LOUISIANA DEPARTMENT OF HEALTH

MCO Amendment 2
Attachment A2 – Changes to Attachment A, *Model Contract*

Item	Change From	Change To	Justification
1	**LIST OF CONTRACT ATTACHMENTS** … **Attachment E:** APM Strategic Plan Requirements and Reporting Template	**LIST OF CONTRACT ATTACHMENTS** … **Attachment E:** APM ~~Strategic Plan Requirements and~~ Reporting Template	The name of this attachment has been changed to more accurately reflect its content.
2	**Glossary** … **Adjudicate** – To deny or pay a Clean Claim.	**Glossary** … **Adjudicate** – To deny or pay a ~~Clean~~ Claim.	This revision expands the scope of the term to include any Claim and resolves conflicts with other provisions of the Contract.
3	**Glossary** … **[new terms]**	**Glossary** … **Alternative Payment Methodology** – A method of reimbursing a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) outside of the Prospective Payment System (PPS). The methodology must be agreed to by the State and the FQHC or RHC, result in a payment to the FQHC or RHC that is at least equal to the amount to which it is entitled under the PPS, and be described in the State Plan. **Alternative Payment Model (APM)** – A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. … **Prospective Payment System (PPS)** – A method of payment in which the Medicaid payment is made based on a predetermined, fixed amount.	This revision provides definitions to differentiate between similar payment-related terms.
4	**Glossary** …	Glossary …	This revision clarifies how time is to be computed.

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	Business Day –Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays. … **Calendar Days** – All seven (7) days of the week. Unless otherwise specified, the term "day" in the Contract refers to Calendar Days.	**Business Day** – Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays. In computing a period of time prescribed in Business Days, the date of the triggering act or event is not to be included. The last day of the period is to be included, unless it is a Saturday, a Sunday, or a State-designated holiday, in which event the period shall run until the end of the next day that falls on a Business Day. … **Calendar Days** – All seven (7) days of the week. Unless otherwise specified, the term "day" in the Contract refers to Calendar Days. In computing a period of time prescribed in Calendar Days, the date of the triggering act or event is not to be included, and the last day of the period is to be included.	
5	**Glossary** … **[new terms]**	**Glossary** … **Rural Area** – Any area outside an urban area. … **Urban Area** – A Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget and applied to Census Bureau data. The most recent delineation files and maps are located at https://www.census.gov.	This revision defines urban vs. rural areas to align with the Medicare program definition (42 CFR §412.62).
6	**Glossary** … **[new term]**	**Glossary** … **Experimental Procedure/Service** – A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be limited or inconclusive. The term applies only to the determination of eligibility for coverage or payment.	This revision adds the definition for "Experimental Procedure/Service" which is referenced in the Contract.

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7	**Acronyms** **…** **[new term]**	**Acronyms** **…** **ABA –** Applied Behavior Analysis	This revision adds an acronym that is referenced in this amendment.
8	2.2.2.2 Substitution of Personnel 2.2.2.2.1 The Contractor's personnel assigned to the Contract shall not be replaced without the prior written consent of the State. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to a project outside the Contract, outside of the Contractor's reasonable control, as the case may be, the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in completing tasks. The Contractor will make every reasonable attempt to assign the personnel listed in its proposal.	2.2.2.2 Substitution of Personnel 2.2.2.2.1 The Contractor's key personnel assigned to the Contract shall not be replaced without the prior written consent of the State. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to a project outside the Contract, outside of the Contractor's reasonable control, as the case may be, the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in completing tasks. The Contractor will make every reasonable attempt to assign the personnel listed in its proposal.	This revision reduces administrative burden by clarifying that only the substitution of key personnel requires prior written approval by LDH.
9	2.2.3.12.3.2 If the Contractor is a New Entrant, the Contractor shall have its pharmacy benefits carved into FFS. During this period, the Contractor will not be responsible for processing POS pharmacy Claims or Prior Authorizations for POS pharmacy Claims, but shall provide any required referrals and coordination for pharmacy services.	2.2.3.12.3.2 If the Contractor is a New Entrant, the Contractor shall have its pharmacy benefits carved into FFS. During this period, the following provisions apply. 2.2.3.12.3.2.1 The Contractor will not be responsible for processing POS pharmacy Claims or Prior Authorizations for POS pharmacy Claims, but shall provide any required referrals and coordination for pharmacy services. 2.2.3.12.3.2.2 The Contractor shall cover physician administered drugs listed on the Medicare Part B Drugs List as medical/professional outpatient Claims. LDH will supply the Contractor with a list each quarter identifying which physician administered drugs must be covered as medical/professional outpatient Claims. The list will also identify codes the Contractor must cover as a medical/professional benefit that could also be payable through FFS as a pharmacy benefit, depending upon how the Provider submits the Claim. If the drug could be covered as either a pharmacy or medical/professional benefit,	This revision is to clarify pharmacy benefits for the New Entrant, which has its pharmacy benefits carved into FFS until the Single PBM contract is operational.

