Office of State Procurement
PROACT Contract Certification of Approval

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

Reference Number: 2000107367 (9)
Vendor: Aetna Better Health, Inc.
Description: Amendment to SOW only
Approved By: Pamela Rice
Approval Date: 10/31/2017

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 9

LAGOV#: 2000107367

LDH #: 060470

Medical Vendor Administration

(Regional/ Program/ Facility)

Bureau of Health Services Financing

AND

Aetna Better Health, Inc.

Contractor Name

Original Contract Amount: 1,964,731,789

Original Contract Begin Date: 02-01-2015

Original Contract End Date: 01-31-2018

RFP Number: 305PUR-DHHRFP-BH

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $1,964,731,789.00 Current Contract Term: 2/1/2015-1/31/2018

See Attachment A-9, Attachment C, Attachment E, Appendix O

Change Contract To: To Maximum Amount: Changed Contract Term: 2/1/2015-1/31/2018

See Attachment A-9, Attachment C, Attachment E, Appendix O

Justifications for amendment:

Revisions contained in this amendment are necessary for the continued successful operation of the Medicaid managed care program.

This Amendment Becomes Effective: 04-01-2017

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, Inc.

CONTRACTOR SIGNATURE — DATE: 9/6/17

PRINT NAME: Laurie A. Brubaker

CONTRACTOR TITLE: President

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE — DATE: 9/14/17

NAME: Jen Steele

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE — DATE

NAME

Contract Amendment #9
Attachment A-9

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Attachment C	Terms of Payment		Delete subsection 7.	The payment provision for participation in the Implementation Advanced Planning Document (IAPD) Electronic Health Record (EHR) Provider Outreach Incentive Program is being removed because the programmatic requirement is being removed.
Attachment E	Incentive-Based Performance Measures Targets for Improvement		Changes contained in the attached document.	This revision will provide for MCO reporting of data in 2017 for incentive based performance measures to be measured in 2018.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	2.6.1.4. The bond amount shall be reevaluated and adjusted following the annual open enrollment process, which includes the period during which members can change MCOs without cause. The adjusted amount shall be equal to seventy-five (75%) of the total capitation	2.6.1.4. The bond amount shall be reevaluated and adjusted following the annual open enrollment process, which includes the period during which members can change MCOs without cause. The adjusted amount shall be equal to ~~seventy-five(75%)~~ fifty percent (50%) of the total capitation payment, exclusive of	This revision was necessary to reflect the decision to reduce the bond amount from 75% to 50%, given that risks to the state are minimized by the timing of PMPM payments (paid one month in arrears). This reduction will also bring Louisiana's bond requirements more in line with

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		payment, exclusive of maternity kick payments, paid to the Contractor for the month following the end of the process. The adjusted bond must be submitted to DHH within 60 days of notification to the MCO of the adjusted amount.	maternity kick payments, paid to the Contractor for the month following the end of the process. The adjusted bond must be submitted to DHH within 60 days of notification to the MCO of the adjusted amount.	those of other managed care states.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	3.7.2 LaHIPP enrollees are mandatorily enrolled in Bayou Health for Specialized Behavioral Health Services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6.	LaHIPP was reinstated 4/20/2017. LDH has determined these members will need to be enrolled in an MCO to receive specialized behavioral health services and transportation services.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	3.8.1.12 Individuals enrolled in the Louisiana Health Insurance Premium Payment Program (LaHIPP).	~~3.8.1.12 Individuals enrolled in the Louisiana Health Insurance Premium Payment Program (LaHIPP).~~	The deleted language has moved to Section 17.12 as revised below.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	5.3.3 DHH shall provide the MCO a monthly supplemental lump sum payment in accordance with the payment terms of any adopt, implement, or upgrade (AIU) support outreach incentive program established in the State of Louisiana's Implementation Advanced Planning Document for Health Information Technology and Health Information Exchange in effect at the time the reimbursable activity occurs in the Current Implementation Advanced Planning Document (IAPD). 5.3.3.1 DHH shall provide the MCO a monthly supplemental lump sum payment in accordance with any meaningful use (MU) support outreach incentive program established in the Current IAPD.	~~5.3.3 DHH shall provide the MCO a monthly supplemental lump sum payment in accordance with the payment terms of any adopt, implement, or upgrade (AIU) support outreach incentive program established in the State of Louisiana's Implementation Advanced Planning Document for Health Information Technology and Health Information Exchange in effect at the time the reimbursable activity occurs in the Current Implementation Advanced Planning Document (IAPD).~~ ~~5.3.3.1 DHH shall provide the MCO a monthly supplemental lump sum payment in accordance with any meaningful use (MU) support outreach incentive program established in the Current IAPD.~~ ~~5.3.3.2 Unless DHH subsequently alters its Current IAPD and notifies the MCO of a change in its payment terms, DHH shall reimburse services described in Section 5.3.3 of this Agreement only if delivered on or~~	LDH is removing this language at the request of CMS.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		5.3.3.2 Unless DHH subsequently alters its Current IAPD and notifies the MCO of a change in its payment terms, DHH shall reimburse services described in Section 5.3.3 of this Agreement only if delivered on or before March 31, 2017 and shall reimburse services described in Section 5.3.3.1 of this Agreement only if delivered on or after January 1, 2017. 5.3.3.3 Payment under this Section shall be subject to the availability of funds under the IAPD. Reimbursement is contingent upon the Provider's acknowledgement of MCO's participation. 5.3.3.4 Payment shall be provided only for completion of a unit of AIU support services or of MU	~~before March 31, 2017 and shall reimburse services described in Section 5.3.3.1 of this Agreement only if delivered on or after January 1, 2017.~~ ~~5.3.3.3 Payment under this Section shall be subject to the availability of funds under the IAPD. Reimbursement is contingent upon the Provider's acknowledgement of MCO's participation.~~ ~~5.3.3.4 Payment shall be provided only for completion of a unit of AIU support services or of MU support services as described in Section 10.7 of this Agreement.~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		support services as described in Section 10.7 of this Agreement.		
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	New subsection added.	5.13.1.9. Third Party Liability (TPL) Data Exchange 5.13.1.9.1 The MCO must: • Receive, process and update TPL files sent by DHH or its contractor; • Update its TPL databases within twenty-four (24) business hours of receipt of said files; and • Transmit to DHH or its contractor in the formats and methods specified by DHH TPL files it or its TPL contractor discovers for each member that has not otherwise been provided by DHH or its contractor. 5.13.1.9.2 If a P enrolled member is unable to have a prescription filled or unable to access immediate care because of incorrect third party insurance coverage, the MCO must	The addition was needed to clarify the MCO's responsibilities regarding the exchange of TPL data.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			verify and update its system within four (4) business hours of receipt of an update request. P enrolled members are members enrolled with the MCO for Medical, Behavioral Health, Pharmacy and Transportation services. This includes updates on coverage, including removal of coverage that existed prior to the member's linkage to the MCO that impacts current provider adjudication or member service access. Such updates must be submitted to DHH Third Party Liability contractor on the Louisiana Department of Health Medicaid Recipient Insurance Information Update Form (found here: http://www.lamedicaid.com/ProvWeb1/ProviderTraining/Packets/2008ProviderTrainingMaterials/Recipient_Insurance_Update.pdf) the same day the update is effectuated in the MCO system.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	5.13.2. Cost Avoidance 5.13.2.1. The MCO shall cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed, except for the "pay and chase" claims identified in 5.13.2.2. 5.13.2.1.1. Claims for labor and delivery and postpartum care may be cost-avoided, including the cost associated with provider and ancillary fees. 5.13.2.2. The MCO shall "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement from the TPL insurer (within sixty days after the end of the month in which the payment was made) for any liable TPL of legal liability if:	5.13.2. Cost Avoidance and Pay and Chase 5.13.2.1. The MCO shall cost-avoid a claim if it establishes the probable existence of other health insurance ~~TPL~~ at the time the claim is filed, except for the "pay and chase" claims identified in 5.13.2.2. ~~5.13.2.1.1. Claims for labor and delivery and postpartum care may be cost-avoided, including the cost associated with provider and ancillary fees.~~ 5.13.2.2. The MCO shall "pay and chase" the full amount allowed under the MCO payment schedule for the claim and then seek reimbursement from the TPL insurer (within sixty days after the end of the month in which the payment was made) for any liable TPL of legal liability if:	The revision is necessary to incorporate a reference to a specific Health Plan Advisory that provides guidance for TPL cost avoidance.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		o The claim is for prenatal care for pregnant women; o The claim is for preventive pediatric services including EPSDT and well-baby screenings); or	o The claim is for prenatal care for pregnant women <u>as defined by HPA 16-17</u>; o The claim is for preventive pediatric services ~~(including EPSDT and well-baby screenings);~~ <u>as defined by HPA 16-17;</u> or	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	5.13.2.3. If a TPL insurer requires the member to pay any co-payment, coinsurance or deductible, the MCO is responsible for making these payments under the method described below, even if the services are provided outside of the MCO network. **Scenario 1 Professional Claim** (table) (Medicaid pays the allowable amount minus TPL payment OR total patient responsibility amount (co-pay, co-insurance,	5.13.2.3. <u>TPL Payment Calculation</u> If a TPL insurer requires the member to pay any co-payment, coinsurance or deductible, the MCO is responsible for making these payments under the method described below, even if the services are provided outside of the MCO network. **Scenario 1 Professional Claim** (table) ~~(Medicaid pays the allowable amount minus TPL payment OR total patient responsibility amount (co-~~	The revisions are necessary to demonstrate TPL payment calculation.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		and/or deductible). The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; thus, the Medicaid allowed amount is the payment.)	~~pay, co-insurance, and/or deductible).~~ The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; ~~thus~~ therefore, the Medicaid allowed amount is the payment.)	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	Additional TPL Payment Calculation Scenarios added to the subsection 5.13.2.3.	Provided in Addendum 1 to Attachment A-9	The additional calculation scenarios are necessary to incorporate an example calculation of LaHIPP recipient claims.
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	~~5.13.3. Post-payment Recoveries~~ 5.13.3.1. Post-payment recovery is necessary in cases where the MCO has not established the probable existence of TPL at the time services were rendered or paid for, or was unable to cost avoid. The following sets forth requirements for MCO recovery: 5.13.3.2. The MCO must seek recovery of reimbursement within	~~5.13.3. Post-payment Recoveries~~ 5.13.3.1. Post-payment recovery is necessary in cases where the MCO has not established the probable existence of TPL at the time services were rendered or paid for, or was unable to cost avoid. The MCO must adhere to the following ~~sets forth~~ requirements for MCO recovery: 5.13.3.2. The MCO must: ~~seek recovery of reimbursement within~~	A revision was needed to clarify the responsibility of the MCOs related to post payment recovery.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		sixty (60) days after the end of the month it learns of the existence of the liable third party after a claim is paid. 5.13.3.3. The MCO must have established procedures for recouping post-payments for DHH's review during the Readiness Review process. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters for the claims.	~~sixty (60) days after the end of the month it learns of the existence of the liable third party after a claim is paid.~~ • Initiate recovery of reimbursement within 60 days after the end of the month it learns of the existence of liable third parties after a claim is paid. • Not perform post payment recoupments for TPL from providers for claims with dates of service (DOS) older than ten (10) months, except when the primary carrier is traditional Medicare, Tricare, or Champus. • Allow providers sixty (60) days from the date stamp of the recovery letter to refute the recovery with a one-time thirty (30) day extension at the provider's request.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			• Refer pay and chase claims directly to the liable third parties. • Refer Point of Sale pharmacy (POS) claims directly to the carrier." • Inform providers they should not send a refund check or initiate a void or adjustment request on post payment recovery claims; MCO shall initiate an automatic recoupment at the expiration of the 60 day time period if an extension request is not received from the provider and at the expiration of the 90 day time period if an extension is requested by the provider. The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters for the claims. • If the liable third party is traditional Medicare, Tricare or Champus VA, and more than 10 months have	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			passed since the DOS, the MCO shall recover from the provider. 5.13.3.3. ~~The MCO must have established procedures for recouping post-payments for DHH's review during the Readiness Review process.~~ The MCO must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the MCO must submit adjusted encounters for the claims.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	New subsection added.	5.13.3.7.1 The MCO, upon receipt of a subpoena duces tecum, shall produce documents responsive to said subpoena by the date of return indicated therein (or shall contact the party who caused issuance of the subpoena, in order to request additional time to respond) if the production is authorized under La. R.S. 13:3715.1. Upon receipt of a request for records not sent via subpoena, the MCO shall release PHI	This revision is necessary to set forth the requirements of La. R.S. 13:3715.1 and to ensure compliance with La. R.S. 40:1165.1 (A)(2)(c).

