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: 2000100373 (3)
Vendor: Amerigroup Louisiana Inc
Description: Provide healthcare services to Medicaid enrollees
Approved By: Pamela Rice
Approval Date: 12/15/2015

Your amendment that was submitted to OSP has been approved.

Rev 2010/08

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Medical Vendor Administration

(Regional/ Program/ Facility)

AND

Amerigroup Louisiana, Inc.

Contractor Name

Amendment #: 3

LaGov #: 2000100373

CFMS #: 733527

DHH #: 060467

Original Contract Amt 1,964,731,789

Original Contract Begin Date 02-01-2015

Original Contract End Date 01-31-2018

AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: 1,964,731,789

See Attachment A-3.

Change To: Maximum Amount: 1,964,731,789

See Attachment A-3.

Justification:

The changes contained in Attachment A-3 are necessary for the continued successful operation of the Medicaid managed care program.

This Amendment Becomes Effective: 07-01-2015

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

Amerigroup Louisiana, Inc.

CONTRACTOR SIGNATURE DATE 10/14/15

PRINT NAME: Sonya Nelson

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Secretary, Department of Health and Hospital or Designee

SIGNATURE DATE 10/19/15

NAME: J. Ruth Kennedy

TITLE: Medicaid Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

Attachment/ Exhibit Letter or Number	Contract Document Name	Change From:	Change To[1]:	Justification
Attachment D	Rate certification		Replace with Mercer Rate Certification dated August 11, 2015	The rate certification was updated to reflect the application of the Full Medicaid Payment methodology to physician and ambulance services.
Attachment E	Incentive-Based Performance Measures		Replace with revised version.	Revisions were needed to clarify the data collection and reporting periods.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**2.6.1.4** The bond amount shall be reevaluated and adjusted in the third (3rd) month of each contract year. The adjusted amount shall be equal to one hundred ten percent (110%) of the total capitation payment, exclusive of maternity kick payments, paid to the Contractor in the second (2nd) month of the contract year. The adjusted bond must be submitted to DHH by the end of the fourth (4th) month of each contract year.	**2.6.1.4** The bond amount shall be reevaluated and adjusted <u>following the annual open enrollment process, which includes the period during which members can change MCOs without cause</u> ~~in the third (3rd) month of each contract year~~. The adjusted amount shall be equal to ~~one hundred ten percent (110%)~~ <u>seventy-five percent (75%)</u> of the total capitation payment, exclusive of maternity kick payments, paid to the Contractor <u>for the month following the end of the process</u>	A revisions was needed to ensure that the adjusted bond amount is commensurate with the enrollment for each plan.

[1] Additions underlined; deletions struck through

			~~cause in the second (2nd) month of the contract year~~. The adjusted bond must be submitted to DHH within 60 days of notification to the MCO of the adjusted amount ~~by the end of the fourth (4th) month of each contract year~~.	
Exhibit E	305PUR-DHHRFP-BH-MCO-2014-MVA	**5.7.3** Risk adjustment will be completed thirty (30) days from the end of the annual open enrollment period and reviewed semi-annually. Risk adjustment may be completed more than semi-annually if determined warranted by DHH.	**5.7.3** Risk adjustment scores will be updated following the full annual open enrollment process, which includes the period during which members can change MCOs without cause. The updated score will be effective for the month following the end of the process ~~completed thirty (30) days from the end of the annual open enrollment period~~ and reviewed semi-annually. Risk adjustment may be completed more than semi-annually if determined warranted by DHH.	A revision was necessary to ensure that PMPMs are commensurate with each MCO's member mix and the associated risk.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**6.23. Medical Transportation Services** 6.23.1. The MCO shall provide emergency and non-emergency medical transportation for its members. Non-emergency medical transportation shall be provided to members who lack	**6.23. Medical Transportation Services** 6.23.1 The MCO shall provide emergency and non-emergency medical transportation for its members. ~~Non-emergency medical transportation shall be provided to members who lack~~	These revisions were necessary to clarify requirements and eliminate duplicative or conflicting information found in other sections. The revisions also ensure consistency with CMS regulations.