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		the Claim shall be reimbursed as submitted (Provider choice of Claim type) and without site of care steerage. The Contractor shall not steer the Provider to submit such Claims to FFS and shall not provide any provider education that would result in utilization moving from the medical/professional benefit to the pharmacy benefit. The Contractor shall, at a minimum, set reimbursement for physician administered drugs using the current FFS reimbursement methodology in the State Plan. The Contractor shall be responsible for coverage of all drugs included in any high cost or gene therapy risk pool. In the event that the Contractor covers a risk pool drug, LDH or its Fiscal Intermediary will accept the Encounter through a manual process. The Contractor may apply edits for physician administered drugs that align with the manufacturer's package insert and FDA approved indications, but may not apply any edit that would indicate a drug is covered under the FFS pharmacy benefit.	
10	2.2.7.3 The Contractor shall require that all providers and all Subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a Material Subcontractor, the Contractor shall require that the Material Subcontractor complies with provisions of this Contract relating to mental health parity. The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. The Contractor shall require mental health parity disclosure on provider Enrollment forms as mandated by LDH.	2.2.7.3 The Contractor shall require that ~~all providers and~~ all Subcontractors take such actions as are necessary to ensure compliance with mental health parity requirements. To the extent that the Contractor delegates oversight responsibilities for behavioral health services to a Material Subcontractor, the Contractor shall require that the Material Subcontractor complies with provisions of this Contract relating to mental health parity. The compliance and review shall be in conjunction with parity analysis on the medical/surgical benefit administration. ~~The Contractor shall require mental health parity disclosure on provider Enrollment forms as mandated by LDH.~~	This revision removes the specified obligation of Providers, as mental health parity is not impacted at the Provider level in such a way that would necessitate a disclosure on a Provider enrollment form.
11	2.3.2 Voluntary MCO Populations The Contractor shall accept Enrollment of the following Louisiana Medicaid Program populations and provide for all SBHS, NEMT services, and NEAT services. …	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. …	This revision aligns the Contract with existing ABA coverage.

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	2.3.2.2 Voluntary MCO Populations may elect to receive all Medicaid Covered Services through the Managed Care Program at any time, effective the earliest possible month that the administrative action can be taken. 2.3.2.3 Voluntary MCO Populations may return to FFS for all Medicaid Covered Services other than SBHS and NEMT/NEAT services at any time, effective the earliest possible month that the administrative action can be taken.	2.3.2.2 Voluntary MCO Populations may elect to receive all Medicaid Covered Services through the Managed Care Program at any time, effective the earliest possible month that the administrative action can be taken. 2.3.2.3 Voluntary MCO Populations may return to FFS for all Medicaid Covered Services other than ABA, SBHS and NEMT/NEAT services at any time, effective the earliest possible month that the administrative action can be taken. … 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: 2.3.3.1 Beneficiaries residing in Nursing Facilities (NF); and 2.3.3.2 Beneficiaries under the age of twenty-one (21) residing in ICF/IIDs. 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 services only, and receive all other Medicaid Covered Services through FFS: 2.3.4.1 Beneficiaries who are enrolled in both the Louisiana Medicaid Program and Medicare (Medicaid dual eligible), except those residing in an institution as specified in this section. 2.3.4.2 LaHIPP Beneficiaries except those residing in an institution as specified in this section.	

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12	2.7.2.4 The Contractor's HNA shall: … 2.7.2.4.4 Identify individuals for referral to Case Management, with more in-depth assessment to occur as part of the POC; … 2.7.3 Enrollees with Special Health Care Needs (SHCN) 2.7.3.1 The Contractor shall implement mechanisms to provide each Enrollee identified as having SHCN with a comprehensive assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. 2.7.3.2 The Contractor shall complete this comprehensive assessment for at least ninety percent (90%) of those Enrollees that the Contractor is able to contact and are willing to engage within ninety (90) Calendar Days of being identified as having SHCN. 2.7.3.3 The Contractor shall offer Case Management to all Enrollees with SHCN regardless of information gathered through this comprehensive assessment or the HNA.	2.7.2.4 The Contractor's HNA shall: … 2.7.2.4.4 Identify individuals for referral to Case Management~~, with more in-depth assessment to occur as part of the POC~~; … 2.7.3 ~~Enrollees with Special Health Care Needs (SHCN)~~ Case Management Assessment 2.7.3.1 The Contractor shall use Claims data and other available data to identify Enrollees who meet the SHCN criteria on at least a monthly basis. The Contractor shall implement mechanisms to provide each Enrollee identified as having SHCN with a comprehensive Case Management assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. 2.7.3.2 The Contractor shall implement mechanisms to provide other Enrollees referred to Case Management with a Case Management assessment to identify any needs or conditions of the Enrollee that require intervention by the MCO, a course of treatment, or regular care monitoring. 2.7.3.3 The Contractor shall complete ~~this comprehensive~~ the required assessment for at least ninety percent (90%) of those Enrollees that the Contractor is able to contact and are willing to engage within ninety (90) Calendar Days of being identified as having SHCN or of being referred to Case Management. 2.7.3.~~3~~4 The Contractor shall offer Case Management to all Enrollees with SHCN regardless of information gathered through this comprehensive assessment or the HNA.	The revision is to distinguish between the assessments given to Enrollees with SHCN and other Enrollees referred to case management. It also establishes a timeframe for Contractors to identify existing Enrollees who may have a SHCN and to align with current practice.

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13	2.7.5.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of identification and shall include assessment of the home environment and priority SDOH (see Population Health and Social Determinants of Health section). Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC, with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.2 Case Management (Medium) (Tier 2) Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of identification and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case	2.7.5.1 Intensive Case Management for High Risk Enrollees (High) (Tier 3) Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of the Case Management assessment being completed~~identification~~ and shall include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.2 Case Management (Medium) (Tier 2) Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A POC shall be completed in person within thirty (30) Calendar Days of the Case Management assessment being completed~~identification~~ and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health*	This revision is to clarify that the Plan of Care is to be completed following the completion of the Case Management assessment, and that it is the Contractors' responsibility to coordinate transitions of care for Enrollees enrolled in Case Management.

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	managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.3 Case Management (Low) (Tier 1) Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of identification and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC, with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.	section). Case Management meetings shall occur at least monthly, with quarterly updates to the POC or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i) and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs. 2.7.5.3 Case Management (Low) (Tier 1) Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and typically require support in care coordination and in addressing SDOH. A POC shall be completed in person within ninety (90) Calendar Days of the Case Management assessment being completed ~~identification~~ and include assessment of the home environment and priority SDOH (see *Population Health and Social Determinants of Health* section). Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC or as needed to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i), with annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed.	

