LOUISIANA DEPARTMENT OF HEALTH

MCO Amendment 9

Attachment A9 – Changes to Attachment A, *Model Contract*

Item	Change From	Change To	Justification
1	**Acronyms** **…** **[add new acronyms]**	**Acronyms** **…** **CPST** – Community Psychiatric Support and Treatment **DBT** – Dialectical Behavior Therapy	
2	2.2.6 Reports and Requests for Information … 2.2.6.2.2 Requests that originate from the Office of the Governor, the LDH Office of the Secretary, or a Louisiana legislator shall be addressed within seventy-two (72) hours;	2.2.6 Reports and Requests for Information … 2.2.6.2.2 Requests that originate from the Office of the Governor, ~~the LDH Office of the Secretary~~, or a Louisiana legislator shall be addressed within ~~seventy-two (72)~~ twenty-four (24) hours unless otherwise directed by LDH; Requests that originate from the LDH Office of the Secretary shall be addressed within seventy two (72) hours unless otherwise directed by LDH.	This revision aligns the contract with current practice.
3	2.3.2 Voluntary MCO Populations The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all Applied Behavior Analysis (ABA), SBHS, NEMT, services, and NEAT services. … 2.3.3 Mandatory MCO Populations for ABA, SBHS, and NEAT Services Only The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for ABA, SBHS, and NEAT services only, and receive all other Medicaid Covered Services through FFS:	2.3.2 Voluntary MCO Populations The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all Applied Behavior Analysis (ABA), SBHS, ~~NEMT, services,~~ and NEMT/NEAT to all Medicaid Covered S~~s~~ervices. … 2.3.3 Mandatory MCO Populations for ABA, SBHS, and NEAT Services Only The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations ~~are automatically enrolled in the Managed Care Program~~ and provide for ABA, SBHS, and NEAT to all Medicaid Covered S~~s~~ervices ~~only~~, and receive all other Medicaid Covered Services through FFS: …	This revision is necessary to clarify the MCOs' obligation to provide NEMT/NEAT services to all Medicaid Covered Services.

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	… 2.3.4 Mandatory MCO Populations for ABA, SBHS, and NEMT/NEAT Services Only The following Louisiana Medicaid Program populations are automatically enrolled in the Managed Care Program for ABA, SBHS, and NEMT/NEAT to services only, and receive all other Medicaid Covered Services through FFS:	2.3.4 Mandatory MCO Populations for ABA, SBHS, and NEMT/NEAT Services Only The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations ~~are automatically enrolled in the Managed Care Program~~ and provide for ABA, SBHS, and NEMT/ NEAT to all Medicaid Covered S~~s~~ervices ~~only~~, and receive all other Medicaid Covered Services through FFS:	
4	2.4.4 In Lieu of Services … **[new provision]**	2.4.4 In Lieu of Services … 2.4.4.6 The Contractor shall identify In Lieu of Services in Encounter Data in accordance with the MCE System Companion Guide.	This revision facilitates the identification of In Lieu of Services in encounter data by utilizing the prefixes established in the MCE System Companion Guide.
5	2.4.5.4 The Contractor may propose to add to or expand upon the VAB(s) proposed in the Contractor's RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval at least six (6) months in advance of the effective date of Enrollment resulting from the Enrollment Period. The Contractor shall submit requests in accordance with the **MCO Manual**.	2.4.5.4 The Contractor may propose to add to or expand upon the VAB(s) proposed in the Contractor's RFP response as pre-approved in writing by LDH. Deletions or reductions to the VAB(s) may be proposed on an annual basis and shall be submitted to LDH for approval ~~at least~~ no later than six (6) months in advance of the ~~effective date of Enrollment resulting from the~~ Enrollment Period. The Contractor shall submit requests in accordance with the **MCO Manual**.	This revision allows for sufficient time to review and approve VAB submissions.
6	2.9.29 Network Provider Agreement Requirements … **[new provision]**	2.9.29 Network Provider Agreement Requirements … 2.9.29.17. All Network Provider Agreements with hospitals, including EDs, shall include a requirement for the development of a discharge plan, with an aftercare appointment with a behavioral health provider as soon as clinically indicated but not later than ten (10) Calendar Days from the date	This update is necessary to improve behavioral health-related follow-up rates. Research indicates that providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.