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			(private health information) or a response explaining why PHI cannot be released to the individual or entity making the request, within fifteen (15) calendar days of receipt of the request and a written authorization, as set forth in La. R.S. 40:1165.1 (A)(2)(c). The MCO is solely responsible for any sanctions and costs imposed by a court for competent jurisdiction for failure to comply with the requirements of La. R.S. 40:1165.1(A)(2)(c) or for failure to respond timely to a subpoena duces tecum. Additionally, DHH may impose sanctions against the MCO for failure to properly or timely respond to requests for PHI.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	New subsection added.	5.13.3.7.2 All records requests received by the MCO shall be investigated by the MCO (or its vendor) for possible TPL recoveries, resulting in issuance of a lien statement (or notice of lack thereof)	This revision is necessary to address the requirements of, and to ensure compliance with, La. R.S. 46:446

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			to the requesting party, as provided for in La. R.S. 46:446.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	New subsection added.	5.13.3.8. When the MCO has actual knowledge that an insurer or other risk bearing entity of one of its members has filed for bankruptcy and the provider files a claim for reimbursement with the MCO with dates of service prior to the date the an insurer or other risk bearing entity filed bankruptcy, the MCO must reimburse the provider with Medicaid as the primary insurer, only if the member was enrolled with the MCO at the time the service was provided and for which the provider has not been paid. The MCO would need to seek reimbursement as a creditor in the bankruptcy proceedings or from a liable third party. If the provider files a claim for reimbursement with the MCO with dates of service after the date the insurer or other risk bearing entity	The added provision addresses situations wherein a member has other insurance on the date of service, but that insurer subsequently files for bankruptcy. The revision also addresses specific guidance by bankruptcy type.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			filed for Chapter 11 bankruptcy, the insurer or other risk bearing entity would continue to be the primary insurer. If the provider files a claim for reimbursement with the MCO with dates of service after the date the insurer or other risk bearing entity filed for Chapter 7 bankruptcy, Medicaid will be the primary insurer.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.1.1. The MCO must provide coverage for all classes of drugs covered by the Medicaid FFS pharmacy benefit. The MCO may manage coverage and utilization of drugs through the formation of a Formulary or Preferred Drug List. Procedures used to manage utilization may include, but are not limited to, prior authorization, utilization and clinical edits. 6.3.1.2. The MCO shall provide coverage for all drugs deemed	6.3.1.1. ~~The MCO must provide coverage for all classes of drugs covered by the Medicaid FFS pharmacy benefit.~~ According to 42 CFR §438.3, the MCO must cover all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and meet the standards in Section 1927 of the Social Security Act. The MCO may manage coverage and utilization of drugs through the formation of a ~~Formulary or~~ Preferred Drug List (PDL), excluding the Common PDL. Procedures used to manage	A revision was needed to clarify the responsibility of the MCOs related to the coverage of drugs and benefits. A reference to the federal regulation was also added to further clarify the issues.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		medically necessary for members under the age of twenty-one (21). 6.3.1.3. The MCO is not required to enforce the DHH monthly prescription drug quantity limits. However, it may not enact prescription quantity limits more stringent than the Medicaid State Plan.	utilization may include, but are not limited to, prior authorization, utilization edits and clinical edits. Self-administered drugs dispensed by a pharmacy, including specialty pharmacies, shall be covered as a pharmacy benefit unless otherwise approved by DHH Pharmacy staff. Physician administered drugs that are not listed on the FFS fee schedule but the manufacturer has signed the federal rebate agreement, should be covered as a pharmacy benefit. Prior authorization and/or other safety edits are allowed on physician administered drugs. 6.3.1.2. The MCO shall provide coverage for all drugs deemed medically necessary for members under the age of 21. 6.3.1.3. The MCO is not required to ~~enforce~~ follow the DHH monthly prescription ~~drug quantity~~ limits. However, it may not enact	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			prescription ~~quantity~~ limits more stringent than the Medicaid State Plan. If prescription limits are adopted, the MCO monthly prescription limits must have Point of Sale (POS) override capabilities when a greater number of prescriptions per month are determined to be medically necessary by the prescriber. MCO monthly prescription limits must have Point of Sale (POS) override capabilities when a greater quantity is determined to be medically necessary by the prescriber and MCO. 6.3.1.4. The "Covered Drug List" is all drugs included in the federal rebate agreement. A subset of the Covered Drug List shall be the "Preferred Drug List (PDL)" listing all preferred agents. The "Common PDL" (list of drugs common to all MCOs without prior authorization) shall be	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			maintained and updated upon DHH request, as well as posted.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.2. Formulary The MCO is required to have a Formulary that follows the minimum requirements below: 6.3.2.1. The Formulary shall be kept up-to-date and available to all providers and members via MCO web site and electronic prescribing tools. 6.3.2.2. The Formulary only excludes coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the MCO shall include in its formulary any FDA-approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or	6.3.2. ~~Formulary~~ Covered Drug List The Covered Drug List shall include all outpatient drugs where the manufacturer has entered into the Federal rebate agreement and met the standards in Section 1927 of the Social Security Act. ~~The MCO is required to have a Formulary that follows the minimum requirements below:~~ 6.3.2.1. ~~The Formulary shall be kept up-to-date and available to all providers and members via~~ The MCO ~~web site and electronic prescribing tools.~~shall expand its Covered Drug List, as needed, to include newly FDA-approved drugs subject to Section 1927(d) of the Social Security Act, which are deemed to be appropriate, safe, and efficacious in	Revisions were needed to clarify the responsibility of the MCOs related to the coverage of drugs and covered pharmacy benefits. The revisions will also ensure consistency with CMS regulations.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		condition for FDA approved indications. 6.3.2.3. The Formulary shall be reviewed in its entirety and updated at least semi-annually and upon DHH request. 6.3.2.4. The MCO shall expand its Formulary, as needed, to include newly FDA approved drugs for FDA approved indications, which are deemed to be appropriate, safe, and efficacious in the medical management of members. 6.3.2.5. The Formulary and any revision thereto shall be reviewed and approved by DHH prior to implementation. Any changes to the Formulary shall be submitted to DHH at least 30 days prior to implementation.	the medical management of members. 6.3.2.2. The ~~Formulary~~ Covered Drug List may only exclude~~s~~ coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the MCO ~~shall~~may include in its Covered ~~formulary any FDA approved d~~Drug~~s~~ List ~~that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition for~~ any FDA approved ~~indications~~ drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition. 6.3.2.3. The Formulary shall be reviewed in its entirety and updated at least semi-annually and upon DHH request.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		6.3.2.6. The Formulary shall include only FDA-approved drug products and certain compounded drugs as deemed appropriate by DHH. For each therapeutic class, the selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the medical needs of members with special needs. 6.3.2.7. The MCO shall authorize the provision of a drug not on the Formulary requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the MCO to support the medical necessity of the drug, and an explanation as to why a generic alternative or other preferred drug in the same therapeutic category cannot be used. Medically accepted	~~6.3.2.4. The MCO shall expand its Formulary, as needed, to include newly FDA-approved drugs for FDA approved indications, which are deemed to be appropriate, safe, and efficacious in the medical management of members.~~ ~~6.3.2.5. The Formulary and any revision thereto shall be reviewed and approved by DHH prior to implementation. Any changes to the Formulary shall be submitted to DHH at least 30 days prior to implementation.~~ ~~6.3.2.6. The Formulary shall include only FDA-approved drug products and certain compounded drugs as deemed appropriate by DHH~~. ~~For each therapeutic class, the selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		indications shall be consistent with Section 1927(k)(6) of the Social Security Act. 6.3.2.8. The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-Formulary drugs. 6.3.2.9. Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization. 6.3.2.10. The MCO shall limit negative changes to the formulary (e.g., remove a drug, impose step therapy, etc.) to four times a year, unless urgent circumstances require more timely action, such as drug manufacturer's removal of	~~medical needs of members with special needs.~~ 6.3.2.~~3~~7~~4~~. ~~The MCO shall authorize the provision of a drug not on the Formulary requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the MCO to support the medical necessity of the drug, and an explanation as to why a generic alternative or other preferred drug in the same therapeutic category cannot be used. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.~~ Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		a drug from the market due to patient safety concerns. The addition of a newly approved generic and removal of the brand equivalent does not constitute a negative formulary change.	6.3.2.45. ~~6.3.2.8. The MCO shall have in place a DHH -approved prior approval process for authorizing the dispensing of non-Formulary drugs.~~ The MCO Covered Drug list should be updated at least weekly from a national drug database. ~~6.3.2.9. Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.~~ ~~6.3.2.10. The MCO shall limit negative changes to the formulary (e.g., remove a drug, impose step therapy, etc.) to four times a year, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns. The addition of a~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			~~newly approved generic and removal of the brand equivalent does not constitute a negative formulary change~~.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.3.1. The PDL is a subset of preferred drug products available on the Formulary and an up-to-date version shall be available to all providers and members through the MCO web site and electronic prescribing tools. 6.3.3.2. The PDL shall be reviewed in its entirety and updated at least semi-annually and upon DHH request. 6.3.3.3. The PDL and any revision thereto, shall be reviewed and approved by DHH prior to implementation. Any changes to the PDL, including but not limited to any/all prior authorization, fail first, step therapy requirements or prescription quantity limits, shall be submitted to DHH at least 30	6.3.3.1. The PDL is a subset of ~~preferred~~ drug products ~~available~~ on the Covered Drug List, ~~Formulary~~ and an up-to-date version shall be available to all providers and members through the MCO web site and electronic prescribing tools. The PDL must be available in electronic format and easily searchable by brand or generic name. The PDL should also be available in a searchable PDF file document listed by therapeutic classes. Any edits on preferred products such as quantity limits, step therapy, or prior authorization should be noted on the PDF file document. 6.3.3.2. ~~The PDL shall be reviewed in its entirety and updated at least semi-annually and upon DHH~~	The revisions were needed to clarify the responsibility of the MCOs related to the coverage of drugs and covered pharmacy benefits.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		days prior to implementation. The MCO shall not replace an approved preferred drug on the PDL without prior approval of DHH. 6.3.3.4. The selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the medical needs of all enrollees, including those with special needs. 6.3.3.5. The MCO shall authorize the provision of a drug not listed on the PDL requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the MCO to support the medical necessity of the drug. Medically accepted indications shall be consistent	~~request.~~ Drugs that are on the Covered Drug List, but not on the PDL must be available to members through a prior authorization process. Pharmacy prior authorizations must be resolved (approved or denied) within 24 hours of the request, seven (7) days a week. A 72 hour supply of the requested medication must be available to recipients in emergency situations. 