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: 2000441827 (3)
Vendor: Community Care Health Plan of Louisiana, Inc. DBA Healthy Blue
Description: Amd 3 to extend MCO emergency contract 1 year
Approved By: Pamela Rice
Approval Date: 12/22/2020

Your amendment that was submitted to OSP has been approved.

Rev 2017-01

AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 3
LAGOV#: 2000441827
LDH #:

Medical Vendor Administration
(Regional / Program / Facility)
Bureau of Health Services Financing

AND

Community Care Health Plan of Louisiana DBA Healthy Blue
Contractor Name

Original Contract Amount: 1,676,850,203
Original Contract Begin Date: 01-01-2020
Original Contract End Date: 12-31-2020
RFP Number: N/A

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $1,676,850,203.00 Current Contract Term: 01/01/20-12/31/20

See attachments
CF-1
12) Maximum Contract Amount: $1,676,850,203.00
13) Estimated Amounts by Fiscal Year: FY20: $838,425,101.50 FY21: $838,425,101.50
B - Statement of Work
C - Performance Measures

Change Contract To: To Maximum Amount: $4,394,059,501.50 Changed Contract Term: 01/01/20-12/31/21

See attachments:
CF-1
12) Maximum Contract Amount: $4,394,059,501.50
13) Estimated Amounts by Fiscal Year: FY20: $838,425,101.50 FY21: $2,358,029,415.00 , FY22: ~~$1,196,604,985.00~~ $1,199,604,985.00
B - Statement of Work
C - Performance Measures

Aaron Lambert
Tara LeBlanc

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 extends the contract through December 31, 2021 in order to avoid a disruption in services to managed care enrollees. This amendment also updates quality performance measures for calendar year 2020 to align with changes made by the National Committee for Quality Assurance, implements the Children's Medicaid Option as a mandatory MCO population for all covered services effective January 1, 2021 per Act 421 of the 2019 Regular Session, and incorporates operational clarifications.

This Amendment Becomes Effective: 12-01-2020

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	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
Community Care Health Plan of Louisiana DBA Healthy Blue	Secretary, Louisiana Department of Health or Designee
CONTRACTOR SIGNATURE: [signature] DATE: 12-07-20	SIGNATURE: [signature] DATE: 12/7/2020
PRINT NAME: Aaron Lambert	NAME: Tara LeBlanc
CONTRACTOR TITLE: CEO	TITLE: Interim Medicaid Executive Director
	OFFICE: Louisiana Department of Health
	PROGRAM SIGNATURE: DATE:
	NAME:

Contract Amendment #3
Attachment B3

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
1	Attachment B Statement of Work	[end of section]	3.4.9 Act 421 Children's Medicaid Option – Certain children with disabilities are eligible for Medicaid state plan services effective January 1, 2021 or the quarter after CMS approval if approval is granted after January 1, 2021. The child must have a disability recognized under the definition used in the SSI program of the Social Security Administration and meet the level-of-care for a nursing facility, hospital, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	This provisions adds the Children's Medicaid Option (CMO) as a mandatory MCO population for all covered services per Act 421 of the 2019 Regular Session.
2	Attachment B Statement of Work	**5.11. Other Payment Terms** … [end of section]	**5.11. Other Payment Terms** … 5.11.5 Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the MCO must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the MCO will not be paid for that work. If the state paid the MCO in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.	This addition is a CMS requirement to address situations where managed care activities have been vacated by a court. CMS issued this guidance as part of their ongoing effort to provide states greater transparency and consistency across CMS' managed care plan contract review process.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
3	Attachment B Statement of Work	6.4.4 Specialized Behavioral Health Services • Psychiatrist (all ages) • Licensed Mental Health Professionals (LMHP) … • Mental Health Rehabilitation Services … • Psychiatric Residential Treatment Facilities (under age 21) • Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services • Outpatient and Residential Substance Use Disorder Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care • Screening for services, including the Coordinated System of Care, may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. The MCO shall ensure (either using MCO care management protocols or by ensuring appropriate, proactive discharge planning by MCO contracted providers) the screening takes place while a youth resides in an out-of-home level of care (such as inpatient, PRTF, SUD residential treatment or TGH) and is prepared for discharge to a home and community-based setting. For settings such as PRTF and TGH with lengths of stay allowing sufficient time for comprehensive and deliberate discharge and aftercare planning, the MCO shall ensure that screening for CSoC takes place at least 30 days and up to 90 days prior to the anticipated discharge date. If CSoC screening shows appropriateness, referral to CSoC up to 90 days prior to	6.4.4 Specialized Behavioral Health Services • Psychiatrist (all ages) • Licensed Mental Health Professionals (LMHP) … • Mental Health Rehabilitation Services … • Peer Support Services (ages 21 and older), effective February 1, 2021 • Psychiatric Residential Treatment Facilities (under age 21) • Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services • Outpatient and Residential Substance Use Disorder Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care • Medication-Assisted Treatment (MAT), including Methadone treatment in Opioid Treatment Programs (OTPs) • Screening for services, including the Coordinated System of Care, may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care. The MCO shall ensure (either using MCO care management protocols or by ensuring appropriate, proactive discharge planning by MCO contracted providers) the screening takes place while a youth resides in an out-of-home level of care (such as inpatient, PRTF, SUD residential treatment or TGH) and is prepared for discharge to a home and community-based setting. For settings such as PRTF and TGH with lengths of stay allowing sufficient time for	This update aligns the specialized behavioral health services with the current service array, including the addition of Peer Support Services, effective February 1, 2021.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		discharge from a residential setting shall occur, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment. • Pending CMS approval for the coverage of Methadone to treat opiate addiction, the MCOs shall contract with the Opioid Treatment Programs (OTP) for the administration of Methadone and clinical treatment services for members in accordance with state and federal regulations. These services may also be provided via an in lieu of service for other members at the discretion of the MCOs. • Pending CMS approval of the 1115 SUD Demonstration waiver and associated State Plan Amendments for the implementation plan, coverage may include, but is not limited to adoption of additional services in the following categories: o Outpatient; o Intensive outpatient services; o Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); o Intensive levels of care in residential and inpatient settings; and o Medically supervised withdrawal management.	comprehensive and deliberate discharge and aftercare planning, the MCO shall ensure that screening for CSoC takes place at least 30 days and up to 90 days prior to the anticipated discharge date. If CSoC screening shows appropriateness, referral to CSoC up to 90 days prior to discharge from a residential setting shall occur, as it is expected to assist in comprehensive discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment. • ~~Pending CMS approval for the coverage of Methadone to treat opiate addiction, the MCOs shall contract with the Opioid Treatment Programs (OTP) for the administration of Methadone and clinical treatment services for members in accordance with state and federal regulations. These services may also be provided via an in lieu of service for other members at the discretion of the MCOs.~~ • ~~Pending CMS approval of the 1115 SUD Demonstration waiver and associated State Plan Amendments for the implementation plan, coverage may include, but is not limited to adoption of additional services in the following categories:~~ o ~~Outpatient;~~ o ~~Intensive outpatient services;~~ o ~~Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);~~	