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		of discharge, for Enrollees with behavioral health-related ED visits and hospitalizations unless there is documented Enrollee refusal. This requirement shall be included in all present and future Network Provider Agreements and may be incorporated through a separate addendum to the agreement. In addition, the Network Provider Agreement shall specify the Contractor's responsibility as it pertains to discharge planning, including securing post-discharge appointments and linkages, and include information on the availability of a dedicated MCO e-mail address and telephone number for EDs and hospitals to utilize for Care Coordination activities.	
7	2.10.3 Provider Relations The Contractor shall: **[new provisions]**	2.10.3 Provider Relations The Contractor shall: … 2.10.3.12. Have a process in place to ensure EDs and hospitals have awareness of behavioral health Network Providers who will accept aftercare appointments within ten (10) Calendar Days of the discharge date for Enrollees presenting with behavioral health needs. This shall include, but is not limited to the following: 2.10.3.12.1 Establishment of a dedicated MCO e-mail address and toll-free telephone number, available and monitored twenty-four (24) hours a day, seven (7) days a week by MCO staff, for EDs and hospitals to request assistance with locating behavioral health providers in the Enrollee's area who will accept an aftercare appointment within ten (10) days of the Enrollee's discharge date and other Care Coordination activities. The telephone number must be answered by a live voice and include immediate handoff to an MCO staff member with detailed knowledge regarding Louisiana Medicaid-funded behavioral health services and Network	This update is necessary to improve behavioral health-related follow-up rates. Research indicates that providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.

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		Providers with appointment availability within ten (10) Calendar Days of the Enrollee's discharge date. 2.10.3.12.2. Development and maintenance of a listing of verified behavioral health Network Providers in each parish, if possible, or region, who can accept an aftercare appointment within ten (10) Calendar Days of the Enrollee's discharge date, which shall be provided to EDs and hospitals upon request. 2.10.3.12.3. Documentation of all requests received through the dedicated e-mail address and telephone number including information on any requests that were not responded to by the Contractor within three (3) hours, any instances in which an appointment could not be secured within ten (10) Calendar Days of the Enrollee's discharge date, and failed attempts by service type. This information shall be provided to LDH upon request, utilized by the Contractor to update provider files (e.g., provider closures, providers not accepting new appointments), assess network adequacy, and be integrated into the Contractor's Network Development and Management Plan Strategy.	
8	2.11.1 Minimum Reimbursement to In-Network Providers 2.11.1.1 The Contractor shall provide reimbursement for MCO Covered Services provided by an in-Network Provider. 2.11.1.2 For MCO Covered Services, the Contractor's rate of reimbursement shall be no less than the published FFS Rate in effect on the date of service or that is contained on the weekly procedure file sent to the Contractor by the FI, or its equivalent, unless mutually agreed to by both the Contractor and the provider in the Network Provider Agreement.	2.11.1 Minimum Reimbursement to In-Network Providers 2.11.1.1 The Contractor shall provide reimbursement for MCO Covered Services provided by an in-Network Provider. 2.11.1.2 For MCO Covered Services, the Contractor's rate of reimbursement shall be no less than the published FFS Rate in effect on the date of service or that is contained on the weekly procedure file sent to the Contractor by the FI, or its equivalent, unless mutually agreed to by both the Contractor and the provider in the Network Provider Agreement.	This revision is to ensure that Network Providers are not reimbursed a rate below the FFS Rate.