6.3.3.3 The PDL ~~and any revision thereto,~~ shall be reviewed by the MCO ~~and approved~~ in its entirety and updated at least annually and upon ~~by~~ DHH request but no more frequently than quarterly with 60 days' notice. ~~prior to implementation. Any changes to the PDL, including but not limited to any/all prior authorization, fail first, step therapy requirements or prescription quantity limits, shall be~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		with Section 1927(k)(6) of the Social Security Act. 6.3.3.6. The MCO shall have in place a DHH-approved prior approval process for authorizing the dispensing of non-PDL drugs. 6.3.3.7. Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization. 6.3.3.8. The MCO shall have at least two "preferred" drugs in each therapeutic class and at least one injectable drug in each class that has an injectable product for behavioral health drugs.	~~submitted to DHH at least 30 days prior to implementation. The MCO shall not replace an approved preferred drug on the PDL without prior approval of DHH~~. 6.3.3.4. ~~The selection of drugs included for each drug class shall be sufficient to ensure enough provider choice and include FDA approved drugs to best serve the medical needs of all enrollees, including those with special needs.~~ The MCO shall limit negative changes to the PDL (e.g., remove a drug, impose step therapy, etc.) to four times a year, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns. The addition of a newly approved generic and removal of the brand equivalent does not constitute a negative PDL change.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			6.3.3.5. The ~~MCO shall authorize the provision of a drug not listed on the PDL requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the MCO to support the medical necessity of the drug. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.~~ PDL and any revision thereto, shall be reviewed and approved by DHH prior to implementation. Any changes to the PDL, including but not limited to any/all prior authorization, fail first, step therapy requirements or prescription quantity limits, shall be submitted to DHH at least 30 days prior to implementation. The MCO shall not replace an approved preferred drug on the PDL without prior approval of DHH.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			6.3.3.6. The ~~MCO shall have in place a DHH -approved prior approval process for authorizing the dispensing of non-PDL drugs.~~ selection of drugs included on the PDL shall be sufficient to ensure enough provider choice and include FDA approved drugs to serve the medical needs of all enrollees, including those with special needs. 6.3.3.7. ~~Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.~~ The MCO shall have at least two "preferred" oral behavioral health drugs in each therapeutic class available at a retail pharmacy without prior authorization. ~~6.3.3.8~~6.3.3.8 The MCO shall have at least two "preferred" drugs in each	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			therapeutic class and at least one injectable drug in each class that has an injectable product for behavioral health drugs. 6.3.3.9 Common PDL The "Common PDL" (list of drugs common to all MCOs without prior authorization) shall be maintained and updated upon DHH request. 6.3.3.~~8~~9.1. A separate "Common PDL" document should be posted with the other PDL documents. 6.3.3.~~8~~9.2. The Common PDL should be reviewed at least annually and upon DHH request.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.4. Submission and Publication of the Formulary and PDL 6.3.4.1. The MCO shall publish and make available to members and providers upon request a hard	6.3.4. ~~Submission and Publication of the Formulary and PDL~~ Prior Authorization for Pharmacy Benefits 6.3.4.1. ~~The MCO shall publish and make available to members and providers upon request a hard copy~~	The revisions are necessary to include removal of the prior authorization requirements for certain diabetes.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		copy of the most current Formulary and PDL. Updates to the Formulary or the PDL shall be made available thirty (30) days before the change. The MCO shall prominently post the most current Formulary on its web site. 6.3.4.2. The MCO shall submit an electronic version of its formulary and PDL to DHH at least quarterly. The formulary and PDL must be provided in a format and program approved by DHH, which may include formulary management software commonly used by prescribers.	~~of the most current Formulary and PDL. Updates to the Formulary or the PDL shall be made available thirty (30) days before the change. The MCO shall prominently post the most current Formulary on its web site.~~ Prior authorization must comply with 42 CFR § 438.3(s)(6) and may be used for drug products only under the following conditions: 6.3.4.1.1. When prescribed drugs included in the federal rebate program have clinical criteria; 6.3.4.1.2. To determine when prescribed drugs are medically necessary; 6.3.4.1.3. When prescribed drugs are inconsistent with FDA-approved labeling, including behavioral health drugs or when prescribed drugs are inconsistent with nationally accepted guidelines;	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			6.3.4.1.4. When prescribed brand name medications has an A-rated generic equivalents. The MCO can encourage a prescriber to complete the FDA Medwatch form, but this should not be required or considered in the approval/denial determination process. If the drug has a narrow therapeutic index and the prior authorization for the brand drug is denied, then DHH pharmacy staff must be notified within 24 hours or the next working day of the denial. All details of the claim and prior authorization must be included. (All drugs listed in the Common PDL are exempt from PA requirements); 6.3.4.1.5. To minimize potential drug over-utilization; 6.3.4.1.6. To accommodate exceptions to Medicaid drug utilization review standards related	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			to proper maintenance drug therapy; and/or 6.3.4.1.7. Under other conditions with DHH Pharmacy approval. 6.3.4.1.8. Prior authorization shall not require more than two failures of preferred products. 6.3.4.2. The MCO ~~shall submit an electronic version of its formulary and PDL to DHH at least quarterly. The formulary and PDL must be provided in a format and program approved by DHH, which may include formulary management software commonly used by prescribers.~~ shall override prior authorization for selected drug products or devices at DHH's discretion. 6.3.4.3. The MCO shall not require prior authorization for a dosage change for any medications (including long-acting injectable	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			antipsychotics) and other medication assisted treatment (including dosages of buprenorphine or buprenorphine/naloxone) that have been previously authorized and/or approved by the MCO, as long as the newly prescribed dose is within established FDA guidelines for that medication. 6.3.4.4. The MCO must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber. 6.3.4.5. The MCO must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The MCO must allow prescribers and pharmacies to submit prior authorization requests	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			by phone, fax or automated process. If the MCO or its pharmacy benefit manager operates a separate call center for prior authorization requests, it will be subject to the provider call center standards set forth in Section 12 of this Contract and monetary penalties set forth in Section 20 of this Contract. 6.3.4.6. The MCO shall not penalize the prescriber or member, financially or otherwise, for prior authorization requests or other inquiries regarding prescribed medications. 6.3.4.7. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing. 6.3.4.8. A member receiving a prescription drug that was on the MCO's PDL and subsequently removed or changed, shall be permitted to continue to receive that	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			prescription drug if determined to be medically necessary for at least sixty (60) days. Medical necessity must be determined in consultation with the prescriber. 6.3.4.9. If a pharmacy prior authorization is under review, the MCO must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product or full unbreakable packages without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable but the MCO is only required to pay one dispensing fee. The MCO must reimburse the pharmacy for dispensing the temporary supply of medication. 6.3.4.10. Pharmacy prior authorization denials may be appealed in accordance with Section 13 of this Contract.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			6.3.4.11. Step Therapy and/or Fail First Protocols 6.3.4.11.1. The MCO may implement step therapy or fail first protocols to drive utilization toward the most efficacious, cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs. However, the MCO must provide a clear process for a provider to request an override of such restrictions. An override shall meet the requirements of R.S. 46:460.34. 6.3.4.11.~~1~~2. Step therapy and/or fail first protocols shall not require more than two failures of preferred products. 6.3.4.12 Submission and Publication of the Covered Drug List, PDL, and Common PDL	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			6.3.4.12.1. The MCO shall publish and make available to members and providers upon request a hard copy of the most current Covered Drug List, PDL and Common PDL. All of the above documents shall be posted together on the MCO web page. Updates to the PDL shall be made available to the provider and DHH thirty (30) days before the effective date of the change. 6.3.4.12.2 The MCO shall submit an electronic version of its PDL to DHH at least quarterly within 30 days of the P&T meeting and 30 days prior to implementation of any changes. The PDL must be provided in a format approved by DHH.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	6.3.5.1. The Contractor shall establish a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, for the development of the Formulary and the PDL. The Committee shall	6.3.5.1. The MCO~~Contractor~~ shall establish a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, for the development of the~~Formulary~~ PDL. The Committee shall represent the needs of all its	The revisions clarify the responsibility of the MCOs related to the P&T Committee.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		represent the needs of all its members including enrollees with special needs. Louisiana network physicians, pharmacists, dentists and specialists, including but not limited to a behavioral health specialist, shall have the opportunity to participate in the development of the Formulary, PDL and clinical drug policies and, prior to any changes to the Formulary or PDL, to review, consider and comment on proposed changes. P&T committee meetings shall comply with the Open Meetings Law, La. R.S. 42:12, et seq. 6.3.5.2. The P&T committee shall meet at least semi-annually in Baton Rouge, Louisiana and upon DHH request to consider products in categories recommended for consideration for inclusion/exclusion on the MCO's	members including enrollees with special needs. Louisiana network physicians, pharmacists, ~~dentists~~ and specialists, including but not limited to a behavioral health specialist, shall have the opportunity to participate in the development of ~~the Formulary, PDL and clinical drug policies and, prior to any changes to the Formulary or PDL, to review, consider and comment on proposed changes. P&T committee meetings shall comply with the Open Meetings Law, La. R.S. 42:12, et seq~~ prior authorization criteria and clinical drug policies. The P&T Committee shall consist of at least six members including 3 non-employee Louisiana providers (either Physicians or Pharmacists) that are not employees of the MCO or PBM. The MCO Medical Director and MCO Behavioral Health Medical Director should participate in all P&T meetings. Changes to prior	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		Formulary or PDL. In developing its recommendations for a Formulary and PDL, the P&T committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product. 6.3.5.3. The MCO shall develop policies governing the conduct of P&T committee meetings, including procedures by which it makes its Formulary and PDL recommendations. P&T Committee meetings shall be open to the public and shall allow for public comment prior to voting by the committee on any change in the preferred drug list or formulary. 6.3.5.4. The MCO shall notify the Department when the P&T committee meeting has been	authorization criteria, clinical drug policies, or PDL, must be submitted to DHH for approval at least 30 days prior to implementation. DHH will consider and comment on proposed changes. 6.3.5.2. The P&T committee shall meet at least ~~semi-annually~~ quarterly in Baton Rouge, Louisiana ~~and upon DHH request~~ to consider products in categories recommended for consideration for inclusion/exclusion on the MCO's ~~Formulary or~~ PDL. ~~In developing its recommendations for a Formulary and PDL, the P&T committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product.~~ The P&T Committee shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness	