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			~~o Intensive levels of care in residential and inpatient settings; and~~ ~~o Medically supervised withdrawal management.~~	
4	Attachment B Statement of Work	6.4.5.1.8. Report on PSH outreach monthly and quarterly using a format to be provided by the LDH PSH program manager; and 6.4.5.1.9. Work with PSH program management to assure an optimal network of qualified service providers trained by the LDH PSH program staff or designee to provide tenancy supports across disability groups and certified to deliver services as defined in the PSH Provider Certification Requirements.	6.4.5.1.8. ~~Report on PSH outreach monthly and quarterly using a format to be provided by the LDH PSH program manager; and~~ ~~6.4.5.1.9.~~ Work with PSH program management to assure an optimal network of qualified service providers trained by the LDH PSH program staff or designee to provide tenancy supports across disability groups and certified to deliver services as defined in the PSH Provider Certification Requirements.	This revision removes a reporting requirement that is duplicative of other monitoring efforts.
5	Attachment B Statement of Work	6.4.7. In recognizing that at least 70 percent of behavioral health can be and is treated in the PCP setting, the MCO shall be responsible for the management and provision of all basic behavioral health services including but not limited to those with mild, moderate depression, ADHD, generalized anxiety, etc. that can be appropriately screened, diagnosed or treated in a primary care setting. MCO support shall include but not be limited to assistance which will align their practices with best practice standards, such as those developed by the American Academy of Pediatrics, for the assessment, diagnosis, and treatment of ADHD, such as increasing the accuracy of ADHD diagnosis, increasing screening for other behavioral health concerns, and increasing the use of behavioral therapy as first-line treatment for children under age 6.	6.4.7. In recognizing that at least 70 percent of behavioral health can be and is treated in the PCP setting, the MCO shall be responsible for the management and provision of all basic behavioral health services including but not limited to those with mild, moderate depression, ADHD, generalized anxiety, etc. that can be appropriately screened, diagnosed or treated in a primary care setting. MCO support shall include but not be limited to assistance which will align their practices with best practice standards in primary care for developmental, social, and emotional concerns, to support early identification and early linkage to treatment~~, such as those developed by the American Academy of Pediatrics, for the assessment, diagnosis, and treatment of ADHD, such as increasing the accuracy of ADHD diagnosis, increasing screening for other behavioral health concerns, and increasing the use of behavioral therapy as first-line treatment for children under age 6~~.	This revision removes ADHD-specific provisions that were addressed through Medicaid's PIP on ADHD, which ended last year.
6	Attachment B	6.6.7. Some EPSDT preventive screening claims should be submitted sooner than within twelve (12) months from date of service due to the fact that the screenings periodicity can range	6.6.7. Some EPSDT preventive screening claims should be submitted sooner than within twelve (12) months from date of service due to the fact that the screenings periodicity can range	This update corrects the link to an outdated periodicity schedule.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	Statement of Work	from every two months and up. See periodicity schedule at: http://www.lamedicaid.com/ provweb1/ProviderTraining/packets/2013ProviderTraining/ Periodicity%20Schedule_2013_R.pdf	from every two months and up. See periodicity schedule at: ~~http://www.lamedicaid.com/ provweb1/ProviderTraining/packets/2013ProviderTraining/ Periodicity%20Schedule_2013_R.pdf~~ http://www.lamedicaid.com/provweb1/ProviderTraining/packets/ 2018ProviderTraining/2018_EPSDT_Periodicity_Schedule.pdf.	
7	Attachment B Statement of Work	6.19.1.12. Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services; and 6.19.1.13. Persons with serious mental illness who have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments and who are at high risk of inpatient admission or Emergency Department visits, including enrollees transitioning across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting.	6.19.1.12. Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services; ~~and~~ 6.19.1.13. Persons with serious mental illness who have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments and who are at high risk of inpatient admission or Emergency Department visits, including enrollees transitioning across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting~~.~~; and 6.19.1.14. Children enrolled under the Act 421 Children's Medicaid Option.	This addition includes the CMO in the special health care needs population.
8	Attachment B Statement of Work	6.38.8. Transition of Care for Integration of Specialized Behavioral Health 6.38.8.1. For the period December 1, 2015 through February 29, 2016 the MCO shall honor all Magellan authorization decisions for outpatient services at the level of service and duration approved prior to December 1, 2015. The MCO must continue to honor existing Magellan authorizations beyond February 29, 2016 until such time as a determination for continued services is complete and the member and provider have been timely notified. These requirements apply to all prior approvals regardless of the provider's status as a contracted or non-contracted provider.	~~6.38.8. Transition of Care for Integration of Specialized Behavioral Health 6.38.8.1. For the period December 1, 2015 through February 29, 2016 the MCO shall honor all Magellan authorization decisions for outpatient services at the level of service and duration approved prior to December 1, 2015. The MCO must continue to honor existing Magellan authorizations beyond February 29, 2016 until such time as a determination for continued services is complete and the member and provider have been timely notified. These requirements apply to all prior approvals regardless of the provider's status as a contracted or non-contracted provider.~~	The referenced provision is being removed, as it is no longer relevant.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
