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: 2000441823 (1)
Vendor: UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Community Plan
Description: Update to reflect state and federal regs. No change in time or money.
Approved By: Pamela Rice
Approval Date: 6/24/2020

Your amendment that was submitted to OSP has been approved.

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Medical Vendor Administration

(Regional/ Program/ Facility)

Bureau of Health Services Financing

AND

UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Communit

Contractor Name

Amendment #: 1

LAGOV#: 2000441823

LDH #:

Original Contract Amount: $2,726,062,141.00

Original Contract Begin Date: 01-01-2020

Original Contract End Date: 12-31-2020

RFP Number: N/A

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $2,726,062,141.00 Current Contract Term : 01/01/20-12/31/20

See attachments:
B - Statement of Work
C - Performance Measures
E - APM Strategic Plan Requirements and Report

Change Contract To: If Changed, Maximum Amount: If Changed, Contract Term:

See attachments:
B1 - Summary of SOW Changes
C - Performance Measures
E - APM Strategic Plan Requirements and Report

Justifications For Amendment:

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP.

This Amendment Becomes Effective: 01-01-2020

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

UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Co

CONTRACTOR SIGNATURE Karl Lirette DATE 5/26/2020

PRINT NAME: Karl Lirette

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE Ruth Johnson Digitally signed by Ruth Johnson Date: 2020.05.28 07:52:15 -05'00' DATE

NAME: Ruth Johnson

TITLE: Medicaid Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE DATE

NAME

Contract Amendment #1
Attachment B1

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment B Statement of Work	**2.6.8 Additional Requirements for MCO Transportation Broker** 2.6.8.1 Commercial General Liability If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its MCO Transportation Broker to maintain, during the life of the contract between the Contractor and the MCO Transportation Broker, Commercial General Liability Insurance, to protect the Contractor, LDH, the MCO Transportation Broker and any subcontractor or provider during the performance of work covered by the Contract or the contract between the Contractor and the MCO Transportation Broker from claims or damages for personal injury, including accidental death, as well as from claims for property damages, which may arise from operations under the Contract or the contract between the Contractor and the MCO Transportation Broker, whether such operations be by the Contractor or by the MCO Transportation Broker, subcontractor or provider, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to LDH. 2.6.8.2 Automobile Liability If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its MCO Transportation Broker to maintain, during the life of the contract between the Contractor and the MCO Transportation Broker, Automobile Liability Insurance to protect the Contractor, LDH, the MCO Transportation Broker and any subcontractor or provider during the performance of work covered by the Contract or the contract between the Contractor and the MCO Transportation Broker that shall have a minimum combined single limit per accident of $1,000,000. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy.	**2.6.8 Additional Requirements for MCO Transportation Broker** 2.6.8.1 Commercial General Liability If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its ~~MCO~~ Transportation Broker to maintain, during the life of the contract between the Contractor and the ~~MCO~~ Transportation Broker, Commercial General Liability Insurance, with a minimum limit per occurrence of $1,000,000 and a minimum general aggregate of $2,000,000, to protect the Contractor, LDH, the ~~MCO~~ Transportation Broker and any subcontractor or provider during the performance of work covered by the Contract or the contract between the Contractor and the ~~MCO~~ Transportation Broker from claims or damages for personal injury, including accidental death, as well as from claims for property damages, which may arise from operations under the Contract or the contract between the Contractor and the ~~MCO~~ Transportation Broker, whether such operations be by the Contractor or by the ~~MCO~~ Transportation Broker, subcontractor or provider, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to LDH. 2.6.8.2 Automobile Liability If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its ~~MCO~~ Transportation Broker to maintain, during the life of the contract between the Contractor and the ~~MCO~~ Transportation Broker, Automobile Liability Insurance to protect the Contractor, LDH, the ~~MCO~~ Transportation Broker and any subcontractor or provider during the performance of work covered by the Contract or the contract between the Contractor and the ~~MCO~~ Transportation Broker that shall have a minimum combined single limit per accident of $1,000,000. ISO form number CA 00 01 (current form	This update aligns insurance limits with the commercial general liability requirements of the MCO.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.	approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.	
2	Attachment B Statement of Work	**2.6.9 Additional Requirements for NEMT/NEAT Providers** 2.6.9.1 Commercial General Liability If the Contractor elects to contract with a Transportation Broker, The Contractor shall require its MCO Transportation Broker to require their NEMT/NEAT providers to maintain, during the life of the provider agreement between the MCO Transportation Broker and the NEMT/NEAT providers, Commercial General Liability Insurance, to protect the Contractor, LDH, the MCO Transportation Broker, and the NEMT/NEAT providers during the performance of work covered by the Contract or the provider agreement from claims or damages for personal injury, including accidental death, as well as from claims for property damages, which may arise from operations under the Contract or the provider agreement, whether such operations be by the MCO Transportation Broker, the NEMT/NEAT providers, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to LDH. 2.6.9.2 Automobile Liability If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its MCO Transportation Broker to require their NEMT/NEAT providers to maintain, during the life of the provider agreement between the MCO Transportation Broker and the NEMT/NEAT providers, Automobile Liability Insurance to protect the Contractor, LDH, the MCO Transportation Broker, and the NEMT/NEAT	**2.6.9 Additional Requirements for NEMT/NEAT Providers** 2.6.9.1 Commercial General Liability If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its ~~MCO~~ Transportation Broker to require their NEMT/NEAT providers to maintain, during the life of the provider agreement between the ~~MCO~~ Transportation Broker and the NEMT/NEAT providers, Commercial General Liability Insurance, with a minimum limit of $100,000 on the business entity, to protect the Contractor, LDH, the ~~MCO~~ Transportation Broker, and the NEMT/NEAT providers during the performance of work covered by the Contract or the provider agreement from claims or damages for personal injury, including accidental death, as well as from claims for property damages, which may arise from operations under the Contract or the provider agreement, whether such operations be by the ~~MCO~~ Transportation Broker, the NEMT/NEAT providers, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to LDH. 2.6.9.2 Automobile Liability If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its ~~MCO~~ Transportation Broker to require their NEMT/NEAT providers to maintain, during the life of the provider agreement between the ~~MCO~~ Transportation Broker and the NEMT/NEAT providers, Automobile Liability Insurance to protect the	This update aligns insurance limits with the emergency rule.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		providers during the performance of work covered by the Contract or the provider agreement that shall have a minimum combined single limit per accident of $300,000 for NEMT providers traveling in-state and $1,000,000 for NEAT providers. NEMT providers must have a $1,000,000 liability limit in order to cross state lines with an enrollee onboard. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles. 2.6.9.3 Workers' Compensation If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its MCO Transportation Broker to require their NEMT/NEAT providers to maintain, during the life of the provider agreement between the MCO Transportation Broker and the NEMT/NEAT providers, Workers' Compensation Insurance to protect the NEMT/NEAT providers during the performance of work covered by the Contract or the provider agreement that shall have a minimum limit of $100,000 per accident/$100,000 per disease/$500,000 per employee in accordance with La. R.S. 23:1035.	Contractor, LDH, the ~~MCO~~ Transportation Broker, and the NEMT/NEAT providers during the performance of work covered by the Contract or the provider agreement that shall have coverage of $25,000 for bodily injury per person, $50,000 per accident, and $25,000 for property damages ~~a minimum combined single limit per accident of $300,000~~ for NEMT providers traveling in-state and $1,000,000 for NEAT providers. NEMT providers must have a $1,5~~0~~00,000 liability limit in order to cross state lines with an enrollee onboard. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles. 2.6.9.3 Workers' Compensation If the Contractor elects to contract with a Transportation Broker, the Contractor shall require its ~~MCO~~ Transportation Broker to require their NEMT/NEAT providers to maintain, during the life of the provider agreement between the ~~MCO~~ Transportation Broker and the NEMT/NEAT providers, Workers' Compensation Insurance to protect the NEMT/NEAT providers during the performance of work covered by the Contract or the provider agreement that shall have a minimum limit of $100,000 per accident/$100,000 per disease/$500,000 per employee in accordance with La. R.S. 23:1035.	
3	Attachment B Statement of Work	(New provision)	4.7.10 In the event of a transition between subcontractors during the term of this contract, the Contractor must ensure that the original subcontractor fulfills all subcontractual obligations, including those that survive the subcontract termination or expiration. In the event that this contract terminates or expires, the Contractor must ensure	This update requires subcontractors to fulfill all contractual obligations.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			that any existing subcontractor fulfills its subcontractual obligations, including those that survive contract termination.	
4	Attachment B Statement of Work	5.4 Withhold of Capitated Payment 5.4.1. A withhold of the monthly capitated payment shall be applied to incentivize quality, health outcomes, and value-based payments. The withhold amount will be equal to two percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments, payments under section 5.18, and the FMP component of the monthly capitated payment.	5.4 Withhold of Capitated Payment 5.4.1. A withhold of the monthly capitated payment ~~shall~~ may be applied to incentivize quality, health outcomes, and value-based payments. The withhold amount will be equal to two percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments, payments under section 5.18, and the FMP component of the monthly capitated payment. In response to the COVID-19 pandemic, LDH shall suspend and refund the CY 2020 quality and VBP withholds. The suspension of the withholds is only in effect for CY 2020. The MCO shall continue to comply with quality and value-based payment reporting as required in the contract.	Allows for the suspension and refund of the withhold of capitated payment in CY 2020 in response to the COVID-19 pandemic.
5	Attachment B Statement of Work	5.4.1.1.5. If NCQA makes changes to any of the measures selected by LDH, such that valid comparison to prior years will not be possible, LDH, at its sole discretion, may elect to eliminate the measure from incentive eligibility, change the affected measure to be reporting only, or replace it with another measure.	5.4.1.1.5. If NCQA makes changes to any of the measures selected by LDH, such that valid comparison to prior years will not be possible, or if it is determined that a measure is not reasonably attainable, LDH, at its sole discretion, may elect to eliminate the measure from incentive eligibility, change the affected measure to be reporting only, or replace it with another measure.	The ED measure was determined not to be reasonably attainable by Mercer.
6	Attachment B Statement of Work	5.4.1.1.12. LDH shall retain the amount of the quality withhold not earned back by the MCO.	5.4.1.1.12. LDH shall retain the amount of the quality withhold not earned back by the MCO. 5.4.1.1.13. LDH shall suspend and refund the MCO quality withhold for CY 2020 that is specific to CY 2020 data collection (CY 2021	Amends the provisions pertaining to the *quality* withhold.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			reporting). Reporting activities and related deliverables for CY 2019 quality withhold and data collection (CY 2020 reporting) remain in effect; however, flexibilities may be afforded by LDH based on NCQA guidance to Medicaid plans.	
7	Attachment B Statement of Work	5.4.1.2. Value-Based Payments 5.4.1.2.1. Half of the total withhold amount, equal to one percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment, shall be applied to incentivize Value-Based Payments (VBP). 5.4.1.2.2. The MCO may earn back the VBP withhold amount for maintaining or increasing its SFY2019 reported use of VBP consistent with the MCO's VBP deliverables and its use of payment models that include categories 2A, 2C, 3 and 4 of the Learning Action Network (LAN) Alternative Payment Models Framework and aligned with the incentive-based measures specified in Attachment C (hereafter collectively referred to as "APM"). 5.4.1.2.3. To earn back the full VBP withhold amount in CY2020, the MCO shall: 5.4.1.2.3.1. Submit the following deliverables to LDH by August 30, 2020: 5.4.1.2.3.1.1. A written update to its VBP Strategic Plan describing the implementation and status of its VBP use for SFY2020. 5.4.1.2.3.1.2. A report on its SFY2020 VBP use as specified in Attachment E.	5.4.1.2. Value-Based Payments 5.4.1.2.1. Half of the total withhold amount, equal to one percent of the monthly capitated payment for physical and basic behavioral health for all MCO members, exclusive of maternity kick payments and the FMP component of the monthly capitated payment, ~~shall~~ may be applied to incentivize Value-Based Payments (VBP). 5.4.1.2.2. The MCO may earn back the VBP withhold amount for maintaining or increasing its ~~SFY2019~~ reported use of VBP consistent with the MCO's VBP deliverables and its use of payment models that include categories 2A, 2C, 3 and 4 of the Learning Action Network (LAN) Alternative Payment Models Framework and aligned with the incentive-based measures specified in Attachment C (hereafter collectively referred to as "APM"). 5.4.1.2.3. ~~To earn back the full VBP withhold amount in CY2020, the~~The VBP withhold shall be suspended for CY 2020; however, the MCO shall comply with VBP reporting requirements. The MCO shall: 5.4.1.2.3.1. Submit the following deliverables to LDH by August 30, 2020: 5.4.1.2.3.1.1. A written update to its VBP Strategic Plan describing the implementation and status of its VBP use for SFY2020.	Amends the provisions pertaining to the *VBP* withhold.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		5.4.1.2.3.1.3. The MCO must report its SFY2020 VBP use using the same method as reported for its CY2017 baseline report and SFY2019 report ("date of payment" or "date of service" approach). 5.4.1.2.3.1.4. If the MCO chooses to report its SFY2020 VBP use using a "date of service" approach, it must submit a refreshed SFY2020 VBP use report by October 15, 2020 and may be subject to longer LDH withholding of VBP funds. 5.4.1.2.3.1.5. The update to the VBP Strategic Plan and SFY2020 VBP use reported in Attachment E must demonstrate the MCO maintained or increased its SFY2019 reported use of APM consistent with categories 2A, 2C, 3, and 4 of the LAN APM Framework and aligned with the incentive-based measures specified in Attachment C. If the MCO did not meet this criteria, the MCO shall describe why the criteria were not met. 5.4.1.2.3.1.6. If LDH determines the Contractor has successfully completed these deliverables, LDH shall reduce the VBP withhold for the remainder of CY2020 to 0.50% of the monthly capitation rate and refund any amounts withheld for VBP through July 2020. The withhold shall not be reduced or refunded for late submissions. 5.4.1.2.3.2. By November 30, 2020, schedule and complete an in-person meeting with LDH to review its VBP Strategic Plan and SFY2020 use report, as delivered in 5.4.1.2.3.1, in comparison to its VBP deliverables for SFY2019. 5.4.1.2.3.2.1. If LDH determines the MCO has successfully completed the VBP requirements and deliverables, LDH shall reduce	5.4.1.2.3.1.2. A report on its SFY2020 VBP use as specified in Attachment E. 5.4.1.2.3.1.3. The MCO must report its SFY2020 VBP use using the same method as reported for its CY2017 baseline report and SFY2019 report ("date of payment" or "date of service" approach). 5.4.1.2.3.1.4. If the MCO chooses to report its SFY2020 VBP use using a "date of service" approach, it must submit a refreshed SFY2020 VBP use report by October 15, 2020~~ and may be subject to longer LDH withholding of VBP funds~~. 5.4.1.2.3.1.5. The update to the VBP Strategic Plan and SFY2020 VBP use reported in Attachment E must demonstrate the MCO maintained or increased its SFY2019 reported use of APM consistent with categories 2A, 2C, 3, and 4 of the LAN APM Framework and aligned with the incentive-based measures specified in Attachment C. If the MCO did not meet this criteria, the MCO shall describe why the criteria were not met. ~~5.4.1.2.3.1.6. If LDH determines the Contractor has successfully completed these deliverables, LDH shall reduce the VBP withhold for the remainder of CY2020 to 0.50% of the monthly capitation rate and refund any amounts withheld for VBP through July 2020. The withhold shall not be reduced or refunded for late submissions.~~ 5.4.1.2.3.2. By November 30, 2020, schedule and complete a~~n in-person~~ meeting with LDH to review its VBP Strategic Plan and SFY2020 use report, as delivered in 5.4.1.2.3.1, in comparison to its VBP deliverables for SFY2019.	