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		scheduled. Official public notification of the P&T meeting shall be made on the MCO provider website and through other applicable avenues such as provider training and/or newsletters. The committee shall include a nonvoting representative from DHH that is provided all documents received by committee members.	and any program benefit associated with the product. 6.3.5.3. The MCO shall develop policies governing the conduct of P&T committee meetings, including procedures by which it makes its ~~Formulary and~~ PDL recommendations. P&T Committee meetings shall be open to the public and shall allow for public comment prior to voting by the committee on any change in the preferred drug list ~~or formulary.~~ The MCO must keep written minutes of the P&T committee meetings. The MCO shall not prohibit any member of the public from attending the P&T committee meetings. 6.3.5.4. The MCO shall notify the Department when the P&T committee meeting has been scheduled. Official public notification of the P&T meeting shall be made on the MCO provider website and	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			through other applicable avenues such as provider training and/or newsletters. The committee shall include a nonvoting representative from DHH that is provided all documents received by committee members.	
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	6.3.7. Drug Utilization Review (DUR) Program The MCO shall maintain a DUR program to assure that outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results in accordance with Section 1927(g) of SSA. DUR (prospective, retrospective and educational) standards established by the MCO shall be consistent with those same standards established by DHH. 6.3.7.1. The MCO shall include review of Mental Health/Substance Abuse (MH/SA) drugs in its	This revision is necessary to ensure compliance with 42 CFR 438.3(s)(2).

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			prospective, retrospective and educational DUR program. 6.3.7.2. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and take into consideration both the quality and cost of the pharmacy benefit. 6.3.7.3. The MCO shall provide for a DUR program that contains the following components: • Prospective DUR program • Retrospective DUR program • Educational DUR program 6.3.7.3.1. Prospective DUR Program 6.3.7.3.1.1. The MCO shall provide for a review of drug therapy at Point of Sale (POS) before each prescription is given to the recipient. Screening should be performed for	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			potential drug problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, duration of therapy, and clinical misuse. The following parameters should be screened at POS. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short-acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits. Reporting capabilities shall exist for these denial codes. The MCOs will need to report data on edits to the Department on a semi-annual basis prior to the submission	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			date requirement of the DUR Annual Report. 6.3.7.3.1.2. Pharmacy claims processing shall be capable of capturing diagnosis codes at the POS and utilizing codes in the adjudication process at POS. Denial of pharmacy claims could be triggered by an inappropriate diagnosis code or the absence of a diagnosis code. 6.3.7.3.1.3. The MCO should assure the pharmacist offers to counsel the patient or caregiver. A log of receipt of prescription and the offer to counsel by the pharmacist shall be incorporated into MCO policy. 6.3.7.3.2. Retrospective DUR Program 6.3.7.3.2.1. The MCO shall provide for the ongoing periodic examination of claims data to identify patterns of	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			gross overuse, abuse, potential fraud, and inappropriate or medically unnecessary care among prescribers, pharmacists, or recipients. 6.3.7.3.2.2. Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. At a minimum, the MCO shall incorporate all of DHH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by DHH pharmacy. 6.3.7.3.3. Educational DUR Program 6.3.7.3.3.1. The MCO shall provide active and ongoing educational outreach programs to educate and inform prescribers and pharmacists	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			on common drug therapy programs with the aim of improving prescribing and/or dispensing practices. The frequency of patterns of abuse and gross overutilization or inappropriate or unnecessary care among prescribers, pharmacists and recipients should be identified. 6.3.7.3.3.2. MCOs should educate prescribers, pharmacists and recipients on therapeutic appropriateness when overutilization or underutilization occurs. DHH expects the MCOs to use current clinical guidelines and national recommendations to alert prescribers and pharmacists of pertinent clinical data. Clinical outcomes shall be monitored by the MCO and reported to DHH on a periodic basis established by the Department. 6.3.7.4. DHH shall review and approve the MCO's DUR policy and	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all DHH DUR initiatives and submit new initiatives to DHH for prior approval at least forty-five (45) days in advance of the proposed effective date. 6.3.7.5. The MCO must provide a detailed description of its DUR program annually to DHH to mimic the FFS DUR annual report to CMS. The annual report shall ensure the requirements of 1927(g) of the Act are being met by the MCO DUR program. The annual report to the state will be due 4 months preceding the CMS deadline. 6.3.7.6. The MCOs shall recommend one Louisiana MCO Medical Director and one Louisiana MCO Pharmacy director to represent all Louisiana MCOs as voting members on the	