9	Attachment B Statement of Work	6.39.3.1. The MCO shall: • Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; • Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment; • Ensure members are referred to service providers in accordance with freedom of choice requirement; • Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and • Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.	6.39.3.1. The MCO shall: • Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; and • ~~Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment;~~ • ~~Ensure members are referred to service providers in accordance with freedom of choice requirement;~~ • ~~Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and~~ • Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.	This revision removes duplicative provisions, which are addressed in the case management and plan of care requirements.
10	Attachment B Statement of Work	6.39.4. Assessments for Mental Health Rehabilitation Services for adults: 6.39.4.1. The MCO shall be responsible for conducting or subcontracting to conduct assessments as per the requirements in the State Plan. LDH will establish process measures to monitor access to timely assessments. 6.39.4.2. Assessment for eligibility shall be completed within fourteen (14) calendar days of referral. 6.39.4.3. Annual recertification for services will be completed within 365 days of most recent certification in order to assure that there is no lapse in service authorization or services to members who remain qualified.	~~6.39.4. Assessments for Mental Health Rehabilitation Services for adults:~~ ~~6.39.4.1. The MCO shall be responsible for conducting or subcontracting to conduct assessments as per the requirements in the State Plan. LDH will establish process measures to monitor access to timely assessments.~~ ~~6.39.4.2. Assessment for eligibility shall be completed within fourteen (14) calendar days of referral.~~ ~~6.39.4.3. Annual recertification for services will be completed within 365 days of most recent certification in order to assure that there is no lapse in service authorization or services to members who remain qualified.~~	Providers are responsible for the assessment, not LDH, so the requirement will be moved to the provider manual.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
11	Attachment B Statement of Work	**7.3.3. Specialists** 7.3.3.1. Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and 7.3.3.2. Travel distance shall not exceed 90 miles for all members.	**7.3.3. Specialists** 7.3.3.1. Travel distance to each specialty type shall not exceed 60 miles ~~for at least 75% of members; and~~ ~~7.3.3.2. Travel distance shall not exceed 90 miles~~ for all members except as indicated in this Contract or the **Provider Network Companion Guide**. [subsequent provisions renumbered]	This modification reduces the distance standard for specialty providers in consideration of enrollee access to care and the feasibility of MCO compliance based on reported data.
12	Attachment B Statement of Work	**7.4. Provider to Member Ratios** 7.4.1. The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the **Provider Network Companion Guide.**	**7.4. ~~Provider to Member~~ Access Ratios** 7.4.1. Network Ratio The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the **Provider Network Companion Guide.** 7.4.2. Linkage Ratio The MCO shall comply with the linkage ratios specified in the **Provider Network Companion Guide**. The linkage ratio is a calculation of the MCO's network provider to his/her patients who are Louisiana Medicaid managed care enrollees, regardless of MCO.	This revision distinguishes between a network vs. linkage ratio to ensure adequacy of both the quantity and capacity of network providers. LDH will continue to provide linkage data to the MCOs.
13	Attachment B Statement of Work	7.6.1.6. The MCO must offer a contract to the following providers: • Louisiana Office of Public Health (OPH); • All OPH-certified School Based Health Clinics (SBHCs); • All small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; • Federally Qualified Health Centers (FQHCs);	7.6.1.6. The MCO must offer a contract to the following providers: • Louisiana Office of Public Health (OPH); • All OPH-certified School Based Health Clinics (SBHCs); • All small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; • Federally Qualified Health Centers (FQHCs);	This addition requires the MCO to offer a contract to any provider that is actively providing services to a CMO enrollee.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		• Rural Health Clinics (RHCs) (free-standing and hospital based); • Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program; • The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and • All providers approved by the LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program. • Local Governing Entities; • Methadone Clinics pending CMS approval; • Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).	• Rural Health Clinics (RHCs) (free-standing and hospital based); • Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program; • The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and • All providers approved by the LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program. • Local Governing Entities; • Methadone Clinics pending CMS approval; • Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs)~~.~~; and	