		transportation to and from services covered by the Contract. In addition, non-emergency medical transportation to access carved out services including but not limited to dental, behavioral health shall be provided by the MCO. 6.23.2. The MCO may establish its own policy for medical transportation services as long as the MCO ensures members' access to care and the MCO's policy is in accordance with current Louisiana Medicaid guidelines for non-emergency and emergency medical transportation (such as whether the member owns a vehicle or can access transportation by friends, relatives or public transit).	~~transportation to and from services covered by the Contract. In addition, non-emergency medical transportation to access carved out services including but not limited to dental, behavioral health shall be provided by the MCO.~~ 6.23.2 Non-Emergency Transportation (NEMT) 6.23.2.1 NEMT shall be provided to and from all medically necessary Medicaid state plan services (including carved out services) for those members who lack viable means of transportation. 6.23.2.2 NEMT transportation includes the following, when necessary to ensure the delivery of necessary medical services: • Transportation for the member and one attendant, by ambulance, taxicab, airplane, bus, or	

			other appropriate means; and • For trips requiring long distance travel, in accordance with Section 6.23.2.3, the cost of meals and lodging and other related travel expenses determined to be necessary to secure medical examinations and treatment for a member. 6.23.2.3. The MCO must have an established process for coordinating medically necessary long distance travel for members who require covered Medicaid state plan services out of state. This may include air travel, lodging, and reimbursement for meals, as supported by medical necessity. 6.23.2.3.1 Coverage and reimbursement for meals and lodging for both the	

			member and one attendant, shall be included when treatment requires more than twelve (12) hours of total travel. "Total travel" includes the duration of the health care appointment and travel to and from that appointment. 6.23.2.3.2 MCO must allow for meals and lodging, for each trip that are not otherwise covered in the inpatient per diem, primary insurance, or other payer source. 6.23.2.3.3 If the MCO denies meals and lodging services to a member who requests these services, the member must receive a written notice of denial explaining the reason for denial and the member's right to an appeal. 6.23.2.4 Other primary private insurance coverage must not	

			impede a member's ability to receive transportation benefits to and from services covered by Medicaid as a secondary payer. If the private insurer has approved out-of-state services that are covered by Medicaid, the MCO must provide transportation, meals and lodging as specified in this section. The MCO~~,~~ may require prior authorization for NEMT and may require documentation to verify coverage of medical services by the primary insurer prior to approval. The MCO cannot deny NEMT because of medical necessity for the service, nor because of the medical provider's location or network status. NEMT to non-Medicaid covered services may be denied. 6.23.~~2~~3. The MCO may establish its own policy for medical	

			transportation services as long as the MCO ensures members' access to care and the MCO's policy is in accordance with current Louisiana Medicaid guidelines for non-emergency and emergency medical transportation (such as whether the member owns a vehicle or can access transportation by friends, relatives or public transit).	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**7.8.9 Non-Emergency Medical Transportation** The MCO is responsible for all necessary Non-Emergency Medical Transportation for its members. This includes transportation to both services covered within the scope of this RFP and all state plan serves currently excluded, such as, but not limited to dental and behavioral health.	**7.8.9 Non-Emergency Medical Transportation** ~~The MCO is responsible for all necessary Non-Emergency Medical Transportation for its members. This includes transportation to both services covered within the scope of this RFP and all state plan serves currently excluded, such as, but not limited to dental and behavioral health.~~ MCO shall have sufficient NEMT providers, including wheelchair lift equipped vans, to transport members to medically necessary services when notified 48 hours in advance, and MCOs must be able to arrive and provide services with sufficient time to	The deleted language was moved to Section 6 as revised above. Section 7 language is specific to the provider network and access standards for NEMT.

			ensure the member arrives at their appointment at least 15 minutes but no more than 1 hour early.	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	7.15.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than $2.50; • Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by DHH; • Update. Ingredient costs of medications must be at least weekly; • Make drug pricing list available to pharmacies for review; and • Afford individual pharmacies a chance to appeal inadequate reimbursement.	7.15.1.8. The MCO may negotiate the ingredient cost reimbursement in its contracts with providers. However, the MCO shall: • pay a per-prescription dispensing fee, as defined in this contract, at a rate no less than $2.50 to all "local pharmacies" as defined in Act 399 of the 2015 Regular Session of the Louisiana Legislature; • Add any state imposed provider fees for pharmacy services, on top of the minimum dispensing fee required by DHH; • Update. Ingredient costs of medications must be at least weekly; • Make drug pricing list available to pharmacies for review; ~~and~~ • Afford individual pharmacies a chance to appeal inadequate reimbursement~~;~~ and • Provide for a "local pharmacy" appeals process in accordance with Act 399 of the	The revision was needed to ensure compliance with Act 399 of the 2015 Regular Session of the Louisiana Legislature.