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		the VBP withhold for the remainder of CY2020 to 0% and refund any remaining amounts withheld for VBP during CY2020. 5.4.1.2.4. LDH shall retain the amount withheld from any MCO for any unearned VBP incentive. … 5.4.7. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract.	~~5.4.1.2.3.2.1. If LDH determines the MCO has successfully completed the VBP requirements and deliverables, LDH shall reduce the VBP withhold for the remainder of CY2020 to 0% and refund any remaining amounts withheld for VBP during CY2020.~~ 5.4.1.2.4. LDH shall refund any amounts withheld for the CY 2020 VBP incentive. In other years, if this contract is extended, LDH shall retain the amount withheld from any MCO for any unearned VBP incentive. … 5.4.7. The provisions of this Section may be invoked alone or in conjunction with any other remedy or adjustment otherwise allowed under this Contract. LDH reserves the right to assess monetary penalties for failure to meet deliverables as required under this section.	
8	Attachment B Statement of Work	(New provision)	5.6.4 Zolgensma Risk Pool Arrangement 5.6.4.1 The amount of the risk pool is determined by the projected Zolgensma costs incorporated into the CY 2020 rates. Maximum allowable cost per claim will be based on Fee for Service reimbursement (wholesale acquisition cost plus professional dispensing fee). LDH will redistribute funds among MCOs based on the actual Zolgensma costs, net of TPL. The MCO shall follow FFS clinical criteria for Zolgensma. The Zolgensma risk pool will be settled following the conclusion of the CY 2020 contract period.	The Zolgensma Risk Pool will be in effect for CY 2020 rates.
9	Attachment B Statement of Work	5.12.2 The MCO and its subcontractors may impose cost sharing on Medicaid members in accordance with 42 CFR §447.50 - §447.82 provided, however, that it does not exceed cost sharing amounts in the Louisiana Medicaid State Plan.	5.12.2 The MCO and its subcontractors may impose cost sharing on Medicaid members in accordance with 42 CFR §447.50 - §447.82 provided, however, that it does not exceed cost sharing amounts in the	This update will align cost sharing amounts with FFS as CMS has suggested.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			Louisiana Medicaid State Plan. The copay tiers in the state plan shall be based on the total amount reimbursed to the pharmacy for the claim.	
10	Attachment B Statement of Work	(New provision)	6.1.11.2 A public health quarantine or isolation order or recommendation also establishes the medical necessity of healthcare services.	This provision will address the COVID-19 outbreak.
11	Attachment B Statement of Work	**6.3.1 Covered Services** 6.3.1.1 The MCO may follow the FFS limit of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than the Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber. 6.3.1.2 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 Covered Drug List** 6.3.2.1 In accordance with 42 CFR §438.3, the MCO shall maintain a Covered Drug List (CDL) which includes all outpatient drugs for which the manufacturer has entered into a Federal rebate agreement and met the standards in Section 1927 of the Social Security Act. The CDL will be provided by LDH to the MCOs as a weekly drug file.	**6.3.1 Covered Services** 6.3.1.1 The MCO ~~may follow the FFS limit~~ shall cover a minimum of four prescriptions per calendar month if prescribed for the member. However, it may not enact prescription limits more stringent than the ~~Medicaid~~ State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber. 6.3.1.2 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 Covered Drug List** 6.3.2.1 In accordance with 42 CFR §438.3, the MCO shall maintain a Covered Drug List (CDL) which includes all outpatient drugs for which the manufacturer has entered into a Federal rebate agreement and meet the standards in Section 1927 of the Social Security Act. The CDL will be provided by LDH to the MCOs as a weekly drug file.	These verbiage updates are required to align contract verbiage with current practice.
12	Attachment B	6.3.2.3. The CDL shall exclude only those drugs or drug categories permitted for exclusion under Section 1927(d) of the Social Security Act, with exceptions listed in the Louisiana State Plan. MCOs are	6.3.2.3. The CDL shall exclude only those drugs or drug categories permitted for exclusion under Section 1927(d) of the Social Security Act, with exceptions listed in the Louisiana State Plan. MCOs are	This update will enhance adult vaccine coverage.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	Statement of Work	allowed to cover vaccines, compounded drugs, diabetic supplies, and rebate eligible OTCs as a regular pharmacy benefit (not value added). MCOs are allowed to cover additional drugs as a value added benefit.	allowed to cover ~~vaccines,~~ compounded drugs, diabetic supplies, and rebate eligible OTCs as a regular pharmacy benefit (not value added). MCOs are allowed to cover additional drugs as a value added benefit. MCOs shall cover, at a minimum, all vaccines and administration covered by FFS for adults and reimburse in the same program types.	
13	Attachment B Statement of Work		6.3.2.8 The medications listed in the U.S. Preventive Services Task Force (USPSTF) A and B Recommendations shall be payable as a pharmacy benefit and exempt from copay. Corresponding age limits may be applied. Physician-administered drugs that are not listed on the FFS fee schedule but for which the manufacturer has signed a federal rebate agreement shall be covered as either a pharmacy benefit or a medical benefit. If the physician administered drug is not on the FFS fee schedule, but the MCO covers as a medical benefit, then reimbursement shall be set as a minimum by the current FFS reimbursement methodology in the Sstate P~~p~~lan.	Verbiage updates are required to align contract verbiage with current practice, and to align PA criteria for provider simplification.
14	Attachment B Statement of Work	**6.3.3. Preferred Drug List** 6.3.3.1 A subset of the CDL shall be the Preferred Drug List (PDL). 6.3.3.2 The PDL shall be established by LDH and indicate the preferred and non-preferred status of covered drugs. 6.3.3.3 The PDL shall be maintained by LDH and made available on the LDH website. The MCO shall make the PDL available to its providers and members through electronic prescribing tools and a static link on the MCO website to the PDL maintained on the LDH website.	**6.3.3. Preferred Drug List** 6.3.3.1 A subset of the CDL shall be the Preferred Drug List (PDL). 6.3.3.2 The PDL is ~~shall be~~ established by LDH and indicate the preferred and non-preferred status of covered drugs. 6.3.3.3 The PDL shall be maintained by LDH and made available on the LDH website: http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf. The MCO shall make the PDL available to its providers and members through electronic prescribing tools and a static link on the MCO website to the PDL maintained on the LDH website.	Verbiage updates are required to align contract verbiage with current practice and required PDL compliance.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		6.3.3.4 LDH shall provide the MCO with a list of drugs included on the PDL by NDC number after each FFS P&T meeting and upon the Secretary's approval of P&T committee recommendations. Changes shall be implemented January 1 and July 1 after FFS P&T, unless otherwise directed by LDH. LDH shall provide the MCOs at least 30 days written notice prior to the implementation date of any changes to the list of drugs included on the PDL. 6.3.3.5 LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL. The MCO shall seek to achieve a 90 percent compliance rate. 6.3.3.6 The MCO shall not enter into agreements with manufacturers to acquire discounts or rebates on drugs. Current MCO manufacturer drug discount or rebate agreements shall be discontinued by 4/30/19. 6.3.3.7 New drugs entering the marketplace in the PDL therapeutic classes shall be added as non-preferred until FFS P&T reviews the drug, unless otherwise directed by LDH. 6.3.3.8 If a branded product is preferred on the PDL, the MCO shall not require the prescriber to indicate in writing that the branded product is medically necessary. The MCO shall reimburse for a brand name drug at a brand reimbursement when the brand drug is preferred. POS denial messaging for the generic entity shall indicate that the brand name is preferred.	6.3.3.4 LDH shall provide the MCO with a list of drugs included on the PDL by NDC number after each FFS Pharmaceutical and Therapeutics Committee (P&T) meeting and upon the Secretary's approval of P&T committee recommendations. Changes shall be implemented January 1 and July 1 after the ~~FFS~~ P&T meeting, unless otherwise directed by LDH. LDH shall provide the MCOs at least 30 days written notice prior to the implementation date of any changes to the list of drugs included on the PDL. ~~6.3.3.5~~ LDH shall monitor the rate of MCO compliance with the PDL. Compliance rate shall be defined as the number of preferred prescriptions paid divided by total prescriptions paid for drugs in therapeutic classes listed on the PDL. The MCO shall seek to achieve a 90 percent compliance rate. 6.3.3.~~6~~5 The MCO shall not enter into agreements with manufacturers to acquire discounts or rebates on drugs. ~~Current MCO manufacturer drug discount or rebate agreements shall be discontinued by 4/30/19.~~ 6.3.3.~~7~~6 New drugs entering the marketplace in the PDL therapeutic classes shall be added as non-preferred until ~~FFS~~ P&T reviews the drug, unless otherwise directed by LDH. 6.3.3.~~8~~7 If a branded product is preferred on the PDL, the MCO shall not require the prescriber to indicate in writing that the branded product is medically necessary. The MCO shall reimburse for a brand name drug at a brand reimbursement when the brand drug is preferred. POS denial messaging for the generic entity shall indicate that the brand name is preferred.	