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			• Providers that are actively serving Act 421 Children's Medicaid Option enrollees, subject to 42 CFR 431.52 and excluding intermediate care facilities (ICFs).	
14	Attachment B Statement of Work	7.9.5.9. Ensure that provider complaints are acknowledged within three (3) business days of receipt; resolve and/or state the result communicated to the provider within thirty (30) business days of receipt (this includes referrals from LDH).	7.9.5.9. Ensure that provider complaints are acknowledged within three (3) business days of receipt; resolve and/or state the result communicated to the provider within thirty (30) ~~business~~ calendar days of receipt (this includes referrals from LDH).	This edit aligns with sections 10.6.5 and 17.2.4.1 of the Statement of Work.
15	Attachment B Statement of Work	[end of section]	7.13.13 The MCO shall require providers of personal care services (PCS) and home health care services to use the state-contracted electronic visit verification (EVV) system in accordance with the timeframes set forth in the 21st Century Cures Act or as directed by LDH.	This addition requires utilization of LDH's EVV system, which was implemented on January 1, 2020. This is necessary to ensure that service reporting is compliant with EVV requirements in the 21st Century Cures Act.
16	Attachment B Statement of Work	**8.5.1. Standard Service Authorization** 8.5.1.1. The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service. 8.5.1.1.1. The service authorization decision may be extended up to fourteen (14) additional calendar days if: 8.5.1.1.1.1. The member, or the provider, requests the extension; or	**8.5.1. Standard Service Authorization** 8.5.1.1. The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed ~~admission,~~ procedure~~,~~ or service requiring a review determination, with the following exceptions: 8.5.1.1.1. The MCO shall make all inpatient hospital service authorizations within two (2) calendar days of obtaining appropriate medical information; and 8.5.1.1.2. The MCO shall make all ~~of authorizations for~~ CPST and PSR service authorizations ~~for which the standard for determination is~~ within five (5) calendar days of obtaining appropriate medical information. ~~8.5.1.1.~~8.5.1.2. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	This revision reduces timing of service authorization decisions to ensure enrollee receipt of services in a timely manner. This edit to calendar days aligns with section 4.3.1 of the Statement of Work, which requires MCO prior authorization staff to authorize services 24 hours per day, 7 days per week. It also removes expedited language, as basic service authorizations are performed sooner than 3 days.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		8.5.1.1.1.2. The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest. 8.5.1.2. The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	~~8.5.1.1.1.~~8.5.1.2.1. The service authorization decision may be extended up to fourteen (14) additional calendar days if: ~~8.5.1.1.1.1.~~8.5.1.2.1.1. The member, or the provider, requests the extension; or ~~8.5.1.1.1.2.~~8.5.1.2.1.2. The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest. ~~8.5.1.2.~~8.5.1.3. The MCO shall make ~~ninety-five percent (95%) of~~ all concurrent review determinations within one (1) ~~business~~ calendar day ~~and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days~~ of obtaining the appropriate medical information that may be required.	
17	Attachment B Statement of Work	8.8.1. Within 90 days of implementation, the MCO is required to implement a Medication Therapy Management (MTM) program. The MTM program should include participation from community pharmacists, and include both in-person and telephonic interventions with trained clinical pharmacists.	8.8.1. Within 90 days of implementation, the MCO is required to implement a Medication Therapy Management (MTM) program. The MTM program should include participation from community pharmacists, and include both in-person and telephonic interventions with trained clinical pharmacists, MTM providers, and enrollees. The MCO shall ensure that all requirements are met regardless of whether the MCO utilizes a contractor for MTM services. The MCO and its contractor, if applicable, shall not limit the MTM services provided for enrollees meeting MTM criteria. MTM criteria must be approved by LDH pharmacy staff. MTM shall be executed as specified herein and as directed by LDH.	This revision clarifies requirements of the MTM program.
18	Attachment B Statement of Work	11.9.2. Consistent with reporting requirements in Section 18.0 of this Contract, the MCO shall submit a quarterly update of the maximum members. The MCO shall track slot availability and notify LDH's Enrollment Broker when filled slots are within ninety percent (90%) of capacity. The MCO is responsible for maintaining a record	11.9.2. ~~Consistent with reporting requirements in Section 18.0 of this Contract, the MCO shall submit a quarterly update of the maximum members.~~ The MCO shall notify LDH of changes to its maximum capacity. The MCO shall track slot availability and notify LDH's Enrollment Broker when filled slots are within ninety percent (90%) of capacity. The MCO is responsible for maintaining a record	This revision was made to align with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		of total PCP linkages of Medicaid members and provide this information quarterly to LDH.	of total PCP linkages of Medicaid members and provide this information quarterly to LDH.	
19	Attachment B Statement of Work	12.1.8. All marketing and member materials and activities shall comply with the requirements in 42 CFR §438.10 and the LDH requirements set forth in this Contract.	12.1.8. All marketing and member materials and activities shall comply with the requirements in 42 CFR §438.10 and the LDH requirements set forth in this Contract and the **Marketing and Member Education Companion Guide**.	This revision incorporates a companion guide to provide clarification and operational guidance.
20	Attachment B Statement of Work	12.2.1. The MCO shall maintain an LDH-approved plan detailing the marketing and member education activities it will undertake and materials it will create during the contract period, incorporating LDH's requirements for participation in the MCO Program.	12.2.1. The MCO shall maintain an LDH-approved plan detailing the marketing and member education activities it will undertake and materials it will create during the contract period, incorporating LDH's requirements for participation in the MCO Program. The MCO shall submit an updated plan in accordance with the **Marketing and Member Education Companion Guide** within 30 days from the effective date of any extension to the Contract and annually thereafter.	This changes supports LDH's ability to monitor marketing and member education activities. Additionally, an updated plan has not been submitted for several years.