			2015 Regular Session of the Louisiana Legislature.	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Addition of New Section	**9.11 Payment for Ambulance Services** The MCO must use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Contract Attachment D – **Mercer Certification, Rate Development Methodology and Rates,** for reimbursement of ambulance services.	The Full Medicaid Payment methodology will be applied to payment for ambulance services.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Addition of New Section	**9.12 Payment for Physician Services** The MCO must use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Contract Attachment D– **Mercer Certification, Rate Development Methodology and Rates,** for reimbursement of physician services.	The Full Medicaid Payment methodology will be applied to payment for physician services.

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	14.5.5 The MCO shall completely process credentialing applications from all types of provider types within thirty (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall: . . .	14.5.5 The MCO shall completely process credentialing applications from all types of provider types within ~~thirty (30)~~ sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall: . . .	A revision was needed to ensure sufficient time for the processing of credentialing applications by the MCOs.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	17.2.5.1 Medicaid-only claims must be filed within one hundred eighty (180) days of the date of service.	17.2.5.1 Medicaid-only claims must be filed within ~~one hundred eighty (180)~~ three hundred sixty five (365) days of the date of service.	A revision was needed to comply with the provisions of Act 21 of the 2015 Regular Legislative Session.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	17.2.5.2 The MCO shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. Claims involving third party liability shall be submitted within the lesser of 180 days of resolution by the third party or 365 days from the date of service.	17.2.5.2 The MCO shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. Claims involving third party liability shall be submitted within ~~the lesser of 180 days of resolution by the third party or~~ 365 days from the date of service.	A revision was needed to comply with the provisions of Act 21 of the 2015 Regular Legislative Session.

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	17.2.5.3 The MCO must deny any claim not initially submitted to the MCO by the one hundred and eightieth (180) calendar day from the date of service, unless DHH, the MCO or its sub-contractors created the error. If a provider files erroneously with another MCO or with DHHs FI, but produces documentation verifying that the initial filing of the claim occurred timely, within the one hundred and eighty (180) calendar day period, the MCO shall process the provider's claim and not deny for failure to meet timely filing guidelines. The MCO shall not deny claims solely for failure to meet timely filing guidelines due to error by DHH or its subcontractors.	17.2.5.3 The MCO must deny any claim not initially submitted to the MCO by the ~~one hundred and eightieth (180)~~ three hundred and sixty-fifth (365) calendar day from the date of service, unless DHH, the MCO or its sub-contractors created the error. If a provider files erroneously with another MCO or with DHHs FI, but produces documentation verifying that the initial filing of the claim occurred timely, within the ~~one hundred and eighty (180)~~ three hundred and sixty-five (365) calendar day period, the MCO shall process the provider's claim and not deny for failure to meet timely filing guidelines. The MCO shall not deny claims solely for failure to meet timely filing guidelines due to error by DHH or its subcontractors.	A revision was needed to comply with the provisions of Act 21 of the 2015 Regular Legislative Session.
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**19.1.2 Contract Monitor** All work performed by the MCO will be monitored by the Medicaid Deputy Director with oversight of Bayou Health or his/her designee: Bayou Health Director	**19.1.2 Contract Monitor** All work performed by the MCO will be monitored by the Medicaid ~~Deputy~~ Director ~~with oversight of Bayou Health~~ or his/her designee: ~~Bayou Health~~ Medicaid Director	A revision was needed to clarify the contract monitor for the managed care contracts.

		Department of Health and Hospitals Bureau of Health Services Financing 628 North 4th St. Baton Rouge, LA 70821 E-mail:	Department of Health and Hospitals Bureau of Health Services Financing 628 North 4th St. Baton Rouge, LA 70821 ~~Email:~~	
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	**25.26.1** The MCO shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the MCO 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.	**25.26.1** The MCO shall perform the services to be provided under this Contract entirely within ~~the boundaries of~~ the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the MCO 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.	A revision was necessary to define the "United States."
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Appendix J	Replace with revised version.	A revision was needed to replace "TBD" with the identifier, "PTB," for the injectable progesterone performance measure.

Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Appendix O – MCO Subcontract Requirements	Replace with revised version.	A reference to "disclosure of information" was corrected to read "disclosure of ownership."
Exhibit 3	305PUR-DHHRFP-BH-MCO-2014-MVA	Appendix LL – Louisiana Rural Parishes Map	Replace with revised version	The federal Office of Management and Budget has updated some parish designations.

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MERCER
MAKE TOMORROW, TODAY

Ms. Jen Steele
Medicaid Deputy Director
Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North 4th Street
Baton Rouge, LA 70821

October 12, 2015

Subject: Louisiana Bayou Health Program – Full Risk-Bearing Managed Care Organization Rate Range Development and Actuarial Certification update for the Period July 1, 2015 through January 31, 2016

Dear Ms. Steele:

The Louisiana Department of Health and Hospitals (DHH) has contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for the State of Louisiana's Bayou Health program for the period of July 1, 2015 through January 31, 2016. This certification update includes two technical revisions effective July 1, 2015. For reference, the original capitation rate certification letter for the period July 1, 2015 through January 31, 2016 is included with this document in Appendix C.

This letter provides an overview of the analyses and methodology to support the technical revisions and the resulting capitation rate ranges effective July 1, 2015 through January 31, 2016 for the purpose of satisfying the requirements of the Centers for Medicare & Medicaid Services (CMS). This rate development process used Medicaid fee-for-service (FFS) medical and pharmacy claims, Bayou Health Shared Savings claims experience, and Bayou Health Prepaid encounter data. It resulted in the development of a range of actuarially sound rates for each rate cell. The capitation rate ranges are summarized in Appendix A and represent payment in full for the covered services. Appendix B shows the full rate development from the base data as shown in the data book released by the State, dated January 31, 2015 and applies all the rate setting adjustments as described in this letter.

Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government mandated assessments, fees, and taxes, and the cost of capital. Note: Please see pages 8-9 of the August 2005, Actuarial Certification of Rates for Medicaid Managed Care Programs, from the American Academy of Actuaries, http://www.actuary.org/pdf/practnotes/health_medicaid_05.pdf.

Technical Revisions

Following the implementation of the Bayou Health at-risk capitated program, effective February 1, 2015, Mercer became aware of two issues requiring a technical revision to the previously certified rates. These are the following:

- A misalignment in the Maternity kick payment delivery event count logic between the State's fiscal agent and what was included in rate development.
- A decision made by the First Circuit Court of Appeals altering the reimbursement to out-of-state border hospitals.

These issues and methodology of the technical revisions are described in detail in the following sections.

Technical Revision #1 (Maternity Kick Payment Delivery Event Count Logic)

Mercer worked with DHH and the State's fiscal agent (Molina) to revise and align the Maternity kick payment delivery event count logic underlying the rate development and the logic implemented by Molina for payment to the Bayou Health managed care organizations (MCOs). A full description of the Maternity kick payment logic can be found in Schedule Z of the Bayou Health MCO financial reporting requirements guideline.

The following describes all the changes made to the inpatient physical health services encounters delivery event count logic. All other logic remains unchanged:

- Included all available diagnoses codes on a claim to identify a delivery. Previously, only the primary diagnosis code was used to identify a delivery.
- Included inpatient hospital claims only (claim type = 01 and billing provider type = 60) to identify a delivery. Previously, outpatient claims and all billing provider types were considered to identify a delivery.

- Restricted the age of the enrolled mother to greater than or equal to 10 years of age to identify a delivery. Previously all ages were considered to identify a delivery.
- Diagnoses code range 640-669 where the 5th digit must be a 1 or 2. Previously all codes in the range 650-669 were used to identify a delivery and no consideration was made for the 5th digit.
- Stillborn deliveries are identified using the following revenue codes: V271, V273-274, or V276-277. Previously, all V27 (V271-V279) were used to identify a stillborn delivery.

