JOINT LEGISLATIVE COMMITTEE ON THE BUDGET
STATE CAPITOL
P.O. BOX 44294, CAPITOL STATION
BATON ROUGE, LOUISIANA 70804
(225) 342-0336

Senator Glen Womack
Chairman

Representative Jack McFarland
Vice Chairman

REVISED

NOTICE OF MEETING

Thursday
November 20, 2025
10:00 A.M.
House Committee Room 5

A G E N D A

Removes Agenda Item #14

I. CALL TO ORDER

II. ROLL CALL

III. BUSINESS

1. Fiscal Status Statement and Five-year Baseline Budget

2. BA-7 Agenda

3. Facility Planning and Control

4. Interpretation of legislative intent for appropriations contained in Acts 4 and 776 of the 2024 Regular Session of the Legislature and Acts 1 and 461 of the 2025 Regular Session of the Legislature, in accordance with the provisions of R.S. 24:653(E)

5. Review and approval of Water Sector Commission recommendations, in accordance with the provisions of R.S. 39:100.56

6. Review and approval of the Calendar Year 2026 operating budget for the Louisiana Public Facilities Authority, in accordance with the provisions of R.S. 9:2346

7. Review and approval of Deputy Sheriffs' Supplemental Pay in accordance with Act 110 of 1982 and the provisions of R.S. 40:1667.8

8. Review and approval of preservation projects utilizing funding from the Construction Subfund Preservation Account, in accordance with the provisions of R.S. 39:100.123

9. Review and approval of Louisiana Economic Development's High Impact Jobs Program rules, in accordance with the provisions of R.S. 51:2771(F)

10. Review and approval of amendments to emergency contracts between the Office of Group Benefits and the following entities, in accordance with the provisions of R.S. 42:802(D):

    A. CaremarkPCS Health, L.L.C., for the provision of pharmacy benefit manager services
    B. HMO Louisiana, Inc., for the provision of a Medicare Advantage plan
    C. Humana Health Benefits Plan of Louisiana, Inc., for the provision of a Medicare Advantage plan
    D. New Orleans Regional Physician Hospital Organization, LLC, d/b/a Peoples Health, for the provision of a Medicare Advantage plan

11. Review and approval of an extension of a contract between the Louisiana Department of Health and Health Services Advisory Group, Inc., in accordance with the provisions of R.S. 39:1615(J)

12. Review and approval of the extension of the contracts between the Louisiana Department of Health and the following Medicaid managed care organizations, in accordance with the provisions of R.S. 39:1615(J):

    A. Aetna Better Health, Inc.
    B. AmeriHealth Caritas Louisiana, Inc.
    C. Community Care Health Plan of Louisiana, Inc., dba Healthy Blue
    D. Humana Health Benefit Plan of Louisiana, Inc.
    E. Louisiana Healthcare Connections, Inc.
    F. United Healthcare of Louisiana, Inc.

13. Review of the extension of the contracts between the Louisiana Department of Environmental Quality and the following entities, in accordance with the provisions of R.S. 39:1615(J):

    A. Leaaf Environmental, LLC
    B. Terracon Consultants, Inc.
    C. PPM Consultants, Inc.

~~**14. Discussion of the Medicaid Managed Care Behavioral Health Program**~~

IV. CONSIDERATION OF ANY OTHER BUSINESS THAT MAY COME BEFORE THE COMMITTEE

V. ADJOURNMENT

Persons who do not feel comfortable giving testimony in person may submit a prepared statement in accordance with Senate Rule 13.79, in lieu of appearing before the committee. Statements may be emailed to dugasl@legis.la.gov and must be received by the committee secretary at least four hours prior to the meeting to be included in the record for this committee meeting.

Audio/visual presentations, such as PowerPoint, must be received by the committee secretary at dugasl@legis.la.gov at least twenty-four hours PRIOR to the scheduled start of the committee

meeting for review and prior approval. Thumb drives will NOT be accepted.

THIS NOTICE CONTAINS A TENTATIVE AGENDA AND MAY BE REVISED PRIOR TO THE MEETING. REVISED NOTICES CAN BE CHECKED ON THE LEGISLATIVE WEBSITE, (https://legis.la.gov), THE WALL OUTSIDE THE COMMITTEE ROOM IN WHICH THE MEETING IS TO BE HELD, AND THE BULLETIN BOARDS OUTSIDE THE HOUSE AND SENATE CHAMBERS (MEMORIAL HALLS), BY CALLING THE PULS LINE 342-2456, AND AT THE BILL ROOM IN THE BASEMENT NEXT TO COMMITTEE ROOM A.

Glen Womack, Chairman

STATE OF LOUISIANA
State General Fund Fiscal Status Statement
Fiscal Year 2025-2026
($ in millions)

November 2025

	OCTOBER 2025	NOVEMBER 2025	NOVEMBER 2025 Over/(Under) OCTOBER 2025
GENERAL FUND REVENUE			
Revenue Estimating Conference - May 21, 2025	$12,290.300	$12,290.300	$0.000
FY 24-25 Revenue Carried Forward into FY 25-26	$453.548	$453.548	$0.000
Total Available General Fund Revenue	**$12,743.848**	**$12,743.848**	**$0.000**
APPROPRIATIONS AND REQUIREMENTS			
Non-Appropriated Constitutional Requirements			
Debt Service	$449.573	$449.573	$0.000
Interim Emergency Board	$1.323	$1.323	$0.000
Revenue Sharing	$90.000	$90.000	$0.000
Total Non-Appropriated Constitutional Requirements	**$540.896**	**$540.896**	**$0.000**
Appropriations			
General (Act 1of 2025 RS)	$11,843.563	$11,843.563	$0.000
Ancillary (Act 459 of 2025 RS)	$0.000	$0.000	$0.000
Judicial (Act 390 of 2025 RS)	$187.856	$187.856	$0.000
Legislative (Act 460 of 2025 RS)	$94.514	$94.514	$0.000
Capital Outlay (Act 2 of 2025 RS)	$0.000	$0.000	$0.000
Total Appropriations	**$12,125.932**	**$12,125.932**	**$0.000**
Other Requirements			
Funds Bill (Act 365 of 2025 RS)	$1.530	$1.530	$0.000
Local Revenue Fund (Act 384 of 2025 RS)	$42.800	$42.800	$0.000
Tourism Promotion District (Act 384 of 2025 RS)	$32.600	$32.600	$0.000
Total Other Requirements	**$76.930**	**$76.930**	$0.000
Total Appropriations and Requirements	**$12,743.758**	**$12,743.758**	**$0.000**
General Fund Revenue Less Appropriations and Requirements	**$0.090**	**$0.090**	**$0.000**

II. FY 2024-2025 Fiscal Status Summary:

In accordance with Act 1092 of the 2001 Regular Session and Act 107 of the 2002 First Extraordinary Session (R.S. 39:75), the first budget status report presented after October 15th shall reflect the fund balance for the previous fiscal year. "At the first meeting of the Joint Legislative Committee on the Budget after publication of the Comprehensive Annual Financial Report for the state of Louisiana, the commissioner of administration shall certify to the committee the actual expenditures paid by warrant or transfer and the actual monies received and any monies or balances carried forward for any fund at the close of the previous fiscal year which shall be reflected in the budget status report."

FY25 GENERAL FUND DIRECT SURPLUS/(DEFICIT) - ESTIMATED (millions)

FY24 Surplus/(Deficit)		**595.088**
FY25 General Fund - Direct Revenues:		
Actual General Fund Revenues	13,597.732	
General Fund - Direct Carryforwards to FY24	426.327	
Other Transfers	0.077	
Balances from prior year surpluses	4.382	
Total FY25 General Fund - Direct Revenues		**14,028.519**
FY25 General Fund - Direct Appropriations & Requirements:		
Draws of General Fund - Direct Appropriations	(11,446.658)	
General Obligation Debt Service	(448.607)	
Transfer to Revenue Sharing Fund (Z06) - Constitution 7:26	(90.000)	
Transfers Out to Various Funds for 20-XXX	(80.845)	
Transfer to Coastal Protection and Restoration Fund (Z12) - Constitution 7:10.2 and R.S. 49:214.5.4	(12.840)	
Transfers to Various Funds per Various Legislative Acts	(53.988)	
Transfer to Revenue Stabilization Fund (Z25) - Constitution 7:10.15. (D) and 7:10.16. (B)(2)	(851.899)	
Use of FY24 Surplus	(594.161)	
Net transfer to LDR for 1% FSGR MOF	(68.546)	
Transfer to Capital Outlay Savings Fund (V42) - R.S. 39.100.121	(5.309)	
Total FY25 General Fund - Direct Appropriations & Requirements		**(13,652.853)**
Adjusted General Fund Direct Cash Balance (FY25)		**970.754**
Obligations Against the General Fund Direct Cash Balance:		
General Fund - Direct Carryforwards to FY26	(453.548)	
FY25 transactions processed in FY26:		
Transfer from Remote Sellers - June 2025 taxes collected by remote sellers in July and distributed to LDR in	32.370	
Transfer from Mineral and Energy Operation Fund (N07) - RS 30:136.3	2.500	
Transfer from Telephone Company Property Assessment Relief Fund (RV9) - RS 47:6014(E)(2)	9.580	
Transfer from LDR - FY25 Individual Income Taxes collected in July	17.616	
Transfer to Video Draw Poker Device Purse Supplement Subfund (G05) (Act 378 of 2025 RLS)	(2.199)	
Total Adjustments		**(393.680)**
Net General Fund Direct Surplus/(Deficit)		**577.074**

III. Current Year Items Requiring Action

IV. Horizon Issues Not Contained in 5-Year Plan

The Hurricane and Storm Damage Risk Reduction System (HSDRSS) Projects were completed May 2022. At that time, the State's share of the total cost was $1.19 billion, and in addition, the State faced accrued construction interest in excess of $600 million. Federal legislation passed in December 2020 and December 2022, provides an option to forgive the accrued construction interest if the State makes specified required payments by September 30, 2021 and by September 30, 2023, which was achieved through payments totaling $800 million and approved crediting of other projects totaling $110 million.

The State must pay the remaining principal by June 1, 2032. According to the U.S. Army Corps of Engineers, as of September 27, 2023, the State's remaining share of the total costs of the HSDRRS is $239 million. However, additional crediting is under review by the Corp, which will further reduce the remaining amount owed.

STATE OF LOUISIANA
Five Year Baseline Projection - Summary
Appropriated for FY 2025 - 2026

	Prior Fiscal Year 2024-2025	Official Current Fiscal Year 2025-2026	Projected Fiscal Year 2026-2027	Projected Fiscal Year 2027-2028	Projected Fiscal Year 2028-2029
REVENUES:					
Taxes, Licenses & Fees	$16,217,300,000	$15,841,500,000	$15,682,100,000	$15,997,100,000	$16,399,100,000
Less Dedications	($3,978,200,000)	($3,551,200,000)	($3,279,700,000)	($3,725,500,000)	($3,825,000,000)
TOTAL REC REVENUES	**$12,239,100,000**	**$12,290,300,000**	**$12,402,400,000**	**$12,271,500,000**	**$12,574,000,000**
ANNUAL REC GROWTH RATE		**0.42%**	**0.91%**	**-1.06%**	**2.47%**
Other Revenues:					
Carry Forward Balances	$426,327,167	$453,547,880	$0	$0	$0
Total Other Revenue	**$426,327,167**	**$453,547,880**	**$0**	**$0**	**$0**
TOTAL REVENUES	**$12,665,427,167**	**$12,743,847,880**	**$12,402,400,000**	**$12,271,500,000**	**$12,574,000,000**
EXPENDITURES:					
General Appropriation Bill (Act 1 of 2025 RS)	$11,244,558,534	$11,390,014,685	$11,633,590,598	$11,979,148,201	$12,188,094,739
Ancillary Appropriation Bill (Act 459 of 2025 RS)	$0	$0	$5,839,179	$11,882,728	$18,137,802
Non-Appropriated Requirements	$538,607,434	$540,895,863	$531,551,307	$527,687,783	$554,604,340
Judicial Appropriation Bill (Act 390 of 2025 RS)	$187,315,555	$187,855,555	$187,855,555	$187,855,555	$187,855,555
Legislative Appropriation Bill (Act 460 of 2025 RS)	$93,021,312	$94,514,289	$94,514,289	$94,514,289	$94,514,289
Special Acts	$0	$0	$4,400,000	$4,400,000	$4,400,000
Capital Outlay Bill (Act 2 of 2025 RS)	$0	$0	$0	$0	$0
TOTAL ADJUSTED EXPENDITURES (less carryforwards)	**$12,063,502,835**	**$12,213,280,392**	**$12,457,750,928**	**$12,805,488,556**	**$13,047,606,725**
ANNUAL ADJUSTED GROWTH RATE		**1.24%**	**2.00%**	**2.79%**	**1.89%**
Other Expenditures:					
Carryforward BA-7s Expenditures	$426,327,167	$453,547,880	$0	$0	$0
Funds Bill (Act 723 of 2024 RS) (Act 365 of 2025 RS)	$48,989,722	$1,530,000	$0	$0	$0
Supplemental Bill (Act 461 of 2025 RS)	$95,036,217	$0	$0	$0	$0
Local Revenue Fund (Act 384 of 2025 RS)	$18,300,000	$42,800,000	$42,800,000	$42,800,000	$42,800,000
Louisiana Tourism Promotion District (Act 384 of 2025 RS)	$13,200,000	$32,600,000	$32,600,000	$32,600,000	$32,600,000
Total Other Expenditures	**$601,853,106**	**$530,477,880**	**$75,400,000**	**$75,400,000**	**$75,400,000**
TOTAL EXPENDITURES	**$12,665,355,941**	**$12,743,758,272**	**$12,533,150,928**	**$12,880,888,556**	**$13,123,006,725**
PROJECTED BALANCE	**$71,226**	**$89,608**	**($130,750,928)**	**($609,388,556)**	**($549,006,725)**
Oil Prices included in the REC forecast	$70.69	$65.09	$63.94	$64.26	$65.94

JOINT LEGISLATIVE COMMITTEE ON THE BUDGET
BA-7 AGENDA
November, 2025

A. Fiscal Status Statement

B. 5-Year Base Line Projection

C. Regular BA-7s

1	WFIS	Department of Wildlife and Fisheries (16-512) Office of the Secretary

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

DEPARTMENT: Louisiana Department of Wildlife & Fisheries	**FOR OPB USE ONLY**	
AGENCY: Office of the Secretary	OPB LOG NUMBER: 115	AGENDA NUMBER: 1
SCHEDULE NUMBER: 16-512		
SUBMISSION DATE: 10/29/2025	**Approval and Authority:**	
AGENCY BA-7 NUMBER: S-26-02		
HEAD OF BUDGET UNIT: Bryan McClinton		
TITLE: Undersecretary		
SIGNATURE *(Certifies that the information provided is correct and true to the best of your knowledge):*		

MEANS OF FINANCING	CURRENT FY 2025-2026	ADJUSTMENT (+) or (-)	REVISED FY 2025-2026
GENERAL FUND BY:			
DIRECT	$30,309,243	$0	**$30,309,243**
INTERAGENCY TRANSFERS	$486,670	$0	**$486,670**
FEES & SELF-GENERATED	$344,975	$0	**$344,975**
Regular Fees & Self-generated	$127,000	$0	**$127,000**
Subtotal of Fund Accounts from Page 2	$217,975	$0	**$217,975**
STATUTORY DEDICATIONS	$16,017,433	$0	**$16,017,433**
Rockefeller Wildlife Refuge and Game Preserve Fund (RK1)	$116,846	$0	**$116,846**
Marsh Island Operating Fund (RS1)	$32,038	$0	**$32,038**
Subtotal of Dedications from Page 2	$15,868,549	$0	**$15,868,549**
FEDERAL	$3,103,510	$616,087	**$3,719,597**
TOTAL	**$50,261,831**	**$616,087**	**$50,877,918**
AUTHORIZED POSITIONS	282	0	**282**
AUTHORIZED OTHER CHARGES	0	0	**0**
NON-TO FTE POSITIONS	0	0	**0**
TOTAL POSITIONS	**282**	**0**	**282**

PROGRAM EXPENDITURES	DOLLARS	POS	DOLLARS	POS	DOLLARS	POS
PROGRAM NAME:						
Office of the Secretary - Admin	$3,812,164	25	$0	0	**$3,812,164**	**25**
Office of the Secretary - Enforcement	$46,449,667	257	$616,087	0	**$47,065,754**	**257**
Program 3	$0	0	$0	0	**$0**	**0**
Program 4	$0	0	$0	0	**$0**	**0**
Program 5	$0	0	$0	0	**$0**	**0**
	$0	0	$0	0	**$0**	**0**
	$0	0	$0	0	**$0**	**0**
	$0	0	$0	0	**$0**	**0**
	$0	0	$0	0	**$0**	**0**
	$0	0	$0	0	**$0**	**0**
Subtotal of programs from Page 2:	$0	0	$0	0	**$0**	**0**
TOTAL	**$50,261,831**	**282**	**$616,087**	**0**	**$50,877,918**	**282**

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

DEPARTMENT: Louisiana Department of Wildlife & Fisheries	FOR OPB USE ONLY	
AGENCY: Office of the Secretary	OPB LOG NUMBER	AGENDA NUMBER
SCHEDULE NUMBER: 16-512		
SUBMISSION DATE: 10/29/2025	ADDENDUM TO PAGE 1	
AGENCY BA-7 NUMBER: S-26-02		

Use this section for additional Dedicated Fund Accounts or Statutory Dedications, if needed.
The subtotal will automatically be transferred to Page 1.

MEANS OF FINANCING	CURRENT FY 2025-2026	ADJUSTMENT (+) or (-)	REVISED FY 2025-2026
GENERAL FUND BY:			
FEES & SELF-GENERATED			
Oyster Sanitation Dedicated Fund Account (Q08)	$217,975	$0	$217,975
[Select Fund Account]	$0	$0	$0
SUBTOTAL (to Page 1)	**$217,975**	**$0**	**$217,975**
STATUTORY DEDICATIONS			
Conservation Fund (W01)	$15,187,680	$0	$15,187,680
Wildlife Habitat & Natural Heritage Trust Fund (W05)	$135,169	$0	$135,169
Crab Development, Management, and Derelict Crab Trap Removal Account (W33)	$113,000	$0	$113,000
Litter Abatement and Education Account (W36)	$99,800	$0	$99,800
Shrimp Development and Management Account (W42)	$70,900	$0	$70,900
Oyster Resource Management Account (W43)	$262,000	$0	$262,000
[Select Statutory Dedication]	$0	$0	$0
SUBTOTAL (to Page 1)	**$15,868,549**	**$0**	**$15,868,549**

Use this section for additional Program Names, if needed.
The subtotal will automatically be transferred to Page 1.

PROGRAM EXPENDITURES	DOLLARS	POS	DOLLARS	POS	DOLLARS	POS
PROGRAM NAME:						
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
	$0	0	$0	0	$0	0
SUBTOTAL (to Page 1)	**$0**	**0**	**$0**	**0**	**$0**	**0**

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

Policy and Procedure Memorandum No. 52, Revised, requires that all Requests for Changes in Appropriation be fully documented. At a minimum, the following questions and statements must be answered. Use Continuation Sheets as needed. FAILURE TO ANSWER ALL QUESTIONS COMPLETELY WILL BE CAUSE TO RETURN THIS DOCUMENT WITHOUT ACTION.

1. What is the source of funding (if other than General Fund (Direct))? Specifically identify any grant or public law and the purposes of the funds, if applicable. A copy of any grant application and the notice of approved grant or appropriation must accompany the BA-7. What are the expenditure restrictions of the funds?
This federal grant, awarded through the U.S. Department of Homeland Security Port Security Grant Program, provided funding to state, local, and private maritime partners to enhance port-wide risk management and protect critical surface transportation infrastructure from terrorism, major disasters, and other emergencies. The funds, totaling $ 616,087, are restricted to acquisitions and major repairs, with a required conservation match of $ 205,363.

2. Enter the financial impact of the requested adjustment for the next four fiscal years.

MEANS OF FINANCING OR EXPENDITURE	FY 2025-2026	FY 2026-2027	FY 2027-2028	FY 2028-2029	FY 2029-2030
GENERAL FUND BY:					
DIRECT	$0	$0	$0	$0	$0
INTERAGENCY TRANSFERS	$0	$0	$0	$0	$0
FEES & SELF-GENERATED	$0	$0	$0	$0	$0
STATUTORY DEDICATIONS	$0	$0	$0	$0	$0
FEDERAL	$616,087	$0	$0	$0	$0
TOTAL	**$616,087**	**$0**	**$0**	**$0**	**$0**

3. If this action requires additional personnel, provide a detailed explanation below:
No additional personnel will be required for this budget adjustment.

4. Explain why this request can't be postponed for consideration in the agency's budget request for next fiscal year.
Delaying equipment purchases and major repairs diminishes the department's efficiency and effectiveness. Limited maritime infrastructure and outdated equipment hinder our ability to meet performance standards and fulfill our mission to enforce state laws and regulations governing the management, conservation, and protection of wildlife and fisheries resources while ensuring public safety on Louisiana's waterways within the Port of New Orleans.

5. Is this an after the fact BA-7, e.g.; have expenditures been made toward the program this BA-7 is for? If yes, explain per PPM No.52.
Expenditures associated with this grant have commenced to address necessary repairs and maintain agency operations. Work has begun on one vessel to ensure it becomes fully operational.

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PERFORMANCE IMPACT OF MID-YEAR BUDGET ADJUSTMENT

1. Identify and explain the programmatic impacts (positive or negative) that will result from the approval of this BA-7.

Approval of this budget adjustment will enable Enforcement agents to complete essential repairs to maritime transportation infrastructure, supporting public safety on waters within the port as well as the conservation, protection, preservation, and management of Louisiana's natural resources, including fish and wildlife.

2. Complete the following information for each objective and related performance indicators that will be affected by this request. *(Note: Requested adjustments may involve revisions to existing objectives and performance indicators or creation of new objectives and performance indicators. Repeat this portion of the request form as often as necessary.)*

OBJECTIVE: The Office of the Secretary - Enforcement, will be able to maintain its performance indicator standards by completing repairs to the maritime infrastructure funded through the approved grant.

LEVEL	PERFORMANCE INDICATOR NAME	PERFORMANCE STANDARD		
		CURRENT FY 2025-2026	ADJUSTMENT (+) OR (-)	REVISED FY 2025-2026
S	Patrols, investigations, education, community policing	300,000		300,000.00
K	Observed compliance - recreational fishing	96.5		96.5
K	Observed compliance - commercial fishing	97		97
K	Observed compliance - oyster fishing	96		96

JUSTIFICATION FOR ADJUSTMENT(S): Explain the necessity of the adjustment(s).
There will be no change to established performance standards. This adjustment ensures that Enforcement can continue to meet and maintain those standards.

3. Briefly explain any performance impacts other than or in addition to effects on objectives and performance indicators. (*For example: Are there any anticipated direct or indirect effects on program management or service recipients ? Will this BA-7 have a positive or negative impact on some other program or agency?*)

Approval of this budget adjustment will allow LDWF Enforcement to repair essential equipment to protect Louisiana residents through patrols, investigations, and community outreach in the Port of New Orleans, while enhancing communication with federal partners.

4. If there are no performance impacts associated with this BA-7 request, then fully explain this lack of performance impact.

There will be no change to the established performance standards. This adjustment ensures that Enforcement can continue to meet and maintain those standards with reliable, updated equipment.

5. Describe the performance impacts of failure to approve this BA-7. (Be specific. Relate performance impacts to objectives and performance indicators.)

Without this funding, the agency will be unable to repair vessels or upgrade electronic equipment necessary for effective coordination with federal partners. Funding is also required to procure a cabin vessel to ensure officer safety and protection from environmental elements.

