Contract Amendment #1
Attachment B1

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

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

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

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

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

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

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

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			Louisiana Medicaid State Plan. The copay tiers in the state plan shall be based on the total amount reimbursed to the pharmacy for the claim.	
10	Attachment B Statement of Work	(New provision)	6.1.11.2 A public health quarantine or isolation order or recommendation also establishes the medical necessity of healthcare services.	This provision will address the COVID-19 outbreak.
11	Attachment B Statement of Work	**6.3.1 Covered Services** 6.3.1.1 The MCO may follow the FFS limit of four prescriptions per calendar month. However, it may not enact prescription limits more stringent than the Medicaid State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber. 6.3.1.2 Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization. **6.3.2 Covered Drug List** 6.3.2.1 In accordance with 42 CFR §438.3, the MCO shall maintain a Covered Drug List (CDL) which includes all outpatient drugs for which the manufacturer has entered into a Federal rebate agreement and met the standards in Section 1927 of the Social Security Act. The CDL will be provided by LDH to the MCOs as a weekly drug file.	**6.3.1 Covered Services** 6.3.1.1 The MCO ~~may follow the FFS limit~~ shall cover a minimum of four prescriptions per calendar month if prescribed for the member. However, it may not enact prescription limits more stringent than the ~~Medicaid~~ State Plan. If prescription limits are enacted, the MCO shall have Point of Sale (POS) override capabilities when a greater number of prescriptions per calendar month are determined to be medically necessary by the prescriber. 6.3.1.2 Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the MCO permit the therapeutic substitution of a prescribed drug without a prescriber's authorization. **6.3.2 Covered Drug List** 6.3.2.1 In accordance with 42 CFR §438.3, the MCO shall maintain a Covered Drug List (CDL) which includes all outpatient drugs for which the manufacturer has entered into a Federal rebate agreement and meet the standards in Section 1927 of the Social Security Act. The CDL will be provided by LDH to the MCOs as a weekly drug file.	These verbiage updates are required to align contract verbiage with current practice.
12	Attachment B	6.3.2.3. The CDL shall exclude only those drugs or drug categories permitted for exclusion under Section 1927(d) of the Social Security Act, with exceptions listed in the Louisiana State Plan. MCOs are	6.3.2.3. The CDL shall exclude only those drugs or drug categories permitted for exclusion under Section 1927(d) of the Social Security Act, with exceptions listed in the Louisiana State Plan. MCOs are	This update will enhance adult vaccine coverage.

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

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

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

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		manager operates a separate call center for PA requests, it will be subject to the provider call center standards set forth in Section 12 of this Contract and monetary penalties set forth in Section 20 of this Contract; 6.3.4.1.3 PA requests shall be approved or denied within 24 hours of receipt, seven (7) days a week. The MCO shall notify the requesting practitioner of the approval or disapproval of the request within 24 hours. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing. PA denials may be appealed in accordance with Section 13 of this Contract; Consistent with the requirements of Section 1927 of the Social Security Act, LDH will hold MCOs to a 99.5% compliance rate with the 24-hour resolution requirement. If a MCO is reporting less than 99.5% compliance on the RX055 report, an explanation shall be included with the report in the notes section; 6.3.4.1.4 The MCO shall have an automated process that allows the pharmacy to dispense without PA up to a 72-hour emergency supply of a product or full unbreakable package. At a minimum, the MCO shall allow two consecutive emergency supply fills per prescription. The MCO shall reimburse the pharmacy for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post payment review to identify misuse; 6.3.4.1.5 The MCO shall prior authorize drugs with a non-preferred status on the PDL;	manager operates a separate call center for PA requests, it will be subject to the provider call center standards set forth in Section 12 of this Contract and monetary penalties set forth in Section 20 of this Contract; 6.3.4.1.3 PA requests shall be approved or denied within 24 hours of receipt, seven (7) days a week. The MCO shall notify the requesting practitioner of the approval or disapproval of the request within 24 hours. Denials of prior authorization requests or offering of an alternative medication shall be provided to the prescriber and member in writing. PA denials may be appealed in accordance with Section 13 of this Contract; Consistent with the requirements of Section 1927 of the Social Security Act, LDH will hold MCOs to a 99.5% compliance rate with the 24-hour PA resolution requirement. If a MCO is reporting less than 99.5% compliance on the RX055 report, an explanation shall be included with the report in the notes section; 6.3.4.1.4 The MCO shall have an automated process that allows the pharmacy to dispense without PA ~~up to~~ a 72-hour emergency supply of a product or full unbreakable package. ~~At a minimum, t~~The MCO shall allow up to two consecutive emergency supply fills per prescription, if needed. The MCO shall reimburse the pharmacy for both the ingredient and the dispensing fee for both fills. Emergency fills may be included in a post payment review to identify misuse; 6.3.4.1.5 The MCO shall prior authorize drugs with a non-preferred status on the PDL;	

