 Attachment H4 - 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 Becomes Effective: 07-01-2023

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

Aetna Better Health of Louisiana, Inc.

DocuSigned by: Jess Hall
3C4FD0B46AB2400...
SIGNATURE — DATE: 11/21/2023

PRINT NAME: Jess R. Hall

CONTRACTOR TITLE: President

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

DocuSigned by: Kimberly Sullivan
6F18D2F97367420...
SIGNATURE — DATE: 11/21/2023

NAME: Kimberly Sullivan

TITLE: Interim Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE — DATE

NAME

MCO Amendment 4
Attachment A4 – Changes to Attachment A, *Model Contract*

Item	Change From	Change To	Justification
1	**Glossary** … **Full Medicaid Pricing (FMP)** - A program to ensure consistent pricing in the Managed Care Program for hospital services, including inpatient hospital, outpatient, hospital-based physician, and ambulance services, and to maintain and increase access to those services for enrolled Medicaid populations.	**Glossary** … **Full Medicaid Pricing (FMP)** - A program to ensure consistent pricing in the Managed Care Program ~~for hospital services, including inpatient hospital, outpatient, hospital-based physician, and ambulance services, and~~ to maintain and increase access to ~~those~~ certain services, as specified in the Contract, for enrolled Medicaid populations.	This is one of multiple revisions in this amendment to comply with the CMS requirement that FMP programs transition to 438.6(c)-compliant directed payment program by stated deadlines.
2	**Glossary** … **[new term]**	**Glossary** … **Prime Rate -** The bank prime loan rate reported by the Federal Reserve on its H.15 statistical release: *Selected Interest Rates.*	The addition of this term provides a definition for the rate used to calculate interest on overdue amounts. See accompanying revision in Section 2.2.3.12.1.1.
3	2.2.3.12 Use of a Pharmacy Benefits Manager (PBM) 2.2.3.12.1 The Contractor shall subcontract with and provide remuneration to the Single PBM designated by LDH for pharmacy Claims payment and administrative services. LDH has the sole discretion to establish the subcontract terms. 2.2.3.12.2 The Contractor shall not make amendments to the Single PBM subcontract without prior written approval from LDH.	2.2.3.12 Use of a Pharmacy Benefits Manager (PBM) 2.2.3.12.1 The Contractor shall subcontract with and provide remuneration to the Single PBM designated by LDH for pharmacy Claims payment and administrative services. LDH has the sole discretion to establish the subcontract terms. 2.2.3.12.1.1 If the Contractor fails to provide payment of undisputed amounts to the Single PBM within the deadlines specified in the subcontract, the Contractor shall pay the Single PBM at a rate of the Prime Rate plus one percent (1%) on any overdue amount not reasonably disputed by the Contractor, calculated daily for the full period in which a fully and properly prepared invoice remains unpaid beyond the applicable deadline. Interest owed to the Single PBM shall be paid within ten (10) Business Days of the Contractor's receipt of the	This revision is to incentivize the MCOs to provide payment to the Single PBM timely, in order to ensure that the Single PBM remains operational. LDH also added language to ensure repayment of any costs incurred due to the Contractor's unwillingness or inability to provide services required under the Single PBM subcontract, for reasons that include, but are not limited to, the Contractor's insolvency.

Item	Change From	Change To	Justification
		applicable invoice for such interest. Any interest payment shall be reported pursuant to instructions provided by LDH. 2.2.3.12.1.2 If the Single PBM notifies LDH, in writing, that the Contractor has failed to provide timely payment to the Single PBM, LDH has the sole discretion to withhold the amount in dispute from the Contractor's monthly Capitation Payment unless and until the Contractor has submitted all amounts owed to the Single PBM. 2.2.3.12.1.3 The Contractor is liable for any costs incurred by LDH due to the Contractor's failure to provide timely payment to the Single PBM and/or for the Contractor's failure to perform any other services required by the subcontract between the Contractor and the Single PBM. LDH may recoup these costs from Contractor through methods that include, but are not limited to, the following: a withhold from the Contractor's monthly Capitation Payment, an offset from the withhold in the last month of payment under Section 6.54, a claim against the performance bond required under section 4.17, or an offset against any other monies owed by LDH to the Contractor. 2.2.3.12.2 The Contractor shall not make amendments to the Single PBM subcontract without prior written approval from LDH.	
4	**[new provision]**	2.2.3.12.4 All performance standards established in the Contract also apply to functions performed by the Single PBM, with the following exceptions. 2.2.3.12.4.1 The following performance standards shall apply to the functions performed by the Single PBM based upon the aggregate performance across all MCOs in the Managed Care Program: • Call center performance standards; and • Prompt pay claims processing standards. 2.2.3.12.4.2 The Encounter Data completion standard for pharmacy Encounters processed by the Single PBM shall be a three percent (3%)	This revision is necessary to address Single PBM functions—many of which are at the Managed Care Program level, while ensuring that the Contractor retains oversight capabilities, as they bear ultimate responsibility for their Subcontractors.