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM LEVEL REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM 1 NAME: Office of the Secretary - Admin

MEANS OF FINANCING:	CURRENT FY 2025-2026	REQUESTED ADJUSTMENT	REVISED FY 2025-2026	ADJUSTMENT OUTYEAR PROJECTIONS FY 2026-2027	FY 2027-2028	FY 2028-2029	FY 2029-2030
GENERAL FUND BY:							
Direct	$3,133,252	$0	**$3,133,252**	$0	$0	$0	$0
Interagency Transfers	$134,304	$0	**$134,304**	$0	$0	$0	$0
Fees & Self-Generated *	$0	$0	**$0**	$0	$0	$0	$0
Statutory Dedications **	$544,608	$0	**$544,608**	$0	$0	$0	$0
FEDERAL FUNDS	$0	$0	**$0**	$0	$0	$0	$0
TOTAL MOF	**$3,812,164**	**$0**	**$3,812,164**	**$0**	**$0**	**$0**	**$0**
EXPENDITURES:							
Salaries	$2,280,891	$0	**$2,280,891**	$0	$0	$0	$0
Other Compensation	$0	$0	**$0**	$0	$0	$0	$0
Related Benefits	$1,149,704	$0	**$1,149,704**	$0	$0	$0	$0
Travel	$85,900	$0	**$85,900**	$0	$0	$0	$0
Operating Services	$78,163	$0	**$78,163**	$0	$0	$0	$0
Supplies	$48,016	$0	**$48,016**	$0	$0	$0	$0
Professional Services	$0	$0	**$0**	$0	$0	$0	$0
Other Charges	$0	$0	**$0**	$0	$0	$0	$0
Debt Services	$0	$0	**$0**	$0	$0	$0	$0
Interagency Transfers	$169,490	$0	**$169,490**	$0	$0	$0	$0
Acquisitions	$0	$0	**$0**	$0	$0	$0	$0
Major Repairs	$0	$0	**$0**	$0	$0	$0	$0
UNALLOTTED	$0	$0	**$0**	$0	$0	$0	$0
TOTAL EXPENDITURES	**$3,812,164**	**$0**	**$3,812,164**	**$0**	**$0**	**$0**	**$0**
POSITIONS							
Classified	22	0	**22**	0	0	0	0
Unclassified	3	0	**3**	0	0	0	0
TOTAL T.O. POSITIONS	**25**	**0**	**25**	**0**	**0**	**0**	**0**
Other Charges Positions	0	0	**0**	0	0	0	**0**
Non-TO FTE Positions		0	**0**	0	0	0	**0**
TOTAL POSITIONS	**25**	**0**	**25**	**0**	**0**	**0**	**0**
***Dedicated Fund Accounts:**							
Reg. Fees & Self-generated	$0	$0	**$0**	$0	$0	$0	$0
[Select Fund Account]	$0	$0	**$0**	$0	$0	$0	$0
[Select Fund Account]	$0	$0	**$0**	$0	$0	$0	$0
****Statutory Dedications:**							
Conservation Fund (W01)	$409,439	$0	**$409,439**	$0	$0	$0	$0
Wildlife Habitat & Natural Heritage Trust Fund (W05)	$135,169	$0	**$135,169**	$0	$0	$0	$0
[Select Statutory Dedication]	$0	$0	**$0**	$0	$0	$0	$0
[Select Statutory Dedication]	$0	$0	**$0**	$0	$0	$0	$0
[Select Statutory Dedication]	$0	$0	**$0**	$0	$0	$0	$0
[Select Statutory Dedication]	$0	$0	**$0**	$0	$0	$0	$0
[Select Statutory Dedication]	$0	$0	**$0**	$0	$0	$0	$0
[Select Statutory Dedication]	$0	$0	**$0**	$0	$0	$0	$0

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM LEVEL REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM 1 NAME: Office of the Secretary - Admin

MEANS OF FINANCING:	State General Fund	Interagency Transfers	Fees & Self-Generated Revenues	Statutory Dedications	Federal Funds	TOTAL
AMOUNT	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
EXPENDITURES:						
Salaries	$0	$0	$0	$0	$0	**$0**
Other Compensation	$0	$0	$0	$0	$0	**$0**
Related Benefits	$0	$0	$0	$0	$0	**$0**
Travel	$0	$0	$0	$0	$0	**$0**
Operating Services	$0	$0	$0	$0	$0	**$0**
Supplies	$0	$0	$0	$0	$0	**$0**
Professional Services	$0	$0	$0	$0	$0	**$0**
Other Charges	$0	$0	$0	$0	$0	**$0**
Debt Services	$0	$0	$0	$0	$0	**$0**
Interagency Transfers	$0	$0	$0	$0	$0	**$0**
Acquisitions	$0	$0	$0	$0	$0	**$0**
Major Repairs	$0	$0	$0	$0	$0	**$0**
UNALLOTTED	$0	$0	$0	$0	$0	**$0**
TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
OVER / (UNDER)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
POSITIONS						
Classified	0	0	0	0	0	0
Unclassified	0	0	0	0	0	0
TOTAL T.O. POSITIONS	**0**	**0**	**0**	**0**	**0**	**0**
Other Charges Positions	0	0	0	0	0	0
Non-TO FTE Positions	0	0	0	0	0	0
TOTAL POSITIONS	**0**	**0**	**0**	**0**	**0**	**0**

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM LEVEL REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM 2 NAME: Office of the Secretary - Enforcement

MEANS OF FINANCING:	CURRENT FY 2025-2026	REQUESTED ADJUSTMENT	REVISED FY 2025-2026	ADJUSTMENT OUTYEAR PROJECTIONS FY 2026-2027	FY 2027-2028	FY 2028-2029	FY 2029-2030
GENERAL FUND BY:							
Direct	$27,175,991	$0	**$27,175,991**	$0	$0	$0	$0
Interagency Transfers	$352,366	$0	**$352,366**	$0	$0	$0	$0
Fees & Self-Generated *	$344,975	$0	**$344,975**	$0	$0	$0	$0
Statutory Dedications **	$15,472,825	$0	**$15,472,825**	$0	$0	$0	$0
FEDERAL FUNDS	$3,103,510	$616,087	**$3,719,597**	$0	$0	$0	$0
TOTAL MOF	**$46,449,667**	**$616,087**	$47,065,754	**$0**	**$0**	**$0**	**$0**
EXPENDITURES:							
Salaries	$20,809,108	$0	**$20,809,108**	$0	$0	$0	$0
Other Compensation	$13,260	$0	**$13,260**	$0	$0	$0	$0
Related Benefits	$13,563,409	$0	**$13,563,409**	$0	$0	$0	$0
Travel	$222,293	$0	**$222,293**	$0	$0	$0	$0
Operating Services	$3,381,856	$0	**$3,381,856**	$0	$0	$0	$0
Supplies	$2,677,109	$0	**$2,677,109**	$0	$0	$0	$0
Professional Services	$127,798	$0	**$127,798**	$0	$0	$0	$0
Other Charges	$756,987	$0	**$756,987**	$0	$0	$0	$0
Debt Services	$0	$0	**$0**	$0	$0	$0	$0
Interagency Transfers	$3,886,119	$0	**$3,886,119**	$0	$0	$0	$0
Acquisitions	$811,728	$599,435	**$1,411,163**	$0	$0	$0	$0
Major Repairs	$200,000	$16,652	**$216,652**	$0	$0	$0	$0
UNALLOTTED	$0	$0	**$0**	$0	$0	$0	$0
TOTAL EXPENDITURES	**$46,449,667**	**$616,087**	$47,065,754	**$0**	**$0**	**$0**	**$0**
POSITIONS							
Classified	257	0	**257**	0	0	0	0
Unclassified	0	0	**0**	0	0	0	0
TOTAL T.O. POSITIONS	**257**	**0**	**257**	**0**	**0**	**0**	**0**
Other Charges Positions	0	0	**0**	0	0	0	**0**
Non-TO FTE Positions		0	**0**	0	0	0	**0**
TOTAL POSITIONS	**257**	**0**	**257**	**0**	**0**	**0**	**0**
***Dedicated Fund Accounts:**							
Reg. Fees & Self-generated	$127,000	$0	**$127,000**	$0	$0	$0	$0
Oyster Sanitation Dedicated Fund Account (Q08)	$217,975	$0	**$217,975**	$0	$0	$0	$0
[Select Fund Account]	$0	$0	**$0**	$0	$0	$0	$0
****Statutory Dedications:**							
Rockefeller Wildlife Refuge and Game Preserve Fund (RK1)	$116,846	$0	**$116,846**	$0	$0	$0	$0
Marsh Island Operating Fund (RS1)	$32,038	$0	**$32,038**	$0	$0	$0	$0
Conservation Fund (W01)	$14,778,241	$0	**$14,778,241**	$0	$0	$0	$0
Crab Development, Management, and Derelict Crab Trap Removal Account (W33)	$113,000	$0	**$113,000**	$0	$0	$0	$0
Litter Abatement and Education Account (W36)	$99,800	$0	**$99,800**	$0	$0	$0	$0
Shrimp Development and Management Account (W42)	$70,900	$0	**$70,900**	$0	$0	$0	$0
Oyster Resource Management Account (W43)	$262,000	$0	**$262,000**	$0	$0	$0	$0
[Select Statutory Dedication]	$0	$0	**$0**	$0	$0	$0	$0

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION, OFFICE OF PLANNING AND BUDGET
REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM LEVEL REQUEST FOR MID-YEAR BUDGET ADJUSTMENT

PROGRAM 2 NAME: Office of the Secretary - Enforcement

MEANS OF FINANCING:	State General Fund	Interagency Transfers	Fees & Self-Generated Revenues	Statutory Dedications	Federal Funds	TOTAL
AMOUNT	**$0**	**$0**	**$0**	**$0**	**$616,087**	**$616,087**
EXPENDITURES:						
Salaries	$0	$0	$0	$0	$0	**$0**
Other Compensation	$0	$0	$0	$0	$0	**$0**
Related Benefits	$0	$0	$0	$0	$0	**$0**
Travel	$0	$0	$0	$0	$0	**$0**
Operating Services	$0	$0	$0	$0	$0	**$0**
Supplies	$0	$0	$0	$0	$0	**$0**
Professional Services	$0	$0	$0	$0	$0	**$0**
Other Charges	$0	$0	$0	$0	$0	**$0**
Debt Services	$0	$0	$0	$0	$0	**$0**
Interagency Transfers	$0	$0	$0	$0	$0	**$0**
Acquisitions	$0	$0	$0	$0	$599,435	**$599,435**
Major Repairs	$0	$0	$0	$0	$16,652	**$16,652**
UNALLOTTED	$0	$0	$0	$0	$0	**$0**
TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**	**$616,087**	**$616,087**
OVER / (UNDER)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
POSITIONS						
Classified	0	0	0	0	0	0
Unclassified	0	0	0	0	0	0
TOTAL T.O. POSITIONS	**0**	**0**	**0**	**0**	**0**	**0**
Other Charges Positions	0	0	0	0	0	0
Non-TO FTE Positions	0	0	0	0	0	0
TOTAL POSITIONS	**0**	**0**	**0**	**0**	**0**	**0**

QUESTIONNAIRE ANALYSIS

(Please reference question numbers, provide detailed information and use continuation sheets as needed.)

GENERAL PURPOSE

This BA-7 budgets the receipt of a federal grant. LDWF Enforcement has been awarded a Port Security Grant from the U.S. Department of Homeland Security totaling $ 616,087 for major repairs and acquisitions. The grant supports state, local, and private maritime partners in enhancing port-wide risk management and protecting critical surface transportation infrastructure from terrorism, major disasters, and other emergencies. Funds are restricted to acquisitions and major repairs, with a required conservation match of $ 205,363. Approval of this budget adjustment will enable LDWF Enforcement to repair essential equipment, supporting patrols, investigations, and community outreach in the Port of New Orleans, while improving communication with federal partners.

REVENUES

Enforcement Program	
Existing Federal Fund Budget	$ 3,103,510
BA-7 Adjustment	$ 616,087
Revised Federal Fund Budget	$ 3,719,597

EXPENDITURES

PROGRAM	MEANS OF FINANCE	MAJOR CATEGORY	AMOUNT
ENFORCEMENT	FEDERAL	ACQUISITIONS	$ 599,435
ENFORCEMENT	FEDERAL	MAJOR REPAIRS	$ 16,652
ENFORCEMENT	FEDERAL	TOTAL	$ 616,087

Expenditure Category	Item	Qty	Cost	Ext. Cost	Federal	Conservation Match
Major Repair	Collar Replacement	1	22,203	22,203	16,652	5,551
Acquisition	Radar System	2	11,341	22,682	17,012	5,671
Acquisition	Sonar System	3	5,080	15,240	11,430	3,810
Acquisition	Tactical Communication	3	8,110	24,330	18,248	6,083
Acquisition	Camera (Tactical Operations)	2	23,500	47,000	35,250	11,750
Acquisition	Electronics Retrofit	2	7,600	15,200	11,400	3,800
Acquisition	Metal Shark Cabin Vessel	1	593,411	593,411	445,058	148,353
Acquisition	RRV Trailer	1	29,443	29,443	22,082	7,361
Acquisition	Radar Systems	1	18,941	18,941	14,206	4,735
Acquisition	Camera (Tactical Operations)	1	33,000	33,000	24,750	8,250
			752,629	**821,450**	**616,087**	**205,363**

OTHER

Fiscal Contact:	Lakeesha Miles, Accounting Manager	(225) 765-2696	lmiles@wlf.la.gov
Programmatic Contact:	Stephen Clark, Enforcement Colonel	(225) 765-2805	sclark@wlf.la.gov
Testifying before JLCB:	Bryan McClinton, Undersecretary	(225) 765-5021	bmcclinton@wlf.la.gov

STATE OF LOUISIANA

Legislative Fiscal Office
BATON ROUGE

Alan M. Boxberger
Legislative Fiscal Officer

Post Office Box 44097
Baton Rouge, Louisiana 70804
Phone: 225.342.7233

To: The Honorable Glen Womack, Chairman
Joint Legislative Committee on the Budget
The Honorable Members of the Joint Legislative Committee on the Budget

From: Alan Boxberger, Legislative Fiscal Officer
Patrice Thomas, Deputy Fiscal Officer

Date: November 13, 2025

Subject: Joint Legislative Committee on the Budget
Meeting November 20, 2025

Attached is the Legislative Fiscal Office BA-7 (Budget Adjustment) write-up for the November 20th meeting of the Joint Legislative Committee on the Budget.

The LFO recommends approval of the BA-7.

Please contact me if you have questions or need additional information.

LEGISLATIVE FISCAL OFFICE
ANALYSIS OF BA-7 REQUEST

DEPARTMENT: Wildlife & Fisheries

AGENCY: Office of Secretary

AGENDA NO.: 1

ANALYST: Richie Anderson

Means of Financing		Expenditures by Program		T. O.
State General Fund:	$0	Administrative	$0	0
Interagency Transfers:	$0	Enforcement	$616,087	0
Self-Generated Revenue:	$0			
Statutory Dedications:	$0			
Federal Funds:	$616,087			
Total	**$616,087**	**Total**	**$616,087**	**0**

I. SUMMARY/COMMENTS

The purpose of this BA-7 request is to increase Federal budget authority by $616,087 in the Enforcement Program within the Louisiana Department of Wildlife and Fisheries (LDWF). The funding source is a Port Security Grant administered by the U.S. Department of Homeland Security, with grant dates from 9/01/25 to 8/31/28. The purpose of this grant is to support maritime partners in enhancing port-wide risk management and protecting critical infrastructure. The Port Security Grant requires a state match of $205,363. The department reports it will use current budget authority of $205,363 out of the Conservation Fund as state match to access the $616,087 in Federal funding. The total funding amount for acquisitions and major repairs is $821,450.

Port Security Grant (This BA-7)	$616,087
Conservation Fund (State Match)	$205,363
Total:	**$821,450**

This Federal funding of $616,087, along with the Conservation Fund Match of $205,363, will allow LDWF's Enforcement to acquire equipment necessary for conducting investigations, patrol operations, and community outreach in the Port of New Orleans. Expenditures are as follows:

Acquisitions: $799,247 ($199,812 Statutory Dedications out of the Conservation Fund and $599,435 Federal)

Item	Number of Items	Port Security Grant	Conservation Fund	Total
Metal Shark Cabin Vessel	1	$445,058	$148,353	$593,411
Tactical Camera	3	$60,000	$20,000	$80,000
Radar System	3	$31,217	$10,406	$41,623
Commercial Duty Trailer	1	$22,082	$7,361	$29,443
Tactical Communication	3	$18,248	$6,082	$24,330
Sonar System	3	$11,430	$3,810	$15,240
Electronics Retrofit	2	$11,400	$3,800	$15,200
Acquisitions Subtotal				**$799,247**

Major Repairs: $22,203 ($5,551 Statutory Dedications out of the Conservation Fund and $16,652 Federal)

Item	Port Security Grant	Conservation Fund	Total
Collar Replacement	$16,652	$5,551	$22,203
Major Repairs Subtotal			**$22,203**
Total			**$821,450**

II. IMPACT ON FUTURE FISCAL YEARS

LEGISLATIVE FISCAL OFFICE
ANALYSIS OF BA-7 REQUEST

If approved, this BA-7 will allow the department to fully expend the total grant funding in FY 26; however, depending on the timing of the delivery of equipment, the associated expenditures may be carried forward into future fiscal years, potentially through the end of the grant period, 8/31/28 (FY 29).

III. LEGISLATIVE FISCAL OFFICE RECOMMENDATION

The Legislative Fiscal Office recommends approval of this BA-7 request.

November 20, 2025

DIVISION OF ADMINISTRATION

Facility Planning & Control

JOINT LEGISLATIVE COMMITTEE

ON THE

BUDGET

Briefing Book

FOR

November 2025

TABLE OF CONTENTS
JOINT LEGISLATIVE COMMITTEE ON THE BUDGET
November 2025

1. Act 751 Request
   Approval of Projects for Funding through the College and University Deferred Maintenance and Capital Improvement Program

2. Request for Act 587 Projects (Revised Funding)

3. Request for an Act 959 Project
   New Indoor Practice Facility
   Grambling State University
   Grambling, Louisiana

4. Request for an Act 959 Project
   Student Union Restroom Renovations
   Louisiana State University
   Baton Rouge, Louisiana

5. Supplemental Funds Request, Interagency Transfer
   Central Louisiana State Hospital Relocation to Pinecrest
   Pinecrest Supports and Services Center
   Pineville, Louisiana
   Project No. 09-340-12-01

6. Reporting of Change Orders over $50,000 and Under $250,000
   A. (CO#1) Air Handling Unit & Building Controls Replacement
      Isaac Greggs Band Building
      Southern University
      Baton Rouge, Louisiana
      Project No. 01-107-18-02, F.01004278 &
      19-671-22-01, F.19002600 (Supplement), 19-615-16-01, F.19002654 (Supplement)

   B. (CO#1) Replacement Emergency Exit Doors and Windows
      Multiple Buildings
      Elayn Hunt Correctional Center
      St. Gabriel, Louisiana
      Project No. 01-107-18-02, F.01004434

   C. (CO#6) Laboratory Ventilation and Fume Hood Improvements
      Pursley Hall
      Southeastern Louisiana University
      Hammond, Louisiana
      Project No. 19-671-22-01, F.19002433 & 01-107-24-05, F.01004584 (Supplement)

   D. (CO#1) Non-State Capital Outlay Project
      Town of Berwick
      Water Meter Replacement, Planning and Construction
      St. Mary Parish, Louisiana
      Project No. 50-M24-21-02, F.50001223

Office of the Commissioner
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 24, 2025

The Honorable Glen Womack, Chairman
Joint Legislative Committee on the Budget
Post Office Box 44294, Capitol Station
Baton Rouge, Louisiana 70804

RE: Approval of Projects for Funding through the College and University Deferred Maintenance and Capital Improvement Program

Dear Chairman Womack:

In accordance with R.S. 17:3369.1(A)(4)(a)(ii), a list of projects approved by the Commissioner of Administration shall be submitted to the Joint Legislative Committee on the Budget for approval. The attached list of projects includes additional projects requested from the university systems.

Please place this item on the agenda of the next meeting of the Committee.

Sincerely,

Taylor F. Barras
Commissioner of Administration

CC: Patrick Fulkerson, FPC
Bruce Janet, ULS
Scott Hebert, ULL
Chris Herring, BOR
Matthew Baker, FPC
Bryan Andries, FPC
Janelle Kirvin, FPC
Margaret Hill, FPC
Ternisa Hutchinson, OPB
Samuel Roubique, OPB
Paul Fernandez, OPB
Brittany Lea, House Fiscal Division
Mark Mahaffey, House Fiscal Division
Daniel Waguespack, House Fiscal Division
Bobbie Hunter, Senate Fiscal Division
Debra Vivien, Senate Fiscal Division
Raynel Gascon, Senate Fiscal Division

College and University Deferred Maintenance and Capital Improvement Program (Act No. 751 - HB 940 of the 2024 Regular Session)

JLCB Project Approval Request - October 10, 2025

System	Item No.	Project No. (If Applicable)	Campus	Project	Building/Site	Project Scope (2-3 Sentences)
ULS	**536**		ULL	NIRC Shooting Berm Environmental Remediation	Former Navy Shooting NIRC Area 31	ULL funded design for demolition / cleanup project on of an old Navy base earthen berm shooting range at our New Iberia Research Center. ULL secured $500,000.00 EPA federal grant to help clean up the "Brown Field" designated site. Required 20% Match to obtain the $500k grant. ULL requests to set aside funds for match for any costs over the $500,000.00 grant
ULS	**537**		ULL	Lee Hall Roof Replacement	Lee Hall	Replace Modified Bitumen (29% of total) and asphalt shingle roof (71% of total) and related items like Ridge , Caps, Dormer Sides, Vent Covers and Roof Jacks, Fascia and Soffit, Wood Rot items
ULS	**538**		ULL	HVAC Chillers and Chilled Water Loop Upgrades Campus Wide (Main LFT)	Multiple Locations	Replace HVAC equipment like chillers, valves and HVAC Controls to maintain the various chilled water loops within the HVAC systems. Current budget limitations do not allow for us to continue to use University funds to self fund these repairs and replacements.

Office of the Commissioner
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 24, 2025

The Honorable Glen Womack, Chairman
Joint Legislative Committee on the Budget
Post Office Box 44294, Capitol Station
Baton Rouge, Louisiana 70804

RE: Request for Act 587 Projects (Revised Funding)

Dear Chairman Womack:

Pursuant to R.S. 39:100:241(I) the Criminal Justice Priority Funding Commission recommends the funding changes indicated on the attached list of previously approved projects.

Please place this item on the agenda of the next meeting of the Committee.