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9	2.11.13 Payment for Hospital Services … 2.11.13.1 … In accordance with Federal regulations, directed payments must be based on actual utilization and delivery of services. As such, within twelve (12) months of the end of the SFY, LDH will perform a reconciliation and provide the Contractor with a reconciliation report that will contain the adjustments to be made to each qualified hospital's next quarterly interim directed payment. If the Contractor fails to perform the reconciliation in accordance with the instructions or within the specified time period, LDH may penalize the Contractor using one (1) or more of the following: • One (1) or more remedies in the Contract Non-Compliance section, including, but not limited to, Contract termination; • Attachment G, *Table of Monetary Penalties*; and • A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor. **[new provision]**	2.11.13 Payment for Hospital Services … 2.11.13.1 … In accordance with Federal regulations, directed payments must be based on actual utilization and delivery of services. As such, within twelve (12) months of the end of the SFY, LDH will perform a reconciliation and provide the Contractor with a reconciliation report that will contain the adjustments to be made to each qualified hospital's next quarterly interim directed payment. If the Contractor fails to perform the reconciliation in accordance with the instructions or within the specified time period, LDH may penalize the Contractor using one (1) or more of the following: • One (1) or more remedies in the Contract Non-Compliance section, including, but not limited to, Contract termination; • Attachment G, *Table of Monetary Penalties*; and • A partial or complete forfeiture of any interest earned on the net directed payments provided to the Contractor. Annually, unless otherwise directed by LDH, the Contractor shall stratify and report on select performance measure results in Attachment H, *Quality Performance Measures*, using a template provided by LDH.	This revision specifies reporting requirements for directed payments for hospital services.
10	2.11.14 Payment for Recruitment and Retention Incentives for psychiatrists and Licensed Mental Health Professionals …	2.11.14 Payment for Recruitment and Retention Incentives for psychiatrists and Licensed Mental Health Professionals …	This addition is necessary to implement a directed payment arrangement, approved by CMS and funded through ARPA, to improve access to DBT.

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	In accordance with 42 CFR §438.6(c), LDH will utilize a CMS-approved directed payment arrangement for specified Network Providers. The payment arrangement will utilize a series of uniform incentive payments dependent upon the retention or recruitment category within which the eligible Network Provider falls. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically. This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment. … 2.11.14.4 This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter.*	In accordance with 42 CFR §438.6(c), LDH will utilize ~~a~~ CMS-approved directed payment arrangements for specified Network Providers. The payment arrangements will utilize a series of uniform incentive payments dependent upon the retention or recruitment category within which the eligible Network Provider falls. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically. These~~This~~ directed payment arrangements will be made through a separate payment term outside of the monthly Capitation Payment. Separate payment term(s) will be captured in the applicable rate certifications(s) but paid separately to the plans from the monthly base capitation rates paid to the Contractor based on the American Rescue Plan Act, 9817 funding. … 2.11.14.4 For applicable dates of service within SFY 2024, unless a renewal is approved by CMS, and enacted by LDH, a State-directed payment arrangement will be utilized for a temporary, uniform rate increase for certain individual or group psychotherapy services over the Medicaid FFS fee schedule in effect as of July 1, 2023 for services provided by an enrolled qualified provider that utilizes Dialectical Behavior Therapy (DBT), an individual or group psychotherapy Evidence-Based Practice. The Contractor shall ensure compliance with the applicable CMS-approved State-directed payment preprint for DBT services. 2.11.14.4.1 Eligible providers will be paid by the Contractor based on submission of eligible claims. The Contractor must ensure the accurate and timely processing of Claims and Encounters. The Contractor will be eligible to receive reimbursement from LDH for the DBT add-on portion of the total reimbursement paid for the applicable individual or group psychotherapy services. To receive reimbursement, the Contractor will invoice LDH on a	