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

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		Opioid Treatment Authority/LDH. The MCO shall submit the policy for LDH approval no later than January 1, 2016.		
19	Attachment B Statement of Work	**6.3.7.3.2 Retrospective DUR Program** 6.3.7.3.2.1 The MCO shall provide for the ongoing periodic examination of claims data to identify patterns of gross overuse, abuse, potential fraud, and inappropriate or medically unnecessary care among prescribers, pharmacists, or recipients. 6.3.7.3.2.2 Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. At a minimum, the MCO shall incorporate all of LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.	**6.3.7.3.2 Retrospective DUR Program** 6.3.7.3.2.1 The MCO, in conjunction with LDH, shall provide for the ongoing periodic examination of claims data to identify patterns of gross overuse, abuse, potential fraud, and inappropriate or medically unnecessary care among prescribers, pharmacists, or recipients. 6.3.7.3.2.2 Claims review must be assessed against predetermined standards while monitoring for therapeutic appropriateness. Prescribers and pharmacists should be contacted via an electronic portal or other electronic means if possible. Facsimile and mail will suffice in some instances. At a minimum, the MCO shall incorporate all of LDH's DUR retrospective initiatives. Retrospective DUR initiatives shall be implemented monthly as directed by LDH pharmacy.	Verbiage updates are required to align contract verbiage with current practice.
20	Attachment B Statement of Work	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives and submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date. 6.3.7.5 The MCO must provide a detailed description of its DUR program annually to LDH to mimic the FFS DUR annual report to CMS. The annual report shall ensure the requirements of 1927(g) of the Act are being met by the MCO DUR program. The annual report to the state will be due 4 months preceding the CMS deadline.	6.3.7.4 LDH shall review and approve the MCO's DUR policy and procedures, DUR utilization review process/procedure and the standards included therein, and any revisions. At a minimum, the DUR program must include all LDH DUR initiatives. ~~and~~ The MCO shall submit new initiatives to LDH for prior approval at least forty-five (45) days in advance of the proposed effective date. 6.3.7.5 The MCO ~~must~~shall provide a detailed description of its DUR program annually to LDH in the CMS template ~~to mimic the FFS~~ for the DUR annual report ~~to CMS~~. The annual report shall ensure the requirements of 1927(g) of the Act are being met by the MCO DUR program. The annual report to the state will be due thirty (30) calendar days after CMS provides the link~~4 months preceding the CMS deadline~~.	Verbiage updates are required to align contract verbiage with current practice.

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

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

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

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		9.10.9.2 The MCO shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. The MCO shall report all identified provider preventable conditions to LDH in a format specified by LDH.	9.10.9.2 The MCO shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. ~~The MCO shall report all identified provider preventable conditions to LDH in a format specified by LDH.~~ PPCs should be identified on the encounter file via the Present on Admission (POA) indicators.	
27	Attachment B Statement of Work	17.9.5 The MCO shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor.	17.9.5 The MCO shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided, including all claims paid, denied or adjusted directly by the MCO or indirectly through a subcontractor, regardless of whether the subcontractor's agreement has since termed.	This update requires subcontractors to fulfill all contractual obligations.
28	Attachment B Statement of Work	**17.11.1 System Requirements** 17.11.1.1 The MCO shall have an automated claims and encounter processing system for pharmacy claims that will support the requirements of this contract and ensure the accurate and timely processing of claims and encounters. The MCO shall allow pharmacies to back bill electronically (reversals and resubmissions) for 365 days from the date of the original submission of the claim. 17.11.1.2 Transaction standards: The MCO shall support electronic submission of claims using most current HIPAA compliant transaction standard (currently NCPDP D.0) 17.11.1.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits. 17.11.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription	**17.11.1 System Requirements** 17.11.1.1 The MCO shall have an automated claims and encounter processing system for pharmacy claims that will support the requirements of this contract and ensure the accurate and timely processing of claims and encounters. The MCO shall allow pharmacies to back bill electronically (reversals and resubmissions) for 365 calendar days from the date of the original submission of the claim. 17.11.1.2 Transaction standards: The MCO shall support electronic submission of claims using the most current HIPAA compliant transaction standard (currently NCPDP D.0). 17.11.1.3 Pharmacy claim edits shall include eligibility, drug coverage, benefit limitations, prescriber and prospective/concurrent drug utilization review edits. 17.11.1.4 The system shall provide for an automated update to the National Drug Code file including all product, packaging, prescription	This update will clarify the verbiage in these provisions.