Item	Change From	Change To	Justification
		<u>error threshold (i.e., Encounters are at least ninety-seven percent [97%] but no greater than one hundred percent [100%] of cash disbursements).</u> <u>2.2.3.12.5 Single PBM Non-Compliance</u> <u>2.2.3.12.5.1 If LDH assesses a Monetary Penalty for Single PBM non-compliance that impacts the Managed Care Program at the program level, LDH shall assess each MCO an equal share of the permissible amount established in the Contract (i.e., a permissible amount divided by the number of MCOs in the Managed Care Program).</u> <u>2.2.3.12.5.2 If LDH assesses a Monetary Penalty for Single PBM non-compliance, the Contractor shall not pass the Monetary Penalty through to the Single PBM at an amount greater than was assessed by LDH in the Notice of Monetary Penalty.</u> <u>2.2.3.12.5.3 The Single PBM may appeal the assessment of a Monetary Penalty directly to LDH in accordance with the process established in the Contract. If the Contractor, or the Single PBM, appeals the assessment of a Monetary Penalty at the program level, the Contractor, or the Single PBM, should submit a joint appeal with other MCOs in the Managed Care Program.</u>	
5	2.3.13.3.7 When the Contractor's request for involuntary Disenrollment is approved by LDH in writing, the Contractor shall notify the Enrollee in writing of the requested Disenrollment. The notice shall include: 2.3.13.3.7.1 The reason for the Disenrollment; 2.3.13.3.7.2 The effective date of the Disenrollment; 2.3.13.3.7.3 An instruction that the Enrollee choose a new MCO; and	2.3.13.3.7 When the Contractor's request for involuntary Disenrollment is approved by LDH in writing, the Contractor shall notify the Enrollee in writing of the requested Disenrollment. The notice shall include: 2.3.13.3.7.1 The reason for the Disenrollment; 2.3.13.3.7.2 The effective date of the Disenrollment; <u>and</u> 2.3.13.3.7.3 An instruction that the Enrollee choose a new MCO<u>.</u>~~; and~~	This revision is to align the contract with 42 CFR §438.56, which does not specify involuntary Disenrollment by the MCO as grounds for a State Fair Hearing.

Item	Change From	Change To	Justification
	2.3.13.3.7.4 A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing.	~~2.3.13.3.7.4 A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing.~~	
6	**[new provision]**	2.4.4.5 The Contractor shall utilize a consistent process to ensure that its licensed clinical staff or Network Provider uses their professional judgement to determine and document that the In Lieu of Service is medically appropriate for the specific Enrollee, based on the clinically oriented target population.	This revision is required by CMS in accordance with State Medicaid Director Letter #23-001 titled, "Additional Guidance on Use of In Lieu of Service and Setting in Medicaid Managed Care," issued January 4, 2023.
7	2.8.1.4.11 Continue the behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/naloxone and naloxone products) prescribed to the Enrollee in a mental health treatment facility for at least sixty (60) Calendar Days after the facility discharges the Enrollee, unless the Contractor's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are: 2.8.1.4.11.1 Not medically necessary; or 2.8.1.4.11.2 Potentially harmful to the Enrollee.	2.8.1.4.11 Continue the behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/naloxone and ~~naloxone~~Naltrexone products) prescribed to the Enrollee in a mental health treatment facility for at least sixty (60) Calendar Days after the facility discharges the Enrollee, unless the Contractor's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are: 2.8.1.4.11.1 Not medically necessary; or 2.8.1.4.11.2 Potentially harmful to the Enrollee.	This revision corrects the provision to include FDA-approved medication assisted treatment.
8	2.11.1 Minimum Reimbursement to In-Network Providers 2.11.1.1 The Contractor shall provide reimbursement for MCO Covered Services provided by an in-Network Provider. 2.11.1.2 For MCO Covered Services, the Contractor's rate of reimbursement shall be no less than the published FFS Rate in effect on the date of service or that is contained on the weekly procedure file sent to the Contractor by the FI, or its equivalent, unless mutually	2.11.1 Minimum Reimbursement to In-Network Providers 2.11.1.1 The Contractor shall provide reimbursement for MCO Covered Services provided by an in-Network Provider. 2.11.1.2 For MCO Covered Services, the Contractor's rate of reimbursement shall be no less than the published FFS Rate in effect on the date of service or that is contained on the weekly procedure file sent to the Contractor by the FI, or its equivalent, unless mutually	This revision is to ensure that NEMT providers are not reimbursed a rate below the FFS Rate.