21	Attachment B Statement of Work	12.13.3. An MCO-issued member ID card that contains information specific to the MCO. The member's ID card shall at a minimum include, but not be limited to, the following information as it applies to the covered populations as specified in section 3.3.3: • The member's name and date of birth; • The MCO's name and address; • Instructions for emergencies; • The PCP's name and telephone numbers (including after-hours number, if different from business hours number); • The toll-free number(s) for: o 24-hour Nurse Line o The Member Services Line o and Filing Grievances o 24-hour behavioral health crisis line o Provider Services and Prior Authorization and	12.13.3. An MCO-issued member ID card that contains information specific to the MCO. The member's ID card shall at a minimum include, but not be limited to, the following information as it applies to the covered populations as specified in section 3.3.3: • The member's name and date of birth; • The MCO's name and address; • Instructions for emergencies; • The PCP's name and telephone numbers (including after-hours number, if different from business hours number); • The toll-free number(s) for: o 24-hour Nurse Line o The Member Services Line o and Filing Grievances o 24-hour behavioral health crisis line o Provider Services and Prior Authorization and	This revision requires new machine-readable ID cards to be phased in effective immediately, with all ID cards converted by June 30, 2021.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		o Reporting Medicaid Fraud (1-800-488-2917)	o Reporting Medicaid Fraud (1-800-488-2917); and • The member's Unique Identifying number encoded into a standard 2D, QR machine-readable barcode and printed with a minimum 3/4" height and width. The MCO shall convert all ID cards to include this barcode by June 30, 2021.	
22	Attachment B Statement of Work	14.9.4 The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on MCO measurement findings.	~~14.9.4 The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on MCO measurement findings.~~	LDH has determined this is not a reasonable expectation.
23	Attachment B Statement of Work	15.4.2. The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider.	15.4.2. ~~The MCO is responsible for the return to the State of~~ LDH may recover from the MCO, via a deduction from the MCO's capitation payment, any money paid for services provided by an excluded provider.	This change promotes operational efficiency.
24	Attachment B Statement of Work	15.7.8. LDH or its agent shall have the right to audit and investigate providers and members within the MCO's network via "complex" or "automated" review for a five (5) year period from the date of service of a claim. LDH may recover from the provider any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State. … 15.7.14. In the event the provider does not refund overpayments identified by the Department or its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department will notify the MCO and the MCO shall initiate a payment withhold on the	15.7.8. LDH or its agent shall have the right to audit and investigate providers and members within the MCO's network via "complex" or "automated" review for a five (5) year period from the date of service of a claim. LDH may recover from the ~~provider~~ MCO, via a deduction from the MCO's capitation payment, any provider overpayments identified by LDH or its agent, and said recovered funds will be retained by the State. The MCO may pursue recovery from the provider as a result of the State-identified overpayment. … 15.7.14. ~~In the event the provider does not refund overpayments identified by the Department or its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of~~	This revision promotes operational efficiency and reduces the possibility of a double recoupment from the provider.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		provider in the amount due to the Department. Upon LDH request, the MCO shall refund to the State any amounts collected. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules. 15.7.15. In the event LDH or its agent recovers funds from a provider due to an overpayment, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH, and shall not seek additional recovery from the provider for the claims the LDH or its agent audited, unless approved by LDH.	~~the conclusion of the appeal process, the Department will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. Upon LDH request, the MCO shall refund to the State any amounts collected. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.~~ ~~15.7.15.~~ In the event LDH or its agent recovers funds from ~~a provider~~ the MCO due to a~~n~~ provider overpayment, the MCO may recover from the provider. If the MCO recovers state-identified improper payments, the MCO shall submit corrected encounter data within thirty (30) calendar days of notification by LDH~~, and shall not seek additional recovery from the provider for the claims the LDH or its agent audited, unless approved by LDH~~. [subsequent provisions renumbered]	
25	Attachment B Statement of Work	16.1.15 All contractor utilized computers and devices must:	16.1.15 The MCO shall comply with LDH electronic visit verification (EVV) requirements for personal care services (PCS) and home health care services in accordance with the timeframes set forth in the 21st Century Cures Act or as directed by LDH. 16.1.16 All contractor utilized computers and devices must: [subsequent provisions renumbered]	This addition requires compliance with system and technical requirements necessary to ensure interoperability with LDH's EVV system, as required by the 21st Century Cures Act.
26	Attachment B Statement of Work	16.3.10. LDH may require the MCO to complete an Information Systems Capabilities Assessment (ISCA), which will be provided by LDH. The ISCA shall be completed and returned to LDH no later than thirty (30) days from the date the MCO signs the Contract LDH.	16.3.10. LDH may require the MCO to complete an Information Systems Capabilities Assessment (ISCA), which will be provided by LDH at least sixty (60) days prior to the due date. ~~The ISCA shall be completed and returned to LDH no later than thirty (30) days from the date the MCO signs the Contract LDH.~~	This change allows for an ISCA to be conducted later in the contract term, as it was not required at the start of the contract.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
27	Attachment B Statement of Work	[new section]	**16.15 CMS Interoperability and Patient Access** The MCO shall be in compliance with the CMS Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issues of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers (referred to as the "CMS Interoperability and Patient Access final rule") no later than July 1, 2021. The MCO shall: 16.15.1 Participate in development meetings as required by LDH. 16.15.2 Implement and maintain a standards-based Patient Access application programming interface (API) to make certain health information about Medicaid and CHIP beneficiaries, as defined by CMS, accessible through the API, enabling enrollees to access their health data on their Internet-enabled devices. 16.15.3 Establish a Payer-to-Payer Data Exchange, to comply with enrollee requests to have their health data transferred from payer to payer, no later than January 1, 2022. 16.15.4 Make standardized information about provider networks available via a Fast Healthcare Interoperability Resources (FHIR) based Provider Directory API. The MCO shall provide current provider directory information via an API no later than July 1, 2021. 16.15.5 Make available required data in the United States Core Data for Interoperability (USCDI) residing in health information exchanges or public health agencies as described in 45 CFR 170.213.	This provision addresses MCO compliance of the Interoperability and Patient Access final rule as required by SHO 20-003, the CMS guidance for state agencies.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			16.15.6 Provide members free access to the MCO's API for purposes of the Patient Access and Provider Directory APIs.	