Sincerely,

Taylor F. Barras
Commissioner of Administration

CC: Matthew Baker, FPC
Bryan Andries, FPC
Janelle Kirvin, FPC
Margaret Hill, FPC
Ternisa Hutchinson, OPB
Samuel Roubique, OPB
Paul Fernandez, OPB
Brittany Lea, House Fiscal Division
Mark Mahaffey, House Fiscal Division
Daniel Waguespack, House Fiscal Division
Bobbie Hunter, Senate Fiscal Division
Debra Vivien, Senate Fiscal Division
Raynel Gascon, Senate Fiscal Division

CRIMINAL JUSTICE PRIORITY FUNDING COMMISSION PROGRAM: 10/16/2025 UPDATE

JUVENILE ORIENTED PROJECTS

	Project Name	Project Number	Working Panel Rating	Possible Rating	% of Points	Recommendation for Grant Award of Funding	CONSTRUCTION: Anticipated Start of Construction	CONSTRUCTION: Anticipated Completion of Construction	FUNDING/MEANS OF FINANCE: Request from Fund	FUNDING/MEANS OF FINANCE: Capital Outlay	FUNDING/MEANS OF FINANCE: Other Means	FUNDING/MEANS OF FINANCE: Total Budget
1	**New Jetson Center for Youth**, East Baton Rouge Parish, LA	08-403-24-01	700	900	78%	$ 15,500,000	4/15/2026	10/15/2027	$ 47,381,580	$ 21,333,860	$ -	$ 68,715,440
2	**Central Louisiana Juvenile Detention Center**, Rapides Parish, LA	50-R52-24-01	778	900	86%	$ 37,978,880	4/3/2026	10/3/2027	$ 37,978,880	$ 1,000,000	$ -	$ 38,978,880
4	**River Parishes Regional Juvenile Detention Center**, Thibodaux, LA	50-R53-24-01	652	800	82%	$ 36,615,100	4/1/2026	10/1/2027	$ 36,615,100	$ -	$ -	$ 36,615,100
					Subtotal	$ 90,093,980						

ADULT & OTHER CRIMINAL JUSTICE PROJECTS

	Project Name	Project Number	Working Panel Rating	Possible Rating	% of Points	Recommendation for Grant Award of Funding	CONSTRUCTION: Anticipated Start of Construction	CONSTRUCTION: Anticipated Completion of Construction	FUNDING/MEANS OF FINANCE: Request from Fund	FUNDING/MEANS OF FINANCE: Capital Outlay	FUNDING/MEANS OF FINANCE: Other Means	FUNDING/MEANS OF FINANCE: Total Budget
10	**Concordia Parish Sheriff's Office Detention Center**, Ferriday, LA	50-N89-24-01	529	900	59%	$ 3,500,000	11/17/2025	9/17/2026	$ 3,000,000	$ -	$ -	$ 3,000,000
11	**Tangipahoa Parish Jail Work Release Dormitory Construction and Infrastructure Upgrades**, Amite City, LA	50-J53-24-02	613	900	68%	$ 1,312,700	4/1/2026	9/1/2026	$ 1,312,700	$ -	$ 145,800	$ 1,458,500
18	**Integrated Criminal Justice Information System Policy Board (ICJIS)**, Statewide Initiative	n/a	n/a	n/a	n/a	$ 5,000,000	n/a	n/a	$ 5,000,000	$ -	$ -	$ 5,000,000
					Subtotal	$ 9,812,700						

Indicates recommended project / Initiative

Total Recommend from Fund	$ 99,906,680
Fund Balance Remaining	$ 93,320

$ 100,000,000	**Total Available from Fund**

APPROVED: 10/16/2025

CRIMINAL JUSTICE PRIORITY FUNDING COMMISSION

Facility Planning and Control
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 24, 2025

The Honorable Glen Womack, Chairman
Joint Legislative Committee on the Budget
Post Office Box 44294, Capitol Station
Baton Rouge, Louisiana 70804

RE: Request for an Act 959 Project
New Indoor Practice Facility
Grambling State University
Grambling, Louisiana

Dear Chairman Womack:

Pursuant to R.S. 39:128 B.(4), Grambling State University (GSU) has requested approval to construct a new indoor practice facility near the existing football fieldhouse. The scope of the project consists of a covered 36,505 SF practice facility including a fifty-yard turf field that is suitable to be used by all sports. This facility represents a major investment in enhancing student-athlete development while positioning GSU as a leader among historically black colleges and universities.

This request is for approval of this project up to the statutory limit as defined in R.S.39:128(4)(a)(i) and is currently estimated at $6,700,000.00. The project will be funded with self-generated revenues. This request has been approved by the Board of Regents for Higher Education and the University of Louisiana System.

Please place this item on the agenda of the next meeting of the Committee.

Sincerely,

Matthew H. Baker
Director

Approved: _____
Taylor F. Barras
Commissioner of Administration

CC: Roy Dowling, FPC
Bruce Janet, ULS
Chris Herring, BOR
Matthew Baker, FPC
Bryan Andries, FPC
Janelle Kirvin, FPC
Margaret Hill, FPC
Ternisa Hutchinson, OPB
Samuel Roubique, OPB
Paul Fernandez, OPB
Brittany Lea, House Fiscal Division
Mark Mahaffey, House Fiscal Division
Daniel Waguespack, House Fiscal Division
Bobbie Hunter, Senate Fiscal Division
Debra Vivien, Senate Fiscal Division
Raynel Gascon, Senate Fiscal Division

Facility Planning and Control
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 24, 2025

The Honorable Glen Womack, Chairman
Joint Legislative Committee on the Budget
Post Office Box 44294, Capitol Station
Baton Rouge, Louisiana 70804

RE: Request for an Act 959 Project
Student Union Restroom Renovations
Louisiana State University
Baton Rouge, Louisiana

Dear Chairman Womack:

Pursuant to R.S. 39:128 B.(4), Louisiana State University (LSU) has requested approval to renovate the restrooms on the first through fourth floors within the LSU Student Union. The LSU Student Union is a high-use facility serving students, faculty, staff, and visitors. The project will improve the functionality, accessibility, and user experience and involves replacing deteriorated components, upgrading fixtures to meet current code and accessibility standards, and refreshing finishes throughout each restroom.

This request is for approval of this project up to the statutory limit as defined in R.S.39:128(4)(a)(i) and is currently estimated at $1,700,000.00. The project will be funded with self-generated auxiliary revenues. This request has been approved by the Board of Regents for Higher Education and the Louisiana State University System.

Please place this item on the agenda of the next meeting of the Committee.

Sincerely,

Matthew H. Baker
Director

Approved: _____
Taylor F. Barras
Commissioner of Administration

CC: James Pugh, FPC
Amanda Mire, LSU
Danny Mahaffey, LSU
Chris Herring, BOR
Matthew Baker, FPC
Bryan Andries, FPC
Janelle Kirvin, FPC
Margaret Hill, FPC
Ternisa Hutchinson, OPB
Samuel Roubique, OPB
Paul Fernandez, OPB
Brittany Lea, House Fiscal Division
Mark Mahaffey, House Fiscal Division
Daniel Waguespack, House Fiscal Division
Bobbie Hunter, Senate Fiscal Division
Debra Vivien, Senate Fiscal Division
Raynel Gascon, Senate Fiscal Division

Facility Planning and Control
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 24, 2025

The Honorable Glen Womack, Chairman
Joint Legislative Committee on the Budget
Post Office Box 44294, Capitol Station
Baton Rouge, Louisiana 70804

RE: Supplemental Funds Request, Interagency Transfer
Central Louisiana State Hospital Relocation to Pinecrest
Pinecrest Supports and Services Center
Pineville, Louisiana
Project No. 09-340-12-01,

Dear Chairman Womack:

Act 24 of 2013, Act 25 of 2014, Act 26 of 2015, Act 2 of 2020, Act 485 of 2021, Act 117 of 2022 and Act 465 of 2023 appropriated a total of $43,402,300.00 to the Pinecrest Supports and Services Center (Louisiana Department of Health) for the planning and construction of a new 120 bed hospital for the Central Louisiana State Hospital at the Pinecrest Supports and Services Center in Pineville, Louisiana.

Facility Planning and Control is requesting authorization to accept supplemental funding for the project in the form of Interagency Transfers from the Louisiana Department of Health in the amount of $1,500,000. This supplemental funding will allow for the design and construction of a new administration building for the newly constructed 120 bed hospital. This funding originates from returned unused Interagency Transfer funds from project 09-320-23-01, F.09000091 (Emergency Renovations to Dormitory 3 / Demo/Remediation – Dormitory 3 Villa Feliciana Medical Complex, Jackson, LA).

Please place this item on the agenda of the next meeting of the Committee.

Sincerely,

Matthew H. Baker
Director

Approved: _____
Taylor F. Barras
Commissioner of Administration

CC: Robert Mayard, FPC
Celeste Gauthier, LDH
Matthew Baker, FPC
Bryan Andries, FPC
Janelle Kirvin, FPC
Margaret Hill, FPC
Ternisa Hutchinson, OPB
Samuel Roubique, OPB
Paul Fernandez, OPB
Brittany Lea, House Fiscal Division
Mark Mahaffey, House Fiscal Division
Daniel Waguespack, House Fiscal Division
Bobbie Hunter, Senate Fiscal Division
Debra Vivien, Senate Fiscal Division
Raynel Gascon, Senate Fiscal Division

Facility Planning and Control
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 24, 2025

The Honorable Glen Womack, Chairman
Joint Legislative Committee on the Budget
Post Office Box 44294, Capitol Station
Baton Rouge, Louisiana 70804

RE: Reporting of Change Orders over $50,000 and Under $250,000

Dear Chairman Womack:

In accordance with R.S. 39:126, any change order in excess of fifty thousand dollars but less than two hundred fifty thousand dollars shall be submitted to the Joint Legislative Committee on the Budget for review but shall not require committee approval. Pursuant to this authority, Facility Planning & Control has issued change orders which are itemized on the attached list.

Please place this item on the agenda of the next meeting of the Committee.

Sincerely,

Matthew H. Baker
Director

Approved: _____
Taylor F. Barras
Commissioner of Administration

CC: Eric Riley, FPC
Cheryl Cloud, FPC
Galen Wilson, FPC
Charles Funderburk, FPC
James Pugh, FPC
Edwin Lee, FPC
Matthew Baker, FPC
Bryan Andries, FPC
Janelle Kirvin, FPC
Margaret Hill, FPC
Ternisa Hutchinson, OPB
Samuel Roubique, OPB
Paul Fernandez, OPB
Brittany Lea, House Fiscal Division
Mark Mahaffey, House Fiscal Division
Daniel Waguespack, House Fiscal Division
Bobbie Hunter, Senate Fiscal Division
Debra Vivien, Senate Fiscal Division
Raynel Gascon, Senate Fiscal Division

JLCB Summary
Reporting of Change Orders over $50,000 and under $250,000

Air Handling Unit & Building Controls Replacement
Isaac Greggs Band Building
Southern University
Baton Rouge, Louisiana

Project No. **01-107-18-02, F.01004278**
19-671-22-01, F.19002600 (Supplement)
19-615-16-01, F.19002654 (Supplement)

Site Code: 2-17-038
State ID: S02216
Date of Contract: June 13, 2024

Original Contract Amount:	**$715,000.00**	
Changes by Previous Change Orders:		
None	$0.00	
Contract Amount Increased by this Change Order:		
Change Order No. 1	$63,418.00	(Executed 09/18/2025)
New Contract Sum:	**$778,418.00**	

The project involves replacement of the existing HVAC system and associated controls at the Isaac Greggs Band Building on the campus of Southern University in Baton Rouge.

Change Order No. 1 increases the contract amount to account for modifications necessary to facilitate the installation and maintenance of the new system. Specifically, the work includes lowering existing ceiling levels to improve accessibility for future maintenance of the newly installed ductwork. The scope also adds new electrical circuits to replace failed existing circuitry originally planned for reuse in controlling the new VAV units, along with the installation of a new chilled water pump and associated controls. The contract time was extended by 115 days to address equipment lead times and complete the additional work.

The total increase of $63,418.00 covers all related material and labor costs. The additional expense will be funded through the existing construction contingency.

JLCB Summary
Reporting of Change Orders over $50,000 and under $250,000

Replacement Emergency Exit Doors and Windows
Multiple Buildings
Elayn Hunt Correctional Center
St. Gabriel, Louisiana

Project No. 01-107-18-02, F.01004434

Site Code: 2-24-004
State ID: Multiple
Date of Contract: November 21, 2024

Original Contract Amount:	**$2,587,500.00**	
Changes by Previous Change Orders:		
None	$0.00	
Contract Amount Increased by this Change Order:		
Change Order No. 1	**$98,659.00**	(Executed 10.02.25)
New Contract Sum:	**$2,686,159.00**	

The project involves the replacement of existing doors and windows across multiple dormitory buildings at the Elayn Hunt Correctional Institute.

Change Order No. 1 increases the project amount by $98,659.00 to address several scope modifications, including the removal of an existing 3'-0" wide door and the installation of a new 4'-0" wide door, frame, and hardware in the Unit #3 Clinic building. In addition, this change order includes the removal and replacement of six (6) additional doors, frames, and hardware located in Beaver 5-B, Fox 4, Fox 2, Golf 1, and Golf 2 dormitories.

The cost increase reflects both material and labor expenses associated with these changes and will be funded from the project's existing contingency funds.

JLCB Summary
Reporting of Change Orders over $50,000 and under $250,000

Laboratory Ventilation and Fume Hood Improvements
Pursley Hall
Southeastern Louisiana University
Hammond, Louisiana

Project No. **19-671-22-01, F.19002433 &**
01-107-24-05, F.01004584 (Supplement)

Site Code: 2-53-004
State ID: S03240
Date of Contract: October 18, 2024

Original Contract Amount:	**$3,200,000.00**	
Changes by Previous Change Orders:		
Change Order No. 1:	($500,000.00)	(Executed 10.18.24)
Change Order No. 2:	$9,324.00	(Executed 02.12.25)
Change Order No. 3:	$18,000.00	(Executed 04.22.25)
Change Order No. 4:	$63,417.00	(Executed 05.20.25)
Change Order No. 5:	$29,548.00	(Executed 06.04.25)
Contract Amount Increased by this Change Order:		
Change Order No. 6:	**$71,333.00**	(Executed 10.14.25)
New Contract Sum:	**$2,891,622.00**	

A construction contract was issued to Dove Group, LLC on October 18, 2024, in the amount of $3,200,000.00 for improvements to the laboratory ventilation system and fume hoods at Pursley Hall, located on the campus of Southeastern Louisiana University. Construction commenced in November 2024 with a 365-consecutive-calendar-day construction duration.

Change Order No. 6, in the amount of $71,333.00, was executed to address unforeseen conditions discovered during demolition of the existing fume hoods. Upon removal, it was determined that the existing acid waste and domestic water piping systems were deteriorated and did not comply with current applicable codes and standards.

Following the submission of RFI #13 by the Contractor, the Design Team issued direction requiring installation of new acid waste piping, domestic water piping, gas piping, and additional core drilling necessary to complete the work.

Additionally, at the request of the User Agency, new fume hood aspirators were furnished and installed, as these were not included in the original contract documents.

The total increase of $71,333.00 covers material and labor costs associated with all items noted above. The additional costs are funded through the project's existing contingency funds.

JLCB Summary
Reporting of Change Orders over $50,000 and under $250,000

Non-State Capital Outlay Project
Town of Berwick
Water Meter Replacement
Planning and Construction (St. Mary)

Project No. 50-M24-21-02, F.50001223

Site Code: N/A
State ID: N/A
Date of Contract: March 12, 2025

Original Contract Amount:	**$424,655.30**	
Changes by Previous Change Orders:		
None	$0.00	
Contract Amount Increased by this Change Order:		
Change Order No. 1	**$ 99,504.00**	(Executed 8/27/25)
New Contract Sum:	**$524,159.30**	

History

- A construction contract was awarded to Core and Main LP for **$424,655.30**. Since the Entity paid all design costs for the project the State is participating at $359,741.48 or 84.71376% of construction or 75% of the total project cost at that time.
- This project is for the replacement of water meters.

Reasons / Justification for JLCB

- Change Order No. 1: To add 160 one-inch water meters to the project.
    - A unit price for the purchase and installation of a one-inch water meter was provided with the bid.
    - The supplier of the water meters had a 5% material increase in June of 2025.
    - The State will participate in the cost of this Change Order No.1 at $74,628.00 or 75%.
- Remaining unobligated State funds after this CO: $124,305.52 (Capitol Outlay Savings Fund).

RS 24:653

§653. Duties and functions

A. The committee shall make such study and examination of the matters pertaining to the budgeting and fiscal affairs of the state and its political subdivisions, their funds, revenues, expenditures, and any other financial affairs of the state and of its political subdivisions as may be deemed desirable by the committee or the legislature. The committee may also study and examine all requests for professional, personal, social service, and consulting service contracts to determine the impact of privatizing state government programs, functions, or activities. The committee shall make such reports of its findings and recommendations with regard to such matters to the legislature upon its request or as is deemed advisable by the committee.

B. Prior to and during each regular session of the legislature, the joint committee may make such studies and hold such hearings with respect to budget requests or statements and with respect to the executive budget as it shall deem appropriate and are necessary to carry out its duties and functions.

C. Following the review, analysis, and study of the proposed executive budget, the committee shall submit its findings and recommendations thereon to the members of the legislature not later than two weeks prior to each regular session of the legislature.

D. The committee shall make such continuing study and examination of matters pertaining to the budgeting of the state revenues and their expenditures, and the fiscal affairs of the state and its agencies, and shall make quarterly reports and recommendations to the legislature and such other reports as the committee or the legislature deems advisable.

E. The committee shall interpret the legislative intent respecting all fiscal and budgetary matters of the state and conduct general oversight and review of the budget execution processes of the various budget units and other agencies of the state when necessary.

F. The committee shall study, review, and approve or disapprove all transfers of funds from one program specified in the allotments established in each agency's budget to another program. Except as provided in R.S. 39:73 and 87.4, no transfer of funds from one program specified in the allotments in an agency's budget to another shall be made without prior approval of the committee.

G. The committee shall have the full power and authority to adopt rules and regulations prescribing and governing its procedures, policies, meetings, and any and all other activities relating to its functions and duties, including the power and authority to issue binding directives to agencies concerning the proper and efficient execution of their respective budgets as same were approved by the legislature.

H.(1) The committee shall have a litigation subcommittee which shall monitor and study the amounts of state funds required to pay judgments and compromises arising out of lawsuits against the state, its departments, and, with respect to payment of state funds as insurance premiums, the insurers thereof. The committee, by its own rules, motions, or resolutions, shall provide for the size, membership, appointment, all administrative matters, and the delegated powers and duties of the litigation subcommittee.

(2) No attorney representing the state or any of its departments or agencies or any of its employees entitled to indemnification under R.S. 13:5108.1 shall sign any compromise or settlement which obligates the state to pay five hundred thousand dollars or more without prior consultation with the attorney general and the members of the litigation subcommittee. The consultation with the members of the litigation subcommittee shall occur in executive session.

(3)(a) At the request of the litigation subcommittee, any department, agency, board, commission, educational institution, or other state entity entitled to indemnification by the state or any employer of an employee entitled to indemnification under R.S. 13:5108.1 shall report on any corrective measures or actions taken to mitigate state risk exposure if the litigation subcommittee determines that such a report is necessary after consideration of a compromise or settlement of litigation.

(b) A meeting of the litigation subcommittee to receive a report from a state entity on corrective measures or actions pursuant to this Paragraph shall occur only after the subject litigation has been concluded. The litigation subcommittee may require that any indemnified state entity or employer of an indemnified employee appear at one or more meetings of the litigation subcommittee to discuss and report on corrective measures or actions.

(c) Any information provided by a state entity pursuant to this Paragraph may only be presented in executive session, and any documentation prepared or compiled by the state entity pursuant to this Paragraph shall not be subject to disclosure pursuant to the Public Records Law set forth in R.S. 44:1 et seq.

I. The committee shall have the authority to nullify a penalty applied by the office of risk management relative to a state agency which has failed to receive certification after undergoing a loss prevention audit, as provided in R.S. 39:1536(B).

J. The committee may establish a subcommittee to execute its duties relative to oversight of performance-based budgeting under the Louisiana Government Performance and Accountability Act, as provided in Subpart D of Part II of Chapter 1 of Subtitle I of Title 39 of the Louisiana Revised Statutes of 1950. When the subcommittee acts on behalf of the committee, the chairman of the subcommittee shall provide to each member of the committee a summary report of the subcommittee's action.

K.(1) In the conduct of its responsibility to discharge the constitutional fiscal and budgetary responsibilities of the Louisiana Legislature, the committee shall consider the operating budgets of public entities and salaries of particular public officials which by law require the approval of the committee in accordance with the following:

(a) The committee shall consider operating budgets in advance of the beginning of a subject entity's fiscal year. If the committee finds that the entity has failed to receive the required approval, either by failure to appear or by committee disapproval of its budget, the committee may adopt a resolution to direct the commissioner of administration and the state treasurer to deny any warrant or payment of money from the state treasury for any amount contained within that budget. The committee may also adopt a resolution to direct the commissioner of administration and state treasurer to recommence the acceptance of warrants. If the committee determines that an entity whose operating funds are administered outside of the state treasury has failed to receive the required approval of its budget, either by failure to appear or by committee disapproval of its budget, the committee may adopt a resolution to that effect, and any expenditure of public monies by such entity shall constitute a violation of the provisions of Article VII, Section 14 of the Constitution of Louisiana.

(b) The consideration of salaries of public officials that by law require the approval of the committee shall occur prior to the execution of any employment contract for that official. The state shall not be liable for any payment of such salary if the salary has not been approved by the Joint Legislative Committee on the Budget. The committee shall have the authority to adopt a resolution to direct the commissioner of administration and the state treasurer to deny any warrant or payment of money from the state treasury for any monies related to the payment of the salary at issue. The committee is also authorized to adopt a resolution to direct the commissioner of administration and state treasurer to recommence the acceptance of warrants.

(2) The provisions of this Section shall have no effect on the provisions of any contract which is in effect prior to July 1, 2008.

(3) Notwithstanding any contrary provision of law, the chairman of the Joint Legislative Committee on the Budget may grant an entity, for good cause shown, an extension of time, not to exceed thirty days, to comply with the provisions of this Subsection, and the Joint Legislative Committee on the Budget may grant an additional extension of time.

L.(1)(a) Upon receipt of the reports from the various departments within the executive branch of state government as provided by R.S. 36:8(A)(6) and the public postsecondary education management boards as provided by R.S. 17:3130(C) and 3351(F), the Joint Legislative Committee on the Budget shall transmit the reports to the legislative fiscal office for review and analysis and may conduct hearings to review the reports.

(b) The legislative fiscal office shall review the reports and perform any additional analysis of the reports that is necessary to provide an accurate actual estimate as compared to the fiscal note as the bill was enacted.

(2) The reports required to be submitted under this Section shall be in a manner as prescribed by the chairman of the Joint Legislative Committee on the Budget and shall be accompanied by such other information as the chairman may require. At a minimum, the report shall present the differences between the original estimate as the bill was enacted and the actual current revenues or expenditures. Depending upon the scope of the original legislation, the comparisons between the fiscal note as the bill was enacted and the actual amounts shall include but not be limited to tax increases, decreases, fee increases and repeals, tax exemptions, suspensions, credits, rebates, exclusions, and deductions, among others.

(3) No later than February first of each year, the committee shall report its findings in a public meeting relative to any legislation that has been enacted that affects state revenues, public postsecondary education management boards and the related institutions or the various departments and the related entities and that legislation has a fiscal impact which has increased by the amount of one million dollars or more over the amount of the fiscal note as the bill was enacted. The review and analysis shall also examine the receipt, expenditure, allocation, dedication, or means of financing to determine specifically how the increases impact state revenue, the departments, agencies, boards, commissions, and like entities within the executive branch of state government, as well as among the public postsecondary education institutions of the state. The Joint Legislative Committee on the Budget shall transmit copies of the final report to the governor, the president of the Senate, and the speaker of the House of Representatives, and distribute a copy to each member of the legislature.

M.(1) All economic and financial reports for projects submitted in conjunction with the request for approval of the Joint Legislative Committee on the Budget in excess of a total state commitment of ten million dollars for the term of the project shall provide the following information:

(a) Inclusion of all input information, data, and assumptions, including but not limited to data sources, economic growth assumptions, and an assessment/basis of the reasonableness of each.

(b) A description of the analytical model employed for the report and how each input was utilized with that model.