The following describes all the changes made to the professional encounters delivery logic, all other logic remains unchanged:

- Restricted to billing provider types 19, 20, and 90 to identify a delivery. Previously all billing provider types were considered to identify a delivery.
- Restricted the age of the recipient to greater than or equal to 10 years of age to identify a delivery. Previously all ages were considered to identify a delivery.

Additionally, after all encounters are identified, a single live-born delivery is identified for a given recipient within a 245-day period, plus or minus. Previously a 120-day period, plus or minus, was used to identify a single delivery.

The revision to the Maternity kick payment delivery event count logic resulted in a reduction in deliveries of 1.98%, which increased the cost per delivery by 2.02%. Table 1-A shows the regional impact to the Maternity kick payment deliveries and cost per delivery. Table 1-B shows the regional impact to the Full Medicaid Pricing (FMP) cost per delivery.

Table 1-A: Regional impact to deliveries and cost per delivery due to the Maternity kick payment delivery event count logic change

Region Description	CY 2013 Deliveries	Original Cost per Delivery	CY 2013 Revised Deliveries	Revised Cost per Delivery	Deliveries % Change	Cost per Delivery % Change	Cost Per Delivery Impact
Gulf	10,987	$5,758.51	10,706	$5,910.05	-2.56%	2.63%	$151.54
Capital	9,772	$5,100.71	9,480	$5,258.10	-2.99%	3.09%	$157.40
South Central	10,504	$5,063.13	10,352	$5,137.39	-1.45%	1.47%	$74.27
North	8,132	$5,207.82	8,080	$5,241.63	-0.65%	0.65%	$33.82
Statewide	**39,396**	**$5,296.26**	**38,617**	**$5,403.03**	**-1.98%**	**2.02%**	**$106.78**

Table 1-B: Regional impact to FMP cost per delivery due to delivery event count logic change

Region Description	CY 2013 Deliveries	Original FMP Cost per Delivery	Revised Deliveries	Revised FMP Cost per Delivery	FMP Cost per Delivery % Change	FMP Cost Per Delivery Impact
Gulf	10,987	$3,053.19	10,706	$3,133.54	2.63%	$80.35
Capital	9,772	$3,046.41	9,480	$3,140.42	3.09%	$94.01
South Central	10,504	$2,662.95	10,352	$2,702.01	1.47%	$39.06
North	8,132	$2,632.96	8,080	$2,650.06	0.65%	$17.10
Statewide	**39,396**	**$2,860.71**	**38,617**	**$2,918.39**	**2.02%**	**$57.68**

Technical Revision #2 (Out-of-State Border Hospital Reimbursement)

A First Circuit Court of Appeals decision, Vicksburg, LLC v. State ex rel. Dep't of Health and Hospitals, 2010-1248 (La. App. 1st Cir. 3/25/11), 63 So.3d205, determined that a reimbursement methodology promulgated by DHH was unconstitutional in its application to River Region. River Region is a hospital located in Vicksburg, Mississippi, and administered inpatient health care services to Louisiana Medicaid patients. Consequently, DHH altered its reimbursement methodology to Mississippi out-of-state (Mississippi trade area) border hospitals fro

Incentive-Based Performance Measures
Targets for Improvement

Identifier	Measure	Measure Description	Target Population	Condition	Target for Improvement
PTB $$	Initiation of Injectable Progesterone Therapy in Women with Previous Pre-Term Births	The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more Progesterone injections between the 16th and 21st week of gestation.	Children's and Maternal Health	Perinatal and Reproductive Health	**MCOs must only report data related to the measure in 2016. Performance will be measured beginning in 2017.**
NQF #0471 (CSEC) $$	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. Performance will be measured beginning in 2017.**
NQF #2082 (HIV) $$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	Chronic Disease	HIV	**MCOs must only report data related to the measure in 2016. Performance will be measured beginning in 2017.**
NQF #0272 (PQI 1) $$	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 between 21 and 56 days after delivery.	Maternal Health	Perinatal and Reproductive Health	**63.12**

Incentive-Based Performance Measures
Targets for Improvement

(AMB) $$	Ambulatory Care	Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months	Population Health	Utilization	**ED Visits 68.37**