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14	2.7.5.4 Transitional Case Management The Contractor shall implement procedures to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing.	2.7.5.4 Transitional Case Management The Contractor shall implement procedures to coordinate the services that it furnishes to the Enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). The Contractor shall provide Transitional Case Management for Enrollees not already enrolled in Case Management Tiers 1, 2, or 3 to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential treatment facilities (PRTFs), therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing.	This revision is to clarify that Transitional Case Management is for Enrollees not already enrolled in tiered Case Management.
15	2.11.2.1 The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 U.S.C. §1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount LDH would pay for such services through FFS as defined by the Prospective Payment System (PPS) rate in effect on the date of service for each Encounter or an alternative payment methodology approved by LDH in writing.	2.11.2.1 The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 U.S.C. §1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount LDH would pay for such services through FFS as defined by the Prospective Payment System (PPS) rate or the Alternative Payment Methodology rate in effect on the date of service for each Encounter ~~or an alternative payment methodology approved by LDH in writing~~.	This revision aligns the Contract with the Louisiana Administrative Code.

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16	2.12.3.4 The Contractor shall not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a Service Authorization determination, for that particular item or service. 2.12.3.4.1 When the provider fails to provide requested medical information, the Contractor may at its discretion, or shall as directed by LDH, impose financial penalties against the provider as appropriate.	2.12.3.4 The Contractor shall not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a Service Authorization determination, for that particular item or service. ~~2.12.3.4.1 When the provider fails to provide requested medical information, the Contractor may at its discretion, or shall as directed by LDH, impose financial penalties against the provider as appropriate.~~	This revision removes the imposition of an unnecessary penalty, as Providers are not reimbursed for services when they fail to provide the requested medical information for Service Authorization determinations.
17	2.12.6.1.1.3 The MCO shall make all determinations for behavioral health crisis response services that require Prior Authorization as expeditiously as the enrollee's condition requires, but no later than one (1) Calendar Day after obtaining appropriate clinical documentation.	2.12.6.1.1.3 The MCO shall make all determinations for any behavioral health crisis ~~response~~ services that require Prior Authorization as expeditiously as the E~~e~~nrollee's condition requires, but no later than one (1) Calendar Day after obtaining appropriate clinical documentation.	This revision applies this standard to any behavioral health crisis service, as it is in the best interest of the Enrollee to have a short turnaround time for crisis services.
18	2.13.8.7.1 Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, PCPs, specialists, hospital PCP groups, pharmacies, behavioral health providers, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving Provider list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified. Provider types shall be delineated by parish and zip code;	2.13.8.7.1 Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, PCPs, specialists, hospital PCP groups, pharmacies, behavioral health providers, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving Provider list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified. Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders shall be clearly identified. Provider types shall be delineated by parish and zip code;	This revision is to comply with the requirements of La. R.S. 40:1125.4, as revised by HB 784 of the 2022 Regular Legislative Session, to identify providers who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders, which are searchable by location.
19	2.16.22 Quality Monitoring Reviews	2.16.22 Quality Monitoring Reviews	This revision is to align with MCO Manual.

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	The Contractor shall collaborate with the other MCOs to develop and implement a plan for monitoring a statistically significant of specialized behavioral health providers and facilities across service categories, which incorporates onsite reviews and member interviews, on a quarterly basis. The Contractor shall submit the plan to LDH for approval no later than sixty (60) Calendar Days after the Operational Start Date of the Contract and at least sixty (60) Calendar Days prior to any Material Change. The Contractor's monitoring plan, monitoring process, and sampling approach shall comply with the requirements as specified by LDH in the MCO Manual.	The Contractor shall collaborate with the other MCOs to develop and implement a plan for monitoring a ~~statistically significant~~representative sample of specialized behavioral health providers and facilities across ~~service categories~~levels of care, which incorporates onsite reviews and member interviews, on a quarterly basis. The Contractor shall submit the plan to LDH for approval no later than sixty (60) Calendar Days after the Operational Start Date of the Contract and at least sixty (60) Calendar Days prior to any Material Change. The Contractor's monitoring plan, monitoring process, and sampling approach shall comply with the requirements as specified by LDH in the MCO Manual.	
20	2.17.1 Value-Based Payment (VBP) Overview The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in the MCO Manual and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of populations (better health), enhance the experience of care for individuals (better care), effectively manage Louisiana Medicaid Program per capita care costs (lower costs), and be designed to meet or exceed the VBP withhold requirements in this Contract. … 2.17.2 Minimum VBP Threshold and Qualifying VBP Arrangements A portion of the Contractor's annual VBP withhold described in the Financial Incentives for MCO Performance section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract and the MCO Manual. Unless otherwise modified by LDH, the minimum VBP threshold for each Measurement Year is as follows: 2.17.2.1 Calendar Year 2023	2.17.1 Value-Based Payment (VBP) Overview The Contractor shall develop and implement a VBP Strategic Plan for achieving the performance benchmarks in this Contract ~~the MCO Manual~~ and paying providers based on performance. The Contractor's VBP strategy shall pertain to measurable outcomes that are meant to improve the health of populations (better health), enhance the experience of care for individuals (better care), effectively manage Louisiana Medicaid Program per capita care costs (lower costs), and be designed to meet or exceed the VBP withhold requirements in this Contract. … 2.17.2 Minimum VBP Threshold and Qualifying VBP Arrangements A portion of the Contractor's annual VBP withhold described in the Financial Incentives for MCO Performance section shall be tied to the Contractor's demonstration that it has met the minimum VBP threshold established as defined by LDH in accordance with this Contract ~~and the MCO Manual~~. Unless otherwise modified by LDH, the minimum VBP threshold for each Measurement Year is as ~~follows:~~ described in the *Financial Incentives for MCO Performance* section.	This revision aligns this section with the updates being made to the *Financial Incentives for MCO Performance* section of the Contract.