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

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
29	Attachment B Statement of Work	**17.11.2 Pharmacy Rebates** The MCO shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to LDH pursuant to the requirements of Section 17.11.3 of this contract. LDH or its vendor shall submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the LDH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA).	**17.11.2 Pharmacy Rebates** The MCO shall submit all drug encounters, with the exception of inpatient hospital drug encounters, to LDH or its contractor pursuant to the requirements of Section 17.11.3 of this contract. LDH or its ~~vendor~~ contractor shall submit these encounters for federal supplemental pharmacy rebates from manufacturers under the authority of the LDH Secretary pursuant to the Section 2501 of the Patient Protection and Affordable Care Act (PPACA).	Verbiage updates are required to align contract verbiage with current practice.
30	Attachment B Statement of Work	**17.11.3 Pharmacy Encounters Claims Submission** 17.11.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to LDH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section 17.9 requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required. 17.11.3.2 The overlap of the 340B Drug Pricing Program and the Medicaid Drug Rebate program creates the possibility of duplicate discounts. States are federally mandated by Section 2501(c) of the Patient Protection and Affordable Care Act (ACA) to seek drug rebates on Managed Care Medicaid claims, meaning that the potential for duplicate discounts exists for managed care claims. Louisiana uses the Health Resources and Services Administration's (HRSA) Medicaid Exclusion File (MEF) for both Fee for Service (FFS) and Managed Care Medicaid claims in order to prevent duplicate discounts.	**17.11.3 Pharmacy Encounters Claims Submission** 17.11.3.1 The MCO shall submit a weekly claim-level detail file of pharmacy encounters to LDH which includes individual claim-level detail information on each pharmacy claim dispensed to a Medicaid patient, including but not limited to the total number of metric units, dosage form, strength and package size, and National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. This weekly submission must comply with Section 17.9 requirements. See the MCO Systems Companion Guide for a complete listing of claim fields required. 17.11.3.2 The overlap of the 340B Drug Pricing Program and the Medicaid Drug Rebate program creates the possibility of duplicate discounts. States are federally mandated by Section 2501(c) of the Patient Protection and Affordable Care Act (ACA) to seek drug rebates on Managed Care Medicaid claims, meaning that the potential for duplicate discounts exists for managed care claims. Louisiana uses the Health Resources and Services Administration's (HRSA) Medicaid Exclusion File (MEF) for both Fee for Service (FFS) and Managed Care Medicaid claims in order to prevent duplicate discounts.	Verbiage updates are required to align contract verbiage with current practice.

Item	Exhibit/ Attachment/ Document	Change From:	Change To:	Justification
		17.11.3.3 Due to this duplicate discount potential, Louisiana requires that covered entities utilize the same carve-in or carve-out designation for Managed Care Medicaid patients as for FFS Medicaid recipients. If a covered entity appears on the Medicaid Exclusion File, Louisiana will exclude that provider's FFS and MCO claims from rebate invoicing. Claims for FFS Medicaid and Managed Care Medicaid recipients are treated identically in regards to exclusion from rebate invoicing. 17.11.3.4 In order to allow covered entities to distinguish Managed Care Medicaid patients from an MCO's private insurance patients, Louisiana requires its MCOs to utilize a unique Processor Control Number (PCN) or Group Number for Louisiana Medicaid. This unique PCN or group number shall be submitted to LDH before processing any pharmacy claims. 17.11.3.5 Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing. This includes both FFS and Managed Care Medicaid. 17.11.3.6 340B Billing Per Covered Entity 17.11.3.6.1 MCOs shall include in their contracts with 340B providers billing instructions on how to identify 340B claims/encounters.	17.11.3.3 ~~Due to this duplicate discount potential, Louisiana requires that~~ The MCO shall require that network providers who are covered entities, as defined by Section 340B of the Public Health Services Act, utilize the same carve-in or carve-out designation for Managed Care Medicaid patients as for FFS Medicaid recipients. If a covered entity appears on the Medicaid Exclusion File, ~~Louisiana~~ LDH will exclude that provider's FFS and MCO claims from rebate invoicing. Claims for FFS Medicaid and Managed Care Medicaid recipients are treated identically in regards to exclusion from rebate invoicing. 17.11.3.4 The MCO shall ~~In order to allow covered entities to distinguish Managed Care Medicaid patients from an MCO's private insurance patients, Louisiana requires its MCOs to~~ utilize a unique Processor Control Number (PCN) or Group Number for Louisiana Medicaid. This unique PCN or group number shall be submitted to LDH before processing any pharmacy claims. 17.11.3.5 Contract pharmacies are not permitted to bill Medicaid for drugs purchased at 340B pricing. This includes both FFS and Managed Care Medicaid. 17.11.3.6 340B Billing Per Covered Entity 17.11.3.6.1 MCOs shall include ~~in their contracts with 340B providers~~ billing instructions on how to identify 340B claims/encounters ~~in their contracts with 340B providers~~.	
31	Attachment B	**17.11.4 Disputed Pharmacy Encounter Submissions**	**17.11.4 Disputed Pharmacy Encounter Submissions**	Verbiage updates are required to align contract verbiage with current practice.

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

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

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

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

17.11.5.43 Any contract for pharmacy benefit manager services shall:

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

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

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

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

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

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

Attachment C – Performance Measures

From:

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

To:

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

Justification:

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