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		6.3.3.9 DXC (formerly Molina) will post weekly drug file data for the MCOs. MCOs shall have 3 business days after receipt of file to download and implement drug PA status. 6.3.3.10 There shall be a mandatory generic substitution for all drugs, when a generic is available, unless the brand is justified with applicable DAW codes or the brand is preferred. 6.3.3.11 Hepatitis C Project: The MCOs will follow the Single PDL preferred/non-preferred status and criteria. The MCO PBM shall program denials of 340B claims for all Hepatitis C direct acting anti-viral (DAA) agents. The denials should be based on the 340B pharmacy list provided by LDH quarterly.	6.3.3.~~9~~8 DXC (formerly Molina) will post weekly drug file data for the MCOs. MCOs shall have 3 business days after receipt of file to download and implement drug PA status, for drugs covered as an outpatient pharmacy benefit. 6.3.3.~~10~~9 There shall be a mandatory generic substitution for all drugs, when a generic is available, unless the brand is justified with applicable DAW codes or the brand is preferred. 6.3.3.~~11~~10 Hepatitis C Project: The MCOs shall ~~will~~ follow the Single PDL preferred/non-preferred status and criteria. The MCO PBM shall program denials of 340B claims for all Hepatitis C direct acting anti-viral (DAA) agents. The denials shall ~~should~~ be based on the 340B pharmacy list provided by LDH quarterly.	
15	Attachment B Statement of Work	**6.3.4 Prior Authorization for Pharmacy Benefits** 6.3.4.1 LDH intends to align FFS and MCO prior authorization (PA) criteria for drugs on the single PDL over time through the Drug Utilization Review (DUR) board. The MCOs shall have input on PA criteria development and representation on the DUR board. Prior to alignment, the MCOs shall maintain PA criteria that is not more restrictive than FFS. The MCO shall have a Prior Authorization (PA) process that complies with 42 CFR § 438.3(s)(6) and the following requirements. 6.3.4.1.1 The MCO shall allow prescribers and pharmacies to submit PA requests by phone, fax or automated process; 6.3.4.1.2 The MCO shall provide access to a toll-free call center for prescribers to call to request PA for non-preferred drugs or drugs that are subject to clinical edits. If the MCO or its pharmacy benefit	**6.3.4 Prior Authorization for Pharmacy Benefits** 6.3.4.1 LDH intends to align FFS and MCO prior authorization (PA) criteria for drugs on the single PDL over time through the Drug Utilization Review (DUR) board. The MCOs shall have input on PA criteria development and representation on the Drug Utilization Review (DUR) board. Prior to alignment, the MCOs shall maintain PA criteria that is not more restrictive than FFS. The MCO shall have a Prior Authorization (PA) process that complies with 42 CFR § 438.3(s)(6) and the following requirements. 6.3.4.1.1 The MCO shall allow prescribers and pharmacies to submit PA requests by phone, fax or automated process; 6.3.4.1.2 The MCO shall provide access to a toll-free call center for prescribers to call to request PA for non-preferred drugs or drugs that are subject to clinical edits. If the MCO or its pharmacy benefit	Verbiage updates are required to align contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		manager operates a separate call center for PA 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; 6.3.4.1.3 PA requests shall be approved or denied within 24 hours of receipt, seven (7) days a week. The MCO shall notify the requesting practitioner of the approval or disapproval of the request within 24 hours. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing. PA denials may be appealed in accordance with Section 13 of this Contract; Consistent with the requirements of Section 1927 of the Social Security Act, LDH will hold MCOs to a 99.5% compliance rate with the 24-hour resolution requirement. If a MCO is reporting less than 99.5% compliance on the RX055 report, an explanation shall be included with the report in the notes section; 6.3.4.1.4 The MCO shall have an automated process that allows the pharmacy to dispense without PA up to a 72-hour emergency supply of a product or full unbreakable package. At a minimum, the MCO shall allow two consecutive emergency supply fills per prescription. The MCO shall reimburse the pharmacy for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post payment review to identify misuse; 6.3.4.1.5 The MCO shall prior authorize drugs with a non-preferred status on the PDL;	manager operates a separate call center for PA 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; 6.3.4.1.3 PA requests shall be approved or denied within 24 hours of receipt, seven (7) days a week. The MCO shall notify the requesting practitioner of the approval or disapproval of the request within 24 hours. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing. PA denials may be appealed in accordance with Section 13 of this Contract; Consistent with the requirements of Section 1927 of the Social Security Act, LDH will hold MCOs to a 99.5% compliance rate with the 24-hour PA resolution requirement. If a MCO is reporting less than 99.5% compliance on the RX055 report, an explanation shall be included with the report in the notes section; 6.3.4.1.4 The MCO shall have an automated process that allows the pharmacy to dispense without PA ~~up to~~ a 72-hour emergency supply of a product or full unbreakable package. ~~At a minimum, t~~The MCO shall allow up to two consecutive emergency supply fills per prescription, if needed. The MCO shall reimburse the pharmacy for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post payment review to identify misuse; 6.3.4.1.5 The MCO shall prior authorize drugs with a non-preferred status on the PDL;	