Item	Change From	Change To	Justification
	agreed to by both the Contractor and the provider in the Network Provider Agreement.	agreed to by both the Contractor and the provider in the Network Provider Agreement. 2.11.1.2.1 For non-emergency, non-ambulance medical transportation, the Contractor, or its Transportation Broker, and transportation provider may not mutually agree to a rate of reimbursement less than the FFS Rate.	
9	2.11.13 Payment for Hospital Services The Contractor is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. In accordance with 42 CFR §438.6(c), the Department will utilize a CMS approved directed payment arrangement for specified hospitals. The payment arrangement will utilize a uniform percentage increase for qualified hospitals, based upon assigned tiered provider classes, for inpatient and outpatient MCO Covered Services provided to Enrollees. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically. As such, this directed payment arrangement must be approved by CMS annually. This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment. The Contractor shall make directed payments to qualified hospitals as directed by the Department and in accordance with the written approval from CMS for the applicable rating period.	2.11.13 Payment for Hospital Services The Contractor is not responsible for reimbursement of graduate medical education (GME) payments or disproportionate share hospital (DSH) payments to providers. In accordance with 42 CFR §438.6(c), the Department will utilize a CMS approved directed payment arrangement for specified hospitals. The payment arrangement will utilize a uniform percentage increase for qualified hospitals, based upon assigned tiered provider classes, for inpatient and outpatient MCO Covered Services provided to Enrollees. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically. As such, this directed payment arrangement must be approved by CMS annually. This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment. The Contractor shall make directed payments to qualified hospitals as directed by the Department and in accordance with the written approval from CMS for the applicable rating period. 2.11.13.1 For each State Fiscal Year (SFY) ~~2023~~, pursuant to CMS approvals, LDH will provide a uniform percentage increase for in-state	This revision replaces absolute dates with relative dates to reduce the frequency of future updates.

Item	Change From	Change To	Justification
	2.11.13.1 For State Fiscal Year (SFY) 2023, pursuant to CMS approvals, LDH will provide a uniform percentage increase for in-state providers of inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals) and a separate uniform percentage increase for long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services for the rating period covering July 1, 2022 through June 30, 2023. This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*. LDH shall utilize an interim payment process, whereby interim directed payments will be calculated based upon 2019 utilization data and paid to qualified hospitals on a quarterly basis. LDH shall provide a quarterly interim direct payment report to the Contractor for each quarter, which identifies the qualified hospitals and the applicable interim directed payment for that quarter. The Contractor shall pay the interim directed payments to the appropriate qualified hospitals, as specified in that report, within ten (10) Business Days of receipt of the report from LDH, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. The Contractor shall not deviate from the payments set forth in the quarterly interim direct payment report, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. If the Contractor fails to pay an interim directed payment in full or within the specified time period for a given quarter, LDH may penalize the Contractor using one (1) or more of the following:	providers of inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals) and a separate uniform percentage increase for long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services for the rating period covering ~~July 1, 2022 through June 30, 2023~~that SFY. This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*. LDH shall utilize an interim payment process, whereby interim directed payments will be calculated based upon ~~2019~~ the utilization data for the period specified in the approved CMS preprint and paid to qualified hospitals on a quarterly basis. LDH shall provide a quarterly interim direct payment report to the Contractor for each quarter, which identifies the qualified hospitals and the applicable interim directed payment for that quarter. The Contractor shall pay the interim directed payments to the appropriate qualified hospitals, as specified in that report, within ten (10) Business Days of receipt of the report from LDH, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. The Contractor shall not deviate from the payments set forth in the quarterly interim direct payment report, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. If the Contractor fails to pay an interim directed payment in full or within the specified time period for a given quarter, LDH may penalize the Contractor using one (1) or more of the following:	