28	Attachment B Statement of Work	17.2.1.3 Process and pay or deny, as appropriate, at least Ninety-nine percent (99%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.	17.2.1.3 Process and pay or deny, as appropriate, ~~at least Ninety-nine percent (99%) of~~ 100% of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.	This revision ensures that 100% of clean claims are processed, in combination with section 17.2.1.2., within 30 days.
29	Attachment B Statement of Work	**17.3 Payment to Providers** … [end of section]	**17.3 Payment to Providers** … 17.3.4 The MCO shall notify providers within five (5) business days of discovery of a system error or "glitch" that impacts their reimbursement. 17.3.4.1 The notification must outline the process of resolution, including time frames, and be posted on the provider portal on the MCO's web page and sent to providers via email and/or fax blast. 17.3.4.2 The MCO should provide its provider call center staff with the relevant information immediately after discovery of the system error or "glitch" occurs in order to ensure that staff will be able to properly answer provider questions.	This revision minimizes provider confusion and improves communication related to payment issues.
30	Attachment B Statement of Work	17.13.1. Louisiana Health Insurance Premium Payment (LaHIPP) program is a Louisiana Medicaid program that pays all or part of the health insurance premium for an employee and their family if: (a) health insurance is available from their job (i.e. Employer Sponsored Insurance); (b) someone in the family has Medicaid; and (c) it is determined that it would cost less for Louisiana Medicaid to pay the health insurance premium for the person who receives Medicaid than it would be for Louisiana Medicaid to pay the cost of the same person's per member per month payment for physical health coverage through the enrollee's managed care	17.13.1. Louisiana Health Insurance Premium Payment (LaHIPP) program is a Louisiana Medicaid program that pays all or part of the health insurance premium for an employee and their family if: (a) health insurance is available from their job (i.e. Employer Sponsored Insurance); (b) someone in the family has Medicaid; and (c) it is determined that it would cost less for Louisiana Medicaid to pay the health insurance premium for the person who receives Medicaid than it would be for Louisiana Medicaid to pay the cost of the same person's per member per month payment for physical health coverage through the enrollee's managed care organization	Adds reference to the CMO as an eligible population for the LaHIPP program.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		organization. The goal of LaHIPP is to reduce the number of the uninsured and lower Medicaid spending by establishing a third party resource as the primary payer of the Medicaid enrollee's medical expenses.	or the enrollee receives Medicaid coverage through the Act 421 Children's Medicaid Option and meets the criteria specific to that program for enrollment in LaHIPP. The goal of LaHIPP is to reduce the number of the uninsured and lower Medicaid spending by establishing a third party resource as the primary payer of the Medicaid enrollee's medical expenses.	
31	Attachment B Statement of Work	17.13.4. LaHIPP members are mandatorily enrolled in Medicaid Managed Care for specialized behavioral health services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6.	17.13.4. All LaHIPP ~~members~~ participants are mandatorily enrolled in Medicaid Managed Care for specialized behavioral health services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution as specified under Section 3.6. LaHIPP participants who receive coverage via the Act 421 Children's Medicaid Option are mandatorily enrolled in Medicaid Managed Care for all Medicaid covered services.	Specifies that CMO enrollees are enrolled with MCOs for full coverage, including physical health, specialized behavioral health, NEMT, and NEAT.
32	Attachment B Statement of Work	17.13.5. The MCO is responsible for payment of LaHIPP participants' total member liability (co-payments, co-insurance and deductibles) if the participant uses a provider that accepts the insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant will be responsible for the member liability. The MCO pays only after the third party has met the legal obligation to pay. The MCO is always the payer of last resort, except when the MCO is responsible for payment as primary payer for mental health services and transportation services not covered by commercial insurance as primary payer.	17.13.5. The MCO is responsible for payment of LaHIPP participants' total member liability (co-payments, co-insurance and deductibles) if the participant uses a provider that accepts the insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant will be responsible for the member liability. The MCO pays only after the third party has met the legal obligation to pay. The MCO is always the payer of last resort, except when the MCO is responsible for payment as primary payer for ~~mental health~~ Medicaid covered services ~~and transportation services~~ not covered by commercial insurance as primary payer (e.g., mental health and transportation services).	This revision clarifies the responsibility of the MCOs to pay for all Medicaid covered services that are not covered by commercial insurance as primary payer.
33	Attachment B	17.13.6. The mental health services listed below are typically not reimbursed by commercial health plans. MCOs should accept the following claims billed directly from the mental health provider	17.13.6. The ~~mental health~~ services listed below are typically not reimbursed by commercial health plans. MCOs should accept the following claims billed directly from the ~~mental health~~ provider	This revision adds services used by enrollees that are commonly not reimbursed by commercial health plans and for which the MCO would be primary payer.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	Statement of Work	without requiring an explanation of benefits from the primary carrier and pay as primary payer. • H0018-Therapeutic Group Home • H0039-Assertive Community Treatment per diem • H0045-Crisis Stabilization • H2017-Psychosocial Rehabilitation Services • H0036-Community psychiatric support and treatment • H2033-Multi-systemic Therapy • H2011-Crisis Intervention Service, per 15 minutes • S9485-Crisis Intervention Mental Health Services	without requiring an explanation of benefits from the primary carrier and pay as primary payer. • H0018-Therapeutic Group Home • H0039-Assertive Community Treatment per diem • H0045-Crisis Stabilization • H2017-Psychosocial Rehabilitation Services • H0036-Community psychiatric support and treatment • H2033-Multi-systemic Therapy • H2011-Crisis Intervention Service, per 15 minutes • S9485-Crisis Intervention Mental Health Services • T1019-Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Personal Care Services (PCS) • T1025, T1026, T2002-Pediatric Day Health Care	