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	2.17.2.1.1 Contractual arrangements linked to a VBP model that includes one or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed six (6) million dollars in total provider payments; or 2.17.2.1.2 The Contractor's total potential provider incentive payments exceed twelve (12) million dollars in total provider payments. 2.17.2.1.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, category 3B APM or category 4 APM that is effective no later than December 2023. 2.17.2.1.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures and provide initial data-based assessments to determine the extent to which providers participated in specific VBP models may be performing differently on targeted quality measures than providers not participating in such VBP models. 2.17.2.2 Calendar Year 2024 2.17.2.2.1 Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed seven (7) million dollars in total provider payments; or 2.17.2.2.2 The Contractor's total potential provider incentive payments exceed fourteen (14) million dollars in total provider payments. 2.17.2.2.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, and one new Network Provider	~~2.17.2.1 Calendar Year 2023~~ ~~2.17.2.1.1 Contractual arrangements linked to a VBP model that includes one or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed six (6) million dollars in total provider payments; or~~ ~~2.17.2.1.2 The Contractor's total potential provider incentive payments exceed twelve (12) million dollars in total provider payments.~~ ~~2.17.2.1.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, category 3B APM or category 4 APM that is effective no later than December 2023.~~ ~~2.17.2.1.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures and provide initial data-based assessments to determine the extent to which providers participated in specific VBP models may be performing differently on targeted quality measures than providers not participating in such VBP models.~~ ~~2.17.2.2 Calendar Year 2024~~ ~~2.17.2.2.1 Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed seven (7) million dollars in total provider payments; or~~ ~~2.17.2.2.2 The Contractor's total potential provider incentive payments exceed fourteen (14) million dollars in total provider payments.~~ ~~2.17.2.2.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, and one new Network~~	

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	Agreement with a category 3B APM or category 4 APM that is effective no later than December 2024. 2.17.2.2.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years. 2.17.2.3 Calendar Year 2025 and Future Calendar Years 2.17.2.3.1 Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total potential provider incentive payments exceed eight (8) million dollars in total provider payments, or 2.17.2.3.2 The Contractor's total potential provider incentive payments exceed sixteen (16) million dollars in total provider payments. 2.17.2.3.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, one new Network Provider Agreement with a category 3B APM, and one new Network Provider Agreement with a category 4 APM that is effective no later than the end of the applicable calendar year. 2.17.2.3.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will	~~Provider Agreement with a category 3B APM or category 4 APM that is effective no later than December 2024.~~ ~~2.17.2.2.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years.~~ ~~2.17.2.3 Calendar Year 2025 and Future Calendar Years~~ ~~2.17.2.3.1 Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total potential provider incentive payments exceed eight (8) million dollars in total provider payments, or~~ ~~2.17.2.3.2 The Contractor's total potential provider incentive payments exceed sixteen (16) million dollars in total provider payments.~~ ~~2.17.2.3.3 The Contractor's VBP models must include at least one new Network Provider Agreement with a category 3A APM, one new Network Provider Agreement with a category 3B APM, and one new Network Provider Agreement with a category 4 APM that is effective no later than the end of the applicable calendar year.~~ ~~2.17.2.3.4 The Contractor must submit an annual report to LDH demonstrating how its VBP models align with LDH MCO incentive-based and other contractual performance measures. The Contractor must also analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate~~	

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	use the results of this data analysis to improve it VBP models and provider support for calendar year 2026 and future calendar years.	~~how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2026 and future calendar years.~~	
21	2.17.3 Qualifying VBP Arrangements The Contractor may only report a provider payment model as a VBP arrangement if the following conditions are met: 2.17.3.1 The payment model includes a Category 2A foundational payment or Category 2B pay for reporting as one component of a broader payment model that includes Category 2C or 3 APMs for the same provider(s); and/or 2.17.3.2 The payment model falls within Categories 2C, 3 or 4 of the LAN Alternative Payment Model Framework; and 2.17.3.3 The payment model is linked to applicable incentive-based measures from Attachment H, *Quality Performance Measures*. 2.17.3.4 VBP models focused on PCPs must include at least two incentive-based measure from Attachment H, *Quality Performance Measures*. VBP arrangements focused on services other than primary care must utilize at least two applicable measures in Attachment H, *Quality Performance Measures*, and these measures do not need to be identified as incentive-based measures.	2.17.3 Qualifying VBP Arrangements The Contractor may only report a provider payment model as a VBP arrangement if the following conditions are met: 2.17.3.1 The payment model includes a Category 2A foundational payment or Category 2B pay for reporting as one component of a broader payment model that includes Category 2C~~, or~~ 3, or 4 APMs for the same provider(s); and/or 2.17.3.2 The payment model falls within Categories 2C, 3 or 4 of the HCP-LAN ~~Alternative Payment Model~~ APM Framework; and 2.17.3.3 The payment model is linked to at least two (2) applicable ~~incentive-based~~ measures from Attachment H, *Quality Performance Measures*. 2.17.3.4 VBP models focused on PCPs must include at least two incentive-based measure from Attachment H, *Quality Performance Measures*. VBP arrangements focused on services other than primary care must utilize at least two applicable measures in Attachment H, *Quality Performance Measures*, and these measures do not need to be identified as incentive-based measures. If there are not at least two applicable measures in Attachment H, *Quality Performance Measures*, the Contractor must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its submission of Attachment E, *APM Reporting Template*.	This revision is to align the Contract with the MCO 3.0 withhold strategy: 1. The performance Measurement Year will be a calendar year basis. 2. LDH will suspend the withholds for the first six months of the Contract (1/1/2023 - 6/30/2023) to allow the New Entrant to gain experience and mitigate reporting and Enrollment concerns of the MCOs. 3. For rating period 7/1/2023 – 6/30/2024 (SFY 24) and subsequent fiscal years, LDH will begin the Quality, VBP, and Health Equity withholds. The performance measurement period will remain on a calendar year basis. The reporting and associated deliverables specified in the Contract will also be on a calendar year basis, but will take the rating period and withholds into account.