Item	Change From	Change To	Justification
	• One (1) or more remedies in the *Contract Non-Compliance* section, including, but not limited to, Contract termination; • Attachment G, *Table of Monetary Penalties*; and • A partial or complete forfeiture of any interest earned on the directed payments provided to the Contractor. 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 SFY 2023, 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: • One (1) or more remedies in the *Contract Non-Compliance* section, including, but not limited to, Contract termination; • Attachment G, *Table of Monetary Penalties*; and • A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor.	• One (1) or more remedies in the *Contract Non-Compliance* section, including, but not limited to, Contract termination; • Attachment G, *Table of Monetary Penalties*; and • A partial or complete forfeiture of any interest earned on the directed payments provided to the Contractor. 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 ~~2023~~, 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: • One (1) or more remedies in the *Contract Non-Compliance* section, including, but not limited to, Contract termination; • Attachment G, *Table of Monetary Penalties*; and • A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor.	
10	2.11.14 Payment for Ambulance Services The Contractor shall use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, or any successive payment model, as detailed in Attachment D, Actuarial Rate Certification Letter, for reimbursement of ambulance services in compliance with 42 CFR §438.6.	~~2.11.14 Payment for Ambulance Services~~ ~~The Contractor shall use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, or any successive payment model, as detailed in Attachment D, Actuarial Rate Certification Letter, for reimbursement of ambulance services in compliance with 42 CFR §438.6.~~	This is one of multiple revisions in this amendment to comply with the CMS requirement that FMP programs transition to 438.6(c)-compliant directed payment program by stated deadlines.

Item	Change From	Change To	Justification
11	**[new provision]**	2.11.14 Payment for Recruitment and Retention Incentives for Psychiatrists and Licensed Mental Health Professionals 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 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. This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment. 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. 2.11.14.1 For SFY 2024, LDH will provide incentive payments for psychiatrists and LMHPs who are enrolled with the Contractor, and have provided at least one (1) eligible home or community based specialized behavioral health service during the rating period of SFY 2023. 2.11.14.2 For SFY 2024, LDH will provide incentive payments for psychiatrists and LMHPs who are enrolled with the Contractor and have been certified in one (1) or more of the following EBPs on or ~~before~~ after January 1, 2021: • 0-5 Parent Psychotherapy • Trauma-Focused Cognitive Behavioral Therapy	This revision adds the directed payment arrangements approved by CMS for SFY 2024.

Item	Change From	Change To	Justification
		• Parent-Child Interaction Therapy • Preschool Post-Traumatic Stress Disorder Treatment • Youth Post-Traumatic Stress Disorder Treatment • Positive Parenting Program • Eye Movement Desensitization and Reprocessing for Adolescents 2.11.14.2.1 Network Providers are only eligible for one (1) incentive payment per EBP service type for which they qualify. 2.11.14.3 For SFY 2024, LDH will provide retention ~~incentive~~ payments for psychiatrists and LMHPs who have been enrolled with the Contractor for a minimum of six (6) consecutive months, certified in one (1) or more of the EBPs identified in this section, and who have provided at least one (1) eligible home or community based EBP service for which they are certified, during SFY 2024 ~~2023.~~ 2.11.14.4 This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*.	
12	2.13.8.7 In accordance with 42 CFR §438.10(h), the Provider Directory shall include, but not be limited to: … 2.13.8.7.7 Instructions for the Enrollee to contact the Contractor's toll free Enrollee services telephone line for assistance in finding a Network Provider or a convenient pharmacy; and	2.13.8.7 In accordance with 42 CFR §438.10(h), the Provider Directory shall include, but not be limited to: … 2.13.8.7.7 Instructions for the Enrollee to contact the Contractor's toll free Enrollee services telephone line for assistance in finding a Network Provider or a convenient pharmacy; ~~and~~	This revision aligns with the health equity goal established by the LDH Health Equity Action Team (HEAT) to improve health outcomes for women.