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			Medicaid DUR Board. The MCO representatives may not be employed by the same MCO plan.	
~~Exhibit 3~~	~~RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA~~	~~Add new subsection~~	~~6.38.2. The MCOs shall adhere to the requirements and procedures as set forth in the Justice-Involved Pre-release Enrollment Program Manual.~~	~~LDH is working with the Department of Corrections (DOC) on a pre-release enrollment program for the offender population that will now be covered by Medicaid through expansion. Specific elements and expectations of the MCOs for implementation of case management for offenders are detailed in the manual.~~
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	6.38.4.4. The MCO shall make service authorizations within five (5) business days following completion of the assessment/recertification.	~~6.38.4.4. The MCO shall make service authorizations within five (5) business days following completion of the assessment/recertification.~~	This provision was removed because the authorization turnaround time requirement is no longer needed with the elimination of the 1915i State Plan Amendment. The provisions of Section 8.5 shall provide authorization turnaround times for MHR.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP 305 PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection	6.38.8. The MCOs shall adhere to the requirements and procedures as set forth in the Justice-Involved Pre-release Enrollment Program Manual.	LDH is working with the Department of Corrections (DOC) on a pre-release enrollment program for the offender population that will now be covered by Medicaid through expansion. Specific elements and expectations of the MCOs for implementation of case management for offenders are detailed in the manual.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection	7.13.11 All contracts and/or agreements between a MCO and its subcontractors and/or providers shall provide that the contractor, subcontractor and/or provider shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical	This language was provided at the request of the Office of the Attorney General to provide for requests for information from an MCO or its subcontractor by any healthcare oversight agency. This revision provides an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

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			Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU, the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			petition the court in the event of non-compliance with an information, records or data request.	
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	~~7.17.4. Specialty Drugs and Specialty Pharmacies~~ 7.17.4.1. DHH recognizes the importance of providing adequate access to specialty drugs to Medicaid members while ensuring proper management of handling and utilization. For the purposes of this contract, "specialty drugs" shall be determined by the definition below. The MCO may limit distribution of specialty drugs from a network of specialty pharmacies that meet reasonable requirements to distribute specialty drugs and is willing to accept the terms of the MCO's agreement. DHH reserves the right to deny specialty pharmacy contracts that include what it	~~7.17.4. Specialty Drugs and Specialty Pharmacies~~ 7.17.4.1. DHH recognizes the importance of providing adequate access to specialty drugs to Medicaid members while ensuring proper management of handling and utilization. For the purposes of this contract, "specialty drugs" shall be determined by the definition below. The MCO shall not ~~may~~ limit distribution of specialty drugs or self-refer to a MCO or PBM-owned specialty pharmacy. ~~from a~~ A network of specialty pharmacies shall be established ~~that meet reasonable requirements~~ to distribute specialty drugs. Any pharmacy that is able to procure specialty drugs from distributors, has	The revisions provides an avenue for addressing circumstances wherein the MCO owns Specialty Pharmacies to prevent the denial of members' freedom of choice of pharmacy providers.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		deems to be overly burdensome terms or requirements, including but not limited to requirements for excessive insurance coverage, unreasonable stocking requirements, or restrictive or duplicative accreditation requirements. A specialty drug is defined as one that is: 7.17.4.1.1. Not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or 7.17.4.1.2. Includes at least two of the following characteristics: 7.17.3.2.2.1. Requires inventory management controls including but not limited to unique storage specifications, short shelf life, and special handling; or	any one of the nationally recognized accreditations and is willing to accept the terms of the MCO~~'s agreement~~ contract shall be allowed to participate in the MCO/PBM's network (any willing provider). All specialty pharmacy contracts between the MCO and specialty pharmacy shall be sent to DHH pharmacy for approval prior to processing any specialty pharmacy claims. DHH reserves the right to deny specialty pharmacy contracts that include what ~~it~~ DHH deems to be overly burdensome terms or requirements, including but not limited to requirements for excessive insurance coverage, unreasonable stocking requirements, or restrictive or duplicative accreditation requirements. The MCO shall accept any one of the nationally recognized accreditation programs to meet its specialty pharmacy network requirement. Specialty pharmacy	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		7.17.3.2.2.2. Must be administered, infused or injected by a health care professional; or 7.17.3.2.2.3. The drug is indicated primarily for the treatment or prevention of: • A complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid arthritis; or • A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States; or 7.17.3.2.2.4. The total monthly cost is $3,000 or more.	network requirements shall be approved by DHH 30 days prior to implementation. Any pharmacy network cancellations shall be approved by DHH at least 60 days prior to cancellation. 7.17.4.1.1. A specialty drug is defined as a prescription drug which meets all of the following criteria: ~~one that is~~: 7.17.4.1.1~~. (a)~~1. The drug cannot be routinely dispensed at a majority of retail community pharmacies due to physical or administrative requirements that limit preparation and/or delivery in the retail community pharmacy environment. Such drugs may include but are not limited to chemotherapy, radiation drugs, intravenous therapy drugs, biologic prescription drugs approved for use by the federal Food and Drug Administration, and/or drugs that	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			require physical facilities not typically found in a retail community pharmacy, such as a ventilation hood for preparation; ~~(b)~~7.17.4.1.1.2. The drug is used to treat complex, chronic, or rare medical conditions ~~(i)~~• That can be progressive; ~~(ii)~~• That can be debilitating or fatal if left untreated or undertreated; or ~~(iii)~~• For which there is no known cure. ~~(c)~~7.17.4.1.1.3. The drug requires special handling, storage, and/or has distribution and/or inventory limitations; ~~(d)~~7.17.4.1.1.4. The drug has a complex dosing regimen or requires specialized administration; ~~(e)~~7.17.4.1.1.5. Any drug that is considered to have limited	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			distribution by the federal Food and Drug Administration; ~~(f)~~7.17.4.1.1.6. The drug requires ~~(i)~~• Complex and extended patient education or counseling; ~~(ii)~~• Intensive monitoring; or ~~(iii)~~• Clinical oversight; and ~~(g)~~7.17.4.1.1.7. The drug has significant side effects and/or risk profile 7.17.4.1.2. Access to specialty drugs ~~A.~~ No entity shall establish definitions, or require accreditation or licensure, effectively limiting access to prescription drugs, including specialty drugs, other than the appropriate governmental or regulatory bodies. ~~Not typically available at community retail pharmacies or under limited~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			~~distribution per manufacturer/FDA; or~~ ~~7.17.4.1.2. Includes at least two of the following characteristics:~~ ~~7.17.3.2.2.1. Requires inventory management controls including but not limited to unique storage specifications, short shelf life, and special handling; or~~ ~~7.17.3.2.2.2. Must be administered, infused or injected by a health care professional; or~~ ~~7.17.3.2.2.3. The drug is indicated primarily for the treatment or prevention of:~~ ~~• A complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			~~arthritis; or~~ ~~• A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States; or~~ ~~7.17.3.2.2.4. The total monthly cost is $3,000 or more.~~	
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	8.4.5. At such time Therapeutic Foster Care (TFC) is added to the Medicaid benefit, the MCO shall work with DHH to develop prior authorization and concurrent utilization review for that service. MCOs may use the Service Definition Manual or other approved Medical Necessity Criteria for Therapeutic Group Homes and other residential levels of care.	~~8.4.5. At such time Therapeutic Foster Care (TFC) is added to the Medicaid benefit, the MCO shall work with DHH to develop prior authorization and concurrent utilization review for that service. MCOs may use the Service Definition Manual or other approved Medical Necessity Criteria for Therapeutic Group Homes and other residential levels of care.~~	This revision removes place holder language in the contract regarding Therapeutic Foster Care. Historically, LDH considered adding Therapeutic Foster Care (TFC) as a covered service, allowing children to remain in the custody of their family while receiving a short term placement for care. Upon consultation with CMS, it was later confirmed that TFC could not be a covered service.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	8.14. Drug Utilization Review (DUR) Program The MCO shall establish and maintain a drug utilization review	~~8.14. Drug Utilization Review (DUR) Program~~ ~~The MCO shall establish and maintain a drug utilization review~~	This section is revised and replaced in Section 6 to ensure compliance with 42 CFR 438.3(s)(2).