Appendix J - Performance Measure Reporting

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Data
PTB $$	Antenatal Progesterone	TBD	DHH/ULM	None	Children's and Maternal Health	Perinatal and Reproductive Health	HP
NQF #0471 (CSEC) $$	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).	TJC	CHIPRA	Children's and Maternal Health	Perinatal and Reproductive Health	HP
(BHRA)	Behavioral Health Risk Assessment (for Pregnant Women)	Percentage of women, regardless of age, that gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence.	AMA-PCPI	CHIPRA	Children's and Maternal Health	Perinatal and Reproductive Health	State
NQF #1391 (FPC)	Frequency of Ongoing Prenatal Care	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following percentages of expected prenatal visits: <21, 21-40, 41-60, 61-80, > or = 80.	NCQA	CHIPRA	Children's and Maternal Health	Perinatal and Reproductive Health	HP
NQF #1382 (LBW)	Percentage of low birth weight births	Percentage of live births that weighted less than 2,500 grams in the state during the reporting period.	CDC	CHIPRA, HRSA	Children's and Maternal Health	Perinatal and Reproductive Health	OPH
NQF #1517 (PPC)	Timeliness of Prenatal Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.	NCQA	CHIPRA	Children's and, Maternal Health	Perinatal and Reproductive Health	HP
(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	NCQA	CHIPRA	Children's Health	Utilization	HP
(CAP)	Child and Adolescents' Access to Primary Care Practitioners	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender. The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line. • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.	NCQA	CHIPRA	Children's Health	Access/Availability of Care	HP
NQF #0038 (CIS)	Childhood Immunization Status	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday.	NCQA	CHIPRA, MU2	Children's Health	Prevention	HP

NQF #1448 (DEV)	Developmental Screening in the First Three Years of Life	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	NCQA	CHIPRA	Children's Health	Prevention	State
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.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HP
NQF #1959 (HPV)	Human Papillomavirus (HPV) Vaccine for Female Adolescents	Percentage of female adolescents that turned 13 years old during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	NCQA	CHIPRA	Children's Health	Prevention	HP
NQF #1407 (IMA)	Immunization Status for Adolescents	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday.	NCQA	CHIPRA	Children's Health	Prevention	HP
NQF #0024 (WCC)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender. The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner, with evidence of : • BMI percentile documentation • Counseling for nutrition • Counseling for physical activity	NCQA	CHIPRA, MU2	Children's Health	Prevention	HP
NQF #1392 (W15)	Well-Child Visits in the First Fifteen Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported.	NCQA	CHIPRA	Children's Health	Utilization	HP
NQF #1516 (W34)	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HP
NQF #0021 (MPM)	Annual Monitoring for Patients on Persistent Medications	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate.	NCQA	MEDICAID ADULT	Chronic Disease	Prevention	HP
NQF #0057 (HA1C)	Comprehensive Diabetes Care: Hemoglobin A1c testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HP
NQF #0018 (CBP)	Controlling High Blood Pressure	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Chronic Disease	Cardiovascular Care	HP

NQF #0277 (PQI08)	Heart Failure Admission Rate	Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish).	AHRQ	MEDICAID ADULT	Chronic Disease	Cardiovascular Care	State
NQF #2082 (HIV) $$	HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200	HRSA HIV/AIDS Bureau	MEDICAID ADULT	Chronic Disease	HIV	HP
NQF #0272 (PQI 1) $$	Diabetes Short Term Complications Rate	Number of discharges for diabetes short term complications per 100,000 Medicaid enrollees age 18 and older.	AHRQ	MEDICAID ADULT	Chronic Disease	Diabetes	State
NQF #0476 (PC-03)	Antenatal Steriods	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns.	TJC	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HP
NQF #0469 (PC-01)	Elective Delivery	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed	TJC	MEDICAID ADULT, MU2	Maternal Health	Perinatal and Reproductive Health	HP
NQF # 1517 (PPC) $$	Postpartum Care (PPC Submeasure)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HP
NQF #1879 (SAA)	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months). The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months).	CMS	MEDICAID ADULT	Population Health	Behavioral Health	HP
(ABA)	Adult BMI Assessment	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.	NCQA	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Prevention	HP
(AMB) $$	Ambulatory Care	Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months	NCQA	CHIPRA	Population Health	Utilization	State
NQF #0105 (AMM)	Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.	NCQA	MEDICAID ADULT, MU2	Population Health	Behavioral Health	HP