34	Attachment B Statement of Work	18.13.1 The MCO shall report to LDH indicators relative to individual evaluations on a monthly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the LDH-issued reporting template.	18.13.1 The MCO shall report to LDH indicators relative to individual evaluations on a ~~monthly~~ quarterly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the LDH-issued reporting template.	This change aligns the contract with current practice.
35	Attachment B Statement of Work	20.3.3. The Table of Monetary Penalties [new penalty]	Failed Deliverables: **Act 421 Children's Medicaid Option** Untimely payment of co-payments and deductibles for LaHIPP participants who are enrolled in the Act 421 Children's Medicaid Option. Penalty:	This provision adds a penalty for failing to pay co-pays and deductibles for LaHIPP-participating CMO enrollees.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			Five thousand dollars ($5,000.00) per occurrence per day that the co-payment or deductible is past due.	
36	Attachment B Statement of Work	[end of section]	20.3.5 Notices of Action 20.3.5.1 LDH may first notify the MCO of incidents of non-compliance and of LDH's authority to impose a monetary penalty via a Notice of Action (NOA). The NOA will include the basis and nature of the violation, the relevant contract sections and/or provisions of law, the deadline to cure the violation, if applicable, and the methodology for calculation of any monetary penalty if the violation is not cured by the established deadline, if applicable. 20.3.5.2 LDH may require the MCO to provide a written response with a detailed explanation of the reasons for the violation, the MCO's assessment or diagnosis of the cause, and MCO's plan to address or cure the deficiency within the timeframe set forth in the NOA. 20.3.5.3 Repeated deficiencies or the repeated failure to resolve any such deficiencies may entitle LDH to pursue any other remedy provided in the Contract or any other appropriate remedy available under law. 20.3.5.4 At any time and at its sole discretion, LDH may impose or pursue one or more remedies for each item of noncompliance and will determine appropriate remedies on a case-by-case basis. 20.3.6 Notices of Monetary Penalty Monetary penalties may be assessed against the MCO at the sole discretion of LDH, regardless of whether an NOA is issued. LDH will notify the MCO of the assessment of monetary penalties via a Notice of Monetary Penalty (NOMP).	Formalizes the process for issuing NOAs and NMPs.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
37	Attachment B Statement of Work	**22.0 RESERVED**	**22.0 ~~RESERVED~~ Disputes and Appeals** 22.1 If LDH chooses to notify the MCO of incidents of non-compliance and of LDH's authority to impose a monetary penalty via a NOA prior to assessing the penalty or sanction, the MCO may dispute infractions contained within the NOA through the following process: 22.1.1 Within fourteen (14) calendar days after receipt of the NOA, the MCO shall submit its dispute of the NOA directly to the Medicaid Deputy Director or his/her designee in writing via e-mail; this submission shall include all arguments, materials, data, and information necessary to resolve the dispute. 22.1.2 The MCO shall waive any dispute or argument not raised within fourteen (14) calendar days of receiving the NOA. The MCO shall also waive the right to use any materials, data, and/or information not contained in or accompanying the MCO's submission submitted within the fourteen (14) calendar days following its receipt of the NOA in any subsequent NOMP issued should the MCO fail to demonstrate compliance as stated in the NOA. 22.1.3 The Medicaid Deputy Director or his/her designee will decide the dispute, reduce the decision to writing, and provide a copy to the MCO. This written decision will be final. 22.2 To appeal the assessment of a monetary penalty or intermediate sanction: 22.2.1 Within seven (7) business days of receipt of the NOMP, the MCO shall submit its appeal in writing to the Medicaid Deputy Director or his/her designee. LDH will issue a written decision within fifteen (15) business days of the appeal.	This new provision establishes a formal process and timeline for resolving disputes and appeals of non-compliance actions.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
			22.2.2 Within five (5) business days of receipt of LDH's written decision, the MCO may request reconsideration of the decision in writing to the LDH Medicaid Director. The LDH Medicaid Director shall issue a written opinion within thirty (30) calendar days. No further appeals to LDH shall be allowed.	
38	Attachment B Statement of Work	25.6.3 The MCO shall assure that medical records and any and all other health and enrollment information an relating to members or potential members, which is provided to or obtained by or through the MCO's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and other state and federal laws, LDH policies or this Contract. The MCO shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.	25.6.3 The MCO shall assure that medical records and any and all other health and enrollment information ~~an~~ relating to members or potential members, which is provided to or obtained by or through the MCO's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and other state and federal laws, LDH policies or this Contract. The MCO shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.	This is a correction of a typographical error.
39	Attachment B Statement of Work	**GLOSSARY** … [add item]	**GLOSSARY** **…** **Act 421 Children's Medicaid Option** – Act 421 of the 2019 Louisiana Regular Session ensures certain children with disabilities are eligible for Medicaid state plan services, regardless of parental income. The child must have a disability recognized under the definition utilized in the Supplemental Security Income (SSI) program of the Social Security Administration, regardless of eligibility for the SSI program, and meet the level-of-care for a nursing facility, hospital, or ICF/IID.	This addition defines the CMO.
40	Attachment B	**ACRONYMS** **…** [add item]	**ACRONYMS** **…** **EVV** – Electronic Visit Verification	This addition adds "EVV" to the acronym list.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
	Statement of Work			
41	Attachment B Statement of Work	**LIST OF MCO COMPANION GUIDES** **…** **11. DOJ Agreement Compliance Guide**	**LIST OF MCO COMPANION GUIDES** **…** **11. DOJ Agreement Compliance Guide** **12. Marketing and Member Education Companion Guide**	This provision incorporates an additional companion guides that provides clarification and operational guidelines.