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		(DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act. 8.14.1. The MCO shall include review of Mental Health/Substance Abuse (MH/SA) drugs in its DUR program. 8.14.2. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and take into consideration both the quality and cost of the pharmacy benefit. 8.14.3. The MCO shall implement an online claims adjudication system, which shall include a prospective review of drug utilization, and include age-specific edits where appropriate.	~~(DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act.~~ ~~8.14.1. The MCO shall include review of Mental Health/Substance Abuse (M/SA) drugs in its DUR program.~~ ~~8.14.2. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and take into consideration both the quality and cost of the pharmacy benefit.~~ ~~8.14.3. The MCO shall implement an online claims adjudication system, which shall include a prospective review of drug utilization, and include age-specific edits where appropriate.~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		8.14.4. The prospective and retrospective DUR standards established by the MCO shall be consistent with those same standards established by DHH. 8.14.5. The MCO's DUR program shall include the standards for each category of DUR, i.e., therapeutic duplication, drug-drug interaction, maximum daily dosage and therapy duration. 8.14.6. The MCO's DUR program shall include a procedure/process for utilization review for each category of DUR. 8.14.7. DHH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. The DUR program and revisions must be submitted to DHH for prior approval at least	~~8.14.4. The prospective and retrospective DUR standards established by the MCO shall be consistent with those same standards established by DHH.~~ ~~8.14.5. The MCO's DUR program shall include the standards for each category of DUR, i.e., therapeutic duplication, drug-drug interaction, maximum daily dosage and therapy duration.~~ ~~8.14.6. The MCO's DUR program shall include a procedure/process for utilization review for each category of DUR.~~ ~~8.14.7. DHH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. The DUR program and revisions must be submitted to DHH for prior approval at least forty-five~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		forty-five (45) days in advance of the proposed effective date.	~~(45) days in advance of the proposed effective date.~~	
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	10.7 Provider EHR Outreach Incentive Program 10.7.1 The MCO shall endeavor to provide AIU support services as described in the State of Louisiana's Implementation Advanced Planning Document for Health Information Technology and Health Information Exchange (IAPD) in effect at the time those services are rendered. 10.7.2 AIU support services shall include those services for which the relevant IAPD makes provision for reimbursement of a non-provider for assisting an eligible Medicaid professional in attesting to adoption, implementation, or upgrading of certified EHR technology under an active, CMS-	~~10.7 Provider ER Outreach Incentive Program~~ ~~10.7.1 The MCO shall endeavor to provide AIU support services as described in the State of Louisiana's Implementation Advanced Planning Document for Health Information Technology and Health Information Exchange (IAPD) in effect at the time those services are rendered.~~ ~~10.7.2 AIU support services shall include those services for which the relevant IAPD makes provision for reimbursement of a non-provider for assisting an eligible Medicaid professional in attesting to adoption, implementation, or upgrading of certified ER technology under an active, CMS-administered Medicaid ER Incentive Program.~~ ~~10.7.3 MU support services shall include those services for which the relevant IAPD makes provision for~~	LDH is removing this language at the request of CMS.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		administered Medicaid EHR Incentive Program. 10.7.3 MU support services shall include those services for which the relevant IAPD makes provision for reimbursement of a non-provider for assisting an eligible Medicaid professional in attesting to meaningful use of certified EHR technology under an active, CMS-administered Medicaid EHR Incentive Program. An eligible Medicaid professional is defined for terms of payment as a provider for whom the MCO was specifically paid under section 10.7.2 for AIU, a provider identified from a state-approved list of providers that have neither attested to MU in the last two program years, and a provider identified from a state-approved list of providers who attested to AIU in a previous year and has not	~~reimbursement of a non-provider for assisting an eligible Medicaid professional in attesting to meaningful use of certified ER technology under an active, CMS-administered Medicaid ER Incentive Program. An eligible Medicaid professional is defined for terms of payment as a provider for whom the MCO was specifically paid under section 10.7.2 for AIU, a provider identified from a state-approved list of providers that have neither attested to MU in the last two program years, and a provider identified from a state-approved list of providers who attested to AIU in a previous year and has not completed a subsequent MU attestation.~~ ~~10.7.4 A unit of AIU or MU support services shall be considered complete upon attestation by an eligible Medicaid professional under the relevant CMS-administered Medicaid ER Incentive Program.~~ ~~10.7.4.1 The MCO shall be responsible for demonstrating that it~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		completed a subsequent MU attestation. 10.7.4 A unit of AIU or MU support services shall be considered complete upon attestation by an eligible Medicaid professional under the relevant CMS-administered Medicaid EHR Incentive Program. 10.7.4.1 The MCO shall be responsible for demonstrating that it provided AIU or MU support services. A written acknowledgement by the provider attesting to the receipt of such services from the MCO along with the provider's Medicaid ID and date of attestation under the relevant CMS-administered EHR Incentive Program shall be sufficient evidence of such services.	~~provided AIU or MU support services. A written acknowledgement by the provider attesting to the receipt of such services from the MCO along with the provider's Medicaid ID and date of attestation under the relevant CMS-administered ER Incentive Program shall be sufficient evidence of such services.~~ ~~10.7.4.2 Payment shall only be made to the primary service provider for the eligible Medicaid professional's attestation under the relevant CMS-administered ER Incentive Program. If DHH receives multiple claims for AIU support services funding or for MU support services funding, it shall require the eligible Medicaid professional to identify the primary service provider prior to distributing any funds. Nothing in this Section shall prohibit an MCO from serving as the primary MU support service provider if it did not serve as the AIU support services provider.~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		10.7.4.2 Payment shall only be made to the primary service provider for the eligible Medicaid professional's attestation under the relevant CMS-administered EHR Incentive Program. If DHH receives multiple claims for AIU support services funding or for MU support services funding, it shall require the eligible Medicaid professional to identify the primary service provider prior to distributing any funds. Nothing in this Section shall prohibit an MCO from serving as the primary MU support service provider if it did not serve as the AIU support services provider. 10.7.4.3 DHH reserves the right to decline payment for insufficient documentation of the attestation described in Section 10.7.4 of this Agreement, for insufficient documentation of the provision of	~~10.7.4.3 DHH reserves the right to decline payment for insufficient documentation of the attestation described in Section 10.7.4 of this Agreement, for insufficient documentation of the provision of support services described in 10.7.3.1 of this Agreement, if the eligible Medicaid professional does not identify the MCO as the primary service provider, or if DHH determines that the eligible Medicaid provider previously adopted certified ER technology.~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		support services described in 10.7.3.1 of this Agreement, if the eligible Medicaid professional does not identify the MCO as the primary service provider, or if DHH determines that the eligible Medicaid provider previously adopted certified EHR technology.		
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	11.~~4.~~10.5. All justice-involved members releasing from incarceration that meet eligibility for the New Adult Group under expansion shall be enrolled in accordance with the process outlined in the Justice-Involved Pre-release Enrollment Program Manual. Justice-involved members shall be given sixty (60) days from the date of their release to change plans.	LDH is working with DOC on a pre-release enrollment program for the offender population that will now be covered by Medicaid through expansion. Specific elements relevant to enrollment are detailed in the manual.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	Add new provision.	~~12.11.2.2~~ The MCOs shall adhere to the requirements and procedures as set forth in the Justice-Involved Pre-release Enrollment Program Manual.	LDH is working with DOC on a pre-release enrollment program for the offender population that will now be covered by Medicaid through expansion. Specific elements and

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
				expectations of the MCOs relative to member packets and welcome calls are detailed in the manual.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	13.6.1.4 Pharmacy appeal requests not resolved in the appropriate timeframe shall be submitted by the MCO to DHH Pharmacy staff for a clinical review. Penalties may be levied for the MCO's failure to adhere to the timeframe according to Section 20.	The addition of this provision is necessary to establish penalties for not meeting prior authorization timeliness without overturning the pharmacy appeal decision.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	~~17.2.5 Timely Filing Guidelines~~ 17.2.5.1 Medicaid-only claims must be filed within three hundred sixty five (365) days of the date of service.	~~17.2.5 Timely Filing Guidelines~~ 17.2.5.1 Medicaid-only claims must be filed within three hundred sixty five (365) days of the date of service. Electronic submission of pharmacy claims (reversals and resubmittals) shall be allowed to process electronically within three hundred sixty five (365) days of service.	This revision is necessary to allow billing of pharmacy claims to transmit electronically for 365 days. Currently, the MCOs allow pharmacists to reverse claims to correct errors electronically, but do not allow the resubmittals with corrected information through electronic means.
Exhibit 3	RFP305PUR-DHHRFP-BH-	17.2.6.3 The MCO shall have the ability to update CPT/HCPCS, ICD-	17.2.6.3 The MCO shall have the ability to update national standard	This revision is specific to updating existing logic and data elements,

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	MCO-2014-MVA	9-CM, and other codes based on HIPAA standards and move to future versions as required.	code sets such as CPT/HCPCS, ~~ICD-9-CM~~ ICD-10-CMS, ~~and other codes based on IPAA standards~~ and move to future versions as required by CMS or DHH. Updates to code sets are to be complete no later than 30 days after notification, unless otherwise directed by DHH. This includes annual and other fee schedule updates. 17.2.6.3.1. Providers must be notified as to when the updates will be in production and of the MCO process for the recycling of denied claims that are due to the system update delays. The recycle of these denied claims shall be complete no later than 15 days after the system update.	not the creation of new logic or system changes and prevents adverse impacts providers and the delivery of services.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	17.2.6.4 The MCO shall comply with use of ICD-10 code sets based on deadlines established by CMS, and comply with DHH deadlines for communication, testing, and implementation.	17.2.6.4 The MCO shall use only national standard code sets such as CPT/HCPS, ICD-10-CMS, etc. (unless it conflicts with DHH policy or state regulations). The MCO shall also comply with ~~use of ICD-10 code sets based on~~ deadlines for communication, testing and implementation of code sets established by CMS~~,~~ and/or DHH. ~~comply with DHH deadlines for communication, testing, and implementation.~~	This revision is specific to updating existing logic and data elements, not the creation of new logic or system changes and prevents adverse impacts providers and the delivery of services.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	17.2.6.6 The MCO shall perform internal audit reviews to confirm claim edits are functioning properly and provide DHH with confirmation of this process. DHH shall be provided the results of internal audit reviews upon request.	A revision was needed to clarify the responsibility of the MCOs related to the performance of internal audits on updates and claim edits to ensure proper functionality. The documentation of this process must be retained to be provided if requested by LDH.
Exhibit 3	RFP305PUR-DHHRFP-BH-	Add new subsection.	17.4.4. The MCO shall submit a sample of remittance advices that were sent to independent, chain and	The addition of this provision is necessary to allow LDH to sample pharmacy remittance advices to

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	MCO-2014-MVA		specialty pharmacies by the PBM to DHH pharmacy staff quarterly. This sample shall include at least 10 RAs from each pharmacy type (independent, chain, and specialty).	ensure compliance with Act 755 of the 2008 Louisiana Regular Session.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	17.10.1.1 The MCO shall have an automated claim and encounter processing system for pharmacy claims that will support the requirements of this contract and ensure the accurate and timely processing of claims and encounters.	17.10.1.1 The MCO shall have an automated claim and encounter processing system for pharmacy claims that will support the requirements of this contract and ensure the accurate and timely processing of claims and encounters. The MCO shall allow pharmacies to back bill electronically (reversals and resubmissions) for 365 days from the date of the original submission of the claim.	This revision is necessary to allow billing of pharmacy claims to transmit electronically for 365 days.
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	17.10.3.2 The MCO must ensure that its pharmacy claims process recognizes claims from 340B pharmacies for products purchased through the 340B discount drug program at the	17.10.3.2 ~~The MCO must ensure that its pharmacy claims process recognizes claims from 340B pharmacies for products purchased through the 340B discount drug program at the claim level utilizing the NCPDP field designed for this~~	This revision allows for billing with claim level indicators required to determine pharmacy claims purchased at 340B prices. This revision will provide the claim level detail necessary to audit claims for federally mandated