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		6.3.4.1.6 The MCO shall not prior authorize drugs with a preferred status on the PDL, except to align with FFS clinical edits; 6.3.4.1.7 For self-administered drugs, the MCO shall not prior authorize drugs not on the PDL, except to align with FFS clinical edits or otherwise directed by LDH;	6.3.4.1.6 The MCO shall not prior authorize drugs with a preferred status on the PDL, except to align with FFS clinical edits; 6.3.4.1.7 For self-administered drugs, the MCO shall not prior authorize drugs not on the PDL, except to align with FFS clinical edits or as otherwise directed by LDH;	
16	Attachment B Statement of Work	(Moved from a different section) 8.6.10. A member, or a provider on Member's behalf, may appeal prior authorization denials in accordance with Section 13 (Grievances and Appeals) of this contract.	6.3.4.1.20 A member, or a provider on Member's behalf, may appeal prior authorization denials in accordance with Section 13 (Grievances and Appeals) of this contract.	This is a current contract requirement and is being moved from section 8.6.10 to 6.3.4.1.20.
17	Attachment B Statement of Work	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents, Synagis, Respiratory monoclonal antibody agents (benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), omalizumab (Xolair®), and reslizumab (Cinqair®), Growth Hormones, Multiple Sclerosis drugs, and Hemophilia agents.	6.3.4.2 As of January 1, 2019, the statewide universal prior authorization form shall be posted and utilized as specified in Act 423 of the 2018 Louisiana Regular Session. In order to obtain necessary information for prior authorization processing, the following therapeutic drug classes shall be considered specialty for prior authorization purposes only: Hepatitis C Direct Acting Antiviral Agents Synagis, Respiratory monoclonal antibody agents (benralizumab (Fasenra®), dupilumab (Dupixent®), mepolizumab (Nucala®), omalizumab (Xolair®), and reslizumab (Cinqair®), Growth Hormones, Multiple Sclerosis drugs, and Hemophilia agents. The MCO shall adhere to the provisions of La. R.S. 46:153.3(C)(1) which exempt HIV/AIDS drugs from the prior authorization process.	This update aligns PA criteria and forms for provider simplification.
18	Attachment B Statement of Work	6.3.6.3 The MCO shall have a specific Suboxone, Subutex and methadone management program and approach, which shall be approved by LDH. The policy and procedure must be in accordance with current state and federal statutes in collaboration with the State	6.3.6.3 The MCO shall have a specific Suboxone, Subutex and methadone management program and approach, which shall be approved by LDH. The policy and procedure must be in accordance with current state and federal statutes in collaboration with the State Opioid Treatment Authority/LDH. ~~The MCO shall submit the policy for LDH approval no later than January 1, 2016.~~	Verbiage updates are required to align contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		Opioid Treatment Authority/LDH. The MCO shall submit the policy for LDH approval no later than January 1, 2016.		
19	Attachment B Statement of Work	**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 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 LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.	**6.3.7.3.2 Retrospective DUR Program** 6.3.7.3.2.1 The MCO, in conjunction with LDH, shall provide for the ongoing periodic examination of claims data to identify patterns of 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 LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.	Verbiage updates are required to align contract verbiage with current practice.
20	Attachment B Statement of Work	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives and submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date. 6.3.7.5 The MCO must provide a detailed description of its DUR program annually to LDH 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.	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives. ~~and~~ The MCO shall submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date. 6.3.7.5 The MCO ~~must~~shall provide a detailed description of its DUR program annually to LDH in the CMS template ~~to mimic the FFS~~ for the 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 thirty (30) calendar days after CMS provides the link~~4 months preceding the CMS deadline~~.	Verbiage updates are required to align contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
21	Attachment B Statement of Work	**7.17.2.1 Internal Claims Dispute Process** 7.17.2.1.1 The MCO shall maintain an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug. Reimbursement should be no less than the FFS rate on the date of service as required by R.S. 46:460.36(D). Ingredient cost rates shall be updated within seven (7) calendar days of new rates being posted from the source of choice of a nationally recognized database. MCOs shall be penalized $1,000 per calendar day for each rate that is not updated within the 7 calendar day timeframe.	**7.17.2.1 Internal Claims Dispute Process** 7.17.2.1.1 The MCO shall maintain an internal claims dispute process to permit local pharmacies to dispute the reimbursement paid for any claim made for the dispensing of a drug. Reimbursement should be no less than the FFS rate on the date of service as required by R.S. 46:460.36(D). Ingredient cost rates shall be updated within ~~seven (7) calendar~~ three (3) business days of new rates being posted from the source of choice of a nationally recognized database. MCOs shall be penalized $1,000 per calendar day for each rate that is not updated within the ~~seven (7) calendar~~ three (3) business day timeframe.	Verbiage is being updated in response to pharmacy provider complaints on delay of rate implementation.
22	Attachment B Statement of Work	7.17.2.1.4 The MCO may require pharmacies to submit claim disputes within a predetermined time limit. Such limit shall be no less than seven (7) business days after the latter of the fill date or the resolution date of any pending AAC rate update request.	7.17.2.1.4 The MCO may require pharmacies to submit claim disputes within a predetermined time limit. Such limit shall be no less than seven (7) business days after the latter of the fill date ~~or the resolution date of any pending AAC rate update request~~.	This update aligns the contract verbiage with current practice, as AAC is no longer used in reimbursement.
23	Attachment B Statement of Work	**7.17.2.2 Treatment of Excessive Disputes of Sufficiently Reimbursed Claims** 7.17.2.2.1 If, within any thirty (30) calendar day period, a pharmacy has disputed claims across ten (10) or more drug entities with distinct pricing and for more than half of the disputes either the pharmacy declined to seek external review of the MCO's internal claims dispute process finding of reasonable reimbursement or the outcome of the external process was that the disputes were properly denied by the MCO on the basis of reasonable reimbursement, then the pharmacy shall be considered as having met the requirements for treatment of excessive disputes of reasonably reimbursed claims. 7.17.2.2.2 For pharmacies meeting such requirements, the MCO may dismiss all disputes submitted to the MCO for a sixty (60) calendar day	~~**7.17.2.2 Treatment of Excessive Disputes of Sufficiently Reimbursed Claims**~~ ~~7.17.2.2.1 If, within any thirty (30) calendar day period, a pharmacy has disputed claims across ten (10) or more drug entities with distinct pricing and for more than half of the disputes either the pharmacy declined to seek external review of the MCO's internal claims dispute process finding of reasonable reimbursement or the outcome of the external process was that the disputes were properly denied by the MCO on the basis of reasonable reimbursement, then the pharmacy shall be considered as having met the requirements for treatment of excessive disputes of reasonably reimbursed claims.~~ ~~7.17.2.2.2 For pharmacies meeting such requirements, the MCO may dismiss all disputes submitted to the MCO for a sixty (60) calendar day~~	This verbiage is no longer needed since NADAC implementation.