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22	2.17.4 Physician Incentive Plans 2.17.4.1 In accordance with 42 CFR §422.208 and §422.210, the Contractor may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. 2.17.4.2 The Contractor's Physician Incentive Plans shall be in compliance with 42 CFR §438.3(i), §422.208, and §422.210 and the MCO Manual.	2.17.4 Physician Incentive Plans 2.17.4.1 In accordance with 42 CFR §422.208 and §422.210, the Contractor may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. 2.17.4.2 The Contractor's Physician Incentive Plans shall be in compliance with 42 CFR §438.3(i), §422.208, and §422.210 and ~~the MCO Manual~~ this Contract.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
23	2.17.6 Preferred VBP Arrangements 2.17.6.1 Preferred VBP arrangements are priorities for LDH based on the potential to improve health care and cost-efficiency. The Contractor shall indicate in its VBP Strategic Plan and subsequent updates to the Plan which of the following preferred VBP arrangements it intends to implement and when it will implement such arrangements during the Contract period: 2.17.6.1.1 Maternity-focused VBP arrangements; 2.17.6.1.2 Models supporting physical and behavioral health integration; 2.17.6.1.3 Patient-centered medical home models that are part of a broader payment model that includes Category 2C or 3 APMs and which support the integration of behavioral health, SDOH, and/or populations with special health care needs;	2.17.6 Preferred VBP Arrangements 2.17.6.1 Preferred VBP arrangements are priorities for LDH based on the potential to improve health care and cost-efficiency. The Contractor shall indicate in its VBP Strategic Plan and subsequent updates to the Plan which of the following preferred VBP arrangements it intends to implement and when it will implement such arrangements during the Contract period: 2.17.6.1.1 Maternity-focused VBP arrangements; 2.17.6.1.2 Models supporting physical and behavioral health integration; 2.17.6.1.3 Patient-centered medical home models that are part of a broader payment model that includes Category 2C, ~~or~~ 3, or 4 APMs and which support the integration of behavioral health, SDOH, and/or populations with special health care needs;	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
24	2.18.6 Claims Reprocessing If the Contractor or LDH or its Subcontractors or Providers discover errors made by the Contractor when a Claim was Adjudicated, the Contractor shall make corrections and reprocess the Claim within fifteen (15) Calendar Days of discovery or notification, or if circumstances exist that prevent the Contractor from meeting this time frame, by a specified date subject to LDH written	2.18.6 Claims Reprocessing If the Contractor or LDH or its Subcontractors or Providers discover errors made by the Contractor when a Claim was Adjudicated, the Contractor shall make corrections and reprocess the Claim within fifteen (15) Calendar Days of discovery or notification, or if circumstances exist that prevent the Contractor from meeting this time frame, by a specified date subject to LDH written	This revision is to clarify that the interest is to be calculated from the original processing deadline and that the 15 Calendar Day deadline applies only to the deadline for paying (and not calculating) the interest.

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	approval. The Contractor shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean Claim remains unpaid beyond either the fifteen (15) Calendar Day Claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later. The Contractor shall automatically recycle all impacted Claims for all providers and shall not require the provider to resubmit the impacted Claims.	approval. The Contractor shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable Celean Claim remains unpaid beyond the thirty (30) Calendar Day Clean Claims processing deadline. Interest owed to the provider shall be paid on the same date that the Claim is Adjudicated and by either the fifteen (15) Calendar Day Claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later. The Contractor shall automatically recycle all impacted Claims for all providers and shall not require the provider to resubmit the impacted Claims.	
25	2.20.2.4 Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, Contractor employees and the public on the Contractor's website required under this Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted. The Contractor shall submit to LDH or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) Calendar Days in advance of making them effective. LDH, at its sole discretion, may require that the Contractor modify its compliance plan.	2.20.2.4 Effective implementation of a well-publicized email address for the dedicated purpose of reporting Fraud. This email address must be made available to Enrollees, providers, Contractor employees and the public on the Contractor's website required under this Contract. The Contractor shall implement procedures to review complaints filed in the Fraud reporting email account at least weekly, and investigate and act on such complaints as warranted. 2.20.2.5 The Contractor shall submit to LDH or its designee the Fraud, Waste, and Abuse Compliance Plan as part of Readiness Review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) Calendar Days in advance of making them effective. LDH, at its sole discretion, may require that the Contractor modify its compliance plan.	This revision clarifies the language as two separate requirements.
26	2.20.6.10 LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within the Contractor's network via "complex" or "automated" review. LDH may recover from the Contractor, via a deduction from the Contractor's Capitation Payment, all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not:	2.20.6.10 LDH or its agent shall have the right to audit, review and investigate providers and Enrollees within the Contractor'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 Contractor, via a deduction from the Contractor's Capitation Payment, all of the following amounts assessed to a provider as a result of LDH's audit, whether the provider is excluded from the Medicaid program or not:	This revision is to align the contract with the MCO lookback period provided in the "General Information and Administration Provider Manual" chapter of the **Medicaid Services Manual**.