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		claim level utilizing the NCPDP field designed for this purpose.	~~purpose.~~ The overlap of the 340B Drug Pricing Program and the Medicaid Drug Rebate program creates the possibility of duplicate discounts. States are federally mandated by Section 2501(c) of the Patient Protection and Affordable Care Act (ACA) to seek drug rebates on Managed Care Medicaid claims, meaning that the potential for duplicate discounts exists for managed care claims. Louisiana uses the Health Resources and Services Administration's (HRSA) Medicaid Exclusion File (MEF) for both Fee for Service (FFS) and Managed Care Medicaid claims in order to prevent duplicate discounts. 17.10.3.3. Due to this duplicate discount potential, Louisiana requires that covered entities utilize the same carve-in or carve-out designation for Managed Care Medicaid patients as for FFS	reimbursement on 340 purchased drugs. This level of detail will also provide information to determine the fiscal impact of 340B drug usage.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			Medicaid recipients. If a covered entity appears on the Medicaid Exclusion File, Louisiana will exclude that provider's FFS and MCO claims from rebate invoicing. Claims for FFS Medicaid and Managed Care Medicaid recipients are treated identically in regards to exclusion from rebate invoicing. 17.10.3.4. In order to allow covered entities to distinguish Managed Care Medicaid patients from an MCO's private insurance patients, Louisiana requires its MCOs to utilize a unique Processor Control Number (PCN) or Group Number for Louisiana Medicaid. This unique PCN or group number shall be submitted to DHH before processing any pharmacy claims. 17.10.3.5. Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing. This	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			includes both FFS and Managed Care Medicaid. 17.10.3.6. 340B Billing Per Covered Entity 17.10.3.6.1. MCOs shall include in their contracts with 340B providers billing instructions on how to identify 340B claims/encounters. 17.10.3.7. 340B Claim Level Indicators 17.10.3.7.1. Carve In Pharmacy Claims: On 340B claims, a value of "20" in NCPDP field 420-DK (Submission Clarification Code) and a value of "8" in NCPDP field 423-DN (Basis of Cost Determination) shall be submitted in the pharmacy claim segment of a billing transaction. 17.10.3.7.2. Professional Services Claims (Physician- Administered Drug Claims~~):~~	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			). Physician-Administered drug claims should use the UD modifier to identify 340B drugs on outpatient physician-administered drug claims. 17.10.3.7.3. Carve-Out Claims: Covered entities who carve out Medicaid recipients should bill according to guidelines provided in each plan's provider manual.	
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	17.11.2 Independent Audits 17.11.2.1 The Contractor shall supply the Department with an exact copy of the report by March 31st of each year. 17.11.2.2 DHH shall use the findings and recommendations of each report as part of its monitoring process. 17.11.2.3 The MCO shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10)	~~17.11.2 Independent Audits~~ ~~17.11.2.1 The Contractor shall supply the Department with an exact copy of the report by March 31st of each year.~~ ~~17.11.2.2 DHH shall use the findings and recommendations of each report as part of its monitoring process.~~ ~~17.11.2.3 The MCO shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report.~~	This is a correction. The independent auditor requirement was removed in a previous amendment and this language should have been struck at that time.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		business days of receipt of the audit report. 17.11.2.4 These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The cost of the audit shall be borne by the MCO or subcontractor.	~~17.11.2.4 These audit requirements are also applicable to any subcontractors or vendors delegated the responsibility of adjudicating claims on behalf of the Contractor. The cost of the audit shall be borne by the MCO or subcontractor.~~	
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	Add new subsection.	17.12 Louisiana Health Insurance Premium Payment (LaHIPP) program is a Louisiana Medicaid program that pays all or part of the health insurance premium for an employee and their family if: (a) health insurance is available from their job (i.e. Employer Sponsored Insurance); (b) someone in the family has Medicaid; and (c) it is determined that it would cost less for Louisiana Medicaid to pay the health insurance premium for the person who receives Medicaid than it would be	LaHIPP was implemented 4/20/2017. LDH has determined these members will need to be enrolled in a MCO to receive specialized Behavioral Health services and transportation services. The added provision is necessary as the members will be enrolled as a B enrollment type.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			for Louisiana Medicaid to pay the cost of the same person's per member per month payment for physical health coverage through the enrollee's managed care organization. The goal of LaHIPP is to reduce the number of the uninsured and lower Medicaid spending by establishing a third party resource as the primary payer of the Medicaid enrollee's medical expenses. 17.12.1 DHH is responsible for determining if an individual qualifies for LaHIPP participation. LaHIPP is not an eligibility category. LaHIPP participants are identified in the TPL file. 17.12.2 DHH is responsible for issuing payment for all or part of LaHIPP participants' health insurance premium.	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			17.12.3 LaHIPP members are mandatorily enrolled in Bayou Health for specialized behavioral health services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6. 17.12.4 The MCO is responsible for payment of LaHIPP participants' total member liability (co-payments, co-insurance and deductibles) if the participant uses a provider that accepts the insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant will be responsible for the member liability. The MCO pays only after the third party has met the legal obligation to pay. The MCO is always the payer of last resort, except when the MCO is responsible	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			for payment as primary payer for mental health services and transportation services not covered by commercial insurance as primary payer. 17.12.5 The mental health services listed below are typically not reimbursed by commercial health plans. MCOs should accept the following claims billed directly from the mental health provider without requiring an explanation of benefits from the primary carrier and pay as primary payer. • H0018-Therapeutic Group Home • H0039-Assertive Community Treatment per diem • H0045-Crisis Stabilization • H2017-Psychosocial Rehabilitation Services • H0036-Community psychiatric support and treatment • H2033-Multi-systemic Therapy	

Exhibit/ Attachment	Document	Change From:		Change To:		Justification
				• H2011-Crisis Intervention Service, per 15 minutes • S9485-Crisis Intervention Mental Health Services		
Exhibit 3	RFP305PUR-DHHRFP-BH-MCO-2014-MVA	18.12.1 The MCO shall provide additional reporting specific to the pharmacy program, including, but not limited to: • Pharmacy help desk performance • Prior authorization performance • Prior Authorization request turnaround time • Number of claims submitted as a 72-hour emergency supply • Denials (name of drug, number of requests, number of denials) • Pharmacy network access • Grievance and appeals • Medication therapy management initiatives		18.12.1 The MCO shall provide ~~additional~~ reporting specific to the pharmacy program~~., including, but not limited to:~~ ~~• Pharmacy help desk performance~~ ~~• Prior authorization performance~~ ~~• Prior Authorization request turnaround time~~ ~~• Number of claims submitted as a 72-hour emergency supply~~ ~~• Denials (name of drug, number of requests, number of denials)~~ ~~• Pharmacy network access~~ ~~• Grievance and appeals~~ ~~• Medication therapy management initiatives~~		This revision was made to clarify reporting expectations. Pharmacy specific reports are recurring reports and are covered in Section 18.10.
Exhibit 3	RFP305PUR-DHHRFP-BH-	**Mental Health Rehabilitation Service**	Ten thousand dollars	~~**Mental Health Rehabilitation Service**~~	~~Ten thousand dollars ($10,000)~~	Removing from the Table of Monetary Penalties, the Mental

Exhibit/ Attachment	Document	Change From:		Change To:		Justification
	MCO-2014-MVA	**Authorization Decision** Failure to comply with mental health rehabilitation service authorization decision, as described in Section 6.37.4 Percentage of mental health rehabilitation service authorization decisions made within five (5) business days following completion of the assessment.	($10,000) per month when MCO's performance is below 95%.	~~**Authorization Decision**~~ ~~Failure to comply with mental health rehabilitation service authorization decision, as described in Section 6.37.4~~ ~~Percentage of mental health rehabilitation service authorization decisions made within five (5) business days following completion of the assessment.~~	~~per month when MCO's performance is below 95%.~~	Health Rehabilitation Service Authorization Decision language due to the language being removed from 6.38.4.
Exhibit 3	RFP305PUR-DHHRFP-BH-	25.23.2 Confidentiality of Alcohol and Drug Abuse Patient Records		25.23.2 Confidentiality of ~~Alcohol and Drug Abuse~~ Patient Records		The revisions are needed to clarify that 42 CFR Part 2 restrictions

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
	MCO-2014-MVA	• The MCO shall agree to comply with the Drug Abuse Prevention, Treatment and Rehabilitation Act; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and applicable sections of the Public Health Service Act, codified at 42. U.S.C. 290dd-2 ("the Privacy Statute"). MCO shall also agree to strictly maintain the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling. MCO shall agree to comply with the Privacy Statute and any of its current and future accompanying regulations (42 CFR Part 2). • The MCO shall ensure that every individual treated by a 42 CFR covered provider is offered to sign	• When applicable, t~~T~~he MCO shall agree to comply with the requirements of ~~Drug Abuse Prevention, Treatment and Rehabilitation Act; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and applicable sections of the Public Health Service Act, codified at~~ 42. U.S.C. 290dd-2 and its implementing regulations, 42 CFR Part 2~~("the Privacy Statute")~~. The MCO shall also agree to strictly maintain the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling. ~~MCO shall agree to comply with the Privacy Statute and any of its current and future accompanying regulations (42 CFR Part 2).~~	apply only to sharing substance abuse member information that originates with treatment providers as designated in the CFR, which is limited in scope and does not apply to all providers. As currently drafted, the contract provision is over-inclusive and can be interpreted to include more than just those providers designated in 42 CFR Part 2.