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		period beginning on the date of the written notification of the outcome of the external dispute process for the claim that met requirements. 7.17.2.2.3 If the MCO implements this sixty (60) calendar day period, it must notify both the pharmacy and the Department within three (3) business days of such action and provide to the Department documentation demonstrating that the pharmacy has met the requirements for such treatment. 7.17.2.2.4 The MCO may pend reimbursement disputes submitted to the MCO's internal dispute process while awaiting the outcome of the external dispute process for the qualifying dispute. 7.17.2.2.5 Upon receipt of written notice of the outcome of the external claims dispute process wherein the internal dispute process outcome is in the pharmacy's favor, the MCO shall process pended disputes in order of receipt. For pended disputes, the seven (7) business days dispute resolution and notification requirement applicable to the internal claims dispute process shall begin on the date of the written notification of the outcome of external claims dispute process. 7.17.2.26 A pharmacy may be considered as meeting requirements for treatment of excessive disputes of sufficiently reimbursed claims anew every sixty (60) calendar days.	~~period beginning on the date of the written notification of the outcome of the external dispute process for the claim that met requirements.~~ ~~7.17.2.2.3 If the MCO implements this sixty (60) calendar day period, it must notify both the pharmacy and the Department within three (3) business days of such action and provide to the Department documentation demonstrating that the pharmacy has met the requirements for such treatment.~~ ~~7.17.2.2.4 The MCO may pend reimbursement disputes submitted to the MCO's internal dispute process while awaiting the outcome of the external dispute process for the qualifying dispute.~~ ~~7.17.2.2.5 Upon receipt of written notice of the outcome of the external claims dispute process wherein the internal dispute process outcome is in the pharmacy's favor, the MCO shall process pended disputes in order of receipt. For pended disputes, the seven (7) business days dispute resolution and notification requirement applicable to the internal claims dispute process shall begin on the date of the written notification of the outcome of external claims dispute process.~~ ~~7.17.2.26 A pharmacy may be considered as meeting requirements for treatment of excessive disputes of sufficiently reimbursed claims anew every sixty (60) calendar days.~~	
24	Attachment B Statement of Work	(New provision)	7.17.4.1.3 The following categories of drugs shall not be considered specialty drugs: • Any oral medications utilized to treat HIV, Hepatitis B or Hepatitis C;	This update clarifies the specialty drug definition.

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			• Any oral medications utilized to treat rheumatoid arthritis, multiple sclerosis or psoriasis (e.g., Aubagio, Gilenya, Otezla, Xeljanz/Xeljanz XR, etc.); • Any oral medications utilized to treat epilepsy or an immunosuppressant (e.g., Mycophenolate, Sirolimus, Tacrolimus, etc.); • Self-administered injectable anticoagulants (e.g., Enoxaparin, Fondaparinux, Dalteparin, Unfractionated heparin, etc.); • Self-administered injectable human growth hormone (excluding drop-ship items) or self-administered medications for migraine prophylaxis (e.g., Aimovig, Ajovy, Emgality); and • Self-administered TNF-alpha blockers (e.g., Enbrel, Humira, Simponi, Cimzia), multiple sclerosis agents (e.g., Copaxone, Interferons, etc.) or psoriatic conditions (e.g., Cosentyx).	
25	Attachment B Statement of Work	**8.10 Pharmacy Administrative Simplification** Not later than September 30, 2015, the MCO shall develop jointly with all other Medicaid Managed Care MCOs a common pharmacy administrative framework that applies equally to each Medicaid Managed Care MCO and collectively meets the requirements of Sections 6.3.1 through 6.3.5.3. The framework and any revision thereto, shall be reviewed and approved by LDH prior to implementation. Any changes to the framework shall be submitted to LDH at least 30 days prior to implementation.	~~**8.10 Pharmacy Administrative Simplification**~~ ~~Not later than September 30, 2015, the MCO shall develop jointly with all other Medicaid Managed Care MCOs a common pharmacy administrative framework that applies equally to each Medicaid Managed Care MCO and collectively meets the requirements of Sections 6.3.1 through 6.3.5.3. The framework and any revision thereto, shall be reviewed and approved by LDH prior to implementation. Any changes to the framework shall be submitted to LDH at least 30 days prior to implementation.~~	Verbiage is being removed since this requirement is no longer needed due to single PDL implementation.
26	Attachment B Statement of Work	**9.10.9 Provider Preventable Conditions** 9.10.9.1 The MCO shall deny payment to providers for Provider Preventable Conditions as defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual.	**9.10.9 Provider Preventable Conditions** 9.10.9.1 The MCO shall deny payment to providers for Provider Preventable Conditions (PPCs) as defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual.	This update aligns the contract requirement with current practice.

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		9.10.9.2 The MCO shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. The MCO shall report all identified provider preventable conditions to LDH in a format specified by LDH.	9.10.9.2 The MCO shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. ~~The MCO shall report all identified provider preventable conditions to LDH in a format specified by LDH.~~ PPCs should be identified on the encounter file via the Present on Admission (POA) indicators.	
27	Attachment B Statement of Work	17.9.5 The MCO shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor.	17.9.5 The MCO shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor, regardless of whether the subcontractor's agreement has since termed.	This update requires subcontractors to fulfill all contractual obligations.
28	Attachment B Statement of Work	**17.11.1 System Requirements** 17.11.1.1 The MCO shall have an automated claims 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. 17.11.1.2 Transaction standards: The MCO shall support electronic submission of claims using most current HIPAA compliant transaction standard (currently NCPDP D.0) 17.11.1.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits. 17.11.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription	**17.11.1 System Requirements** 17.11.1.1 The MCO shall have an automated claims 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 calendar days from the date of the original submission of the claim. 17.11.1.2 Transaction standards: The MCO shall support electronic submission of claims using the most current HIPAA compliant transaction standard (currently NCPDP D.0). 17.11.1.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits. 17.11.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription	This update will clarify the verbiage in these provisions.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		and pricing information. The system shall provide online access to reference file information. The system should maintain a history of the pricing schedules and other significant reference data. The drug file for both retail and specialty drugs, including price, must be updated at a minimum every seven (7) calendar days, at the MCO's discretion they may update the file more frequently. 17.11.1.5 The MCO must comply with the claims history requirements in Section 16.13. The historical encounter data submission shall be retained for a period not less than ten (10) years, following generally accepted retention guidelines. 17.11.1.6 Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old. 17.11.1.7 The MCO shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia. 17.11.1.8 Provisions should be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime."	and pricing information. The system shall provide online access to reference file information. The system should maintain a history of the pricing schedules and other significant reference data. The drug file for both retail and specialty drugs, including price, ~~must~~ shall be updated within three (3) business ~~at a minimum every seven (7) calendar~~ days of receipt of the drug file~~, at the MCO's discretion they may update the file more frequently~~. 17.11.1.5 The MCO must comply with the claims history requirements in Section 16.13. The historical encounter data submission shall be retained for a period not less than ten (10) years, following generally accepted retention guidelines. 17.11.1.6 Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old. 17.11.1.7 The MCO shall ensure that the manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia. 17.11.1.8 Provisions ~~should~~ shall be made to maintain permanent history by service date for those services identified as "once-in-a-lifetime."	