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27	[new provision]	4.4.1.7 LDH will not withhold funds from the Contractor for MCO performance until July 2023.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
28	4.4.2 Earning the Quality and Health Outcomes Withhold 4.4.2.1 For each Measurement Year, the Contractor may earn back the quality withhold for the Measurement Year based on its performance relative to incentive-based measures and targets as established by LDH.	4.4.2 Earning the Quality and Health Outcomes Withhold 4.4.2.1 For each Measurement Year, the Contractor may earn back the applicable quality withhold ~~for the Measurement Year~~ based on its performance relative to incentive-based measures and targets as established by LDH for that Measurement Year.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.
29	4.4.3 Earning the VBP Withhold For each Contract year, the Contractor may earn back the VBP withhold based on meeting the VBP reporting and performance requirements and targets as established by this Contract and as described in the *Value-Based Payment* section. 4.4.3.1 The Contractor may earn back the VBP withhold amount for submitting VBP deliverables and meeting VBP targets specified by LDH as demonstrated within the Contractor's reported use of VBP consistent with payment models that include categories 2A, 2C, 3 and/or 4 of the Learning Action Network (LAN) Alternative Payment Models (APM) Framework and aligned with the incentive-based measures specified in Attachment H, *Quality Performance Measures*. 4.4.3.2 To earn back the full VBP withhold amount related to performance, the Contractor shall: 4.4.3.2.1 Annually, on or before August 30, submit to LDH a written VBP mid-year report describing the implementation and status of its VBP use and evidence that each VBP model includes financial incentives for providers linked to at least two of the Contractor's incentive-based measures in Attachment H, *Quality Performance Measures*, or other Attachment H, *Quality Performance Measures*, measures for non-primary care VBP arrangements. As part of its VBP agreements, the Contractor shall not hold providers accountable for meeting a	4.4.3 Earning the VBP Withhold For each ~~Contract~~ Measurement ~~y~~Year, the Contractor may earn back the applicable VBP withhold based on meeting the VBP reporting and performance requirements and targets for that Measurement Year as established by this Contract including ~~and~~ as described in the *Value-Based Payment* section. 4.4.3.1 The Contractor may earn back the VBP withhold amount for submitting VBP deliverables and meeting VBP targets specified by LDH as demonstrated within the Contractor's reported use of VBP consistent with the HCP-LAN APM Framework and VBP requirements of this Contract~~payment models that include categories 2A, 2C, 3 and/or 4 of the Learning Action Network (LAN) Alternative Payment Models (APM) Framework and aligned with the incentive-based measures specified in Attachment H, *Quality Performance Measures*~~. 4.4.3.2 The VBP Measurement Year is the calendar year. To earn back the full VBP withhold amount related to performance for each Measurement Year, the Contractor shall: 4.4.3.2.1 Annually, on or before August 30, submit to LDH a written VBP mid-year report describing the implementation and status of its VBP use and evidence that each VBP model includes financial incentives for providers linked to at least two of the Contractor's incentive-based measures in Attachment H,	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #22.

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	higher target for the incentive-based measure than the target to which LDH holds the Contractor for the same measure unless the provider is already performing above the benchmark set by LDH for Contractor performance on the incentive-based measure. 4.4.3.2.1.1 If the Contractor implements a VBP arrangement with primary care providers, the VBP arrangement must include at least two incentive-based measures from Attachment H, *Quality Performance Measures*, one of which must be an incentive-based measure, in order for the MCO to report the primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template reporting*. 4.4.3.2.1.2 If the Contractor implements a VBP arrangement for services other than primary care, the Contractor must include at least any two (2) applicable measures from Attachment H, *Quality Performance Measures*, in the VBP arrangement, in order for the Contractor to count the non-primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template* reporting. If there are not at least two (2) applicable measures in Attachment H, *Quality Performance Measures*, the Contractor must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its Attachment E, *APM Strategic Plan Requirements and Reporting Template*, reporting. 4.4.3.2.1.3 To increase simplification and consistency in provider performance data reporting, the Contractor must use performance measure specifications in its VBP arrangements that align with the LDH specifications for measures in Attachment H, *Quality Performance Measures* when the Contractor is utilizing any measure included in Attachment H, *Quality Performance Measures*. 4.4.3.2.1.4 If LDH determines that the mid-year report demonstrates an increase in VBP use by the Contractor, alignment with performance measures in Attachment H, *Quality Performance Measures*, and is consistent with LDH	*Quality Performance Measures*, or other Attachment H, *Quality Performance Measures*, measures for non-primary care VBP arrangements. ~~As part of its VBP agreements, the Contractor shall not hold providers accountable for meeting a higher target for the incentive-based measure than the target to which LDH holds the Contractor for the same measure unless the provider is already performing above the benchmark set by LDH for Contractor performance on the incentive-based measure.~~ ~~4.4.3.2.1.1 If the Contractor implements a VBP arrangement with primary care providers, the VBP arrangement must include at least two incentive-based measures from Attachment H, *Quality Performance Measures*, one of which must be an incentive-based measure, in order for the MCO to report the primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template* reporting.~~ ~~4.4.3.2.1.2 If the Contractor implements a VBP arrangement for services other than primary care, the Contractor must include at least any two (2) applicable measures from Attachment H, *Quality Performance Measures*, in the VBP arrangement, in order for the Contractor to count the non-primary care VBP in its Attachment E, *APM Strategic Plan Requirements and Reporting Template* reporting. If there are not at least two (2) applicable measures in Attachment H, *Quality Performance Measures*, the Contractor must justify its rationale for selecting different VBP measures and must seek approval from LDH to include the VBP arrangement in its Attachment E, *APM Strategic Plan Requirements and Reporting Template*, reporting.~~ 4.4.3.2.1.~~3~~1 To increase simplification and consistency in provider performance data reporting, the Contractor must use performance measure specifications in its VBP arrangements that align with the LDH specifications for measures in Attachment H, *Quality Performance Measures* when the Contractor is utilizing any measure included in Attachment H, *Quality Performance Measures*.	