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		a consent form for the disclosure of substance use treatment information to the individual's PCP for the purpose of healthcare integration in accordance with 42 CFR Part 2, Subpart C. • The MCO shall have the ability to track provider compliance with offering consent forms for members receiving substance use services by 42 CFR covered providers, including the number of members receiving substance use services by provider and the number of consent forms offered and signed. The MCO shall report this information to DHH upon request. • The MCO shall educate contracted providers on protocols for requesting and receiving patient records in accordance	• The MCO shall ensure that every individual treated by a provider that is a~~42 CFR~~ covered "Part 2 program", as defined in 42 CFR Part 2, ~~provider~~ is offered to sign a consent form for the disclosure of substance use treatment information to the individual's PCP for the purpose of healthcare integration in accordance with 42 CFR Part 2, Subpart C. • The MCO shall have the ability to track provider compliance with offering consent forms for members receiving substance use services from Part 2 programs ~~by 42 CFR covered providers,~~ including the number of members receiving substance use services by each provider and the number of consent forms offered and signed. The MCO shall report this information to DHH upon request. • The MCO shall educate contracted providers on protocols for requesting	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
		with 45 CFR Part 160 and 42 CFR Part 2. • Disclosures of substance use information without written consent by the patient must be compliant with 42 CFR Part 2. • Disclosures of substance use information must be accompanied by a statement prohibiting re-disclosure. • MCO shall develop policies and procedures which outline HIPAA requirements and 42 CFR Part 2 requirements for the purpose of healthcare integration. These policies and procedures shall outline instances in which 42 CFR Part 2 overrides HIPAA requirements.	and receiving patient records in accordance with 45 CFR Parts 160 and 164 (HIPAA) and 42 CFR Part 2. • When ~~Disclosures of~~ substance use information is subject to the requirements of 42 CFR Part 2, any disclosure of that information without the written consent of ~~by~~ the patient must be compliant with 42 CFR Part 2~~.~~ ~~• Disclosures of substance use information~~ and must be accompanied by a statement notifying the recipient of the prohibition~~ing~~ against re-disclosure. • The MCO shall develop policies and procedures which outline HIPAA requirements and 42 CFR Part 2 requirements for the purpose of healthcare integration. These policies and procedures shall outline	

Exhibit/ Attachment	Document	Change From:	Change To:	Justification
			instances in which 42 CFR Part 2 overrides HIPAA requirements.	
Exhibit 4	RFP305PUR-DHHRFP-BH-MCO-2014-MVA Appendix O		Replace with updated version	The revisions adds a requirement at the request of the AG's office related to requests for information by healthcare oversight agencies.

Terms of Payment

Maximum Contract Amount:
The maximum contract amount for each contract year is the product of projected enrollment in the MCO and the projected Per Member Per Month capitation rate. For calculation purposes, the projected Per Member Per Month capitation rate is the statewide composite prior to risk adjustment.

Contract Year	Projected Member Months	Projected Per Member Per Month Capitation Rate	Maximum Contract Amount
Contract year 1 - February 1, 2015 to January 31, 2016	2,007,023	$302.90	$607,927,267
Contract year 2 - February 1, 2016 to January 31, 2017	2,156,211	$310.90	$670,366,000
Contract year 3 - February 1, 2017 to January 31, 2018	2,161,943	$317.51	$686,438,522
3-Year Total			$1,964,731,789

DHH reserves the right to adjust Per Member Per Month capitation rates in the following instances:

1. Changes to core benefits and services included in the capitation rates;
2. Changes to Medicaid population groups eligible to enroll in an MCO;
3. Legislative appropriations and budgetary constraints; or
4. Changes in federal requirements.

Terms of Payment:

1. DHH shall make monthly risk-adjusted capitation rate payments for each member enrolled into the MCO. Capitation rates are developed in accordance with 42 CFR 438.6 and are actuarially sound.

2. MCO agrees to accept payment in full and shall not seek additional payment from a member for any unpaid costs, including costs incurred during the retroactive period of eligibility.

3. DHH reserves the right to defer remittance of the monthly capitation rate payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

4. The monthly risk-adjusted capitation rate payment shall be based on the total number of Medicaid eligibles assigned to the MCO as of the last working day of the previous month and paid in the weekly payment cycle nearest the 15th calendar day of the month.

5. In addition to the monthly capitated rate, DHH shall provide MCOs a one-time supplemental lump sum payment for each obstetrical delivery. This kick payment is intended to cover the cost of prenatal care, the delivery event, and post-partum care and normal newborn hospital costs.

6. If the MCO is identified by the Internal Revenue Service (IRS) as a covered entity and thereby subject to an assessed fee (“Annual Fee”) whose final calculation includes an applicable portion of the MCO’s net premiums written from DHH’s Medicaid/CHIP lines of business, DHH shall make an annual payment to the MCO in each calendar year payment is due to the IRS (the “Fee Year”). This annual payment will be calculated by DHH (and its contracted actuary) as an adjustment to each MCO’s capitation rates for the full

amount of the Annual Fee allocable to Louisiana Medicaid/CHIP with respect to premiums paid to the MCO for the preceding calendar year (the "Data Year.") The adjustment will be to the capitation rates in effect during the Data Year.

~~7. In addition to all other payments described herein, LDH shall provide MCOs a monthly supplemental lump sum payment in accordance with the payment terms of any adopt, implement, or upgrade (AIU) support incentive program or meaningful use (MU) support incentive program established in the State of Louisiana's Implementation Advanced Planning Document for Health Information Technology and Health Information Exchange in effect during the fiscal year in which the reimbursable activity occurs.~~

Effective Date of Enrollment

MCO enrollment for members in a given month will be effective at 12:01AM on the first calendar day of the month of Medicaid eligibility not to exceed 12 months of retroactive eligibility.

Withhold of Capitation Rate

As outlined in detail in Section 5.3 of the RFP, a withhold of a portion of the monthly capitation rate payment shall be applied to provide an incentive for MCO compliance with the requirements of this contract. The withhold amount will be equivalent to two percent (2%) of the monthly capitation rate payment for all MCO enrollees, exclusive of maternity kick payments.

Incentive-Based Performance Measures
Targets for Improvement

Identifier	Measure	Measure Description	Target Population	Condition	Target for Improvement
PTB $$	Initiation of Injectable Progesterone Therapy in Women with Previous Pre-Term Births	The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation.	Children's and Maternal Health	Perinatal and Reproductive Health	**MCOs must only report data related to the measure in ~~2016~~ 2017. Performance will be measured beginning in ~~2017~~ 2018.**
NQF #0471 (CSEC) $$	Cesarean Rate for Low-Risk First Birth Women	The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).	Children's and Maternal Health	Perinatal and Reproductive Health	**26.47**
(AWC) $$	Adolescent Well Care Visit	The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement Year	Children's Health	Utilization	**40.69**
NQF # 0108 $$	Follow-up Care for Children Prescribed ADHD Medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Children's Health	Behavioral Health	**MCOs must only report data related to the measure in ~~2016~~ 2017. Performance will be measured beginning in ~~2017~~ 2018.**
NQF #2082 (HIV) $$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	Chronic Disease	HIV	**MCOs must only report data related to the measure in ~~2016~~ 2017. Performance will be measured beginning in ~~2017~~ 2018.**
NQF #0272 (PQI 1) $$	Diabetes Short Term Complications Rate	Number of discharges for diabetes short term complications per 100,000 Medicaid enrollees age 18 and older.	Chronic Disease	Diabetes	**17.15**
NQF # 1517 (PPC) $$	Postpartum Care (PPC Submeasure)	The percentage of deliveries that had a postpartum visit on or	Maternal Health	Perinatal and Reproductive Health	**63.12**

Incentive-Based Performance Measures
Targets for Improvement

		between 21 and 56 days after delivery.			
(AMB) $$	Ambulatory Care- ED Visits	Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months	Population Health	Utilization	**ED Visits 63.87**
#09 (FUH) $$	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the member received follow-up within 30 days of discharge. - The percentage of discharges for which the member received follow-up within 7 days of discharge.	NCQA	CHIPRA	Behavioral Health	**MCOs must only report data related to the measure in ~~2016~~ 2017. Performance will be measured beginning in ~~2017~~ 2018.**

Subcontract Requirements Checklist for MCOs

MCO Name:

Subcontractor Name:

Summary of services to be provided:

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	LDH Feedback
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.		
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).		
3	Specify the effective dates of the subcontract agreement.		
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.		
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.		
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	LDH Feedback
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.		
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.		
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.		
10	Identify the population covered by the subcontract.		
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.		
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.		
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.		
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.		
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	LDH Feedback
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.		
17	Include record retention requirements as specified in the contract between DHH and the MCO.		
18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, and the State Auditor's Office, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.		
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 15.1.10. **The completed disclosure of ownership must be submitted with the checklist.**		
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.		
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	LDH Feedback
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.		
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.		
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.		
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.		
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.		
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.		
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.		
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.		
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	LDH Feedback
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.		
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.		
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.		
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.		
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.		
36	Include a conflict of interest clause as stated in the contract between DHH and the MCO.		
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.		
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	LDH Feedback
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.		
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.		
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.		
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.		
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	LDH Feedback
44	Contains the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.		