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
29	Attachment B Statement of Work	**17.11.2 Pharmacy Rebates** The MCO shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to LDH pursuant to the requirements of Section 17.11.3 of this contract. LDH or its vendor shall submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the LDH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA).	**17.11.2 Pharmacy Rebates** The MCO shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to LDH or its contractor pursuant to the requirements of Section 17.11.3 of this contract. LDH or its ~~vendor~~ contractor shall submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the LDH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA).	Verbiage updates are required to align contract verbiage with current practice.
30	Attachment B Statement of Work	**17.11.3 Pharmacy Encounters Claims Submission** 17.11.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to LDH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section 17.9 requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required. 17.11.3.2 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.	**17.11.3 Pharmacy Encounters Claims Submission** 17.11.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to LDH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, and National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section 17.9 requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required. 17.11.3.2 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.	Verbiage updates are required to align contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		17.11.3.3 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 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. 17.11.3.4 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 LDH before processing any pharmacy claims. 17.11.3.5 Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing. This includes both FFS and Managed Care Medicaid. 17.11.3.6 340B Billing Per Covered Entity 17.11.3.6.1 MCOs shall include in their contracts with 340B providers billing instructions on how to identify 340B claims/encounters.	17.11.3.3 ~~Due to this duplicate discount potential, Louisiana requires that~~ The MCO shall require that network providers who are covered entities, as defined by Section 340B of the Public Health Services Act, utilize the same carve-in or carve-out designation for Managed Care Medicaid patients as for FFS Medicaid recipients. If a covered entity appears on the Medicaid Exclusion File, ~~Louisiana~~ LDH 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. 17.11.3.4 The MCO shall ~~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 LDH before processing any pharmacy claims. 17.11.3.5 Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing. This includes both FFS and Managed Care Medicaid. 17.11.3.6 340B Billing Per Covered Entity 17.11.3.6.1 MCOs shall include ~~in their contracts with 340B providers~~ billing instructions on how to identify 340B claims/encounters ~~in their contracts with 340B providers~~.	
31	Attachment B	**17.11.4 Disputed Pharmacy Encounter Submissions**	**17.11.4 Disputed Pharmacy Encounter Submissions**	Verbiage updates are required to align contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	Statement of Work	17.11.4.1 On a weekly basis, LDH will review the MCO's pharmacy encounter claims and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process.	17.11.4.1 ~~On a weekly basis,~~ At least quarterly, LDH ~~will~~ may review the MCO's pharmacy encounter claims and send a file back to the MCO of disputed encounters that were identified through the drug rebate invoicing process.	
32	Attachment B Statement of Work	**17.11.5 Use of a Pharmacy Benefits Manager (PBM)** If the MCO utilizes a PBM for pharmacy claims payment, then the following requirements shall apply: 17.11.5.1 The MCO must use a PBM to process prescription claims. The PBM must pay claims in accordance with Section 17 of this contract. 17.11.5.2 The MCO must identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the MCO shall obtain LDH approval. The MCO will submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO must provide a plan documenting how it will monitor such Subcontractors. These assurances and procedures must be transmitted to LDH for review and approval prior to the date pharmacy services begin. 17.11.5.3 Any contract for pharmacy benefit manager services shall: 17.11.5.3.1 Be limited to a transaction fee, not to exceed $1.25 per processed claim. The transaction fee covers non-claims costs, exclusive of amounts paid to a pharmacy for a prescription, including the ingredient cost, dispensing fee and provider fee;	**17.11.5 Use of a Pharmacy Benefits Manager (PBM)** If the MCO utilizes a PBM for pharmacy claims payment and administrative services, then the following requirements shall apply: ~~17.11.5.1 The MCO must use a PBM to process prescription claims. The PBM must pay claims in accordance with Section 17 of this contract.~~ 17.11.5.1~~2~~ The MCO ~~must~~ shall identify the proposed PBM and the ownership of the proposed PBM. Before entering into a subcontract with a PBM, the MCO shall obtain written ~~LDH~~ approval by LDH. The MCO ~~will~~ shall submit a written description of the assurances and procedures that ~~must~~ shall be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The MCO ~~must~~ shall provide a plan documenting how it will monitor such PBM ~~Subcontractors~~. These assurances and procedures ~~must~~ shall be transmitted to LDH for review and approval prior to the date pharmacy services begin. 17.11.5.2 The Contractor shall submit a plan for oversight of the PBM's performance prior to the implementation of the Contractor's PBM. The plan shall be subject to LDH approval and comply with this Contract and all LDH requirements; and	Verbiage updates are required to align contract verbiage with current practice and compliance with Act 483 of the 2018 Regular Session.

<table>
<tr><th>Item</th><th>Exhibit/ Attachment/ Document</th><th>Change From:</th><th>Change To:</th><th>Justification</th></tr>
<tr><td></td><td></td><td>17.11.5.3.2 Exclude any rebates or discounts, direct or indirect, from any pharmaceutical manufacturer; and,

17.11.5.3.3 Exclude "spread pricing," defined as any amount charged or claimed by a pharmacy benefit manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.

17.11.5.4 The MCO must submit a plan for oversight of the PBM's performance prior to the implementation of the MCO's PBM. The plan must be approved by LDH and comply with this contract and all LDH requirements.</td><td>17.11.5.3 The Contractor PBM shall not deny any Louisiana licensed pharmacy or Louisiana licensed pharmacist the right to be a participating provider in the Contractor or PBM provider network if the pharmacy or pharmacist meets all requirements of participation in the Louisiana Medicaid program.

17.11.5.43 Any contract for pharmacy benefit manager services shall:

17.11.5.43.1 Be limited to a transaction fee, not to exceed $1.25 per processed claim. The transaction fee covers non-claims costs, exclusive of amounts paid to a pharmacy for a prescription, including the ingredient cost, dispensing fee and provider fee;

17.11.5.43.2 Exclude any rebates or discounts, direct or indirect, from any pharmaceutical manufacturer; and,

17.11.5.43.3 Exclude "spread pricing," defined as any amount charged or claimed by a pharmacy benefit manager to a managed care organization that is in excess of the amount paid to the pharmacy for a prescription, including the ingredient cost, provider fee and dispensing fee.

~~17.11.5.4 The MCO must submit a plan for oversight of the PBM's performance prior to the implementation of the MCO's PBM. The plan must be approved by LDH and comply with this contract and all LDH requirements.~~</td><td></td></tr>
<tr><td>33</td><td>Attachment B

Statement of Work</td><td>20.3.3 Table of Monetary Penalties<table><tr><td>Incentive Based Performance Measure</td><td>Amounts withheld for MCO Incentive Based Performance Measure</td></tr></table></td><td>20.3.3 Table of Monetary Penalties<table><tr><td>~~Incentive Based Performance Measure~~</td><td>~~Amounts withheld for MCO Incentive Based Performance Measure~~</td></tr></table></td><td>The retention of the quality withhold for failure to meet incentive-based performance measures is not considered a monetary penalty. A monetary penalty, as amended, is</td></tr>
</table>

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		outcomes may be permanently retained upon validation of calculated rate by LDH's contracted external quality review organization.	~~outcomes may be permanently retained upon validation of calculated rate by LDH's contracted external quality review organization.~~	assessed via a deduction from the next monthly capitation payment.
34	Attachment B Statement of Work	**21.5 Payment of Monetary Penalties and Sanctions** 21.5.1 Monetary penalties or sanctions assessed by LDH that cannot be collected through the withhold specified in Section 5.3 shall be due and payable to LDH within thirty (30) calendar days after the MCO's receipt of the notice of monetary penalties or sanctions.	**21.5. Payment of Monetary Penalties and Sanctions** 21.5.1. Monetary penalties or sanctions assessed by LDH that cannot be collected through ~~the withhold specified in Section 5.3~~ a deduction from the next monthly capitation payment made to the MCO or from the withhold in the last month of payment under Section 25.63 shall be due and payable to LDH within thirty (30) calendar days after the MCO's receipt of the notice of monetary penalties or sanctions."	This update corrects the mechanism for assessing penalties or sanctions. The withhold mechanism specified in Section 5 is applied to incentivize quality, health outcomes, and value-based payments, rather than to assess penalties or sanctions.
35	Attachment B Statement of Work	**25.63 Withholding in Last Month of Payment** During the transition to a new Contractor, for the last month of the Contract, the Department shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of one hundred and eighty (180) days from the due date of such amount. LDH may retain and offset this withhold if the outgoing Contractor does not fulfill its contractual obligations, including but not limited to repaying any outstanding monetary penalties and sanctions, or does not repay LDH for payments made on behalf of ineligible recipients, some of which may extend past the term of the Contract.	**25.63 Withholding in Last Month of Payment** ~~During the transition to a new Contractor,~~ For the last month of the Contract, the Department shall withhold seventy-five percent (75%) of the final payment to the Contractor for a maximum of one hundred and eighty (180) days from the due date of such amount. LDH may retain and offset this withhold if the outgoing Contractor does not fulfill its contractual obligations, including but not limited to repaying any outstanding monetary penalties and sanctions, or does not repay LDH for payments made on behalf of ineligible recipients, some of which may extend past the term of the Contract.	This update ensures funds are available to secure contract obligations regardless of contract expiration scenario.
36	Attachment E - APM Strategic Plan Requirements and Report	Previous Attachment E PDF	Attachment E was revised to delete the VBP Plan Requirements.	The updated attachment includes additional informational tabs that weren't included in the original.

Attachment C – Performance Measures

From:

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	**2021 (2020 data measurement year) and Subsequent Years Target for Improvement**
AMB-ED $$	Ambulatory Care-ED Visits	This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.	NCQA	CHIPRA	Population Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

To:

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	**2021 (2020 data measurement year) and Subsequent Years Target for Improvement**
~~AMB-ED $$~~	~~Ambulatory Care-ED Visits~~	~~This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.~~	~~NCQA~~	~~CHIPRA~~	~~Population Health~~	~~Utilization~~	~~HEDIS~~	~~NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year~~

Justification:

The ED measure was determined to not be reasonably attainable by Mercer.