Item	Change From	Change To	Justification
	2.13.8.7.8 Customer service email address, telephone number, and/or electronic link that individuals may use to notify the Contractor of inaccurate Provider Directory information.	2.13.8.7.8 Customer service email address, telephone number, and/or electronic link that individuals may use to notify the Contractor of inaccurate Provider Directory information~~.~~; and 2.13.8.7.9 Network Provider's gender, race, and ethnicity, if available.	
13	2.13.10.3 The toll-free line shall have an automated system, available twenty-four (24)-hours a day, seven (7) days a week. This automated system shall include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages and that Enrollee services staff return all calls by close of business the following Business Day.	2.13.10.3 The toll-free line shall have an automated system, available twenty-four (24)-hours a day, seven (7) days a week. This automated system shall include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages and that Enrollee services staff return all calls by close of business the following Business Day. Voicemail requirements are not applicable to lines that are staffed twenty-four (24)-hours a day, seven (7) days a week.	This revision applies to call center lines which are staffed by call center agents on a 24/7 basis, negating the need for a voice messaging function.
14	**[new provision]**	2.15.2.4 The Contractor may extend the timeframe for disposition of a Grievance by up to fourteen (14) Calendar Days if: 2.15.2.4.1 The Enrollee requests the extension; or 2.15.2.4.2 The Contractor shows (to the satisfaction of LDH, upon its request) that there is a need for additional information and how the delay is in the best interest of the Enrollee. 2.15.2.5 If the timeframe is extended other than at the Enrollee's request, the Contractor shall complete all of the following:	This revision is to allow for extensions in alignment with 42 CFR §438.408.

Item	Change From	Change To	Justification
		2.15.2.5.1 Provide oral notice of the extension to the Enrollee by close of business on the day the Contractor decides to extend the timeframe ; 2.15.2.5.2 Provide written notice of the reason for the extension within two (2) Calendar Days after the Contractor decides to extend the timeframe. The written notice shall also inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and 2.15.2.5.3 Resolve the Grievance as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.	
15	2.15.3.5 Notice of Appeal Resolution 2.15.3.5.1 The Contractor shall provide the Enrollee with a written notice of Appeal resolution using a template approved by LDH in writing. 2.15.3.5.2 The Contractor shall include on the notice a unique identifying number, corresponding to the number on the notice of Adverse Benefit Determination that gave rise to the Appeal. 2.15.3.5.3 For Appeals not resolved wholly in favor of the Enrollees, the notice shall include all information required under 42 CFR 438.408, including, but not limited to, informing the Enrollee of their right to seek a State Fair Hearing if the Enrollee is not satisfied with the Contractor's decision in response to an Appeal, and the process for doing so.	2.15.3.5 Extension of Timeframes 2.15.3.5.1 The Contractor may extend the timeframes for resolution of Appeals by up to fourteen (14) Calendar Days if: 2.15.3.5.1.1 The Enrollee requests the extension; or 2.15.3.5.1.2 The Contractor shows (to the satisfaction of LDH, upon its request) that there is a need for additional information and how the delay is in the best interest of the Enrollee. 2.15.3.5.2 If the timeframe is extended other than at the Enrollee's request, the Contractor shall complete all of the following: 2.15.3.5.2.1 Provide oral notice of the extension to the Enrollee by close of business on the day the Contractor decides to extend the timeframe; 2.15.3.5.2.2 Provide written notice of the reason for the extension within two (2) Calendar Days after the Contractor decides to extend	This revision is to allow for extensions in alignment with 42 CFR §438.408.