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		quarterly basis for the portion of the claims attributable to the state directed payment. The initial invoice is due by the fifteenth (15th) of the month following the close of the first eligible calendar year quarter during which a qualified provider submitted and was reimbursed for a claim for the provision of an eligible DBT service. The Contractor will be reimbursed by LDH within thirty (30) Calendar Days of invoice receipt. 2.11.14.54 This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*.	
11	2.11 Provider Reimbursement … **[new provisions]**	2.11 Provider Reimbursement … 2.11.17 Payment for Recruitment and Retention Incentives for Nurses Providing Skilled Nursing Services in the Extended Home Health Program In accordance with 42 CFR §438.6(c), LDH will utilize a directed payment arrangement to disburse recruitment and retention bonuses for skilled nursing services provided under the extended home health program. The payment arrangement will be dependent upon the individual nurse meeting monthly service thresholds. CMS approval of a directed payment arrangement is for one (1) rating period and it is not renewed automatically. This directed payment arrangement will be made through a separate payment term outside of the monthly Capitation Payment. The Contractor shall make directed payments to qualified network providers as directed by LDH and in accordance with the written approval from CMS for the applicable rating period. 2.11.17.1 LDH will provide a one-time recruitment lump sum payment contingent upon the individual nurse meeting service thresholds. Individual	This addition is necessary to implement a directed payment arrangement, approved by CMS and funded through ARPA, to improve access to home health services.

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		nurses are only eligible to receive the recruitment lump sum bonus once, and this bonus may not be duplicated under any circumstances. 2.11.17.2 For each SFY, pursuant to CMS approval, LDH will provide an additional recurring monthly retention payment to qualified Network Providers contingent upon the individual nurse meeting service thresholds. Additionally, the qualified Network Provider employing the individual nurse will be eligible to receive a monthly administrative fee. 2.11.17.3 This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*. **[subsequent provisions renumbered]**	
12	2.12 Utilization Management 2.12.1 General Requirements … 2.12.1.2 The Contractor shall submit written policies and procedures to LDH or its designee for approval as part of Readiness Review and prior to any substantive changes. Policies and procedures shall include, but not be limited to: 2.12.1.2.1 The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services; 2.12.1.2.2 Provisions for ensuring confidentiality of clinical information;	2.12 Utilization Management 2.12.1 General Requirements … 2.12.1.2 The Contractor shall submit written policies and procedures to LDH or its designee for approval as part of Readiness Review and prior to any substantive changes. Policies and procedures shall include, but not be limited to: 2.12.1.2.1 The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services; 2.12.1.2.1.1 For SBHS, the Contractor shall provide the following for each unique service: 2.12.1.2.1.1.1 Any Prior Authorization requirements; 2.12.1.2.1.1.2 Number of pass-through visits or Encounters permitted as applicable;	This revision is to ensure LDH's awareness of the MCOs' service authorization criteria for specialized behavioral health services and associated policies/procedures, and approve of such criteria/policies before implemented by the MCOs.

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	2.12.1.2.3 The reporting of Fraud and Abuse information identified through the program to LDH in accordance with 42 CFR §455.1(a)(1); 2.12.1.2.4 Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each Enrollee, in accordance with the **MCO Manual**. The Contractor shall collect and provide health records to LDH upon request;	2.12.1.2.1.1.3 Detailed medical necessity criteria and source; 2.12.1.2.1.1.4 Clinical documentation required for Prior Authorization and decision-making; 2.12.1.2.1.1.5 Comprehensive Service Authorization criteria and source used by the Contractor's staff to determine whether a service should be approved or partially denied; and 2.12.1.2.1.1.6 Standard authorization period. 2.12.1.2.2 Provisions for ensuring confidentiality of clinical information; 2.12.1.2.3 The reporting of Fraud and Abuse information identified through the program to LDH in accordance with 42 CFR §455.1(a)(1); 2.12.1.2.4 Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each Enrollee, in accordance with the **MCO Manual**. The Contractor shall collect and provide health records to LDH upon request; and	
13	2.12 Utilization Management 2.12.1 General Requirements … 2.12.1.3 All documentation and/or records maintained by the Contractor, its Material Subcontractors, and its Network Providers related to MCO Covered Services, charges, operations and agreements under this Contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an Enrollee or an authorized agent of the State or Federal government or any of its authorized agents unless those records are subject	2.12 Utilization Management 2.12.1 General Requirements … 2.12.1.3 All documentation and/or records maintained by the Contractor, its Material Subcontractors, and its Network Providers related to MCO Covered Services, charges, operations and agreements under this Contract shall be maintained for at least ten (10) calendar years following termination of the Contract ~~after the last good, service or supply has been provided to an Enrollee or an authorized agent of the State or Federal government or any of its authorized agents~~ unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by	This revision aligns the contract with the record retention requirements in 42 CFR §438.3(h).