Attachment C

Performance Measures

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2021 (2020 data measurement year) and Subsequent Years Target for Improvement
PTB $$	Initiation of Injectable Progesterone for Preterm Birth Prevention	The percentage of women 15-45 years of age with evidence of a previous preterm singleton birth event (24-36 weeks completed gestation) who received one or more progesterone injections between the 16th and 24th week of gestation for deliveries during the measurement year.	State	None	Children's and Maternal Health	Perinatal and Reproductive Health	Section V	Equal to the best performance reported to LDH by any MCO for the prior measurement year
AWC $$	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 OB/GYN practitioner during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
ADD $$	Follow-up Care for Children Prescribed ADHD Medication-Initiation Phase	The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit /hyperactivity disorder (ADHD) medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
ADD $$	Follow-up Care for Children Prescribed ADHD Medication-Continuation Phase	The percentage of children 6-12 years of age as of the index period start date with a newly prescribed ambulatory prescription dispensed for attention-deficit /hyperactivity disorder (ADHD) medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	NCQA	CHIPRA, MU2	Children's Health	Behavioral Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2021 (2020 data measurement year) and Subsequent Years Target for Improvement
~~AMB-ED $$~~	~~Ambulatory Care-ED Visits~~	~~This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.~~	~~NCQA~~	~~CHIPRA~~	~~Population Health~~	~~Utilization~~	~~HEDIS~~	~~NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year~~
PPC $$	Prenatal and Postpartum Care - Timeliness of Prenatal Care	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
PPC $$	Prenatal and Postpartum Care – Postpartum Care (PPC Numerator 2)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
FUH $$	Follow-Up After Hospitalization for Mental Illness - Within 30 days of discharge	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 a follow-up visit with a mental health practitioner within 30 days of discharge.	NCQA	MEDICAID ADULT	Behavioral Health	Behavioral Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2021 (2020 data measurement year) and Subsequent Years Target for Improvement
CBP $$	Controlling High Blood Pressure - Total	The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year based on the following criteria: • Members 18-59 whose BP was <140/90 • Members 60-85 with diagnosis of diabetes who BP was 150-90 • Members 60-85 without a diagnosis of diabetes whose BP was 150/90	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Chronic Disease	Cardiovascular Care	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Hemoglobin A1c (HBA1c) testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with a Hemoglobin A1c (HbA1c) test.	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Eye exam (retinal) performed	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with an eye exam (retinal) performed.	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CDC $$	Comprehensive Diabetes Care - Medical attention for nephropathy	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with medical attention for nephropathy.	NCQA	CHIPRA	Chronic Disease	Diabetes	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source	2021 (2020 data measurement year) and Subsequent Years Target for Improvement
W15 $$	Well-Child Visits in the First 15 Months of Life - Six or more well-child visits.	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
W34 $$	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CPA $$	CAHPS Health Plan Survey 5.0H, Adult (Rating of Health Plan, 8+9+10)	This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.	NCQA	MEDICAID ADULT	Adult	Member Satisfaction	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
CPC $$	CAHPS Health Plan Survey 5.0H, Child (Rating of Health Plan-General Population, 8+9+10)	This measure provides information on parents' experience with their child's Medicaid organization.	NCQA	MEDICAID, CHIPRA	Child	Member Satisfaction	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
HEDIS Measures							
CIS	Childhood Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS
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. Report all individual vaccine numerators and combinations.	NCQA	CHIPRA	Children's Health	Prevention	HEDIS
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	HEDIS

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

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
CCS	Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer: • Women 21-64 who had cervical cytology performed every 3 years • Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years	NCQA	MEDICAID ADULT, MU2	Population Health	Prevention	HEDIS
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	MEDICAID	Population Health	Pulmonary/ Critical Care	HEDIS
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	HEDIS/CAHPS
MSC	Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation. MCOs will report three components (questions): • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS/CAHPS
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	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
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	HEDIS
BCS	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	NCQA	MEDICAID ADULT, MU2	Senior Care	Prevention	HEDIS
CAP	Child and Adolescents' Access to Primary Care Practitioners	Percentage of children ages 12 months – 19 years who had a visit with a PCP. The MCO reports four separate percentages: • Children 12-24 months and 25 months – 6 years who had a visit with a PCP in the measurement year • Children 7-11 years and adolescents 12-19 years who had a visit with a PCP in the measurement year or the year prior to the measurement year.	NCQA	CHIPRA	Children's Health	Access/ Availability of Care	HEDIS
COL	Colorectal screening	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS
SSD	Diabetes screening for people with Schizophrenia or Bipolar who are using Antipsychotic medications	The percentage of members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	MEDICAID ADULT	Population Health	Behavioral Health	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
SPC	Statin Therapy for Patients with Cardiovascular Disease	• The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy (were dispensed at least one high or moderate-intensity statin medication during the measurement year.) • The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who had statin adherence of at least 80% (who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.)	NCQA	MEDICAID ADULT	Population Health	Cardiovascular Care	HEDIS
CDC	Comprehensive Diabetes Care - HbA1c poor control (>9.0%)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with HbA1c poor control (>9.0%).	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS
CDC	Comprehensive Diabetes Care - HbA1c control (<8.0%)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with HbA1c control (<8.0%).	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS
CDC	Comprehensive Diabetes Care - BP control (<140/90 mm Hg).	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) with BP control (<140/90 mm Hg).	NCQA	MEDICAID ADULT	Chronic Disease	Diabetes	HEDIS
PCR	Plan All-Cause Readmissions	For members 18 -64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	NCQA	MEDICAID ADULT	Population Health	All Cause Readmissions	HEDIS

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
AAP	Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported: • 20-44 years • 45-64 years • 65 years and older • Total	NCQA	MEDICAID ADULT	Population Health	Prevention	HEDIS
FUH	Follow-Up After Hospitalization for Mental Illness - Within 7 days of discharge	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 a follow-up visit with a mental health practitioner within 7 days of discharge.	NCQA	CHIPRA	Behavioral Health	Behavioral Health	HEDIS
AMB	Ambulatory Care-Outpatient Visits	This measure summarizes utilization of ambulatory care Outpatient Visits per 1,000 member months.	NCQA	MEDICAID	Population Health	Utilization	HEDIS
PQI Measures							
PQI01	Diabetes Short Term Complications Admission Rate	Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older.	AHRQ	MEDICAID ADULT	Chronic Disease	Diabetes	Section V
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	Section V

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
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	Section V
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	Section V
Vital Record Measures							
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	Section V
NQF (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	Section V
CMS Measures							
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	Section V
CCP-CH	Contraceptive Care-Postpartum (ages 15-20)	The percentage of women ages 15-20 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported.	CMS	CHIPRA	Maternal Health	Perinatal and Reproductive Health	OPA

Identifier	Measure	Measure Description	Measure Steward	Federal Reporting Program	Target Population	Condition	Specification Source
CCP-AD	Contraceptive Care-Postpartum (ages 21-44)	The percentage of women ages 21-44 who had a live birth and were provided a most or moderately effective method of contraception within 3 and 60 days of delivery. Four rates are reported.	CMS	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	OPA
NSV	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	Section V

Instructions: Fill in the cells that are shaded yellow in this worksheet and in the APM reporting template. For questions on terms see the Definitions tab.

MCO Name & Contact Person/e-mail for questions on APM Report (note reporting time period and if you are using an incurred/date of service approach)	

Alternative Payment Models are health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper (https://hcp-lan.org/groups/apm-refresh-white-paper/). See 'refreshed' APM Framework tab for a summary graphic.

Types of APMs (Subcategories)

Question	LAN APM Category	APM Types - Subcategories Select all that apply by putting an X in column C in each applicable row		Brief description of type of providers/services involved (e.g. primary care, hospitals, maternity providers, etc.). May include additional APM detail such as noting provider payment arrangements that include multiple APMs or shared savings approaches that have not yet been reconciled.
Which types of APM payment models were in effect during any portion of the payment period.	2A		Foundational payments for infrastructure and operations	
	2B		Pay for Reporting	
	2C		Pay for Performance	
	3A		APMs with Shared Savings	
	3B		APMs with Shared Savings and Downside Risk	
	4A		Condition-specific population-based payment	
	4B		Comprehensive population-based payment	
	4C		Integrated Finance & Delivery System	