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	specifications, LDH will refund any VBP-related amounts withheld for the calendar year through June of that year. The VBP withhold amounts shall not be refunded for late submissions. 4.4.3.2.2 Annually, on or before March 15 submit to LDH a report on its VBP use for the prior calendar year as specified in Attachment E, *APM Strategic Plan Requirements and Reporting Template*, and a VBP year-end report. In reporting its VBP use and provider payments, the Contractor shall use a "date of payment" approach to complete Attachment E, *APM Strategic Plan Requirements and Reporting Template*. If the Contractor did not meet the VBP targets identified in 4.4.3.2.4, 4.4.3.2.5, 4.4.3.2.6 below, if applicable, the Contractor shall describe why the VBP targets were not met. 4.4.3.2.3 If LDH determines that the Contractor's use of recognized VBP models meets the following VBP targets in each specific calendar year as described below, LDH will refund any remaining amounts withheld for VBP. Recognized VBP arrangements exclude LAN APM category 2B (pay for reporting) models and VBP models that do not have a link to at least two of the applicable Contractor performance measures in Attachment H, *Quality Performance Measures*, as defined in 4.4.3.2.1 above. 4.4.3.2.4 Calendar Year 2023 4.4.3.2.4.1 Contractual arrangements linked to a VBP model that includes one (1) or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed six (6) million dollars in total provider payments, OR the Contractor's total potential provider incentive payments exceed twelve (12) million dollars in total provider payments. … 4.4.3.2.5 Calendar Year 2024	4.4.3.2.1.2~~4~~ If LDH determines that the mid-year report demonstrates ~~an increase in~~ VBP use by the Contractor that~~, alignment with~~ includes applicable performance measures in Attachment H, *Quality Performance Measures*, and is consistent with LDH specifications in this Contract, LDH will refund ~~any~~a portion of the VBP-related amounts withheld for the calendar year prior to the end of the calendar year~~through June of that year~~. The VBP withhold amounts shall not be refunded for late submissions. 4.4.3.2.2 Annually, on or before March 15, submit to LDH a report on its VBP use for the prior calendar year as specified in Attachment E, *APM ~~Strategic Plan Requirements and~~ Reporting Template*, and a VBP year-end report. In reporting its VBP use and provider payments, the Contractor shall use a "date of payment" approach to Attachment E, *APM ~~Strategic Plan Requirements and~~ Reporting Template*. If the Contractor did not meet the VBP targets identified in 4.4.3.2.4~~, 4.4.3.2.5, 4.4.3.2.6 below~~, if applicable, the Contractor shall describe why the VBP targets were not met. 4.4.3.2.3 If LDH determines that the Contractor's use of recognized VBP models meets the following VBP targets in each specific calendar year as described below, LDH will refund any remaining amounts withheld for VBP. Recognized VBP arrangements exclude certain LAN APM category 2A and 2B ~~(pay for reporting)~~ models and VBP models that do not have a link to at least two of the applicable Contractor performance measures in Attachment H, *Quality Performance Measures*, as defined in the *Value-based Payment* sections of this Contract ~~4.4.3.2.1 above~~. 4.4.3.2.4 Unless otherwise modified by LDH, the minimum VBP thresholds for each Measurement Year are as follows: 4.4.3.2.4.1 Calendar Year 2023 4.4.3.2.4.1.1 Contractual arrangements linked to a VBP model that includes one (1) or more of the HCP LAN categories identified by LDH account for at least forty percent (40%) of total provider payments in the Measurement Year	

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	4.4.3.2.5.1 Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total potential provider incentive payments related to this Measurement Year exceed seven (7) million dollars in total provider payments, or the Contractor's total potential provider incentive payments exceed fourteen (14) million dollars in total provider payments. … 4.4.3.2.5.4 The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years. 4.4.3.2.6 Calendar Year 2025 and Future Calendar Years 4.4.3.2.6.1 Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total potential provider incentive payments exceed eight (8) million dollars in total provider payments, or the Contractor's total potential provider incentive payments exceed sixteen (16) million dollars in total provider payments. … 4.4.3.2.6.4 The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for calendar year 2025 and future calendar years. 4.4.3.2.7 LDH may refund to the Contractor some of the remaining amounts withheld for VBP during the calendar year if the Contractor partially	and the Contractor's total ~~potential~~ provider incentive payments related to this Measurement Year exceed six (6) million ~~dollars in total provider payments~~, OR the Contractor's total ~~potential~~ provider incentive payments exceed twelve (12) million dollars ~~in total provider payments~~. *[subsequent provisions renumbered]* 4.4.3.2.4.2~~5~~ Calendar Year 2024 4.4.3.2.4.2.1~~5.1~~ Contractual arrangements linked to a VBP model account for at least fifty percent (50%) of total provider payments in the Measurement Year and the Contractor's total ~~potential~~ provider incentive payments related to this Measurement Year exceed seven (7) million dollars ~~in total provider payments~~, or the Contractor's total ~~potential~~ provider incentive payments exceed fourteen (14) million dollars ~~in total provider payments~~. *[subsequent provisions renumbered]* 4.4.3.2.4.2.4~~5.4~~ The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve it VBP models and provider support for ~~calendar year 2025 and~~ future calendar years. 4.4.3.2.4.3~~6~~ Calendar Year 2025 and Future Calendar Years 4.4.3.2.4.3.1~~6.1~~ Contractual arrangements linked to a VBP model account for at least sixty percent (60%) of total provider payments, and the Contractor's total ~~potential~~ provider incentive payments exceed eight (8) million dollars ~~in total provider payments~~, or the Contractor's total ~~potential~~ provider incentive payments exceed sixteen (16) million dollars ~~in total provider payments~~. *[subsequent provisions renumbered]*	