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	to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the State or Federal government. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	or on behalf of the State or Federal government. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	
14	2.12.3 General Service Authorization Requirements … 2.12.3.6 The Contractor shall maintain written procedures including, but not limited to, the following: … 2.12.3.6.4 A process to ensure that authorization requirements of the Contractor shall either be furnished to the healthcare provider within twenty-four (24) hours of a request for the requirements or posted in an easily searchable format, that includes the date of last review, on the Contractor's website. The Contractor shall furnish these requirements to Providers in addition to the Prior Authorization information and training that must be furnished under the Provider Services and Support section;	2.12.3 General Service Authorization Requirements … 2.12.3.6 The Contractor shall ~~maintain~~ develop and implement written procedures including, but not limited to, the following: … 2.12.3.6.4 A process to ensure that authorization requirements of the Contractor shall either be furnished to the healthcare provider within twenty-four (24) hours of a request for the requirement. In addition, the Contractor shall post a listing of all items and services that require prior authorization in an easily searchable format, that includes the date of last review, on the Contractor's public website. The Contractor shall furnish these requirements to Providers in addition to the Prior Authorization information and training that must be furnished under the Provider Services and Support section;	This revision is anticipation of Act 233, which requires MCOs to provide a publicly available website with a list of all items and services that require Prior Authorization.
15	2.12.3.6.5 A process to arrange for another level of care if appropriate when the Contractor denies a Service Authorization request.	2.12.3.6.5 A process to arrange for another level of care if appropriate when the Contractor denies a Service Authorization request. For SBHS, the Contractor shall have a process by which the Contractor's staff may connect the Enrollee to another service or service provider (e.g., locating a provider, ensuring the provider has availability, and/or securing an appointment), if appropriate, to ensure Enrollee continuity of care; and	This revision is meant to ensure and address Enrollee continuity of care, as needed, when an MCO denies a specialized behavioral health service.

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16	2.12.4 Service Authorization Criteria … **[new provision]**	2.12.4 Service Authorization Criteria … 2.12.4.5. The Contractor shall establish and implement a six (6) month Service Authorization period for CPST and PSR services unless otherwise approved by LDH based on justification provided by the Contractor.	This change is to standardize the authorization period for CPST and PSR services to reduce provider abrasion.
17	2.12.5 Service Authorization Staffing Requirements … **[new provision]**	2.12.5 Service Authorization Staffing Requirements … 2.12.5.6. The Contractor shall ensure that all staff making Service Authorization decisions for SBHS participate in training and inter-rater reliability testing at least annually, or more frequently based on updates to the service definition or medical necessity criteria.	This change is meant to ensure MCO staff making UM decisions are knowledgeable regarding SBHS and any updates to those services.
18	2.12.6 Service Authorization Determination Timing and Notices … 2.12.6.4 Notices of Determinations … 2.12.6.4.3 Informal Reconsideration … 2.12.6.4.3.2 In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the Enrollee or a provider acting on behalf of the Enrollee and with the Enrollee's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer	2.12.6 Service Authorization Determination Timing and Notices … 2.12.6.4 Notices of Determinations … 2.12.6.4.3 Informal Reconsideration … 2.12.6.4.3.2 In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the Enrollee or a provider acting on behalf of the Enrollee and with the Enrollee's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [42 CFR §438.402(c)(1)(ii)]. For SBHS, the Contractor shall clearly identify the documentation to be submitted by the provider to obtain	These revisions address provider concerns regarding the informal reconsideration process.