Item	Change From	Change To	Justification
		the timeframe. The written notice shall also inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and 2.15.3.5.2.3 Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. 2.15.3.6 Notice of Appeal Resolution 2.15.3.~~5~~6.1 The Contractor shall provide the Enrollee with a written notice of Appeal resolution using a template approved by LDH in writing. 2.15.3.~~5~~6.2 The Contractor shall include on the notice a unique identifying number, corresponding to the number on the notice of Adverse Benefit Determination that gave rise to the Appeal. 2.15.3.~~5~~6.3 For Appeals not resolved wholly in favor of the Enrollees, the notice shall include all information required under 42 CFR §438.408, including, but not limited to, informing the Enrollee of their right to seek a State Fair Hearing if the Enrollee is not satisfied with the Contractor's decision in response to an Appeal, and the process for doing so.	
16	2.18.15.3 For Encounter Data submissions, the Contractor shall: … 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	2.18.15.3 For Encounter Data submissions, the Contractor shall: … 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	For the purpose of assessing monetary penalties, this revision ensures that pharmacy encounters do not impact overall performance.

Item	Change From	Change To	Justification
	Subcontractor has a capitation arrangement with a provider. If the Contractor or its subcontracted vendor(s), individually or in aggregate, fails to submit complete Encounter Data as measured by a comparison of Encounters to cash disbursements within a 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, Table of Monetary Penalties. 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.	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, Table of Monetary Penalties. 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.	
17	2.18.12.2 The Contractor's Claims Dispute process shall allow providers the option to request binding arbitration for Claims that have denied or underpaid Claims or a group of Claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the Contractor and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the provider mutually agree to extend this deadline. All costs of	2.18.12.2 The Contractor's Claims Dispute process shall allow providers the option to request binding arbitration for Claims that have denied or underpaid Claims or a group of Claims bundled~~, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the Contractor and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association~~. Arbitration conducted pursuant to this Section shall be binding on all parties. ~~The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the provider mutually agree to extend this deadline.~~ All costs of	This revision removes requirements that are not required by other regulatory bodies for administrative simplification.

Item	Change From	Change To	Justification
	arbitration, not including attorney fees, shall be shared equally by the parties.	arbitration, not including attorney fees, shall be shared equally by the parties.	
18	2.20.1.9 The Contractor, as well as its Subcontractors and providers, shall comply with all Federal requirements (42 CFR Part 1002) on exclusion and debarment screening. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the Contractor dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	2.20.1.9. Unless the Contractor has verified and confirmed that the provider is enrolled with the State or until the State implements its own screening of MCO-only providers and has notified the Contractor that it has fully assumed this function, the Contractor, as well as its Subcontractors and providers, shall comply with all federal requirements (42 CFR Part 455, Subpart B and 42 CFR Part 438, Subpart H) on disclosure reporting. If the Contractor cannot verify and confirm that provider is enrolled with the State, the Contractor shall ensure that provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract submit routine disclosures to the Contractor in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including: 2.20.1.9.1 Upon the provider submitting an application for enrollment; 2.20.1.9.2 Upon the provider executing a Network Provider Agreement; 2.20.1.9.3 Upon revalidation; and 2.20.1.9.4 Within thirty-five (35) Calendar Days after any change of ownership has occurred. 2.20.1.10 The Contractor, as well as its Subcontractors and providers, shall comply with all Federal requirements (42 CFR Part 1002) on exclusion and debarment screening. Any unallowable funds	This provision from the previous contract is being restored with modifications since this responsibility has not fully transitioned from the Contractor to the State.

Item	Change From	Change To	Justification
		made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the Contractor dependent upon the entity that identifies the payment of unallowable funds to excluded individuals. [subsequent provisions renumbered]	
19	2.20.3.6 The Contractor and its Subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and §438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. The Contractor and its Subcontractors shall screen all employees, contractors, and Network Providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any Federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436. … 2.20.3.10 The Contractor, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all employees and Subcontractors as specified in the *Debarment/Suspension/Exclusion* section to capture all exclusions.	2.20.3.6 The Contractor and its Subcontractors shall comply with all applicable provisions of 42 CFR §438.608 and §438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Unless a ~~Network~~ ~~P~~provider has previously been screened by LDH pursuant to 42 CFR §455.436, t~~T~~he Contractor and its Subcontractors shall screen all employees, contractors, and ~~Network~~ ~~P~~providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any Federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436, except when the Contractor has verified and confirmed that a provider is enrolled with the State. … 2.20.3.10 The Contractor, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all employees, and Subcontractors~~, and Network Providers~~ as specified in the *Debarment/Suspension/Exclusion* section ~~to capture all exclusions or that it has verified and confirmed that the Subcontractor or Network Provider is enrolled with the State.~~	This revision relieves the Contractor from conducting duplicative provider screening activities.