(c) Results in terms of value-added, household earnings, and employment, and a description of each concept.

(d) Results by industry sector, with an assessment of possible adverse effects on sectors that compete with the subsidized company for in-state customers.

(e) Explicit identification of the project's effect on direct expenditure requirements in the state budget or any reduction in taxes or state revenues, including but not limited to tax exemptions, exclusions, deductions, reductions, repeals, rebates, incentives, abatements, or credits.

(f) An additional assessment by the secretary of the Department of Economic Development regarding the extent to which the project would not have occurred but for the proposed state financial support. The secretary's assessment shall reference other business factors which contributed to the project activity occurring and factors which will be required for ongoing sustainability including but not limited to labor, transportation, energy, among others.

(g) Cost/benefit comparisons of the incentives in the package compared to the costs in the package shall be for the same period of time or the same term, both for the direct benefits to the state as well as the indirect benefits to the state.

(2)(a) The department shall submit the request for Joint Legislative Committee on the Budget approval of the project with the analysis to the committee for its review at least seventeen business days, or as permitted by the chairman, prior to the meeting for which the department is seeking the committee's approval. In the event that the chairman specifies a request submission period that is less than seventeen business days, the chairman shall notify all members of the committee of the revised submission time period. Presentation of the information required shall be in a format developed by the department in consultation with the Legislative Fiscal Office and the Joint Legislative Committee on the Budget.

(b) Upon receipt of the request, the Joint Legislative Committee on the Budget shall transmit the report to the legislative fiscal office for evaluation of the department's assessment and the legislative fiscal office shall make such information available to the committee during its review.

(3) For the purposes of this Section and notwithstanding any other provision of law to the contrary, "project" shall mean any public-private partnership, agreement with a nonpublic party, lease, cooperative endeavor agreement, memorandum of understanding, or other contractual agreement which would result in or is expected to result in the obligation of state resources or the expenditure of revenues from the operation, management, or control of a state resource for the purposes of engendering economic growth or development in the state through the utilization of certain incentives, including but not limited to tax exemptions, exclusions, deductions, reductions, repeals, rebates, incentives, abatements, or credits.

N.(1) The committee shall have a dedicated fund review subcommittee which shall review and make recommendations on special funds in the state treasury that dedicate state revenue.

(2) The committee, by its own rules, motions, or resolutions, shall provide for the size, membership, appointment, all administrative matters, and the delegated powers and duties of the dedicated fund review subcommittee. The committee shall provide that the membership of the subcommittee is bipartisan and diverse.

(3) No later than September 1, 2017, and every two years thereafter, the committee shall provide for the dedicated fund review subcommittee.

(4) The dedicated fund review subcommittee shall conduct the review of special funds and submit recommendations to the committee as required in R.S. 49:308.5.

Added by Acts 1976, No. 538, §3, eff. March 10, 1980. Acts 1984, No. 694, §1; Acts 1997, No. 738, §1; Acts 1997, No. 1465, §1, eff. July 15, 1997; Acts 1998, 1st Ex. Sess., No. 11, §1; Acts 2001, No. 894, §1, eff. June 26, 2001; Acts 2008, No. 842, §1, eff. July 8, 2008; Acts 2010, No. 861, §10; Acts 2013, No. 96, §2, eff. July 1, 2013; Acts 2014, No. 704, §1, eff. July 1, 2014; Acts 2017, No. 355, §1, eff. June 22, 2017; Acts 2018, No. 612, §8, eff. July 1, 2020; Acts 2019, No. 404, §16; Acts 2023, No. 291, §1.

NOTE: See Acts 2019, No. 404, §§16 and 20 regarding the repeal of certain changes made to R.S. 24:653(N)(3) in Acts 2018, No. 612.

NOTE: See Acts 2018, No. 612 and Acts 2019, No. 404 providing for the effects of the conversion of certain dedicated funds to special statutorily dedicated fund accounts.

Items for Consideration - November 19, 2025 Water Sector Commission Meeting				
Round	**Entity**	**Type**	**Comments**	**Previous Actions**
Requests for Additional Funding and Match Commitment Change				
Phase 1 - Round 2	Delcambre	Sewer	Request for $2,961,589 in additional WSP funding and increase Local Match by $102,030. Local Match would increase from $3,958,470 to $4,060,500, This is a decrease from 79.2% of Local Match to 51%. Original WSP grant amount of $5,000,000 would increase to $7,961,589, an increase of 59.23%. JLCB approval is required.	
Phase 1 - Round 2	St. Bernard Parish	Sewer	A request was submitted to the WSC at the September 2025 meeting and was deferred pending a formal bid procedure. St. Bernard is requesting an additional $334,340 to complete the Farmsite Pump Station project and $3,585,950 to complete the Riverbend Consolidation project for a total of $3,920,290. There is no increase in local match. This results in a local match decrease from 51.3% to 32.39%. Original grant amount of $6,731,368 would increase to $10,651,658, an increase of 58.24%. JLCB approval is required.	
Phase 1 - Round 1	Consolidated Water District No. 1, Terrebonne Parish	Water	Request for additional WSP funding of $4,100,000. Local Match of $7,200,000 would increase to pay engineering costs for a total of $9,100,000 in Local Match. This results in a decrease in Local Match commitment from 163% to 100%. Original grant amount of $5,000,000 would be increased to $9,100,000, an increase of 82%. JLCB approval is required.	
Phase 1 - Round 2	Ville Platte	Water	Request for additional funding and decrease in Local Match commitment, (WSP increase of $1,645,071 with no Local Match increase) which would result in a decrease of Local Match commitment from 22.86% to 17.71%. Original grant amount of $5,000,000, increased to $5,695,315 on August 8, 2025, would now increase to $7,340,386 for a total increase of 46.81%. JLCB approval is required. OCD has this project designated as high-risk.	Received additional $695,315 with reduction of local match from 26% to 22.86% at August 8, 2025 WSC Meeting and approved at JLCB Meeting August 9, 2025.

Patricia A. Dubroc
President and CEO

Martin Walke
Vice President

Joni M. Leggio
Vice President

LPFA
LOUISIANA PUBLIC FACILITIES AUTHORITY

BOARD OF TRUSTEES

Ronald H. Bordelon, Chairman
Dannye W. Malone, Vice Chairman
Craig A. Cheramie, Secretary-Treasurer
David W. Groner
Casey R. Guidry
Heather C. Songy
Matthew T. Valliere

October 27, 2025

The Honorable Glen Womack
Chairman
Joint Legislative Committee on the Budget
11th Floor, State Capitol
Baton Rouge, LA 70804

The Honorable Jack McFarland
Vice Chairman
Joint Legislative Committee on the Budget
11th Floor, State Capitol
Baton Rouge, LA 70804

Re: Proposed LPFA Budget for Calendar Year 2026

Dear Chairman Womack and Vice Chairman McFarland:

Thank you for your consideration of our proposed Budget for calendar year 2026. This proposed Budget was approved by LPFA's Board of Trustees at a public meeting held on October 8, 2025. I have also included a copy of the resolution adopted by the Board of Trustees approving our proposed 2026 Budget.

As always, the LPFA will operate solely on self-generated revenues. We are not requesting, and we have never received any funds from the State for our operations.

The proposed 2026 amount budgeted for operating revenues, excluding investment earnings is $2.67 million, which includes an increase of $45,804 over 2025, a 1.74% increase over 2025, primarily attributed to increases in anticipated Program Fees, resulting from the restructuring of one of our outstanding bond issues and from higher demand in the Authority's numerous loan and revolving fund programs. These funds are anticipated to be recurring revenues.

The amount budgeted for operating expenditures has increased by $45,804 accordingly, to provide for the continued funding of several vital projects and services and market increases, as well as to maintain a balanced budget. It also includes reallocation of several one-time expenses. As a result, you will note minimal overall increases to the proposed 2026 budget request.

The total expenditures, which includes operating expenditures and acquisitions requested for 2026 total approximately $2.998 million, a 1.57% increase, over the 2025 revenue request, excluding contingencies for Acquisitions and 1.55% with Acquisitions.

CELEBRATING 50 years 1974-2024

Honorable Glen Womack
Honorable Jack MacFarland
October 27, 2025

Here are a few brief highlights about the proposed 2026 budget:

- Overall **revenues** have increased by $45,804 primarily due to increases in Program Fees due to the prior bond restructuring and higher demand in our loan and revolving fund financing programs, along with higher market rates. Our various loan programs continue to provide interest savings to local government borrowers.

- Overall **expenses** have increased by $45,804, including providing for acquisition contingencies, as a result of the increase in revenues and providing for a balanced budget.

- The amount budgeted for **Total Personnel Services** increased by $71,603. $31,824 of this amount includes funding projected increases in related benefits, including unused Paid Time Off (PTO). $29,944 of this amount, 2.74% of 2025 salaries, will fund cost of living adjustments for current employees, with executive staff receiving lower cost of living adjustments. The remaining $10,000 of the salary adjustment amount will be allocated to restructure a vacant position for our new college planning center.

- The amount budgeted for total **Operating Services Expenses** has decreased by $72,299, in comparison to 2025, due to the elimination of one-time projects related to the Authority's 50th anniversary.

- The amount budgeted for **Professional Services** has increased by $46,500, or approximately 18.2% over 2025 to provide for additional marketing, graphics and communication services for program development as well as legal and compliance oversight services.

- The amount budgeted for "**Acquisitions and Major Repairs**" contingencies has not changed and remains at $35,000.

- The number of **authorized employees** remains at 14.

- The number of **funded employees** remains the same at 12.
  LPFA employees are all unclassified.

- LPFA employees are not considered State employees.

- We do not participate in the State retirement plan, but instead have a **defined contribution retirement plan**.

Honorable Glen Womack
Honorable Jack MacFarland
October 27, 2025

- LPFA employees do not participate in State Group Benefits and have no LPFA provided health insurance coverage during retirement. LPFA employees are eligible for Medicare.

- LPFA employees are not eligible for Social Security.

I have attached information about our recent bond financings and lower rate Economic Development programs and education financing activities. Our student loan division, the Louisiana Education Loan Authority (Lela), acts as a resource to students and parents throughout the state to provide information on applying for federal aid, scholarships, and access to lower cost supplemental financing to pay for college costs through our LelaCHOICE loan programs. Additionally, we continue to administer our existing Federal Family Education Loan Program (Ffelp) loan portfolio. We also provide a student loan refinancing program to help families in Louisiana ease their prior student loan debt burden by refinancing their student loans at a lower interest rate.

Please contact me if you have any questions or if you would like me to meet with you or your staff about our proposed 2026 Budget.

Very truly yours,

Patricia A. Dubroc

Patricia A. Dubroc

Enclosures

cc: Members, LPFA Board of Trustees

LPFA: 10/08/25

LOUISIANA PUBLIC FACILITIES AUTHORITY

On the motion of Trustee Malone, seconded by Trustee Groner, the following resolution was unanimously adopted:

A resolution approving the Annual Budget of the Louisiana Public Facilities Authority for Calendar Year 2026 and the submitting of the Annual Budget of the Louisiana Public Facilities Authority to the Joint Legislative Committee on the Budget; and providing for other matters with respect thereto.

WHEREAS, the Louisiana Public Facilities Authority (the "Authority") is a public trust and public corporation established by a private corporation for the benefit of the State of Louisiana (the "State") by a certain Indenture of Trust dated August 21, 1974 (the "Indenture of Trust"), under and pursuant to the provisions of the Louisiana Public Trust Act, Louisiana Revised Statutes 9:2341-2347 of 1950, as amended (the "Act"); and

WHEREAS, each year the Authority operates pursuant to a budget; and

WHEREAS, the Board of Trustees of the Authority desires to approve the Annual Budget attached hereto as Exhibit "A" for calendar year 2026; and

WHEREAS, pursuant to Act 915 of the 1999 Regular Session of the Louisiana Legislature ("Act 915"), the Authority is to submit its proposed annual operating budget to the Joint Legislative Committee on the Budget for its review and approval;

WHEREAS, it is now the desire of the Board of Trustees of the Authority to authorize and direct the submitting of the Authority's annual operating budget for 2026 to the Joint Legislative Committee on the Budget in accordance with Act 915;

NOW, THEREFORE, BE IT RESOLVED BY THE TRUSTEES OF THE LOUISIANA PUBLIC FACILITIES AUTHORITY:

SECTION 1. The Trustees, for and on behalf of the Authority, hereby approve the Annual Budget attached hereto as Exhibit "A" for calendar year 2026.

SECTION 2. The Trustees, for and on behalf of the Authority, hereby authorize and direct the Staff of the Authority to submit a copy of the Authority's annual operating budget for 2026, as approved pursuant to Section 1 hereof, no later than November 1, 2025, to the Joint Legislative Committee on the Budget in accordance with Act 915.

SECTION 3. The Chairman, Vice-Chairman, Secretary-Treasurer and any Assistant Secretary are hereby authorized and directed to do all things necessary to effectuate and implement the purpose and intent of this Resolution.

SECTION 4. This Resolution shall become effective upon its adoption.

Member	Yea	Nay	Absent	Abstaining
Ronald H. Bordelon	X			
Craig A. Cheramie	X			
David Groner	X			
Casey R. Guidry	X			
Dannye W. Malone	X			
Heather C. Songy			X	
Matthew T. Valliere	X			

This Resolution was declared adopted on this 8th day of October, 2025.

* * * *

(Other items of business not pertinent to the foregoing resolution may be found in the official minutes of the Board of Trustees of the Authority.)

Upon motion duly made, seconded and unanimously carried, the meeting was adjourned.

CERTIFICATE OF ASSISTANT SECRETARY

I, the undersigned, do hereby certify that I am an Assistant Secretary of the Board of Trustees of the Louisiana Public Facilities Authority (the "Authority"), a public trust duly organized and existing under and by virtue of the laws of the State of Louisiana, and in such capacity I have access to all records of the Authority.

I do hereby further certify that at a meeting of the Trustees of the Authority, duly called, held and convened, according to law, on the 8th day of October, 2025, a quorum being present and voting thereon, the above and foregoing Resolution was unanimously adopted and that said Resolution is a full true and correct copy of said Resolution as it appears on the records of the Authority and that the same has not been revoked or amended and is now in full force and effect.

IN WITNESS WHEREOF, I have hereunto set my hand and attached the seal of the Authority this 8th day of October, 2025.

LOUISIANA PUBLIC FACILITIES AUTHORITY

SEAL

By: Patricia A. Dubuc
Assistant Secretary

Louisiana Public Facilities Authority
Proposed Budget for 2026

As Proposed
Date and Time Printed **10-08-2025 5:28PM**

Account ID	State Object Class	Account	Combined 2025 Budget	Proposed 2026 Budget	Difference
		Operating Revenues			
50100		Financing Acceptance Fees	425,000	425,000	0
50150		Financing Application Fees	0	2,500	2,500
50250		Program Admin Fees - LPFA State Administered Programs	177,500	167,024	(10,476)
50260		Program Admin Fees-Student Loans	1,780,000	1,820,750	40,750
		Program Fees - General	0	0	0
50300		Multifamily & Other Program Fees	35,000	32,530	(2,470)
		Interest Income-LPFA Loan Programs: Bond Bank & Rural	210,000	225,500	15,500
58800		Miscellaneous Income	0	0	0
		Total Operating Revenues	**2,627,500**	**2,673,304**	**45,804**
			without interest income:		1.74%
			with interest income:		1.55%
		Operating Expenses			
72200	2700	Advertising	20,000	20,000	0
72400	2500	Auto Mileage-Ex Staff-In State	11,000	10,000	(1,000)
72425	2600	Auto Mileage-ExStaff-Out State	200	1,000	800
72450	2520	Auto Mileage-RegStaff-In State	19,000	17,000	(2,000)
72475	2620	Auto Mileage-RegStaff-OutState	400	400	0
72485	2530	Auto Mileage-Trustee-In State	8,000	8,000	0
72490	2630	Auto Mileage-Trustee-Out State	0	0	0
72500	3000	Unreimbursed Project Costs	400	0	(400)
	3000	DNR Program Fees	15,000	12,000	(3,000)
72600	3000	Bank Charges	5,000	5,000	0
72800	2700	Outreach & Program Promotion & Development	105,000	105,000	0
72900	3000	Unreimbursed Progr Issua Costs	400	400	0
73000	3460	Casual Labor	10,000	39,000	29,000
73900	3100	Copier Expense	6,500	8,000	1,500
74300	2900	Freight and Shipping	16,000	16,000	0
74400	3030	Depreciation Expense-Equipment	7,000	2,000	(5,000)
74410	3030	Depreciation Exp-IT Equipment	11,400	6,800	(4,600)
74500	3020	Depreciation Exp-Improvements	400	1,500	1,100
74600	3040	Depreciation Exp-Software	2,000	0	(2,000)
74700	2890	Dues and Membership	22,000	22,000	0
75100	3400	Fees - Accounting Services	3,500	2,000	(1,500)
75110	3400	Fees - Accounting Audits	41,000	40,000	(1,000)
75200	3430	Fees - Legal	45,000	55,000	10,000
76200	3460	Fees -Program Dev. Services- Design/ Web/ Media /Third Party	155,000	165,000	10,000
77500	3000	Grants\Technical Assistance\Advocacy	125,000	100,000	(25,000)
77700	2380	Insurance - Employee Benefits	304,900	306,700	1,800
78100	2760	Insurance Surety and D&O	33,000	30,000	(3,000)
78200	2740	Insurance - Property/Liability	10,000	10,000	0
78400	2730	Insurance - Worker's Comp	5,000	5,000	0
79000	2920	Internet Service Costs/ Backup Testing	60,000	50,000	(10,000)
79100	3100	Miscellaneous	750	750	0
79300	3100	Office Expenses- IT & Non- IT Equipment;Supplies	50,000	50,000	0
79301	2875	Office Exp - Software	25,000	25,000	0
80000	2900	Postage Expenses	5,000	5,000	0
80100	2710	Printing and Binding	65,000	40,000	(25,000)
80200	2890	Publications/Reports	750	750	0
81100	2830	Rent - Office	190,000	200,000	10,000
81101	2830	Rent - Storage Facility	12,000	12,000	0
81400	2800	Repairs and Maintenance-Non IT	4,000	4,000	0
81500	2820	Repairs & Maintenance-IT	58,000	55,301	(2,699)
82000	2340	Retirement Plan Expenses	120,576	124,600	4,024
82200	2130	Salaries-Regular	1,094,059	1,134,003	39,944
82400	2400	Salaries-Unused Vacation&Sick	40,000	75,000	35,000

Account ID	State Object Class	Account		Combined 2025 Budget	Proposed 2026 Budget	Difference
82450	2400	Salaries-PTO Carryover		20,000	10,000	(10,000)
82700	2200	Wages		665	0	(665)
82800	2210	Student Labor		20,500	21,000	500
82900	2890	Subscriptions		5,000	5,000	0
84900	2360	Payroll Taxes-FICA Medicare		15,000	16,000	1,000
84950	2371	Payroll Taxes-Unemployment		700	700	0
85000	3000	Taxes and Licenses		50	50	0
85600	2910	Telephone Expenses		22,000	20,000	(2,000)
86000	2500	Travel-Exec Staff-In State		4,600	4,600	0
86050	2600	Travel-Exec Staff-Out of State		1,000	1,000	0
86100	2520	Travel-Reg Staff-In State		10,000	10,000	0
86150	2620	Travel-Reg Staff-Out of State		750	750	0
86200	2510	Travel-Conf & Conven-In State		28,000	25,000	(3,000)
86250	2610	Travel-Conf & Conven-Out State		48,000	51,000	3,000
86300	2530	Travel-Trustee-In State		4,000	4,000	0
86350	2630	Travel-Trustee-Out of State		10,000	10,000	0
86400	2220	Trustee Per Diem		20,000	20,000	0
		Total Operating Expenses		**2,917,500**	**2,963,304**	**45,804**
						1.57%
		Income from Operations		**(290,000)**	**(290,000)**	**(0)**
		Nonoperating Revenues (Expenses)				
50400		Interest Income		325,000	325,000	0
54700		Gain/Loss-Realized/Unrealized		0	0	0
		Net Income		**35,000**	**35,000**	**(0)**
		Acquisitions:				
	4450	Capitalized Software		0	0	0
	4451	Capitalized Hardware		15,000	15,000	0
	4453	Software		0	0	0
	4454	Hardware		10,000	10,000	0
	4456	Software Less Than $1000		0	0	0
	4457	Hardware Less Than $1000		0	0	0
	4490	Office Equipment		10,000	10,000	0
	4491	Capitalized Office Equipment		0	0	0
	4492	Office Equipment Less Than $1000		0	0	0
	4610	Major Repairs - Buildings		0	0	0
		Total Acquisitions:		**35,000**	**35,000**	**0**
						0.00%
		Total Expenditures in BR Forms:		**2,952,500**	**2,998,304**	**45,804**

1.55%

Stacye Bradford

From: Tricia Dubroc <dubroc@lela.org> on behalf of Tricia Dubroc
Sent: Tuesday, October 21, 2025 5:43 PM
To: Stacye Bradford
Cc: Martin Walke; Joni Leggio; Amy Tuminello
Subject: 2026 Proposed LPFA Budget as approved by the Board of Trustees 10-8-25
Attachments: Final Proposed 2026 LPFA Budget As approved by the Board of Trustees 10-8-25.pdf

Hi Stacye,

Attached please find a copy of the proposed LPFA 2026 Budget as approved by the Board on 10-8-25 (with the approved requested & amended change) to include as an exhibit to the resolution.

Thank you!

Tricia

Tricia A. Dubroc
Lpfa-Lela President & CEO
Cell: 225-405-0511
Office Toll-free: 800-228-4755
www.lpfa.com
www.lela.org

BUDGET REQUEST

BR-0
(8/22)

Year Ending December 31, 2026

NAME OF DEPARTMENT: Louisiana Public Facilities Authority

ADDRESS: 2237 South Acadian Thruway Suite 650
Baton Rouge, LA

BUDGET UNIT:_____

SCHEDULE NUMBER:_____

ZIP CODE: 70808

FAX NUMBER: (225) 923-0021

TELEPHONE NUMBER: (225) 923-0020

AGENCY WEB ADDRESS: lpfa.com and lela.org

TO THE OFFICE OF PLANNING AND BUDGET:

THE ACCOMPANYING FORMS, STATEMENTS AND EXPLANATIONS HAVE BEEN APPROVED BY US AND ARE COMPRISED AS FOLLOWS:

OPERATIONAL PLAN PACKAGE:	NUMBERED PAGE 1 THROUGH PAGE_____
EXISTING OPERATING BUDGET PACKAGE:	NUMBERED PAGE 1 THROUGH PAGE_____
CONTINUATION BUDGET PACKAGE:	NUMBERED PAGE 1 THROUGH PAGE_____
TECHNICAL/OTHER ADJUSTMENT BUDGET PACKAGE:	NUMBERED PAGE 1 THROUGH PAGE_____
NEW/EXPANDED BUDGET REQUEST PACKAGE:	NUMBERED PAGE 1 THROUGH PAGE_____
TOTAL REQUEST SUMMARY PACKAGE:	NUMBERED PAGE 1 THROUGH PAGE_____
ADDENDA TO REQUEST (WHERE APPLICABLE)	NUMBERED PAGE 1 THROUGH PAGE_____

WE HEREBY CERTIFY THAT THE STATEMENTS AND FIGURES ON THE ACCOMPANYING FORMS ARE TRUE AND CORRECT TO THE BEST OF OUR KNOWLEDGE.