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	making the adverse determination [42 CFR §438.402(c)(1)(ii)]. 2.12.6.4.3.3 The informal reconsideration shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.	approval of SBHS or a more appropriate course of action or treatment based upon the approved Service Authorization criteria. 2.12.6.4.3.3 The Contractor shall offer the informal reconsideration at a mutually agreed upon time, which ~~The informal reconsideration~~ shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.	
19	2.16.8 Performance Measures … 2.16.8.4 Reporting of quality measures shall include stratification of performance measure results across different populations with attention to geography, ethnicity, race, and disability status.	2.16.8 Performance Measures … 2.16.8.4 Reporting of quality measures shall include stratification of performance measure results across different populations with attention to geography, ethnicity, race, and ~~disability status~~ as directed by LDH.	LDH doesn't currently require the Contractor to stratify quality measures based on disability status. This revision is necessary to provide flexibility for future updates to stratification categories.
20	2.18.9.3 The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor's process for the recycling of Denied Claims that are due to system update delays. The recycling of these Denied Claims shall be completed no later than fifteen (15) Calendar Days after the system update. 2.18.9.4 Except as otherwise specified by LDH in writing, the Contractor shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. The Contractor shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or LDH.	2.18.9.3 ~~The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor's process for the recycling of Denied Claims that are due to system update delays. The recycling of these Denied Claims shall be completed no later than fifteen (15) Calendar Days after the system update.~~ The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates.	This revision clarifies that the 15-day timeline for recycling claims is applicable to system updates impacting code sets. Note: the two provisions were reordered for clarity. The new 2.18.9.3 has not changed, but the new 2.18.9.5 contains the following revisions: The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor's process for the recycling of all impacted Claims, including Denied Claims, that are due to system update ~~delay~~s. The recycling of all impacted ~~Denied~~ Claims shall be completed

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	2.18.9.5 The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates.	2.18.9.4 Except as otherwise specified by LDH in writing, the Contractor shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. The Contractor shall also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or LDH. 2.18.9.5 ~~The Contractor shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than thirty (30) Calendar Days after notification, unless otherwise directed by LDH in writing. This includes annual and other fee schedule updates.~~ The Contractor shall notify LDH and providers as to when system updates will be in production and of the Contractor's process for the recycling of all impacted Claims, including Denied Claims, that are due to system updates. The recycling of all impacted Claims shall be completed no later than fifteen (15) Calendar Days after the system update.	no later than fifteen (15) Calendar Days after the system update.
21	2.18.15 Encounter Data … 2.18.15.3.2 Submit the Encounter Data in accordance with the Encounter reconciliation schedule published by LDH or its contracted review organization, including Encounters reflecting a zero dollar amount ($0.00) and Encounters in which the Contractor or its Subcontractor has a capitation arrangement with a provider. If the Contractor or its subcontracted vendor(s), excluding the Single PBM, individually or in aggregate, fails to submit complete Encounter Data as measured by a comparison of Encounters to cash disbursements within a one percent (1%) error threshold (i.e., Encounters are at least ninety-nine percent [99%] but no greater than one hundred percent [100%] of	2.18.15 Encounter Data … 2.18.15.3.2 Submit the Encounter Data in accordance with the Encounter reconciliation schedule published by LDH or its contracted review organization, including Encounters reflecting a zero dollar amount ($0.00) and Encounters in which the Contractor or its Subcontractor has a capitation arrangement with a provider. If the Contractor or its subcontracted vendor(s), excluding the Single PBM, individually or in aggregate, fails to submit complete Encounter Data as measured by a comparison of Encounters to cash disbursements within a ~~one~~ two percent (2~~1~~%) error threshold (i.e., Encounters are at least ninety-eight ~~nine~~ percent [~~99~~98%] but no greater than one hundred percent [100%] of cash disbursements), LDH may impose Monetary Penalties in accordance with Attachment G, *Table of Monetary Penalties*. LDH, at its sole discretion, may waive the	This revision expands the non-pharmacy encounter reconciliation completeness threshold to 98-100% in order to align with current standards.