Attachment C – Performance Measures

<table>
<tr><th>Item</th><th></th><th>Attachment C – Performance Measures</th></tr>
<tr><td rowspan="3">C1</td><td>From</td><td>
<table>
<tr><th>Identifier</th><th>Measure</th><th>Measure Description</th><th>Measure Steward</th><th>Federal Reporting Program</th><th>Target Population</th><th>Condition</th><th>Specification Source</th><th>2021 (2020 data measurement year) and Subsequent Years Target for Improvement</th></tr>
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<tr><td>To</td><td>
<table>
<tr><th>Identifier</th><th>Measure</th><th>Measure Description</th><th>Measure Steward</th><th>Federal Reporting Program</th><th>Target Population</th><th>Condition</th><th>Specification Source</th><th>Measurement Year (MY) 2020 ~~2021 (2020 data measurement year) and Subsequent Years~~ Target for Improvement</th></tr>
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</td></tr>
<tr><td>Justification</td><td>Aligns with NCQA changes and applies the performance measures, as amended, to MY 2020 retroactively.</td></tr>
<tr><td rowspan="3">C2</td><td>From</td><td>
<table>
<tr><td>AWC $$</td><td>Adolescent Well Care Visit</td><td>The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.</td><td>NCQA</td><td>CHIPRA</td><td>Children's Health</td><td>Utilization</td><td>HEDIS</td><td>NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year</td></tr>
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<tr><td>To</td><td>
<table>
<tr><td>~~AWC $$~~</td><td>~~Adolescent Well Care Visit~~</td><td>~~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.~~</td><td>~~NCQA~~</td><td>~~CHIPRA~~</td><td>~~Children's Health~~</td><td>~~Utilization~~</td><td>~~HEDIS~~</td><td>~~NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year~~</td></tr>
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</td></tr>
<tr><td>Justification</td><td>Aligns with NCQA changes, which combined this measure into Child and Adolescent Well-Care Visits.</td></tr>
<tr><td>C3</td><td>From</td><td>[new measure]</td></tr>
</table>

Item		Attachment C – Performance Measures								
	To	WCV $$	Child and Adolescent Well-Care Visits	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	Report Only
	Justification	Adds new NCQA measure.								
C4	**From**	PPC $$	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
	To	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.~~ The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester, on or before 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
	Justification	Updates measure description to align with NCQA updates.								

Item		Attachment C – Performance Measures								
C5	**From**	PPC $$	Prenatal and Postpartum Care – Postpartum Care (PPC Numerator 2)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	MEDICAID ADULT	Maternal Health	Perinatal and Reproductive Health	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
	To	PPC $$	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.~~ The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 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
	Justification	Updates measure description to align with NCQA updates.								
C6	**From**	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

Item		Attachment C – Performance Measures								
	To	CBP $$	Controlling High Blood Pressure - Total	~~The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year based on the following criteria:~~ ~~• Members 18-59 whose BP was <140/90~~ ~~• Members 60-85 with diagnosis of diabetes who BP was 150-90~~ ~~• Members 60-85 without a diagnosis of diabetes whose BP was 150/90~~ The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.	NCQA	MEDICAID ADULT, MU2, CMS HEALTH HOMES	Chronic Disease	Cardiovascular Care	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
	Justification	Updates measure description to align with NCQA updates.								
C7	**From**	CDC $$	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
	To	~~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~~

Item		Attachment C – Performance Measures								
	Justification	Removes measure which was retired by NCQA.								
C8	**From**	W15 $$	Well-Child Visits in the First 15 Months of Life - Six or more well-child visits.	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	NCQA	CHIPRA	Children's Health	Utilization	HEDIS	NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year
	To	~~W15~~ ~~$$~~	~~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~~
	Justification	Aligns with NCQA changes, which combined this measure into Well-Child Visits in the First 30 Months of Life.								
C9	**From**	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

Item		Attachment C – Performance Measures
	To	~~W34~~ ~~$$~~ | ~~Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life~~ | ~~The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.~~ | ~~NCQA~~ | ~~CHIPRA~~ | ~~Children's Health~~ | ~~Utilization~~ | ~~HEDIS~~ | ~~NCQA Quality Compass Medicaid National 50th percentile [All LOBs (Excluding PPOs and EPOs): Average] for the year prior to the measurement year~~
	Justification	Aligns with NCQA changes, which combined this measure into Well-Child Visits in the First 30 Months of Life.
C10	**From**	[new measure]
	To	W30 $$ | Well-Child Visits in the First 30 Months of Life | The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits. | NCQA | CHIPRA | Children's Health | Utilization | HEDIS | Report Only
	Justification	Adds new NCQA measure.

Item		Attachment C – Performance Measures								
C11	**From**	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
	To	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~~ The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. BMI percentile documentation Counseling for nutrition Counseling for physical activity	NCQA	CHIPRA, MU2	Children's Health	Prevention	HEDIS

Item		Attachment C – Performance Measures								
	Justification	Updates measure description to align with NCQA updates.								
C12	**From**	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
	To	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).~~ The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA	MEDICAID ADULT	Population Health	Behavioral Health	HEDIS
	Justification	Updates measure description to align with NCQA updates.								
C13	**From**	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

Item		Attachment C – Performance Measures								
	To	~~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~~
	Justification	Removes measure which was retired by NCQA.								
C14	**From**	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
	To	~~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~~
	Justification	Removes measure which was retired by NCQA.								
C15	**From**	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

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<tr><th>Item</th><th></th><th>Attachment C – Performance Measures</th></tr>
<tr><td rowspan="2"></td><td>To</td><td>
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<tr><td>~~CAP~~</td><td>~~Child and Adolescents' Access to Primary Care Practitioners~~</td><td>~~Percentage of children ages 12 months – 19 years who had a visit with a PCP. The MCO reports four separate percentages:~~
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<tr><td>Justification</td><td>Removes measure which was retired by NCQA.</td></tr>
<tr><td rowspan="3">C16</td><td>From</td><td>[reinstated measure]</td></tr>
<tr><td>To</td><td>
<table>
<tr><td>AMB-ED</td><td>Ambulatory Care-ED Visits</td><td>This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.</td><td>NCQA</td><td>MEDICAID</td><td>Population Health</td><td>Utilization</td><td>HEDIS</td></tr>
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<tr><td>Justification</td><td>Reinstates measure, which was previously removed, as a monitored measure.</td></tr>
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