HEAD OF DEPARTMENT: _____

PRINTED NAME/TITLE: President and CEO

DATE:

EMAIL ADDRESS: dubroc@lpfa.com

HEAD OF BUDGET UNIT: _____

PRINTED NAME/TITLE: President and CEO

EMAIL ADDRESS: dubroc@lpfa.com

PROGRAM CONTACT PERSON: Tricia A. Dubroc

TITLE: President and CEO

TELEPHONE NUMBER: (225) 923-0020

EMAIL ADDRESS: dubroc@lpfa.com

FINANCIAL CONTACT PERSON: Tricia A. Dubroc

TITLE: President and CEO

TELEPHONE NUMBER: (225) 923-0020

EMAIL ADDRESS: dubroc@lpfa.com

TABLE OF CONTENTS

BR-TC
(08/20)

BUDGET REQUEST DOCUMENTS:

BR-0	X
BR-TC	X
BR-1	X
BR-2	X
BR-6	X
BR-6A	N/A
BR-6B	X
BR-6S	N/A
BR-7	N/A
BR-8	X
BR-9E	N/A
BR-10	X
BR-12	N/A
BR-13	X
BR-14A	X
BR-14B	N/A
BR-15A	X
BR-15B	X
BR-15C	X
BR-15D	X
BR-15E	X
BR-15F	X
BR-15G	X
BR-15H	X
BR-15I	X
BR-15J	X
BR-15K	X

BR-16A	X
BR-16B	X
BR-16C	X
BR-16D	X
BR-17A	X
BR-18	X
BR-18A	N/A
BR-18B	N/A
BR-19	X
BR-19A	N/A
BR-19B	N/A
BR-20A	X
BR-20B	N/A
BR-20BX	N/A
BR-20C	N/A
BR-20D	N/A
BR-21A	N/A
BR-SUPP	N/A

CB-0	
CB-1	
CB-2	
CB-4	
CB-5	
CB-6	
CB/BR-	X
CB-7	
CB-8	
CB/BR-20A	
CB/BR-21A	
T/OAP-0	
T/OAP-1A	
T/OAP-2A	
NE-0	
NE-DS	
NE-AS	
NE-A	
NE-B	
NE-C	
TR-0	
TR-SUMM1, 1A, 1B	
TR-SUMM2, 2A, 2B	
OPERATION PLAN	

ADDENDA TO REQUEST:

IT-0	
SUNSET REVIEW	
WFC-1	
WFC-2	
WFC-3	
CHILD-DT	
CHILD-DS	
CHILD-DC	
CHILD-AS	
CHILD-AC	
CHILD-1	
CHILD-2	

PLEASE PLACE AN "X" IN THE SPACE PROVIDED IF YOUR BUDGET REQUEST INCLUDES THE INDICATED FORM.

PLEASE PLACE "N/A" IN THE SPACE PROVIDED IF YOUR BUDGET REQUEST DOES NOT INCLUDE THE INDICATED FORM BECAUSE IT IS NOT APPLICABLE.

SUMMARY STATEMENT OF MEANS OF FINANCING FOR YEARS SHOWN

BR-1
(8/20)

LINE NO.	MEANS OF FINANCING	PRIOR YEAR ACTUAL 2024 (no negatives)	EXISTING OPERATING BUDGET 2025 (no negatives)	TOTAL REQUEST 2026 (no negatives)	OVER/UNDER EXISTING OPERATING BUDGET	PERCENT CHANGE
1	FEES & SELF-GENERATED REVENUES	$ 4,228,716	$ 2,952,500	$ 2,998,304	$ 45,804	1.55%
2						
3	**TOTAL MEANS OF FINANCING**	**$ 4,228,716**	**$ 2,952,500**	**$ 2,998,304**	**$ 45,804**	**1.55%**

Note: Column totals on BR-1 from should equal corresponding Column totals on BR-2 form.

SUMMARY STATEMENT OF EXPENDITURES FOR YEARS SHOWN

BR-2
(8/22)

LINE NO.	CATEGORY OF EXPENDITURE	PRIOR YEAR ACTUAL 2024 (no negatives)	EXISTING OPERATING BUDGET 2025 (no negatives)	TOTAL REQUEST 2026 (no negatives)	OVER/UNDER EXISTING OPERATING BUDGET	PERCENT CHANGE
1	PERSONAL SERVICES:					
2	Salaries	$ 943,379	$ 1,094,059	$ 1,134,003	$ 39,944	3.65%
3	Other Compensation	$ 8,000	$ 41,165	$ 41,000	$ (165)	-0.40%
4	Related Benefits	$ 484,010	$ 501,176	$ 533,000	$ 31,824	6.35%
5	**TOTAL PERSONAL SERVICES**	**$ 1,435,389**	**$ 1,636,400**	**$ 1,708,003**	**$ 71,603**	**4.38%**
6	OPERATING EXPENSES:					
7	Travel	$ 56,605	$ 144,950	$ 142,750	$ (2,200)	-1.52%
8	Operating Services	$ 456,107	$ 824,400	$ 752,801	$ (71,599)	-8.68%
9	Supplies	$ 34,421	$ 57,250	$ 58,750	$ 1,500	2.62%
10	**TOTAL OPERATING EXPENSES**	**$ 547,133**	**$ 1,026,600**	**$ 954,301**	**$ (72,299)**	**-7.04%**
11	**PROFESSIONAL SERVICES**	**$ 107,310**	**$ 254,500**	**$ 301,000**	**$ 46,500**	**18.27%**
12	OTHER CHARGES:					
13	Other Charges	N/A	N/A	N/A	N/A	N/A
14	Debt Service	N/A	N/A	N/A	N/A	N/A
15	Interagency Transfers	N/A	N/A	N/A	N/A	N/A
16	TOTAL OTHER CHARGES	**$ -**	**$ -**	**$ -**	**$ -**	N/A
17	ACQUISITIONS & MAJOR REPAIRS:					
18	Acquisitions	$ -	$ 35,000	$ 35,000	$ -	0.00%
19	Major Repairs	$ -	$ -	$ -	$ -	N/A
20	**TOTAL ACQUISITIONS & MAJOR REPAIRS**	**$ -**	**$ 35,000**	**$ 35,000**	**$ -**	**0.00%**
21	UNALLOTTED	N/A	N/A	N/A	N/A	N/A
22	**TOTAL EXPENDITURES & REQUEST**	**$ 2,089,832**	**$ 2,952,500**	**$ 2,998,304**	**$ 45,804**	**1.55%**
23	AUTHORIZED T. O. FRE POSITIONS					
24	Classified	-	-	-	-	0.00%
25	Unclassified	14	14	14	-	0.00%
26	**TOTAL AUTHORIZED T. O. FTE POSITIONS**	**14**	**14**	**14**	**-**	**0.00%**
27	TOTAL AUTHORIZED OTHER CHARGES POSITION	-	-	-	-	0.00%
28	TOTAL NON-T.O. FTE POSITIONS**	-	-	-	-	0.00%

* Authorized Other Charges Positions are those reported under Objects 3670, 3680, and 3681.
** Non-T.O. FTE Positions are those reported under Object 2200 (exclude WAEs).

Note: There should be no **NEGATIVE** numbers in the following columns: PRIOR YEAR ACTUAL, EXISTING OPERATING BUDGET, AND TOTAL REQUEST.

MEANS OF FINANCING OTHER THAN GENERAL FUND DIRECT

BR-6
(8/22)

REVENUE OBJECT	SOURCE (FEDERAL, INTERAGENCY TRANSFERS, ETC.) * Give the Legal Citation Authorizing These Funds and Describe Fully Their Purpose and Use.	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET	DETAIL SHEET NOS.
	SELF-GENERATED REVENUES					
	Financing Acceptance Fees	$ 842,397	$ 425,000	$ 425,000	$ -	
	Financing Application Fees	$ 2,000	$ -	$ 2,500	$ 2,500	
	Program Administrative Fees	$ 2,203,732	$ 1,957,500	$ 1,987,774	$ 30,274	
	Program Fees - General	$ 2,002	$ -	$ -	$ -	
	Multifamily and other Program Fees	$ 21,036	$ 35,000	$ 32,530	$ (2,470)	
	Interest Income - Loan Programs	$ 276,770	$ 210,000	$ 225,500	$ 15,500	
	Interest Income	$ 490,577	$ 325,000	$ 325,000	$ -	
	Program Investment Earnings	$ -	$ -	$ -	$ -	
	Miscellaneous Income	$ 2,356	$ -	$ -	$ -	
	Realized and unrealized gain or loss on investments	$ 387,846	$ -	$ -	$ -	
	TOTAL SELF-GENERATED REVENUES	**$ 4,228,716**	**$ 2,952,500**	**$ 2,998,304**	**$ 45,804**	
	PUBLIC TRUST ACT: LA. R.S. 9:2341-47 The Louisiana Public Facilities Authority (LPFA) is a financing authority created as a public trust and public corporation by a Louisiana corporation, pursuant to an Indenture of Trust. The State of Louisiana is the beneficiary of the LPFA trust. LPFA was established to benefit the State of Louisiana and its citizens through the issuance of taxable and tax-exempt bonds as well as through other means of public service and economic development. The purposes of the LPFA are to promote, encourage and further the accomplishment of all activities beneficial to the state and which have a public purpose.					

*** NOTE: Each individual grant, interagency transfer, self-generated revenue source, etc. must be listed separately, and a BR-6A and BR-6B detail sheet must be completed for each separate item listed on the BR-6**

Financing Acceptance Fees

The Authority requires a financing acceptance fee usually equal to one-twentieth of one percent of the face amount of issued bonds less the financing application fee. The financing acceptance fee covers general administration expenses incurred by the Authority. This fee is due upon the closing of a bond issue and is recorded as revenue at such time.

Financing Application Fees

by the Authority's Board of Trustees. In December 2025, the LPFA Board of Trustees waived collecting any Financing Application fees in conjunction with the LPFA's 50th anniversary. Fees are anticipated to resume in 2026 at this time.

Program Administrative Fees

The Authority acts as both the issuer and administrator for certain bond programs. The Authority is compensated as administrator through a fee usually based upon a percentage of either the outstanding bonds or assets of the program or an agreed upon fee arrangement. The percentages vary from one-tenth of one percent to one percent. The fee is assessed to cover program administrative costs incurred by the Authority.

Multi-family and Other Program Fees

The Authority assesses an annual issuer fee on all multi-family bond issues. The fee is typically based upon a percentage of the outstanding bond principal balance as of January 1 of each year. The percentage usually is either one-twentieth of one percent for pre-1985 issues or one-tenth of one percent for issues thereafter. The Authority also collects fees and interest from its other programs such as the Bond Bank and Rural Development Loan Programs and related structured revolving loan partnership programs. These fees cover general administration expenses incurred by the Authority.

Interest Income

The Authority receives interest income from the investment of Authority assets.

Program Investment Earnings

Program Investment Earnings consist primarily of residual funds of retired program bond issues. Residual proceeds represent cash and investment balances of a program bond issue that remain after the extinguishment of all obligations, including applicable arbitrage rebate to the federal government. The residuals are due to the Authority unless the program issue's Indenture of Trust identifies another recipient. The residual funds are recognized as income to the Authority upon the termination of the program bond issue's Indenture of Trust. All residuals from project financings are paid to the project borrower.

Line No.	DEPARTMENT OF BR-8 Tracking Sheet Program:		PRIOR YEAR ACTUAL 2024 (NO NEGATIVE NUMBERS IN THIS COLUMN)	EXISTING OPERATING BUDGET 2025 (NO NEGATIVE NUMBERS IN THIS COLUMN)	TOTAL REQUEST 2026 (NO NEGATIVE NUMBERS IN THIS COLUMN)	OVER/UNDER EXISTING OPERATING BUDGET
1	General Fund		-	-	-	
2	Self-Generated Revenues:					
3		Financing Acceptance Fees	842,397	425,000	425,000	-
4		Financing Application Fees	2,000	-	2,500	2,500
5		Program Administrative Fees	2,203,732	1,957,500	1,987,774	30,274
6		Program Fees - General	2,002	-	-	-
7		Multifamily and Other Program Fees	21,036	35,000	32,530	(2,470)
8		Interest Income - Loan Programs	276,770	210,000	225,500	15,500
9		Interest Income	490,577	325,000	325,000	-
10		Program Investment Earnings	-	-	-	-
11		Miscellaneous Income	2,356	-	-	-
12		Realized and unrealized gain or loss on investments	387,846	-	-	-
13						
14						
15	**TOTAL REVENUE**		**4,228,716**	**2,952,500**	**2,998,304**	**45,804**
16						
17	Classified		N/A	N/A	N/A	N/A
18	Unclassified		14	14	14	-
19	TOTAL AUTHORIZED T. O. FTE POSITIONS		14	14	14	-
20	TOTAL AUTHORIZED OTHER CHARGES POSITIONS*		-	-	-	-
21	TOTAL NON-T.O. FTE POSITIONS**		-	2	2	-
22	**TOTAL POSITION CONTROL**		14	14	14	-
23						
24	2100	Salaries-Classified - Regular	N/A	N/A	N/A	N/A
25	2110	Salaries-Classified - Overtime	N/A	N/A	N/A	N/A
26	2120	Salaries-Classified - Termination	N/A	N/A	N/A	N/A
27	2130	Salaries-Unclassified - Regular	943,379	1,094,059	1,134,003	39,944
28	2140	Salaries-Unclassified - Overtime	N/A	N/A	N/A	N/A
29	2150	Salaries-Unclassified - Termination	N/A	N/A	N/A	N/A
30		TOTAL SALARIES	**943,379**	**1,094,059**	**1,134,003**	**39,944**
31						
32	2200	Other Compensation - Wages	-	665	-	(665)
33	2210	Other Compensation - Students	-	20,500	21,000	500
34	2221	Compensation Board of Trustees	8,000	20,000	20,000	-
35	2230	Evening Instruction	N/A	N/A	N/A	N/A
36		TOTAL OTHER COMPENSATION	**8,000**	**41,165**	**41,000**	**(165)**
37						
38	2300	Retirement - State	N/A	N/A	N/A	N/A
39	2310	Retirement - School Employees	N/A	N/A	N/A	N/A
40	2320	Retirement - Teachers	N/A	N/A	N/A	N/A
41	2330	Retirement - School Lunch	N/A	N/A	N/A	N/A
42	2340	Retirement - Other	134,025	120,576	124,600	4,024
43	2350	FICA Tax - State	N/A	N/A	N/A	N/A
44	2360	Medicare Tax - State	14,256	15,000	16,000	1,000
45	2370	Unemployment Taxes	261	700	700	-
46	2380	Group Insurance - State	223,974	304,900	306,700	1,800
47	2400	Other Related Benefits	111,494	60,000	85,000	25,000
48	2410	Taxable Fringe Benefits	-	-	-	-
49		TOTAL RELATED BENEFITS	**484,010**	**501,176**	**533,000**	**31,824**
50						
51	TOTAL PERSONNEL SERVICES		**1,435,389**	**1,636,400**	**1,708,003**	**71,603**
52						
53	2500	In State Travel - Administrative	3,591	15,600	14,600	(1,000)
54	2510	In State Travel - Conferences	10,598	28,000	25,000	(3,000)
55	2520	In State Travel - Field Travel	6,847	29,000	27,000	(2,000)
56	2530	In State Travel - Board Members	6,786	12,000	12,000	-
57	2550	In State IT Travel / Training	-	-	-	-
58	2600	Out of State Travel - Administrative	463	1,200	2,000	800
59	2610	Out of State Travel - Conferences	28,206	48,000	51,000	3,000
60	2620	Out of State Travel - Field Travel	114	1,150	1,150	-
61	2630	Out of State Travel - Board Members	-	10,000	10,000	-
62	2650	Out of State IT Travel / Training	-	-	-	-
63						
64	TOTAL TRAVEL		**56,605**	**144,950**	**142,750**	**(2,200)**
65						
66	2700	Advertising	111,104	125,000	125,000	-
67	2710	Printing	13,700	65,000	40,000	(25,000)
68	2720	Insurance - Automotive	N/A	N/A	N/A	N/A
69	2730	Insurance - Workman's Compensation	2,775	5,000	5,000	-
70	2740	Insurance - Fire & Extended Coverage	6,240	10,000	10,000	-
71	2750	Insurance -Malpractice	N/A	N/A	N/A	N/A
72	2760	Insurance - Other	25,622	33,000	30,000	(3,000)
73	2770	Maintenance of Prop & Equip - Auto	N/A	N/A	N/A	N/A
74	2780	Maintenance of Prop & Equip - Other	N/A	N/A	N/A	N/A
75	2790	Maintenance of Buildings	N/A	N/A	N/A	N/A
76	2791	Maintenance - Pest Control	N/A	N/A	N/A	N/A
77	2792	Maintenance - Waste Disposal	N/A	N/A	N/A	N/A
78	2800	Maintenance of Equipment	-	4,000	4,000	-
79	2810	Maintenance - Janitorial / Custodial	N/A	N/A	N/A	N/A
80	2811	Maintenance of Grounds	N/A	N/A	N/A	N/A

Line No.	DEPARTMENT OF BR-8 Tracking Sheet Program:		PRIOR YEAR ACTUAL 2024 (NO NEGATIVE NUMBERS IN THIS COLUMN)	EXISTING OPERATING BUDGET 2025 (NO NEGATIVE NUMBERS IN THIS COLUMN)	TOTAL REQUEST 2026 (NO NEGATIVE NUMBERS IN THIS COLUMN)	OVER/UNDER EXISTING OPERATING BUDGET
81	2820	Maintenance of Data Processing Equipment	29,648	58,000	55,301	(2,699)
82	2825	Maintenance of Data Processing Software	-	-	-	-
83	2830	Rentals - Buildings	180,038	202,000	212,000	10,000
84	2840	Rentals - Equipment	N/A	N/A	N/A	N/A
85	2850	Rentals - Data Processing Equipment	N/A	N/A	N/A	N/A
84	2870	Rentals - Other	N/A	N/A	N/A	N/A
85	2875	Data Processing - Licensing Software	18,000	25,000	25,000	-
86	2880	Internet Provider Costs	19,034	60,000	50,000	(10,000)
87	2890	Dues & Subscriptions	16,740	27,750	27,750	-
88	2900	Mail, Delivery & Postage	8,164	21,000	21,000	-
89	2910	Telephone - Services	14,456	$22,000	$20,000	(2,000)
90	2930	Telephone - Other Comm Services	N/A	N/A	N/A	N/A
91	2935	Data Processing - Contract Services	N/A	N/A	N/A	N/A
92	2940	Utilities - Gas	N/A	N/A	N/A	N/A
93	2950	Utilities - Electricity	N/A	N/A	N/A	N/A
94	2960	Utilities - Water	N/A	N/A	N/A	N/A
95	2970	Utilities - Other	N/A	N/A	N/A	N/A
96	2990	Lab Fees	N/A	N/A	N/A	N/A
97	2991	Operating Services - Security	N/A	N/A	N/A	N/A
98	3000	Miscellaneous	9,409	145,850	117,450	(28,400)
99	3010	Depreciation Expense-Building	N/A	N/A	N/A	N/A
100	3020	Depreciation Expense-Improvements	1,177	400	1,500	1,100
101	3030	Depreciation Expense-Equipment	-	18,400	8,800	(9,600)
102	3040	Depreciation Expense-Software	-	2,000	-	(2,000)
103	3090	Credit Card Transaction Fees	N/A	N/A	N/A	N/A
104	3091	Credit Card Discount Fees	N/A	N/A	N/A	N/A
105						
106	TOTAL OPERATING SERVICES		**456,107**	**824,400**	**752,801**	**(71,599)**
107						
108						
109	3100	Office Supplies	34,421	57,250	58,750	1,500
110	3120	Computer Supplies	N/A	N/A	N/A	N/A
111	3130	Clothing & Uniforms	N/A	N/A	N/A	N/A
112	3140	Medical Supplies	N/A	N/A	N/A	N/A
113	3160	Food Supplies	N/A	N/A	N/A	N/A
114	3170	Automotive Supplies	N/A	N/A	N/A	N/A
115	3180	Operating Supplies - Other	N/A	N/A	N/A	N/A
116	3190	Bldgs, Grounds & Gen Plant Supplies	N/A	N/A	N/A	N/A
117	3200	Household Supplies	N/A	N/A	N/A	N/A
118	3300	Repair & Maintenance Supplies - Auto	N/A	N/A	N/A	N/A
119	3310	Repair & Maintenance Supplies - Other	N/A	N/A	N/A	N/A
120	3320	Software	N/A	N/A	N/A	N/A
121	3330	Voc-Tech School Buildings Supplies	N/A	N/A	N/A	N/A
122	3340	Stores Increase	N/A	N/A	N/A	N/A
123						
124	TOTAL SUPPLIES		**34,421**	**57,250**	**58,750**	**1,500**
125						
126	TOTAL OPERATING SERVICES		**547,133**	**1,026,600**	**954,301**	**(72,299)**
127						
128	3400	Accounting & Auditing	29,710	44,500	42,000	(2,500)
129	3410	Management Consulting	N/A	N/A	N/A	N/A
130	3420	Engineering & Architectural	N/A	N/A	N/A	N/A
131	3430	Legal	34,812	45,000	55,000	10,000
132	3440	Medical	N/A	N/A	N/A	N/A
133	3460	Other Professional Services	42,788	165,000	204,000	39,000
134	3470	Other Professional Travel	N/A	N/A	N/A	N/A
135	3471	Professional Travel	N/A	N/A	N/A	N/A
136						
137	TOTAL PROFESSIONAL SERVICES		**107,310**	**254,500**	**301,000**	**46,500**
138						
139	3650	Other Charges	0	0	0	0
140	3670	Other Charges-Salaries-Classified	0	0	0	0
141	3680	Other Compensation	0	0	0	0
142	3690	Related Benefits	0	0	0	0
143	3700&3710	Travel	0	0	0	0
144	3720	O/C - Operating Services	0	0	0	0
145	3730	O/C - Supplies	0	0	0	0
146	3735&3780	Other Charges	0	0	0	0
147	3740	O/C - Professional Services	0	0	0	0
148	3750	O/C - Acquisitions / Major Repairs	0	0	0	0
149	3750 & 3770	Major Repairs	0	0	0	0
150	3840	Other Charges-Client Payments Section 110	0	0	0	0
151						
152	TOTAL OTHER CHARGES		0	0	0	0
153						
154	4800-4899	Debt Service				
155	4900	IAT - Commodities & Services	0	0	0	0
156	4940	IAT - Transfer of Funds	0	0	0	0
157	4960	IAT - Printing	0	0	0	0
158	4970	IAT - Data Processing	0	0	0	0

Line No.	DEPARTMENT OF BR-8 Tracking Sheet Program:		PRIOR YEAR ACTUAL 2024 (NO NEGATIVE NUMBERS IN THIS COLUMN)	EXISTING OPERATING BUDGET 2025 (NO NEGATIVE NUMBERS IN THIS COLUMN)	TOTAL REQUEST 2026 (NO NEGATIVE NUMBERS IN THIS COLUMN)	OVER/UNDER EXISTING OPERATING BUDGET
159	4980	IAT - Insurance	0	0	0	0
160	5000	IAT - Other Maintenance	0	0	0	0
161	5010	IAT - Rentals	0	0	0	0
162	5020	IAT - Dues & Subscriptions	0	0	0	0
163	5030	IAT - Postage	0	0	0	0
164	5040	IAT - Telephone & Telegraph	0	0	0	0
165	5050	IAT - Utilities	0	0	0	0
166	5080	IAT - Laboratory Fees	0	0	0	0
167	5110	IAT - Office Supplies	0	0	0	0
168	5140	IAT - Automotive Supplies	0	0	0	0
169	5150	IAT - Other Operating Services	0	0	0	0
170						
171	TOTAL INTERAGENCY TRANSFER		0	0	0	0
172						
173	TOTAL O/C & IAT		0	0	0	0
174						
175	4400	Land				
176	4410	Buildings				
177	4420	Capitalized Automobile => $5000	0	0	0	0
178	4440	Equipment $1000 - $4999	0	0	0	0
179	4441	Equipment < $1000	0	0	0	0
180	4442	Equipment => $5000	0	0	0	0
181	4450	Capitalized Computer Software => $5000	0	0	0	0
182	4451	Capitalized Computer Hardware => $5000	0	15,000	15,000	0
183	4452	Capitalized Data Comm Facilities => $5000	0	0	0	0
184	4453	Software $1000 - $4999	0	0	0	0
185	4454	Hardware $1000 - $4999	0	10,000	10,000	0
186	4455	Data Comm Facilities $1000 - $4999	0	0	0	0
187	4456	Software < $1000	0	0	0	0
188	4457	Hardware < $1000	0	0	0	0
189	4458	Data Comm Facilities < $1000	0	0	0	0
190	4470	Household	0	0	0	0
191	4480	Medical	0	0	0	0
192	4490	Office Equipment $1000 - $4999	0	10,000	10,000	0
193	4491	Capitalized Office Equipment => $5000	0	0	0	0
194	4492	Office Equipment < $1000	0	0	0	0
195	4512	Library Reference < $1000	0	0	0	0
196	4520	Boats $1000 - $4999	0	0	0	0
197	4521	Capitalized Boats => $5000	0	0	0	0
198	4522	Boats < $1000	0	0	0	0
199	4530	Communications $1000 - $4999	0	0	0	0
200	4531	Capitalized Communications => $5000	0	0	0	0
201	4532	Communications < $1000	0	0	0	0
202	4540	Other Acquisitions $1000 - $4999	0	0	0	0
203	4541	Capitalized Other Acquisitions => $5000	0	0	0	0
204	4542	Other Acquisitions < $1000	0	0	0	0
205						
206	TOTAL ACQUISITIONS		0	35,000	35,000	0
207						
208	4610	Major Repair - Building	0	0	0	0
209	4620	Major Repair - Auto	0	0	0	0
210	4640	Major Repair - Boats	0	0	0	0
211	4650	Major Repair - Aircraft	0	0	0	0
212	4740	Major Repair - Other	0	0	0	0
213						
214	TOTAL MAJOR REPAIR		0	0	0	0
215						
216	TOTAL ACQUISITION & MAJOR REPAIR		0	35,000	35,000	0
217						
218	**TOTAL EXPENDITURES**		2,089,832	2,952,500	2,998,304	45,804
219						

* Authorized Other Charges Positions are those reported under Objects 3670, 3680, and 3681.
** Non-T.O. FTE Positions are those reported under Object 2200 (exclude WAEs).