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	cash disbursements), LDH may impose Monetary Penalties in accordance with Attachment G, *Table of Monetary Penalties*. LDH, at its sole discretion, may waive the penalty if Encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) fall below the completion threshold during the transition to a new vendor; however, this grace period shall not exceed ninety (90) Calendar Days for Encounters processed by either the exiting vendor or the new vendor.	penalty if Encounters processed by subcontracted vendors (e.g., pharmacy, non-emergency transportation, vision) fall below the completion threshold during the transition to a new vendor; however, this grace period shall not exceed ninety (90) Calendar Days for Encounters processed by either the exiting vendor or the new vendor.	
22	2.20.6 Rights of Review and Recovery by Contractor and LDH … **[new provisions]**	2.20.6 Rights of Review and Recovery by Contractor and LDH … 2.20.6.5 Before the Contractor executes a recoupment related to Fraud, Waste, or Abuse under investigation by the Contractor's Special Investigation Unit (SIU), the provider shall have forty-five (45) Calendar Days from receipt of written notification of findings and/or recoupment to submit a written response to the Contractor as to why the findings and/or recoupment are not valid or should not be put into effect on the date specified in the notice. If the provider fails to submit a written response within the time period provided, the Contractor may execute the recoupment on the date specified in the notice. All Fraud, Waste, or Abuse recoupment notifications shall be addressed from the Contractor's SIU and include the information listed in the *Payment Recoupments* section of this Contract. **[subsequent provisions renumbered]**	This revision reinstates the timeframe from the previous contract to allow the Contractor to research potential fraud, waste, and abuse more efficiently while providing sufficient time to providers to respond to the request. This change will also allow the Contractor a better opportunity to meet the requirement in Section 2.20.6.4 of completing all complex reviews within ten (10) months (three hundred (300) Calendar Days) of the date the case was opened unless an extension is authorized by LDH.

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23	4.4.1 MCO Performance Withhold Amount … 4.4.1.7 - LDH will not withhold funds from the Contractor for MCO performance until July 2023.	4.4.1 MCO Performance Withhold Amount … 4.4.1.7 - LDH will not withhold funds from the Contractor for MCO performance until ~~July 2023~~January 2024.	This revision specifies that the 2% quality, VBP, and health equity withholds for the entirety of measurement year 2023 have been suspended.
24	4.4.1 MCO Performance Withhold Amount … **[new provision]**	4.4.1 MCO Performance Withhold Amount … 4.4.1.8 LDH may, at its sole discretion, suspend the withhold for a specified period with written notification to the Contractor.	This revision provides clarification regarding withhold provisions.
25	4.14 Post-Payment Recoveries … **[new provision]**	4.14 Post-Payment Recoveries … 4.14.1.11 The Contractor shall maintain a system to monitor cases where the Louisiana Patient's Compensation Fund (PCF) has assumed liability for future medical payments for Medicaid recipients. The Contractor shall bill the PCF on at least an annual basis for future medical payments related to medical malpractice lawsuits, as established by either a Judgment or a Settlement Agreement, pursuant to La R.S. 40:1299.43. **[subsequent provisions renumbered]**	This revision aligns the contract with La. R.S. §40:1299.43.
26	5.4 Post-Turnover Services … 5.4.4 The Contractor shall maintain all data and records related to Enrollees and providers for ten (10) years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is	5.4 Post-Turnover Services … 5.4.4 The Contractor shall maintain all data and records related to Enrollees and providers for ten (10) years following termination of ~~after the date of final payment under~~ the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. Under no circumstances shall the Contractor or any of	This revision aligns the contract with the record retention requirements in 42 CFR §438.3(h).