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
1. Total Annual Provider Payments				
All provider payments	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified payment period. Managed Care Incentive Program (MCIP) payments should be excluded from any calculations in this report.	$0	Percentage of Total Provider Payments	#DIV/0!
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**	
2. Alternative Payment Model Framework - Category 2 (All methods below are linked to quality).				
Category 2A Incentive Payments only (Foundational Payments for Infrastructure & Operations)	**Category 2A APMs ONLY** - Total dollars paid to providers for foundational spending to improve care , e.g. care coordination payments, PCMH payments, infrastructure payments, during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is for foundational spending to improve care.	$0	% of Total provider payments that are paid under Category 2A APMs ONLY	#DIV/0!
Contracts that include Category 2A APMs	**Provider Payments under Contracts that include Category 2A APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** foundational spending to improve care.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A APM	#DIV/0!
		For Provider Contracts with Category 2A APMs - % of provider payments that are linked to foundational payments		#DIV/0!
Category 2B Incentive Payments only (Pay for Reporting)	**Category 2B APMs ONLY** - Total dollars paid to providers for pay for reporting , e.g. payments for reporting on HEDIS measures ('pay-per-click') during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is linked to pay for reporting.	$0	% of Total provider payments that are paid under Category 2B APMs ONLY	#DIV/0!
Contracts that include Category 2B APMs	**Provider Payments under Contracts that include Category 2B APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** pay for reporting.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2B APM	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.		
	For Provider Contracts with Category 2B APMs - % of provider payments that are linked to pay for reporting	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.				
Category 2C Incentives only (Rewards for Performance)	**Category 2C APMs ONLY** - Total dollars paid to providers for pay for performance (P4P) rewards to improve care, such as provider performance to population-based target for quality such as a target HEDIS rate. Do not include FFS or base payments to providers. Do not include payments to providers for reporting HEDIS or other measures.	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Category 2C Penalties only (Penalties for Performance)	**Category 2C APMs ONLY** - Total dollars for any penalties applied to providers based on performance to quality measures. Do not include FFS or base payments to providers. Do not include penalties for non-reporting.	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Contracts that include Category 2C APMs	Total dollars paid under provider contracts that include FFS/base payment **plus (or minus)** any P4P payments or penalties, as applicable, (linked to quality) during payment period	$0	% of Total provider payments that are paid under contracts that include at least one Category 2C APM	#DIV/0!
		For Provider Contracts with Category 2C APMs - % of provider payments that are linked to P4P		#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
Alternative Payment Model Framework - Category 3 (All methods below are linked to quality)				
Category 3 - Only **Shared Savings** Payments to providers	Total **shared savings** dollars ONLY paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are paid out under Category 3 shared savings arrangements	#DIV/0!
Category 3 - Only **Downside Risk** 'recoupments' applied to providers	Total **downside risk** collections or recoupments applied to providers under contracts that include Category 3 APMs and paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are collected or applied to providers under Category 3 shared risk arrangements	#DIV/0!
Contracts that include Category 3 APMs	Total dollars paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality), include FFS/base payment **plus** any shared savings **or minus** downside risk applied during payment period, as applicable.	$0	% of Total provider payments that are paid under contracts that include at least one Category 3 APM	#DIV/0!
Alternative Payment Model Framework - Category 4 (All methods below are linked to quality)				
Contracts with Category 4 APMs	Total dollars paid in Population-based APMs (Category 4) during payment period. (Include the full prospective payment/capitation)	$0	% of Total provider payments that are paid under contracts that include Category 4 APMs	#DIV/0!
For calculation only - Contracts with one or more APMs in category 2A, 2C, 3 or 4 (excludes contracts with only Category 2B APMs)				
Automated calculation of payments under provider contract with one or more APMs in categories 2A, 2C, 3 and 4	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs as reported above. **If an MCO reported a contract(s) with more than one APM Categories (e.g., Category 2 and 3) in more than one of the following cells: C8, C15, C21 or C23, this total it will be overstated.**	$0		
Overstated provider payments in contracts with multiple APMs	In cases of provider contracts that include mulitple APM categories, enter total amount of the overstated provider contract(s) so that no provider contract is counted more than once in cells C8, C15, C21, or C23.	$0		
VBP BENCHMARK (Contracts with one or more APMs in category 2A, 2C, 3 or 4)				

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.				
Contracts that include Category 2A, 2C, 3 or 4 APMs (unduplicated)	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs (all with links to quality). This may be less than the combination of provider contract payments reported under each applicable LAN category as calculated in cell C25. If a contract includes more than one type of APM, it should only be counted once in the VBP benchmark.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A, 2C, 3 or 4 APM	**#DIV/0!**

Definitions

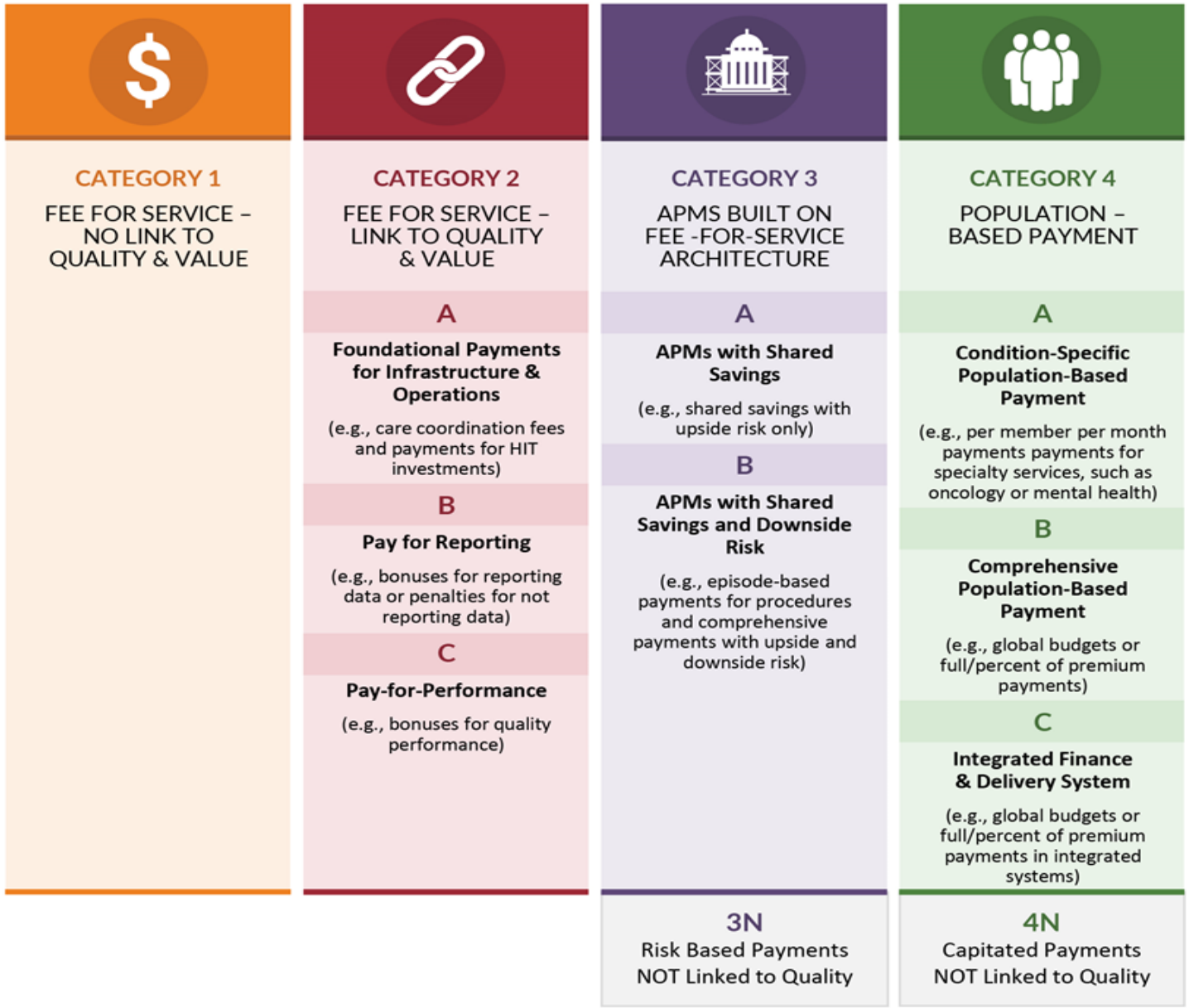
Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper and the graphic included on the 'refreshed' APM Framework tab. https://hcp-lan.org/groups/apm-refresh-white-paper/
Category 2 APM (must be linked to quality)	Fee-for-service linked to quality. These payments utilize traditional FFS payments, but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics. Examples are described in more detail in other definitions and include: 2A: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems 2C: Rewards and Penalties for Performance: Bonus payments/rewards and/or penalties for quality performance on specified measures, including those in DRG systems.
Category 3 APM (excludes risk-based payment models that are NOT linked to quality)	Alternative payment methods (APMs) built on **fee-for-service architecture** while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are **based on cost performance against a target**, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are retrospectively eligible for shared savings, and those that do not may be held financially accountable. Examples include: 3A: APMs with upside gain sharing based on a budget target/shared savings: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); Oncology COE with retrospective shared savings (no shared risk). 3B: APMs with upside gain sharing and downside risk: retrospective bundled payments with up and downside risk, retrospective episode-based payments with shared savings and losses; PCMH with retrospective shared savings and losses; Oncology COE with retrospective shared savings and losses.

Definitions

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

Definitions

Terms	Definitions
Pay for performance	The use of financial incentives to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. [APM Framework Category **2C** if there is a link to quality].
Payment Period	The twelve month period, applicable to the specified MCO reporting requirements.
Population-based payment for conditions	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period including inpatient care and facility fees. [APM Framework Category **4A** if there is a link to quality].
Population-based payment not condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could be, for example, primary care services or professional services that are not specific to any particular condition. [APM Framework Category **3B** if there is a link to quality].
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **3B**].
Provider	For the purposes of this report, provider includes all providers for which there is MCO health care spending. For the purposes of reporting APMs, this definition of provider includes medical, behavioral, pharmacy, DME, PCMH/FCMH, dental, vision, transportation, and local health departments (e.g., lead screening) etc. as applicable.
Shared risk/losses	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the applicable payment period.



Note - This is a draft refreshed framework. The comment period has closed. The LAN may issue clarifications or changes.