SCHEDULE OF WAGES AND STUDENT LABOR

BR-10
(8/22)

Title of Position (Indicate if Student or Wages) (List by Program)	Detailed Explanation for Existing Operating Budget	Prior Year Actual Expend-itures 2024	Existing Operating Budget 2025			Total Request 2026		
			Hourly Rate of Pay	No. of Hours Employ.	Amount	Hourly Rate of Pay	No. of Hours Employ.	Amount
1 Waged Worker	Performs duties and responsibilities for both programs.	$ -	$ -	0	$ -	$ -	0	$ -
2 Student Worker- Graduate Ethan Rainach	Performs duties and responsibilities for both programs.	$ -	$ 20.00	1,050	$ 21,000	$ 20.00	1,050	$ 21,000
Total Positions 3								
TOTAL WAGES AND STUDENT LABOR		**$ -**		**1,050**	**$ 21,000**		**1,050**	**$ 21,000**

COMPENSATION OF BOARD OR COMMISSION MEMBERS (TRUSTEES) (2221)

BR-13
(8/22)

Name of Member	Statutory Authority for Payment	No. of Per Diem Days	Per Diem Rate	What Other Expenses Are Paid With The Exception Of Travel? (Itemize Type and Amount)	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
Craig Cheramie	La R.S. 9:2343(A)	20	$200 per day	None	$ 1,200	$ 5,000	$ 4,000	$ (1,000)
Ronald H. Bordelon	La R.S. 9:2343(A)	20	$200 per day	None	$ 1,400	$ 5,000	$ 4,000	$ (1,000)
Matthew T. Valliere	La R.S. 9:2343(A)	12	$200 per day	None	$ -	$ 2,000	$ 2,400	$ 400
David W. Groner	La R.S. 9:2343(A)	12	$200 per day	None	$ 1,600	$ 2,000	$ 2,400	$ 400
Danny W. Malone	La R.S. 9:2343(A)	12	$200 per day	None	$ 1,200	$ 2,000	$ 2,400	$ 400
Casey R. Guidry	La R.S. 9:2343(A)	12	$200 per day	None	$ 1,000	$ 2,000	$ 2,400	$ 400
Heather C. Songy	La R.S. 9:2343(A)	12	$200 per day	None	$ 1,600	$ 2,000	$ 2,400	$ 400
						$ -	$ -	$ -
TOTAL COMPENSATION					**$ 8,000**	**$ 20,000**	**$ 20,000**	**$ -**

SCHEDULE OF TRAVEL EXPENSE (25; 26) DETAIL

BR-14A
(8/20)

OBJECT CLASS	LIST BY PROGRAM	DESTINATION	PURPOSE OF TRAVEL	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026
	IN STATE TRAVEL:					
2500	Administrative	Statewide	To promote, encourage and further the accomplishment of all activities	$ 3,591	$ 15,600	$ 14,600
			which are or may become of benefit to the state of Louisiana and			
			which have public purpose, including industrial, economic, and community			
			development, health, education, environmental, and public safety; to provide			
			leadership training programs, bond financing seminars, economic development			
2510	Conferences, Conventions and Training	Statewide	training for local governments and rural areas, educational and networking	$ 10,598	$ 28,000	$ 25,000
			opportunities for state and local governments; community outreach initiatives;			
			professional training seminars for human resources, computer, and continuing			
			education on federal and state bond laws; to attend economic development			
			conferences, bond closings, groundbreaking ceremonies for bond financings, and public			
2520	Field Travel	Statewide	relations seminars and activities; to meet with clients and prospective clients; and to	$ 6,847	$ 29,000	$ 27,000
			perform general economic development activities.			
			To develop and market supplemental student loan and outreach programs and other related			
			programs which make higher education more accessible and affordable to Louisiana students,			
			parents and teachers; to provide information on financial aid access and FAFSA completion services			
2530	Board Members	Statewide	In Louisiana; to attend professional training seminars for human resources, accounting, personnel,	$ 6,786	$ 12,000	$ 12,000
			computer and client users; to attend student loan conferences of third party service providers;			
			to develop in-school lower cost loan programs; to attend student aid operations			
			functions and student loan bond closings and seminars. To attend board meetings,			
			bond commission meetings and other special functions promoting LPFA programs and services.			
			To attend board meetings, bond closings, bond commission meetings and other			
			special functions promoting LPFA programs and services.			
Explain Existing Operating Budget by Program. Use Continuation Sheet.						

SCHEDULE OF TRAVEL EXPENSE (25; 26) DETAIL

BR-14A
(8/02)

OBJECT CLASS	LIST BY PROGRAM	DESTINATION	PURPOSE OF TRAVEL	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026
	OUT OF STATE TRAVEL:					
2600	Administrative		SEE THE ATTACHED DESCRIPTION OF PROPOSED 2026 OUT OF STATE TRAVEL	$ 463	$ 1,200	$ 2,000
2610	Conferences, Conventions and Training			$ 28,206	$ 48,000	$ 51,000
2620	Field Travel			$ 114	$ 1,150	$ 1,150
2630	Board members			$ -	$ 10,000	$ 10,000
Explain Existing Operating Budget. Use Continuation Sheet.						

PROPOSED OUT OF STATE TRAVEL BUDGET FOR 2026

EMPLOYEES

Staff Member:	2 People	
Purpose:	NAHEFFA Spring Conference	
Location:	To be determined by NAHEFFA	
Costs to Attend:		$4,300
Staff Member:	2 People	
Purpose:	NAHEFFA Fall Conference	
Location:	To be determined by NAHEFFA	
Costs to Attend:		$4,300
Staff Member:	1 person	
Purpose:	Board Meeting	
Location:	To be determined by NAHEFFA	
Costs to Attend:		$1,500

Staff Member:	1 person	
Purpose:	CDFA Board Meeting	
Location:	To be determined by CDFA	
Costs to Attend:		$1,500
Staff Member:	2 People	
Purpose:	CDFA Board Meeting & Annual Educational Conference	
Location:	To be determined by CDFA	
Costs to Attend:		$4,300
Staff Member:	1 person	
Purpose:	CDFA or NAHEFFA Board Meeting & Strategic Planning	
Location:	To be determined by CDFA	
Costs to Attend:		$1,500

Staff Member:	1 person	
Purpose:	A meeting or meetings with the MSRB, IRS, SEC, or other Government Agencies at the request of the agencies or in connection with NAHEFFA or CDFA initiatives	
Location:	Washington, D.C.	
Costs to Attend:		$1,500
Staff Member:	1 person	
Purpose:	Accounting Training and CPE Seminar	
Location:	To be determined	
Costs to Attend:		$3,200
Staff Member:	1 person	
Purpose:	SPRF Annual Conference	
Location:	To be determined by SPRF	
Costs to Attend:		$2,300

EMPLOYEES CONTD.	Event/Item	Estimated Amount
Staff member:	2 persons	
Purpose:	Education Finance Council Annual Spring Meeting	
	Annual mtg and training on student loan bond issues, secondary market issues, regulatory compliance	
Location:	To be determined by EFC	
Cost:	Cost:	4,300
Staff member:	Staff member: 2 persons	
Purpose:	Purpose: Education Finance Council Mid-Year Meeting- Training and industry updates	
Location:	Location: Washington D.C.	
Cost:	Cost:	4,300
Staff member:	Staff member: 1 person	
Purpose:	Purpose: US DOE Office of Federal Student Aid (FSA) Annual Meeting	
Location:	Location: As determined by FSA	
Cost:	Cost:	2,000
Staff member:	2 persons	
Purpose:	Education Finance council RoundtableMeeting and Hill Day- Washington DC	
Location:	Washington DC	
Cost:		3,500
Staff member:	2 persons	
Purpose:	Education Finance Council Strategic Planning Meeting	
Location:	Location: To be determined by the association	
Cost:		3,500
Staff member:	2 persons	
Purpose:	Southwest Financial Aid Administration Association annual meeting and 2 SWASFAA Board Meetings	3,500
Location:	Location: To be determined by SWASFAA	
Cost:	Purpose: Interacting with schools and financial aid administrators federal regulations	
Staff member:	1 person	
Purpose:	National Financial Aid Administration Association - compliance	2,500
Location:	Location: To be determined by the respective organizations	
Cost:	Purpose: Interacting with schools and financial aid administrators	
Staff member:	1 person	
Purpose:	National College Access Network NCAN	
Location:	Training on FAFSA completion and regulatory environment	
Cost:	Staff Member:	
	Purpose:	
	Location:	
	Costs to Attend:	3,000
TRUSTEES		
Staff member:	Council of Development Finance Agencies, National Association of Health and Educational Facilities Finance	
Purpose:	Authorities or Education Finance Council - Capital Hill Day; Advocacy; Economic Development meetings as determined	
Location:	Location: Washington, DC and various locations	
Cost:	Purpose: Educate and update Louisiana's Congressional Delegation about LPFA's Programs and Services	
	Board Memberes	10,000
	Total for Trustees	10,000

SCHEDULE OF OPERATING SERVICES--DETAIL 1

DETAILED EXPLANATION MUST BE PROVIDED

BR-15A
(08/22)

ADVERTISING 2700	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
Advertising and Business Promotions	$ 111,104	$ 125,000	$ 125,000	$ -
TOTAL	**$ 111,104**	**$ 125,000**	**$ 125,000**	**$ -**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF OPERATING SERVICES--DETAIL 2

DETAILED EXPLANATION MUST BE PROVIDED

BR-15B
(8/22)

PRINTING 2710	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
Printing and Binding	$ 13,700	$ 65,000	$ 40,000	$ (25,000)
TOTAL PRINTING	**$ 13,700**	**$ 65,000**	**$ 40,000**	**$ (25,000)**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF OPERATING SERVICES--DETAIL 3

DETAILED EXPLANATION MUST BE PROVIDED

BR-15C
(08/22)

INSURANCE	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
2720 - AUTOMOTIVE	N/A	N/A	N/A	N/A
2730 - WORKMAN'S COMPENSATION	$ 2,775	$ 5,000	$ 5,000	$ -
2740 - FIRE & EXTENDED COVERAGE	$ 6,240	$ 10,000	$ 10,000	$ -
				$ -
2750 - MALPRACTICE	N/A	N/A	N/A	N/A
2760 - OTHER				
Insurance Surty and D&O	$ 25,622	$ 33,000	$ 30,000	$ (3,000)
TOTAL OTHER	**$ 25,622**	**$ 33,000**	**$ 30,000**	**$ (3,000)**
PAGE TOTAL	**$ 34,637**	**$ 48,000**	**$ 45,000**	**$ (3,000)**

SCHEDULE OF OPERATING SERVICES--DETAIL 4

DETAILED EXPLANATION MUST BE PROVIDED

BR-15D
(08/22)

MAINTENANCE OF PROPERTY AND EQUIPMENT	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
2770 - AUTOMOTIVE	N/A	N/A	N/A	N/A

Explain Existing Operating Budget by Program. Use Continuation Sheet if Necessary.

SCHEDULE OF OPERATING SERVICES--DETAIL 5

DETAILED EXPLANATION MUST BE PROVIDED

BR-15E
(08/22)

MAINTENANCE OF PROPERTY AND EQUIPMENT	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
2780 - PROPERTY & EQUIP. - OTHER	N/A	N/A	N/A	N/A
2790 - BUILDINGS	N/A	N/A	N/A	N/A
2800 - EQUIPMENT	$ -	$ 4,000	$ 4,000	$ -
2810 - JANITORIAL/CUSTODIAL	N/A	N/A	N/A	N/A
2820 - DATA PROCESSING - REPAIRS MAINTENANCE IT	$ 29,648	$ 58,000	$ 55,301	$ (2,699)
2825 - DATA PROCESSING - SOFTWARE	$ -	$ -	$ -	$ -
PAGE TOTAL	**$ 29,648**	**$ 62,000**	**$ 59,301**	**$ (2,699)**

Explain Existing Operating Budget by Program. Use Continuation Sheet if Necessary.

SCHEDULE OF OPERATING SERVICES--DETAIL 6

DETAILED EXPLANATION MUST BE PROVIDED

BR-15F
(08/22)

RENTALS	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
2830 - BUILDINGS				
Office	$ 166,518	$ 190,000	$ 200,000	$ 10,000
Storage Facility	$ 13,520	$ 12,000	$ 12,000	$ -
TOTAL BUILDINGS	**$ 180,038**	**$ 202,000**	**$ 212,000**	**$ 10,000**
2840 - EQUIPMENT	N/A	N/A	N/A	N/A
2850 - DATA PROCESSING	N/A	N/A	N/A	N/A
2860 - THIRD PARTY LEASES	N/A	N/A	N/A	N/A
2865 - DATA PROCESSING EQUIPMENT - FINANCING	N/A	N/A	N/A	N/A
2870 - OTHER (SPECIFY)	N/A	N/A	N/A	N/A
*AUTO, AIRCRAFT, BOAT	N/A	N/A	N/A	N/A
2875 - DATA PROCESSING EQUIPMENT - SOFTWARE	$ 18,000	$ 25,000	$ 25,000	$ -
2880 - INTERNET PROVIDER COSTS	$ 19,034	$ 60,000	$ 50,000	$ (10,000)
PAGE TOTAL	**$ 217,072**	**$ 287,000**	**$ 287,000**	**$ -**

Explain Existing Operating Budget by Program. Use Continuation Sheet to list specifics as outlined in the Instruction Manual.

SCHEDULE OF OPERATING SERVICES--DETAIL 7

DETAILED EXPLANATION MUST BE PROVIDED

BR-15G
(08/22)

DUES AND SUBSCRIPTIONS 2890	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
Dues and Membership	$ 12,482	$ 22,000	$ 22,000	**$ -**
Publications/Reports	$ 109	$ 750	$ 750	**$ -**
Subscriptions	$ 4,149	$ 5,000	$ 5,000	**$ -**
TOTAL DUES AND SUBSCRIPTIONS	**$ 16,740**	**$ 27,750**	**$ 27,750**	**$ -**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF OPERATING SERVICES--DETAIL 7 | DETAILED EXPLANATION MUST BE PROVIDED | BR-15G Continuation Sheet (08/22)

DUES AND SUBSCRIPTIONS 2890	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
DUES AND MEMBERSHIP			
Council of Development Finance Agencies	$ 3,150	$ 3,150	$ -
National Ass'n. of Health & Education Fac. Finance Authorities	$ 4,150	$ 4,150	$ -
Louisiana Ind. Dev. Executives Assn.	$ 200	$ 200	$ -
Louisiana Assoc. of Non Profit Org.	$ 100	$ 100	$ -
Louisiana Business Incubation Assoc.	$ 100	$ 100	$ -
Miscellaneous	$ 5,000	$ 5,000	$ -
Southwest Assoc. of Student Aid Admin.	$ 250	$ 250	$ -
Louisiana Assoc. of Student Aid Admin.	$ 250	$ 250	$ -
Education Finance Council	$ 1,000	$ 1,000	$ -
National College Access Network	$ 2,000	$ 2,000	$ -
Louisiana Banker's Association	$ 1,000	$ 1,000	$ -
National Association of Financial Aid Administrators	$ 4,800	$ 4,800	$ -
TOTAL DUES AND MEMBERSHIP	**$ 22,000**	**$ 22,000**	**$ -**

SCHEDULE OF OPERATING SERVICES--DETAIL 7 | DETAILED EXPLANATION MUST BE PROVIDED | BR-15G Continuation Sheet (08/22)

DUES AND SUBSCRIPTIONS 2890	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
PUBLICATIONS AND REPORTS			
Legal Directories Publication	$ 30	$ 30	$ -
Louisiana Governmental Studies	$ 375	$ 375	$ -
Secretary of State Publications	$ 75	$ 75	$ -
Louisiana Press Association	$ 20	$ 20	$ -
Louisiana Assoc. of Non Profit Org.	$ 20	$ 20	$ -
Legal Directories Publication	$ 30	$ 30	$ -
La. Assoc. of College Reg.and Admiss. Off.	$ 50	$ 50	$ -
Louisiana Bankers Association	$ 125	$ 125	$ -
Louisiana Press Association	$ 25	$ 25	$ -
TOTAL PUBLICATIONS AND REPORTS	**$ 750**	**$ 750**	**$ -**

SCHEDULE OF OPERATING SERVICES--DETAIL 7 | DETAILED EXPLANATION MUST BE PROVIDED | BR-15G Continuation Sheet (9/09)

DUES AND SUBSCRIPTIONS 2890	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
SUBSCRIPTIONS			
The Bond Buyer	$ 1,300	$ 1,300	$ -
New Orleans City Business	$ 100	$ 100	$ -
State Bond Commission	$ 35	$ 35	$ -
Tax Analysts	$ 150	$ 150	$ -
Capitol City Press	$ 75	$ 75	$ -
Finder Binder	$ 135	$ 135	$ -
B.R. Business Report	$ 50	$ 50	$ -
Metro Press Clipping	$ 1,025	$ 1,025	$ -
Sheshunoff Publications	$ 55	$ 55	$ -
Capital City Press	$ 125	$ 125	$ -
Postsecondary Education	$ 525	$ 525	$ -
Miscellaneous- Economic Development/Green Bank/Healthcare	$ 1,000	$ 1,000	$ -
Chronical of Higher education	**$ 425**	**$ 425**	$ -
TOTAL SUBSCRIPTIONS	**$ 5,000**	**$ 5,000**	**$ -**

SCHEDULE OF OPERATING SERVICES--DETAIL 8

DETAILED EXPLANATION MUST BE PROVIDED

BR-15H
(08/22)

MAIL, DELIVERY & POSTAGE 2900	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
Freight and Shipping	$ 2,574	$ 16,000	$ 16,000	$ -
Postage Expense	$ 5,590	$ 5,000	$ 5,000	$ -
TOTAL MAIL, DELIVERY & POSTAGE	**$ 8,164**	**$ 21,000**	**$ 21,000**	**$ -**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

Major articles mailed:

1) Quarterly LPFA Newsletter sent to clients for education and awareness.
2) Annual Report sent to clients for education and awareness.
3) Ongoing Student Loan marketing materials including direct mail campaigns to high school students.
4) Ongoing Board of Trustees meeting agendas.

SCHEDULE OF OPERATING SERVICES--DETAIL 9

DETAILED EXPLANATION MUST BE PROVIDED

BR-15I
(08/22)

TELEPHONE SERVICES	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
2910 - TELEPHONE SERVICES	$14,456	$22,000	$20,000	$ (2,000)
2930 - OTHER COMMUNICATION SERVICES	N/A	N/A	N/A	N/A
2935 - DATA PROCESSING - CONTRACT SERVICES	N/A	N/A	N/A	N/A
PAGE TOTAL	**$ 14,456**	**$ 22,000**	**$ 20,000**	**$ (2,000)**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF OPERATING SERVICES--DETAIL 10

DETAILED EXPLANATION MUST BE PROVIDED

BR-15J
(8/22)

UTILITIES	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
2940 - GAS	N/A	N/A	N/A	N/A
2950 - ELECTRICITY	N/A	N/A	N/A	N/A
2960 - WATER	N/A	N/A	N/A	N/A
2970 - OTHER	N/A	N/A	N/A	N/A
PAGE TOTAL	**0**	**0**	**0**	**0**

Explain Existing Operating Budget By Program. Use Continuation Sheet if Necessary.

SCHEDULE OF OPERATING SERVICES--DETAIL 11

DETAILED EXPLANATION MUST BE PROVIDED

BR-15K
(08/22)

OTHER OPERATING SERVICES	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
2980 - LAUNDRY	N/A	N/A	N/A	N/A
2990 - LABORATORY FEES	N/A	N/A	N/A	N/A
2991 - SECURITY	N/A	N/A	N/A	N/A
3000 - MISCELLANEOUS				
Unreimbursed Project Costs	$ -	$ 400	$ -	$ (400)
DNR Program Expenses	$ -	$ 15,000	$ 12,000	$ (3,000)
Bank Charges	$ 4,907	$ 5,000	$ 5,000	$ -
Unreimbursed Program Issuance Costs	$ 2,482	$ 400	$ 400	$ -
Taxes and Licenses	$ 20	$ 50	$ 50	$ -
Bad Debt Expense	$ -	$ -	$ -	$ -
Grants/ Technical Assistance/Advocacy	$ 2,000	$ 125,000	$ 100,000	$ (25,000)
TOTAL MISCELLANEOUS	**$ 9,409**	**$ 145,850**	**$ 117,450**	**$ (28,400)**
3020 - DEPRECIATION EXPENSE-IMPROVEMENTS	$ 1,177	$ 400	$ 1,500	$ 1,100
3030 - DEPRECIATION EXPENSE-EQUIPMENT	$ -	$ 18,400	$ 8,800	$ (9,600)
3040 - DEPRECIATION EXPENSE-SOFTWARE	$ -	$ 2,000	$ -	$ (2,000)
PAGE TOTAL	**$ 10,586**	**$ 166,650**	**$ 127,750**	**$ (38,900)**

Explain Existing Operating Budget By Program. Use Continuation Sheet if Necessary.