NQF #0283 (PQI15)	Asthma in Younger Adults Admission Rate	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/Critical Care	State
NQF #1800 (AMR)	Asthma Medication Ratio	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	NCQA	None - recommended by IPRO	Population Health	Pulmonary/Critical Care	HP
NQF #0648 (CTR)	Care Transition - Transition Record Transmitted to Health Care Professional	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	AMA-PCPI	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Care Coordination	HP
NQF #0032 (CCS)	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer	NCQA	MEDICAID ADULT, MU2	Population Health	Prevention	HP
NQF #0275 (PQI05)	COPD and Asthma in Older Adults Admission Rate	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older.	AHRQ	MEDICAID ADULT	Population Health	Pulmonary/Critical Care	State
NQF #0039 (FVA)	Flu Vaccinations for Adults Ages 18 to 64	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.	NCQA	MEDICAID ADULT	Population Health	Prevention	HP Survey
NQF #0576 (FUH)	Follow up After Hospitalization for Mental Illness	The percentage of discharges for patients 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	NCQA	CHIPRA, MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Behavioral Health	HP
NQF #0004 (IET)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. Initiation of AOD Treatment. Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Population Health	Behavioral Health	HP
NQF #0027 (MSC)	Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation	NCQA	MEDICAID ADULT	Population Health	Prevention	HP Survey

NQF #1799 (MMA)	Medication Management for People with Asthma	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.	NCQA	CHIPRA	Population Health	Pulmonary/Critical Care	HP
(PCR)	Plan All-Cause Readmission Rate	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probaility ofan acute readmission.	NCQA	MEDICAID ADULT, CMS HEALTH HOMES	Population Health	Utilization	HP
NQF #0418 (CDF)	Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented. The percentage of patients aged 18 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	CMS	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Population health	Prevention	State
(CAT)	Call Answer Timeliness	Percentage of calls received by the organization's Member Services call centers (during operating hours) during the performance measurement year that were answered by a live voice within 30 seconds.	NCQA	None	Population Health	Access/Availability of Care	HP
(ACCA)	Ambulatory Care-Sensitive Condition Admission	This measure is used to assess the age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital per 100,000 population under age 75 years.	CIHI	CMS HEALTH HOMES	Population Health	Access/Availability of Care	HP
NQF #0033 (CHL)	Chlamydia Screening in Women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NCQA	CHIPRA, MEDICAID ADULT	Population Health, Maternal Health	Perinatal and Reproductive Health, Sexually Transmitted Infectious Diseases	HP
NQF #0031 (BCS)	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer. Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	NCQA	MEDICAID ADULT, MU2	Senior Care	Prevention	HP

Administrative Measures

Measure	Minimal Performance Standard
% of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact.	≥95%
% of regular and expedited service authorization request processed in timeframes in the contract.	≥95%
Rejected claims returned to provider with reason code within 15 days of receipt of claims submission.	≥99%
% of Call Center calls answered within 30 seconds.	≥95%
Call Center average speed of answer.	30 Seconds
Call Center call abandonment rate.	≤5%
% of grievances and request for appeals received by the MCO including grievances received via telephone and resolved within the timeframe of the contract.	≥95%
% of clean claims paid for each provider type with 15 business days.	≥90%
% of clean claims paid for each provider type within 30 calendar days.	≥99%

Subcontract Requirements Checklist for MCOs

Plan Name:

Subcontractor Name:

Summary of services to be provided:

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH 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.		
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.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
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.		
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.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
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, the State Auditor's Office, the Office of the Attorney General, 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.		
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.		

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)	DHH Feedback
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	Provide that the subcontractor, if performing a key internal control, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by DHH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.		
31	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)	DHH Feedback
32	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.		
33	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.		
34	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.		
35	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.		
36	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.		
37	Include a conflict of interest clause as stated in the contract between DHH and the MCO.		
38	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.		
39	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)	DHH Feedback
40	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.		
41	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.		
42	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.		
43	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.		
44	Require that		

RURAL AND URBAN LOUISIANA PARISHES

(as designated by the Federal Office of Management and Budget)