Item	Change From	Change To	Justification
		2.20.3.11 The Contractor, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the *Debarment/Suspension/Exclusion* section or that it has verified and confirmed that the provider is enrolled with the State. **[subsequent provisions renumbered]**	
20	6.54 Withholding in Last Month of Payment; Offsets Against Future Payments Under a New Contract For the last month of the Contract, LDH shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of one hundred eighty (180) Calendar Days from the due date of such amount. LDH may retain and offset this withhold if the Contractor does not fulfill its contractual obligations, some of which may extend past the term of the Contract, including, but not limited to, paying LDH any outstanding Monetary Penalties and sanctions assessed during the term of the Contract, paying LDH any Monetary Penalties and sanctions assessed after the term of the Contract for any Contractor noncompliance that occurred during the term of the Contract, or repaying LDH for payments made on behalf of ineligible Enrollees. Should LDH identify Contractor non-compliance with any surviving provisions of the Contract after termination or expiration of the Contract and Contractor and LDH have entered into a new contract for MCO services, LDH may offset any such Monetary Penalties and sanctions against future payments to Contractor. Penalties for	6.54 Withholding in Last Month of Payment; Offsets Against Future Payments Under a New Contract For the last month of the Contract, LDH shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of one hundred eighty (180) Calendar Days from the due date of such amount. LDH may retain and offset this withhold if the Contractor does not fulfill its contractual obligations, some of which may extend past the term of the Contract, including, but not limited to, paying LDH any outstanding Monetary Penalties and sanctions assessed during the term of the Contract, paying LDH any Monetary Penalties and sanctions assessed after the term of the Contract for any Contractor noncompliance that occurred during the term of the Contract, or repaying LDH for payments made on behalf of ineligible Enrollees. Should LDH identify Contractor non-compliance with any ~~surviving~~ provisions of the Contract after termination or expiration of the Contract and Contractor and LDH have entered into a new contract for MCO services, LDH may offset any such Monetary Penalties and sanctions against future payments to Contractor. Penalties for Contractor noncompliance that occurred partially during the term of	This revision is to resolve ambiguity.

Item	Change From	Change To	Justification
	Contractor noncompliance that occurred partially during the term of the Contract and partially during the term of the new contract for MCO services shall be assessed in accordance with the terms of the Contract for the entirety of the noncompliance. Any notice requirements by LDH, and Contractor dispute rights relating to the Monetary Penalties and/or payment offsets, shall be in accordance with the terms of the Contract.	the Contract and partially during the term of the new contract for MCO services shall be assessed in accordance with the terms of the Contract for the entirety of the noncompliance. Any notice requirements by LDH, and Contractor dispute rights relating to the Monetary Penalties and/or payment offsets, shall be in accordance with the terms of the Contract.	

MCO Amendment 4

Attachment F4 – Changes to Attachment F, *Provider Network Standards*

Item	Change From	Change To	Justification	MCO Feedback
1	Notes: … 4 For purposes of assessing Network Adequacy for OB/GYN specialty services, access standards are established based on female members age 21 and over. The Contractor shall not include OB/GYN providers in its assessment of Network Adequacy for Primary Care Services. 5 For purposes of reporting Network Adequacy for both physical and behavioral health services, adult is defined as an Enrollee age 21 and over and pediatric is defined as an enrollee under age 21.	Notes: … 4 For purposes of assessing Network Adequacy for OB/GYN specialty services, access standards are established based on female members age ~~21~~18 and over. The Contractor shall not include OB/GYN providers in its assessment of Network Adequacy for Primary Care Services. 5 For purposes of reporting Network Adequacy for ~~both~~ physical health services, adult is defined as an Enrollee age 18 and over and pediatric is defined as an Enrollee under age 18 and for behavioral health services, adult is defined as an Enrollee age 21 and over and pediatric is defined as an ~~e~~ Enrollee under age 21.	This revision reinstates the age criteria established in the previous contract to reflect that adult internal medicine, family, and general practice physicians commonly serve individuals aged 18 and older, thereby better distinguishing them from pediatric physicians for the purpose of assessing network adequacy.	