SCHEDULE OF SUPPLIES-DETAIL 3

DETAILED EXPLANATION MUST BE PROVIDED

BR-16A
(08/22)

OFFICE SUPPLIES 3100	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
Copier Expense	$ 3,544	$ 6,500	$ 8,000	$ 1,500
Office Expenses	$ 30,877	$ 50,000	$ 50,000	$ -
Miscellaneous	$ -	$ 750	$ 750	$ -
TOTAL OFFICE SUPPLIES	**$ 34,421**	**$ 57,250**	**$ 58,750**	**$ 1,500**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF SUPPLIES-DETAIL 2 | DETAILED EXPLANATION MUST BE PROVIDED | BR-16B (8/22)

OPERATING SUPPLIES	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
3110 - PHARMACEUTICALS	N/A	N/A	N/A	N/A
3120 - COMPUTER	N/A	N/A	N/A	N/A
3130 - CLOTHING - UNIFORMS	N/A	N/A	N/A	N/A
3140 - MEDICAL	N/A	N/A	N/A	N/A
3150 - EDUCATION & RECREATION	N/A	N/A	N/A	N/A
3160 - FOOD	N/A	N/A	N/A	N/A
PAGE TOTAL	**0**	**0**	**0**	**0**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF SUPPLIES-DETAIL 3

DETAILED EXPLANATION MUST BE PROVIDED

BR-16C
(08/22)

OTHER OPERATING SUPPLIES	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
3170 - AUTOMOTIVE	N/A	N/A	N/A	N/A
3180 - OTHER	N/A	N/A	N/A	N/A
3185 - PURCHASING CARD	N/A	N/A	N/A	N/A
3190 - BUILDINGS, GROUNDS & GENERAL PLANT	N/A	N/A	N/A	N/A
3200 - HOUSEHOLD	N/A	N/A	N/A	N/A
3210 - FARM	N/A	N/A	N/A	N/A
3220 - PERSONAL ITEMS	N/A	N/A	N/A	N/A
3230 - OTHER MEDICAL	N/A	N/A	N/A	N/A
PAGE TOTAL	**0**	**0**	**0**	**0**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF SUPPLIES--DETAIL 4

DETAILED EXPLANATION MUST BE PROVIDED

BR-16D
(08/22)

REPAIR & MAINTENANCE SUPPLIES	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
3300 - AUTOMOTIVE	N/A	N/A	N/A	N/A
3310 - OTHER	N/A	N/A	N/A	N/A
3320 - SOFTWARE	N/A	N/A	N/A	N/A
3330 - VOC-TECH SCHOOL BLDG. SUPPLIES	N/A	N/A	N/A	N/A
3340 - STORES INCREASE	N/A	N/A	N/A	N/A
3350 - STORES DECREASE	N/A	N/A	N/A	N/A
PAGE TOTAL	**0**	**0**	**0**	**0**

Explain Existing Operating Budget By Program. Use Continuation Sheet If Necessary.

SCHEDULE OF PROFESSIONAL SERVICE | DETAILED EXPLANATION MUST BE PROVIDED | BR-17A (9/09)

OBJECT CLASS	DESCRIPTION	NAME AND ADDRESS OF INDIVIDUAL AND/OR FIRM	NATURE OF WORK PERFORMED AND JUSTIFICATION FOR SERVICES	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
3400	Accounting			$ -	$ 3,500	$ 2,000	$ (1,500)
3400	Audit	Duplantier, Hrapman, Hogan & Maher, LLP		$ 29,710	$ 41,000	$ 40,000	$ (1,000)
3400	Audit	Louisiana State Legislative Auditor		$ -	$ -	$ -	$ -
	SUB-TOTAL			**$ 29,710**	**$ 44,500**	**$ 42,000**	**$ (2,500)**
3430	Legal			$ -	$ -	$ -	$ -
3430	Legal	Breazeale Sachse Wilson, LLP		$ 3,049	$ 7,000	$ 7,000	$ -
3430	Legal	Gregory A. Pletsch & Asscociate			$ 3,000	$ 3,000	$ -
3430	Legal	Jacob S. Capraro		$ 31,763	$ 30,000	$ 40,000	$ 10,000
3430	Legal	Kutak Rock		$ -	$ 3,000	$ 3,000	$ -
3430	Legal	Foley & Lardner		$ -	$ 2,000	$ 2,000	$ -
3430	Legal	Law Offices of R. Gray Sexton		$ -	$ -	$ -	$ -
	SUB-TOTAL			**$ 34,812**	**$ 45,000**	**$ 55,000**	**$ 10,000**
3460	Casual Labor	Temporary services		$ -	$ 10,000	$ 39,000	$ 29,000
3460	Media Graphics/ Third Party	Heitmann communications		$ -	$ 25,000	$ 25,000	$ -
3460	Media Graphics/ Third Party	Don Kadair Photography		$ 1,005	$ 1,500	$ 1,500	$ -
3460	Media Graphics/ Third Party	Object 9		$ 13,575	$ 30,000	$ 27,500	$ (2,500)
3460	Media Graphics/ Third Party	various		$ -	$ 2,020	$ -	$ (2,020)
3460	Media Graphics/ Third Party	Dr. James Richardson		$ -	$ 17,500	$ -	$ (17,500)
3460	Media Graphics/ Third Party	Prisma (formerly Vivid Ink) or Similar		$ -	$ 5,000	$ 10,000	$ 5,000
3460	Media Graphics/ Third Party	EGB Creative or Similar		$ 4,527	$ 5,000	$ 20,000	$ 15,000
3460	Media Graphics/ Third Party	Encoura Mailing Lists		$ 9,281	$ -	$ 15,000	$ 15,000
3460	Media Graphics/ Third Party	R.Kannanaugh - remote services FAFSA Completion		$ -	$ 24,000	$ 36,000	$ 12,000
3460	Media Graphics/ Third Party	Various : Website and Program Content Creation		$ 5,400	$ 24,980	$ 20,000	$ (4,980)
3460	Media Graphics/ Third Party	:		$ 9,000	$ 20,000	$ 10,000	$ (10,000)
	SUB-TOTAL			**$ 42,788**	**$ 165,000**	**$ 204,000**	**$ 39,000**
	PAGE TOTAL			**$ 107,310**	**$ 254,500**	**$ 301,000**	**$ 46,500**
				NOTE:	Casual Labor is a separate entry on the LPFA's budget but is rolled into this section on BR17A		

Explain Existing Operating Budget by Program. Use Continuation Sheet if Necessary.

NATURE OF WORK PERFORMED AND JUSTIFICATION FOR SERVICES

Postlethwaite and Netterville, APAC – 8550 United Plaza Blvd. Suite 1001, Baton Rouge, LA 70809 – Provides some accounting services related to LPFA operations, including but not limited to payroll, maintenance of general ledger and financial statement preparation. Provides independent audit function for the LPFA's student loan program.

Brezeale, Sachse & Wilson, LLP – P.O. Box 3197, Baton Rouge, LA 70821 – Provides legal counsel and expertise relative to student loan, labor,ongoing LPFA administrative matters, LouLease Program and general matters for the LPFA.

Gregory A. Pletsch & Associates – 8555 United Plaza Blvd. Suite 301, Baton Rouge, LA 70809 – Provides legal counsel to both programs of the LPFA.

ENCOURA - Austin, Texas. Provides contact lists of potential Louisiana college bound seniors.

Jacob S. Capraro – 1100 Poydras Street, Suite 2900, New Orleans, LA 70163 – Provides legal counsel and expertise to both programs of the LPFA.

Foley & Lardner – 777 East Wisconsin Ave., Milwaukee, WI 53202 – Provides legal counsel and expertise in connection with the LPFA's student loan program with respect to drafting and maintaining the federally required "Privacy Policy" for the student loan program and matters related thereto.

Kutak Rock – 4435 Main Street, Suite 810, Kansas City, MO 64111 – Provides legal counsel and expertise in connection with LPFA bond issues and programs.

Don Kadair Photography – 8590 Oliver Ave, Baton Rouge, LA 70809– Provides professional photography services for both programs of the LPFA. Services include photography for the newsletters, brochures, other publications and the LPFA Annual Report.

Wrights media: 2407 Timberloch Place, Ste B, The Woodlands, TX 77380-1039Services utilized on an as needed basis in conjunction with Bond Deal of the year for LPFA in 2024

Dr. James Richardson - 3165 Kleinert Avenue, Baton Rouge, LA 70806 – The Authority periodically uses Dr. Richardson to prepare and update a study detailing the economic impact of the Authority and its financings on the State of Louisiana. Dr. Richardson prepared his first study after the 25th anniversary of the Authority's creation. Dr. Richardson has updated this study after the Authority's 30th, 35th and 40th anniversaries and other study updates as needed including the Authority's 50th anniversary in 2024-25.

DHHM- Duplantier, Hrappmann, Hogan & Maher/ as selected by Louisiana Legislative Auditor - 1615 Poydras st. Suite 2100 New Orleans, LA 70112 – Provides primary general independent audit function related to LPFA operations.

Object 9 - Baton Rouge Location: 312 W Ardenwood Dr., Baton Rouge, LA 70806 – Provides expertise in the design and production of marketing print materials, digital services and graphics for the LPFA's student loan programs as well as expertise in the design and production of letterhead, business cards, logo designs, and other services for both programs of the LPFA.

EGB Creative - 15214 Oakview Lane, Baton Rouge, LA 70817 – Provides creative, digitial and design services.

CBM Technology - 218 E. Bridge St., Breaux Bridge, LA 70517 – Provides IT and security services & support on behalf of the Authority

Heitman Communications: 7062 Sevenoaks Avenue, Baton Rouge, LA 70806 - The Authority utilizes these services to generate newsletter and communications for the development of the Authority's programs and services

Hometown Video Productions- 638 Penalver Street Baton Rouge, LA 70802 – Provides contracted services to creative and produce video content for LPFA services and programs

Prisma (formerly Vivid Ink) - 8640 Airline Hwy., Baton Rouge, LA 70815 - Provides graphics and production of mixed media program items, as needed.

SCHEDULE OF OTHER CHARGES (35; 36; 37; 38; 39; 40; 41; 42; 43; 48)

BR-18
(8/13)

LINE NO.	DESCRIPTION	PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET	DETAIL SHEET NOS.
1						
2	N/A	N/A	N/A	N/A	N/A	N/A
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23	**TOTAL OTHER CHARGES**					
	AUTHORIZED OTHER CHARGES POSITIONS:					
24	Other Charges-Salaries Classified (3670)					
25	Other Charges-Compensation (3680)					
26	Other Charges-Wages (3681)					
27	TOTAL AUTHORIZED OTHER CHARGES POSITIONS*					

* Authorized Other Charges Positions are those reported under Objects 3670, 3680, and 3681 (exclude WAEs).

SCHEDULE OF INTERAGENCY TRANSFERS

BR-19
(6/08)

LINE NO		PRIOR YEAR ACTUAL 2024	EXISTING OPERATING BUDGET 2025	TOTAL REQUEST 2026	OVER/UNDER EXISTING OPERATING BUDGET
1	General Fund				$0
2	Interagency Transfer				$ -
3	Self Generated Revenue				$0
4	Statutory Dedications:				$0
5	(List Statutory Dedications Separately)				$0
6	IEB				$0
7	Federal Funds				$0
8	**TOTAL REVENUE**	$ -	$ -	$ -	$ -
	DESCRIPTION				
	(To Be Transferred To)				
9	State of Lousiana per 2015 Act 121	$0	$0	$0	$0
10					$0
11					$0
12					$0
13					$0
14					$0
15					$0
16					$0
17					$0
18					$0
19					$0
20					$0
21					$0
22					$0
23	**TOTAL INTERAGENCY TRANSFERS**	$0	$0	$0	$0

Note: Copies of all IAT agreements requested to be funded should be included in the agency's budget request submission. Verify that all such agreements are included prior to submitting the budget request. This excludes statewide IAT agreements - ie. OTM, Risk Management.

DETAIL OF ACQUISITIONS REQUESTED BR-20A

(USE THIS FORM TO EXPLAIN ACQUISITIONS AUTHORIZED IN THE EXISTING OPERATING BUDGET) (9/09)

Priority Number	OBJ CLASS	QUANTITY	EQUIPMENT REPLACED DESCRIPTION BY PROGRAM	AMOUNT	OBJ CLASS	QUANTITY	NEW EQUIPMENT DESCRIPTION BY PROGRAM	AMOUNT
							Both Programs*	
					4450		**Acquisitions - Capitalized Software**	
								$ -
							Subtotal	**$ -**
					4451		**Acquisitions - Capitalized Hardware**	
						1	It equipment and other office items, as needed	$ 15,000
								$ -
							Subtotal	**$ 15,000**
					4453		**Acquisitions - Software**	
								$ -
							Subtotal	**$ -**
					4454		**Acquisitions - Hardware**	
						3	Laptop Computers or office equipment as needed	$ 10,000
						3	Desktop Computers	
							Subtotal	**$ 10,000**
					4456		**Acquisitions - Software Less Than $1000**	
							Subtotal	**$ -**
					4457		**Acquisitions - Hardware Less Than $1000**	
							Subtotal	**$ -**
					4490		**Acquisitions - Office Equipment**	
							Various Office items to Replace Old or	$ 10,000
							Broken Items	
							Subtotal	**$ 10,000**
					4491		**Acquisitons - Capitalized Office Equipment**	
								$ -
							Subtotal	**$ -**
					4492		Acquisitions - Office Equipment Less Than $1000	
							Subtotal	**$ -**

Itemized Equipment currently authorized in the Existing Operating Budget. Use Continuation Sheet.

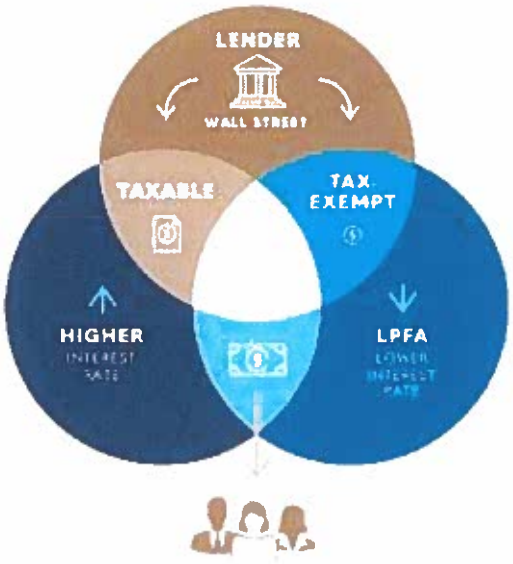
1	2	3	4	5	6			7	8			9	10			
Name of Incumbent	C or U	Date of Vacancy	Class or Title of Position (including Pay Scale Group)	Current Semi-Monthly Salary as of 10/15/2025 - - - -	Semi-Monthly Increases To Be Given Prior to End of Current Year			Total Base for Requested Year (Column 5 + Column 6B) X 26	Total Salary Adjustments for Requested Year			Total Salary for Requested Year Column 7 + Column 8C	Related Benefits			
					6A Date	6B Biweekly Amount	6C Total Amount		8A Date	8B Biweekly Amount	8C Total Amount		Retirement	F.I.C.A. Tax	F.I.C.A. Medicare Tax	Group Insurance
Martin Walke	U		Vice President of Economic and Program Development	$6,791		$0	$0	$162,972	1/1/2026	*	*	*	*	$0	*	*
Currently Vacant			LPFA Programs Administration and Marketing	$0				$70,000								
Patricia A. Dubroc	U		President and CEO	$8,745		$0	$0	$209,871	1/1/2026	*	*	*	*	$0	*	*
Amy Tuminello	U		Accountant	$4,255		$0	$0	$102,130	1/1/2026	*	*	*	*	$0	*	*
Currently Vacant	U		Economic Dev. Programs & Outreach	$0		$0	$0	$70,000	1/1/2026	*	*	*	*	$0	*	*
Stacye Bradford	U		Executive Assistant	$3,456		$0	$0	$82,944	1/1/2026	*	*	*	*	$0	*	*
Joni Leggio	U		Assistant Vice President of Student Loans	$4,668		$0	$0	$112,036	1/1/2026	*	*	*	*	$0	*	*
Barbara A. Carmichael	U		Marketing Representative	$3,004		$0	$0	$72,100	1/1/2026	*	*	*	*	$0	*	*
Currently Vacant	U		Marketing and Operations Coordinator-	$0		$0	$0	$40,000	1/1/2026	*	*	*	*	$0	*	*
Emily Singleton	U		Public Information / IT Manager	$3,220		$0	$0	$77,273	1/1/2026	*	*	*	*	$0	*	*
Kentra Davis	U		Compliance Analyst	$2,364		$0	$0	$56,746	1/1/2026	*	*	*	*	$0	*	*
Geralyn King	U		Administrative Assistant	$2,091		$0	$0	$50,189	1/1/2026	*	*	*	*	$0	*	*
Rachel Simmons	U		Receptionist	$1,658		$0	$0	$39,798	1/1/2026	*	*	*	*	$0	*	*
			Part-time assistance	$0		$0	$0	$18,000	1/1/2026	*	*	*	*	$0	*	*
	Column 7 reflects salaries as of October 15, 2025.															
			NOTE: For 2026: Propose a Cost of Living Adjustment up to 3.2% Executive staff to receive a lower adjustment than staff.													
		NOTE:	Student Worker: Ethan Rainach- (Refer to BR-10) 20hrs													
SUBTOTALS	0			$40,252		$0	$0	$1,164,059		$0	$0	$1,134,003	$39,944	$0	$16,700	$306,700
LESS ATTRITION												$0	$0	$0	$0	$0
TOTALS	0			$40,252		$0	$0	$1,164,059		$0	$0	$1,134,003	$39,944	$0	$16,700	$306,700

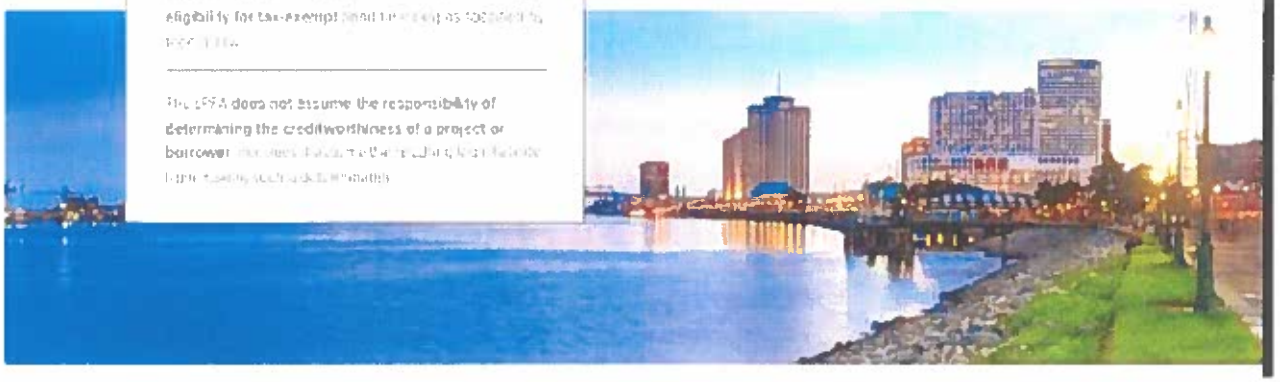
Activity Information: LPFA
New Bonds Issued

Project Category	FY 2022	FY 2023	FY 2024
Hospitals/Healthcare	$ 200,000,000.00	$ 105,000,000.00	$ 25,500,000.00
Economic Development	$ 14,350,000.00	$ 268,320,000.00	$ 1,523,075,000.00
Student Loans	$ -	$ -	$ -
Universities	$ 29,820,000.00	$ 291,125,000.00	$ 81,170,000.00
Multi-Family Housing	$ -	$ -	$ -
State of Louisiana	$ 19,790,000.00	$ -	$ 1,500,000.00
Communities	$ 45,725,000.00	$ -	$ 60,000,000.00
TOTAL	**$ 309,685,000.00**	**$ 664,445,000.00**	**$ 1,691,245,000.00**

LPFA Information on Programs and Services:

IMPROVING ECONOMIC DEVELOPMENT
BY PROVIDING ACCESS TO CAPITAL





LPFA

HAS ISSUED MORE THAN

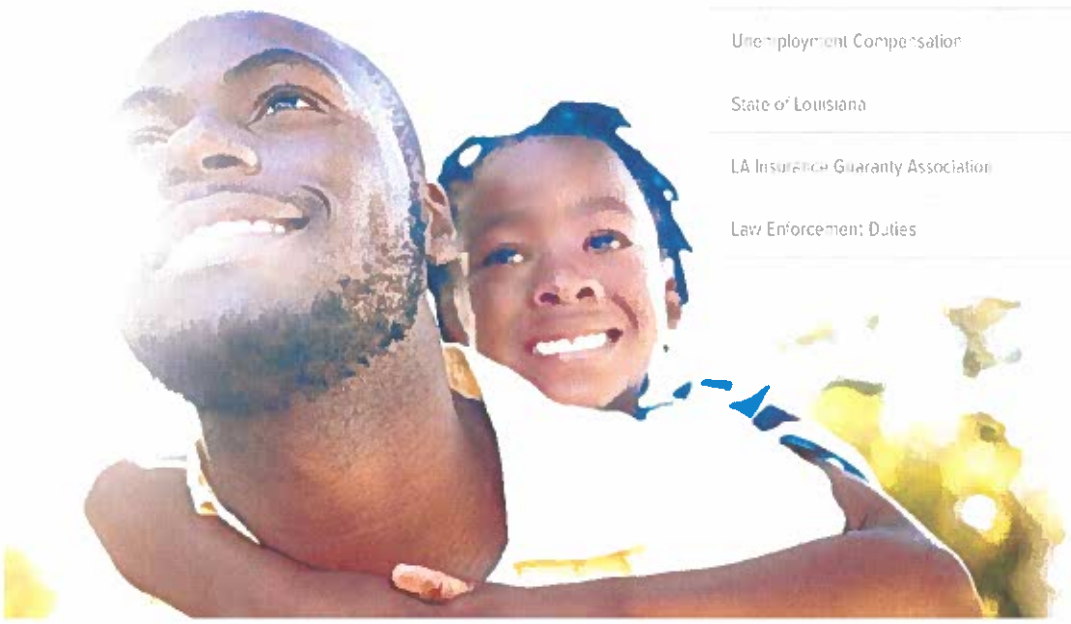
$31.47

BILLION

IN BONDS

(1974-2024).

Total Bonds Since Inception Chart	Total Bonds for 2024
Categories	
Health Care	$10,797,502,096.00
Economic Development	$8,584,269,800.00
Student Loans	$2,439,000,000.00
Universities	$3,793,435,408.00
School Boards	$1,220,000,000.00
Communities	$1,044,295,000.00
Multi-Family Housing	$676,000,000.00
Single-Family Housing	$327,000,000.00
Unemployment Compensation	$1,550,000,000.00
State of Louisiana	$556,200,000.00
LA Insurance Guaranty Association	$187,000,000.00
Law Enforcement Duties	$73,700,000.00



Louisiana Public Facilities Authority (LPFA)
Revolving Loan Fund Programs
(as of November 1, 2025)

The following is a summary of Revolving Loan Funds managed by the LPFA for Louisiana utilizing dedicated reserve funds.

The Low Interest Capital Facilities Bond Bank Program – this program assists local government or non-profit entities by reducing their overall borrowing costs. If an entity has a need to purchase capital facilities or equipment, it may borrow up to $3 million for a term not to exceed 10 years. The entity negotiates the best interest terms with its commercial banker for 75 percent of the total amount of the project loan. The LPFA funds the remaining 25 percent of the loan, up to a maximum of $750,000, at an interest rate 50 percent of the bank's interest rate. For example, if the bank charges an interest rate of 4% for its portion of the loan, the LPFA's interest rate for its portion would be 2%. This allows the entity to save on its overall or total borrowing costs.