Item	Change From	Change To	Justification
	meets the VBP targets in 4.4.3.2.4, 4.4.3.2.5, 4.4.3.2.6, if applicable and describes to LDH's satisfaction why the Contractor did not fully meet the VBP targets. 4.4.3.2.8 LDH shall retain the amount of the VBP withhold not earned back by the Contractor.	4.4.3.2.4.3.4~~6.4~~ The Contractor must analyze VBP and quality performance to determine the extent to which providers participating in specific VBP models performed differently on targeted quality measures than providers not participating in such VBP models. The Contractor shall indicate how it will use the results of this data analysis to improve ~~it~~ VBP models and provider support for ~~calendar year 2025 and~~ future calendar years. 4.4.3.2.4.3.5~~7~~ LDH may refund to the Contractor some of the remaining amounts withheld for VBP ~~during the calendar year~~ if the Contractor partially meets the applicable VBP targets in 4.4.3.2.4~~, 4.4.3.2.5, 4.4.3.2.6, if applicable~~ and describes to LDH's satisfaction why the Contractor did not fully meet the VBP targets. 4.4.3.2.4.3.6~~8~~ LDH shall retain the amount of the VBP withhold not earned back by the Contractor.	
30	4.4.4 Earning Health Equity Withhold For each Contract year, the Contractor may earn back the Health Equity withhold based on its reporting and performance relative to health equity requirements as established by this Contract and LDH as described in the *Health Equity* section. … 4.4.4.1.2.2 The annual report submitted to LDH by December 31 must demonstrate progress on meeting Health Equity milestones and goals as outlined in Section 2.7 of the Contract.	4.4.4 Earning Health Equity Withhold For each ~~Contract~~ Measurement Y~~y~~ear, the Contractor may earn back the applicable Health Equity withhold based on its reporting and performance relative to H~~h~~ealth E~~e~~quity requirements for that Measurement Year as established by this Contract and LDH as described in the *Health Equity* section. … 4.4.4.1.2.2 The annual report submitted to LDH by December 31 must demonstrate progress on meeting Health Equity milestones and goals as outlined in Section 2.6~~7~~ of the Contract.	This revision is to align the Contract with the MCO 3.0 withhold strategy as outlined in Item #21 and corrects a section reference.
31	4.4.5.4 The Contractor shall distribute provider-specific profile reports to providers using the common format and frequency effective the first quarter of calendar year X, as approved by LDH in writing.	4.4.5.4 The Contractor shall distribute provider-specific profile reports to providers using the common format and frequency effective the first quarter of calendar year 2023~~X~~, as approved by LDH in writing.	This revision corrects a previous omission.

Item	Change From	Change To	Justification
32	4.14.3.5 The Contractor shall submit an annual report of all health insurance collections for Enrollees plus copies of any Form 1099s received from health insurance companies for that period of time.	4.14.3.5 The Contractor shall submit an annual report of all health insurance collections ~~for Enrollees plus copies of any Form 1099s received from health insurance companies for that period of time~~.	This revision is to align with current practice. The reporting of this information is associated with the 022 Third Party Liability Report.
33	4.19 Reimbursement for COVID-19 Vaccine Incentive Distribution 4.19.1 LDH will pay the Contractor, on a monthly, non-risk basis, for the costs of COVID-19 vaccine incentive distribution to its Enrollees in accordance with the Louisiana Medicaid COVID-19 "Shot Per 100,000" COVID vaccine administration member incentive program. The Enrollee incentive amount paid shall be determined by LDH. The Contractor is entitled to a nine percent (9%) administration fee in addition to the amount of the incentive distributed through the "Shot Per 100,000" program. All payments associated with this program shall be paid on an administrative cost basis, separately from the monthly Capitation Payments. LDH will identify eligible Enrollees by leveraging existing data extraction processes and weekly COVID vaccine administration reports and by utilizing the Contractor's internal resources. The Contractor will use various data sources and internal databases to confirm Enrollee eligibility for the incentive. 4.19.2 The Contractor shall submit all data related to the COVID-19 vaccine incentive in accordance with the terms and conditions of this Contract and the reporting template developed for the "Shot Per 100,000" program. 4.19.3 The Contractor shall report expenditures for COVID-19 vaccine incentives on a date of service basis. 4.19.4 The Contractor shall distribute the COVID-19 vaccine incentive to Enrollees within five (5) Business Days of LDH validating the Enrollee's eligibility to receive the COVID-19 vaccine incentive.	4.19 Reimbursement for COVID-19 Vaccine Incentive Distribution 4.19.1 LDH will pay the Contractor, on a monthly, non-risk basis, for the costs of COVID-19 vaccine incentive distribution to its Enrollees in accordance with the Louisiana Medicaid COVID-19 "Shot Per 100,000" COVID vaccine administration member incentive program. The Enrollee incentive amount paid shall be determined by LDH. The Contractor is entitled to a nine percent (9%) administration fee in addition to the amount of the incentive distributed through the "Shot Per 100,000" program. All payments associated with this program shall be paid on an administrative cost basis, separately from the monthly Capitation Payments. ~~LDH~~ The Contractor will identify eligible Enrollees by leveraging LDH's existing data extraction processes and weekly COVID vaccine administration reports and by utilizing the Contractor's internal resources. The Contractor will use various data sources and internal databases to confirm Enrollee eligibility for the incentive. 4.19.2 The Contractor shall submit all data related to the COVID-19 vaccine incentive in accordance with the terms and conditions of this Contract and the reporting template developed for the "Shot Per 100,000" program. 4.19.3 The Contractor shall report expenditures for COVID-19 vaccine incentives on a date of service basis. 4.19.4 The Contractor shall distribute the COVID-19 vaccine incentive to Enrollees within five (5) Business Days of ~~LDH~~ the Contractor validating the Enrollee's eligibility to receive the COVID-19 vaccine incentive.	This revision is to align with current practice.