Item	Change From	Change To	Justification
	longer. Under no circumstances shall the Contractor or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.	
27	6.24.1 HIPAA Disclosure Process 6.24.1.1 The Contractor shall protect confidential information and documents in accordance with 42 U.S.C. §671(a)(8), 42 U.S.C. §5106a, 42 U.S.C. §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La. R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable. The Contractor shall disclose in writing any use or disclosure of PHI other than as permitted by the Contract within three (3) Calendar Days of becoming aware of the use or disclosure. 6.24.1.2 The Contractor is required to submit incident reports affecting Providers or Enrollees receiving services to LDH with a CAP and timelines for implementation of correction for approval by LDH within ten (10) Business Days of the Contractor's discovery of any HIPAA breaches, as defined at 45 CFR §164.402. The incident report shall include, at a minimum:	6.24.1 HIPAA Disclosure Process 6.24.1.1 The Contractor and its Subcontractors shall protect confidential information and documents in accordance with 42 U.S.C. §671(a)(8), 42 U.S.C. §5106a, 42 U.S.C. §290dd-2, 45 CFR §1355.21, 45 CFR §205.50, 45 CFR §1355.30, 42 CFR Part 2, La. R.S. 46:56, and 45 CFR Parts 160 and 164, as applicable. The Contractor shall disclose in writing any use or disclosure of PHI by the Contractor or any of its Subcontractors other than as permitted by the Contract within ~~three (3) Calendar Days~~ forty-eight (48) hours of becoming aware of the use or disclosure. 6.24.1.2 The Contractor is required to submit incident reports affecting Providers or Enrollees receiving services to LDH with a CAP and timelines for implementation of correction for approval by LDH within ten (10) Business Days of the Contractor's discovery of any HIPAA breaches, as defined at 45 CFR §164.402, that are committed by the Contractor or any of its Subcontractors. The incident report shall include, at a minimum:	This revision aligns the HIPAA Disclosure Process with current practice.

28	6.26 Security 6.26.1 Contractor's personnel shall comply with all security regulations in effect at the State's premises and externally for materials and property belonging to the State or to the project. Where special security precautions are warranted (e.g., correctional facilities), the State shall provide such procedures to the Contractor, accordingly. 6.26.2 The Contractor shall comply with the Office of Technology Services' Information Security Policy at http://www.doa.la.gov/Pages/ots/InformationSecurity.aspx. **[new provision]**	6.26 Security 6.26.1 Contractor's personnel shall comply with all security regulations in effect at the State's premises and externally for materials and property belonging to the State or to the project. Where special security precautions are warranted (e.g., correctional facilities), the State shall provide such procedures to the Contractor, accordingly. 6.26.2 The Contractor shall comply with the Office of Technology Services' (OTS) Information Security Policy at http://www.doa.la.gov/Pages/ots/InformationSecurity.aspx. 6.26.3 The Contractor is responsible for reporting to the State any known Data Breach or Security Event, as defined in the OTS Information Security Policy, no later than forty-eight (48) hours after confirmation of the event. The Contractor shall notify the Information Security Team ("IST") by calling the Information Security Hotline at 1-844-692-8019 and emailing the security team at infosecteam@la.gov.	This language is required by the Office of Technology Services (OTS) Information Security Team.
29	**PART 6: TERMS AND CONDITIONS** **…** 6.47 Record Retention 6.47.1 The Contractor shall retain, and require Subcontractors to retain, as applicable, financial records, supporting documents, statistical records, and all other records pertinent to an award, including, but not limited to Enrollee Grievance and Appeal records in 42 CFR §438.416; base data in 42 CFR §438.5(c); MLR reports in 42 CFR §438.8(k); and the data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610, shall be retained for a period of ten (10) years from	**PART 6: TERMS AND CONDITIONS** **…** 6.47 Record Retention 6.47.1 The Contractor shall retain, and require Subcontractors to retain, as applicable, financial records, supporting documents, statistical records, and all other records pertinent to an award, including, but not limited to Enrollee Grievance and Appeal records in 42 CFR §438.416; base data in 42 CFR §438.5(c); MLR reports in 42 CFR §438.8(k); and the data, information, and documentation specified in 42 CFR §438.604, §438.606, §438.608, and §438.610, shall be retained for a period of ten (10) years following termination of the Contract ~~from the date of submission of the final expenditure report~~. The only exceptions are the following:	This revision aligns the contract with the record retention requirements in 42 CFR §438.3(h).

	the date of submission of the final expenditure report. The only exceptions are the following:		