MCO Amendment 4
Attachment G4 – Changes to Attachment G, *Table of Monetary Penalties*

<table>
<tr><th>Item</th><th>Change From</th><th>Change To</th><th>Justification</th></tr>
<tr>
<td>1</td>
<td>
<table>
<tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr>
<tr><th colspan="2">Claims Management</th></tr>
<tr><td>Encounter Data</td><td>Ten thousand dollars ($10,000) per Calendar Day that the monthly encounter data has not been received in the format and per the specifications outlined in the Contract and MCO System Companion Guide.

Twenty-five thousand dollars ($25,000) per occurrence in each bimonthly reconciliation in which LDH or its designee determines that the Contractor or its subcontracted vendor(s), individually or in aggregate, failed to submit complete encounter data within a one percent (1%) error threshold plus an additional ten thousand dollars ($10,000) for each additional percentage point or fraction thereof.

Five thousand dollars ($5,000) for the first month for failure meet the encounter processing performance standards for reported repairable errors. For each additional month, the penalty increases to twenty-five thousand dollars ($25,000) per month.

Note: At the discretion of LDH, the penalties specified above may not apply for encounter data for the first month after the Operational Start Date, new required</td></tr>
</table>
</td>
<td>
<table>
<tr><th>Failed Deliverable or Deficiency</th><th>Penalty</th></tr>
<tr><th colspan="2">Care Management</th></tr>
<tr><td>Encounter Data</td><td>Ten thousand dollars ($10,000) per Calendar Day that the monthly encounter data has not been received in the format and per the specifications outlined in the Contract and MCO System Companion Guide.

Twenty-five thousand dollars ($25,000) per occurrence in each bimonthly reconciliation in which LDH or its designee determines that the Contractor or its subcontracted vendor(s), individually or in aggregate, failed to submit complete encounter data within ~~a one percent (1%)~~ the applicable error threshold plus an additional ten thousand dollars ($10,000) for each additional percentage point or fraction thereof.

Five thousand dollars ($5,000) for the first month for failure meet the encounter processing performance standards for reported repairable errors. For each additional month, the penalty increases to twenty-five thousand dollars ($25,000) per month.

Note: At the discretion of LDH, the penalties specified above may not apply for encounter data for the first month after the Operational Start Date, new required</td></tr>
</table>
</td>
<td>This update is to account for the additional error threshold established via this Amendment for pharmacy Encounters processed by the Single PBM.</td>
</tr>
</table>

Item	Change From		Change To		Justification
		services are added, or major system changes are implemented to permit time for development and implementation of a system for exchanging data and training of staff and Health Care Providers.		*services are added, or major system changes are implemented to permit time for development and implementation of a system for exchanging data and training of staff and Health Care Providers.*	

MCO Amendment 4

Attachment H4 – Changes to Attachment H, *Quality Performance Measures*

Item	Change From			Change To			Justification	MCO Feedback
	Objectives	**Measures**	**Measure Description**	**Objectives**	**Measures**	**Measure Description**		
1.	Prevent prematurity and reduce infant mortality	23. Initiation of Injectable Progesterone for Preterm Birth Prevention	The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.	~~Prevent prematurity and~~ ~~r~~Reduce infant mortality ***[subsequent measures renumbered]***	~~23. Initiation of Injectable Progesterone for Preterm Birth Prevention~~	~~The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.~~	The FDA withdrew approval of Makena (progesterone) and its generics for this indication effective April 6, 2023, so this measure is being retired. The objective has been edited to reflect the remaining measure in this category related to reducing infant mortality.	
2.	38. Colorectal Cancer Screening		$$: The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	38. Colorectal Cancer Screening		$$: The percentage of members 45~~50~~-75 years of age who had appropriate screening for colorectal cancer:~~.~~ • 46-49 years • 50-75 years • Total The total is the sum of the age stratifications.	NCQA changed the age range beginning in measurement year 2022.	