The Rural Development Loan Program – this program is for rural communities and is specifically issued in conjunction with a U.S. Department of Agriculture Rural Development (USDA-RD) Community Loan. When the USDA-RD approves a loan for a local community, it requires the community to have an interim loan secured to begin the project while the loan is being processed. The LPFA will provide up to 40 percent of the interim financing needed for projects having a Rural Development commitment for permanent financing. Like the aforementioned loan program, the community negotiates the best interest terms with its commercial banker for 60 percent of the USDA-RD total loan amount and the LPFA will fund the remaining 40 percent of the loan, up to a maximum of $2 million, at an interest rate 50 percent of the bank's interest rate. The maximum term length on these loans is 2 years. The LPFA must receive an A-1 letter from the USDA-RD State Office, signed by the State Director, to serve as collateral for the loan.

The Economic Development and Essential Purpose Loan Program -- The LPFA is aware that from time-to-time economic development and other essential projects in Louisiana need emergency or bridge financing. Under this program, the LPFA may provide interim, emergency, or bridge financing to projects that meet these guidelines. The borrower must demonstrate that the applicable project will not be able to proceed without the LPFA financing or that an emergency exists such that the health or safety of citizens of Louisiana would be put at risk without the LPFA financing (i.e. financing the drilling of a water well when funds have been appropriated for such purpose but will not be available in a timely manner to maintain the public's access to water if the well is not started immediately). The repayment of the loan must be secured by the pledge of funds that have been appropriated by the State, are due to be paid to the borrower by the State, the Federal Government, or any program or activity of either thereof, under contracts, grants, or other provisions. The entity's total borrowing from the

Program shall be no more than $2,000,000. The loan issued by the LPFA shall bear interest at a rate of 1% to 3% per annum and shall have a final maturity of not more than two (2) years.

The Louisiana University & College Essential Loan Program – this program provides colleges and universities with short term financing for projects that meet the guidelines of La. R.S. 39:128(B)(1) giving critical assistance to these entities and reducing their borrowing costs. Any Louisiana public college and university as authorized by La. R.S. 39:128(B)(1) is eligible for this program. The maximum borrowing may not exceed $1,000,000, may not exceed a term longer than 1 year, and shall be charged an interest rate of 1.50%.

Should you have any questions concerning any of these programs, please contact Martin Walke, Vice President of the LPFA, at 225-923-0020 or 800-228-4755.



LPFA

LOUISIANA PUBLIC FACILITIES AUTHORITY

Low Interest Local Government Bond Bank Program

LPFA
LOUISIANA PUBLIC FACILITIES AUTHORITY

Low Interest Local Government Bond Bank Program

Program Overview:

The LPFA's Low Interest Local Government Bond Bank Program saves local governments money by providing up to 25% of a financing at a reduced interest rate.

The local government works with its local bank to obtain the most favorable interest rate and borrows 75% of the necessary funds from the local bank at the negotiated interest rate.

The LPFA provides the remaining 25% of the loan at an interest rate equal to one-half of the local bank's interest rate. Thus, the local government saves a substantial amount in interest costs by participating in the Program.

Since its inception, the Program has saved local governments more than $4.7 million in future interest.

Contact Us:

For more information about our programs, please visit lpfa.com or contact Martin Walke, CLEcD, Vice President, at walke@lpfa.com, (225) 923-0020 or (800) 228-4755.

Program Guidelines:

Authorization:	Louisiana Public Facilities Authority Board of Trustees
Source of Funds:	Louisiana Public Facilities Authority
Use of Proceeds:	Purchase of capital facilities and equipment (No Refunding)
Purpose:	To reduce overall borrowing costs of local government entities
Security:	Excess Revenue Certificates of Indebtedness
Eligibility:	Any Louisiana local governmental entity

Eligibility Requirements:

Maximum Total Borrowing (Bank Portion plus LPFA Program Portion):	$3,000,000
Maximum LPFA Program Portion:	25% of Total Borrowing or $750,000, whichever is less
Interest Rate (LPFA Program Portion):	One half of the Local Bank Rate
Repayment Term:	Maximum of 10 years with equal annual payments
LPFA Program Borrowing Limit for each local governmental entity:	Total LPFA loans outstanding including the new request cannot exceed $750,000

Financing Request Process:

- Submit a request to the LPFA once a loan has been secured with a local bank.
- Only requests for participation made by the local governmental entity on its official letterhead will be considered valid. Please include a copy of the terms from the local bank.
- Requests must be for a specifically identified financing by the local governmental entity.
- Valid requests will be logged in as received.
- Projects will be funded in order of the date the request is received on a first come, first served basis as monies are available.
- At the time funds become available, the local governmental entity that is first in line for funds will be contacted and the funds will be offered to that local governmental entity for the specifically identified financing. If the local governmental entity is no longer in need of funds from the Program for the specifically identified financing, the funds will be offered to the local governmental entity that is next in line for Program funds.

2237 South Acadian Thruway, Suite 650, Baton Rouge, LA 70808 Ph: 225-923-0020 Fax: 225-923-0021



LPFA

LOUISIANA PUBLIC FACILITIES AUTHORITY

Rural Development Low Interest Loan Program

LPFA
LOUISIANA PUBLIC FACILITIES AUTHORITY

Rural Development Low Interest Loan Program

Program Overview:

The LPFA's Rural Development Low Interest Loan Program helps provide local governments and non-profits with interim financing for capital and infrastructure projects until permanent financing is received from the U.S. Department of Agriculture's (USDA) Rural Development Program.

The borrower works with its local bank to obtain the most favorable interest rate possible and borrows 60% of the necessary funds from the local bank at the negotiated interest rate. The LPFA provides the remaining 40% of the loan at an interest rate equal to one-half of the local bank's interest rate. Thus, the borrower saves a substantial amount in interest costs by participating in the Program.

Since its inception, the Program has saved borrowers more than $1,100,000 in future interest costs.

Contact Us:

For more information about our programs, please visit lpfa.com or contact Martin Walke, CLEcD, Vice President, at walke@lpfa.com, (225) 923-0020 or (800) 228-4755.

Program Guidelines:

Authorization:	Louisiana Public Facilities Authority Board of Trustees
Source of Funds:	Louisiana Public Facilities Authority
Use of Proceeds:	Purchase of capital facilities and equipment (No Refunding)

Eligibility Requirements:

Eligibility:	Any Louisiana local government entity or not-for-profit corporate entity
Maximum Total Borrowing:	40% of total USDA Loan; up to $5,000,000
Maximum LPFA Program Portion:	40% of total USDA Loan or $2,000,000, whichever is less
Repayment Terms:	Maximum of 2 years; Paid out with proceeds of permanent financing from USDA
LPFA Program Borrowing Limit:	No limits imposed

Financing Request Process:

- Submit a request to LPFA.
- Only requests for participation made by the local governmental entity on its official letterhead will be considered valid.
- Requests must be for a specifically identified financing by the local governmental entity (ex. USDA A-1 Letter).
- Valid requests will be logged in as received.
- Projects will be funded in order of the date the request is received on a first come, first served basis as monies are available.
- At the time funds become available, the local governmental entity that is first in line for funds will be contacted and the funds will be offered to that local governmental entity for the specifically identified financing. If the local governmental entity is no longer in need of funds from the Program for the specifically identified financing, the funds will be offered to the local governmental entity that is next in line for Program funds.

2237 South Acadian Thruway, Suite 650, Baton Rouge, LA 70808 Ph: 225-923-0020 Fax: 225-923-0021

FAFSA Completion

GUIDE & WORKBOOK

A Lela
LOUISIANA EDUCATION LOAN AUTHORITY
A DIVISION OF EDFA
PUBLICATION

Class of 2026



FAFSA ASSISTANCE
see Pg. 2

REGISTER TO WIN A $1,000 SCHOLARSHIP
see Pg. 4

3 CREATE YOUR FSA ID
Pg. 3

3 FAFSA CHECKLIST
Pg. 3

4 SCHOLARSHIPS
Pg. 4

LOUISIANA'S NONPROFIT RESOURCE FOR FAFSA COMPLETION & COLLEGE ACCESS

LELA *Impact*

21,336 *Families*

Lela assisted over 21,336 Louisiana families in 2024.

$15,000 *in Scholarships*

Lela awarded $15,000 in scholarships to Louisiana students in 2024.

1,439 **FAFSA** *Assistance*

Lela assisted over 1,439 students with the FAFSA in 2024.

For the eleventh consecutive year Lela provided its "how to" FAFSA Completion Guide & Parent Guide to every Louisiana high school.

INTRODUCTION TO LELA *Who is Lela?*

Lela
LOUISIANA EDUCATION LOAN AUTHORITY
A DIVISION OF LPFA

The Louisiana Education Loan Authority (Lela) is Louisiana's nonprofit resource for free FAFSA completion assistance, college access and affordable financing, and is a division of the Louisiana Public Facilities Authority (LPFA)— a nonprofit public trust established to bring financing assistance and advantages to the people of Louisiana. Lela's mission is to develop projects and programs which provide resources for college access and statewide outreach initiatives to help ensure students' success on their path to and through college. The Lela team assists families remotely with FAFSA completion through its free virtual completion sessions, FAFSA HELPline, offers free resources to Louisiana high school counselors and provides low cost supplemental loans for college expenses. *(see back cover)*

Website: Lela.org
Follow Lela on:

This public document was designed at a cost of $513.75. This document was published for Lela, a division of the Louisiana Public Facilities Authority (LPFA), 2237 S Acadian Thruway, Suite 650, Baton Rouge, LA 70808 to promote public awareness of the programs and services provided by Lela under authority of Title 9, chapter 2-A of the Louisiana Revised Statutes.

FAFSA® form

What is the FAFSA?

The FAFSA is the **Free Application for Federal Student Aid**. Completing this free form is the first step toward getting federal financial aid to help pay for college. It can be filed at **studentaid.gov**.

FAFSA HELPLINE
CALL (844) 463-2372
(844) GO FAFSA

NEED HELP *Completing the* FAFSA?

STUDENTS & PARENTS

Scan here to request a FREE virtual FAFSA session!

SCAN HERE!

SCHOOL COUNSELORS

ELECTRONIC RESOURCES AVAILABLE TO POST ON YOUR SCHOOL WEBSITE

- FAFSA Completion Guide and Workbook
- Parent's Guide for College Planning
- Senior Checklist for College Planning

For more information visit @ lela.org

ALL SERVICES ARE *FREE!*

FAFSA COMPLETION - CREATE YOUR STUDENT AND PARENT FSA ID AT STUDENTAID.GOV

STEP 1

FSA ID

CREATE YOUR FSA ID AT STUDENTAID.GOV/FSA-ID/CREATE-ACCOUNT

FSA ID ITEMS NEEDED

- Social Security or Alien Registration card
- Personal Email Address
- Cell Phone Number
- Download an Authenticator App

Create your FSA ID account at studentaid.gov/fsa-id/create-account

Student Username: _____

Student Password: _____

Personal Email Address: _____

Cell Phone Number: _____

Contributor Invitation Code: _____

Backup Code: _____



IDENTIFY YOUR PARENT CONTRIBUTOR

Never married, divorced or separated	Report parent who provided more financial support during the last 12 months
Unmarried and both legal parents living together	Report both legal parents
Married	Report both of your parents
Remarried (after being widowed or divorced)	Parent and stepparent
Widowed	Report the surviving parent and step-parent (if remarried)

Parent Username: _____

Parent Password: _____

Personal Email Address: _____
(Do not use the same email address as your child/student.)

Cell Phone Number: _____

Contributor Invitation Code: _____

Backup Code: _____



FAFSA COMPLETION - ONCE YOUR FSA ID IS CREATED, BEGIN YOUR FAFSA AT STUDENTAID.GOV

STEP 2

FAFSA

SUBMIT YOUR FAFSA AT STUDENTAID.GOV | *Scheduled to launch on October 1, 2025*

FAFSA ITEMS NEEDED

- FSA ID for Student & Parents(s)
- Parent(s) Social Security number(s)
- Parent(s) legal name(s)
- Parent(s) date(s) of birth
- IRS Income Tax Return & W-2s for Year 2024 for student & parent(s)
- Records of Untaxed Income for student & parent(s)
- Records of Assets for student & parent(s)
- List of Schools you're interested in attending

QUESTIONS? CONTACT A LELA SPECIALIST FOR ASSISTANCE!

info@lela.org

SCHOLARSHIP OPPORTUNITIES BEGIN AT LELA.ORG.
REGISTER TO WIN NOW!

STEP 3

SCHOLARSHIPS



2 WAYS TO WIN Lela Scholarships!





College Financial Aid PROCESS

2025 - 2026

- **COMPLETE ADMISSIONS APPLICATIONS** and meet all requirements for your colleges of interest.
- **CREATE FSA IDs** for student and parent at studentaid.gov/fsa-id/create-account.
- **COMPLETE THE 2026-27 FAFSA** when it becomes available, using your 2024 IRS Tax Return.
- **REVIEW YOUR FAFSA SUBMISSION SUMMARY** for accuracy, which will be sent to the student's email from Federal Student Aid.
- **CREATE YOUR STUDENT ACCOUNT** at the college by following instructions from the admissions office.
- **RESPOND TO VERIFICATION REQUESTS** from the college financial aid office in a timely manner so your aid can be processed quickly.
- **REVIEW YOUR FINANCIAL AID OFFER** and accept only what you will need to complete the 2026-27 academic year.
- **COMPLETE ENTRANCE COUNSELING** if you accept student loans, to understand your rights and responsibilities as a Borrower.
- **SIGN YOUR MASTER PROMISSORY NOTE** if you accept student loans, **PROMISING TO REPAY** any money that you borrow.
- **FINANCIAL AID WILL BE** sent directly to your college and **DEPOSITED INTO YOUR STUDENT ACCOUNT**.



NEED ADDITIONAL FUNDING TO COVER YOUR COLLEGE EXPENSES?

STUDENTS OR PARENTS WHO NEED TO "FILL A FUNDING GAP" AFTER FACTORING IN ALL SCHOLARSHIPS, GRANTS, FEDERAL AND STATE DOLLARS, CONSIDER-

LelaCHOICE

LOUISIANA'S NONPROFIT EDUCATION LOANS

Choose Quality. Choose Community. Choose Lela.

FOR MORE DETAILS AND TO APPLY, VISIT LELACHOICE.ORG

Pre-Qualify Now!

FOR MORE INFORMATION ABOUT LELA'S PROGRAMS, CONTACT US:

ANN CARMICHAEL | *Marketing, Outreach & Program Development Manager* | CARMICHAEL@LELA.ORG

JONI LEGGIO | *Vice President* | LEGGIO@LELA.ORG

Committed to Louisiana students since 1984

FOLLOW US AND STAY CONNECTED! *Ask Lela* *@askLela* *askLelaCollegeResources*

LelaCHOICE

LOUISIANA'S NONPROFIT EDUCATION LOANS

Choose Quality. Choose Community. Choose Lela.

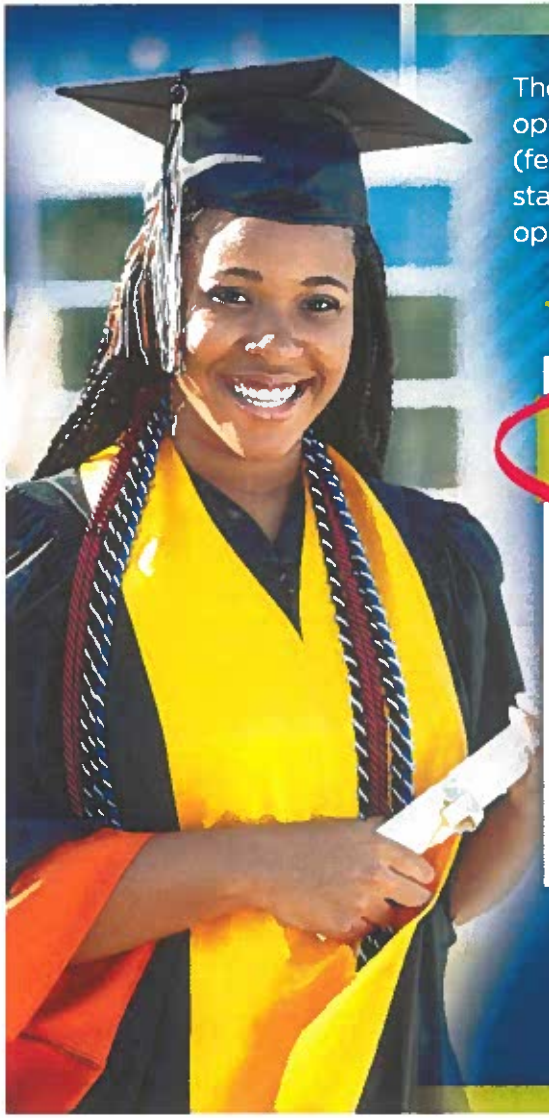
EDUCATION LOAN FINANCING

- For Students, Parents & Grad Students
- Fixed Lower Interest Rates!
- No Origination or Processing Fees!
- No Capitalized Interest, ever!
- Earn an interest rate reduction with auto payment

2.94%

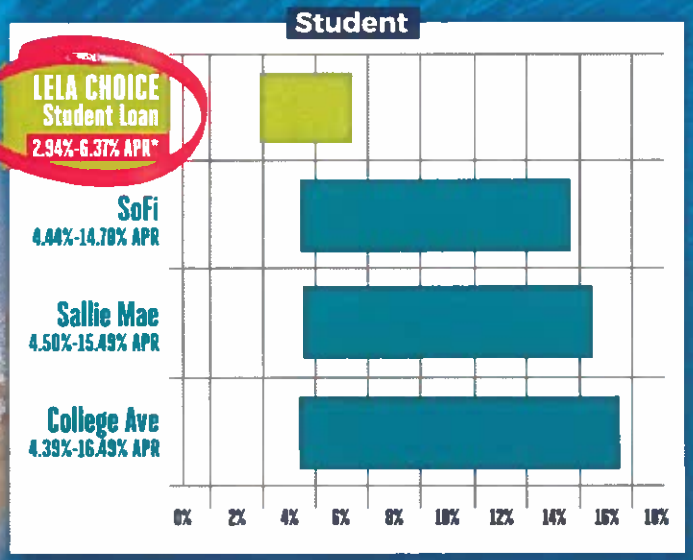
Fixed rate as low as 2.94% APR*

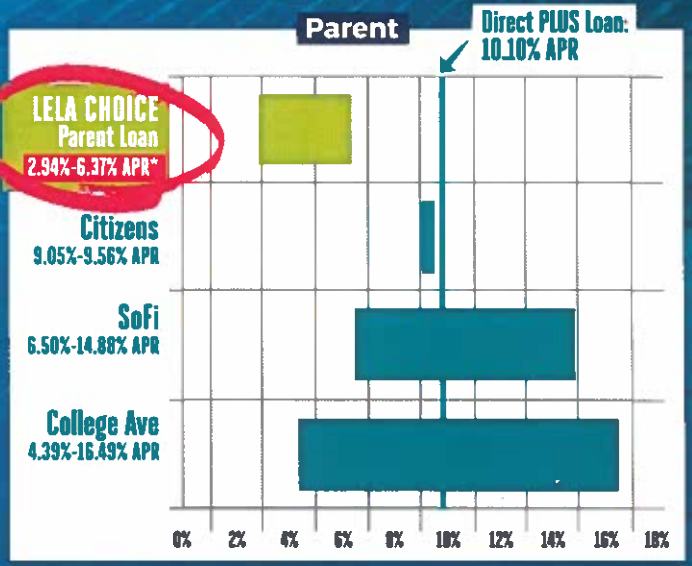
(with autopay).



The LelaCHOICE supplemental student loan program offers students and parents a more responsible financing option that can help fill the gap between the total education cost of attendance and the traditional sources (federal and state) of financial aid. This program provides Louisiana residents attending in-state and out-of-state eligible education programs as well as out of state students attending a Louisiana eligible institution an opportunity to access more affordable funds. Borrow up to cost of attendance minus other annual aid.

Compare LelaCHOICE rates to other lenders!





*SEE BACK FOR DISCLOSURE DETAILS.

visit lelachoice.org for more information and to apply.

Lela reserves the right to change the program in any way from time to time without notice.

100% nonprofit

Who we are

The Louisiana Education Authority (Lela) is a division of the Louisiana Public Facilities Authority (LPFA), a nonprofit public trust established to bring financing assistance and advantages to the people of Louisiana. As part of a nonprofit public trust, Lela's mission is to make higher education more accessible and affordable for the people of Louisiana.

How we give back

Together, Lela and the LPFA are committed to **making Louisiana a better place to live, work and raise our families** by furthering education, healthcare, economic development and job creation in the state. Since 1974, the LPFA has **issued over $31 billion in bonds to finance over 800 projects** which has helped to generate **more than 450,000 jobs** in Louisiana! Over the years, Lela has saved students over $23 million by paying the upfront fees for students on their federal student loans and through incentives has offered borrowers the potential to save over $255 million throughout repayment!

A PROGRAM OF Lela LOUISIANA EDUCATION LOAN AUTHORITY

*Many lenders only offer limited information about their actual rates upfront. They do not provide all the rate details within the range of rates depicted on these graphs. The specific rate an applicant is offered will be determined by the loan type selected and the applicant's or, if applicable, the cosigner's credit history and credit score. APRs were retrieved from the lenders' websites on May 7, 2024, for fixed-rate loans for student borrowers while the student is enrolled at least half time and for parent or family borrowers while the student for whom the loan being requested is enrolled at least half time. The ranges contain rates offered to applicants with a wide range of credit scores and for a variety of repayment options and terms.

Because each lender offers different in-school repayment options and different repayment terms, an identical loan comparison between lenders is not possible. However, the APRs in the chart are listed as the highest and lowest rates for each lender and include potential rate reductions that may not apply to every borrower. For example, a 0.25% automatic payment interest rate reduction (repayment benefit) has been included for the lowest rate displayed for all private lenders as well as the highest rate for Lela, SoFi and College Ave. For complete details on how APRs were calculated, visit the lenders' websites. **The U.S. Department of Education does not provide APR calculations for federal loans. As a guide for comparing costs, however, the expected costs of the Federal Direct PLUS Loan for 2024-2025 is approximately equivalent to an APR of 10.10%, which is based on borrowing $10,000, a 4.228% origination fee and a fixed interest rate of 9.08% during the 120-month principal and interest repayment period.**

visit **lelachoice.org** for more information and to apply.

Lela reserves the right to change the program in any way from time to time without notice.

LelaCHOICE

LOUISIANA'S NONPROFIT EDUCATION LOANS

Choose Quality. Choose Community. Choose Lela.



Louisiana's Nonprofit Education Loans

INTRODUCING

LelaCHOICE

LOUISIANA'S NONPROFIT EDUCATION LOANS

Choose Quality. Choose Community. Choose Lela.

Graduate
NO COSIGNER LOANS

- For Graduate Students
- Fixed Lower Interest Rates!
- No Origination or Processing Fees!
- No Capitalized Interest, ever!
- Earn an interest rate reduction with auto payment



LelaCHOICE No Cosigner Loan for Graduates

The **LelaCHOICE loan** is for graduate students enrolled at least half-time. When financial aid, savings and other income likely won't be enough to pay all college costs, this no-cosigner loan allows you to reach your goals and choose the in-school repayment options that works with your budget.

FIXED ANNUAL PERCENTAGE RATE
5.45% APR — 5.68% APR*
(WITH AUTOPAY)

FIXED ANNUAL PERCENTAGE RATE
5.70% APR — 5.80% APR*
(WITHOUT AUTOPAY)

100% nonprofit

*The 0.25% interest rate reduction will apply once principal and interest payments begin to be automatically deducted and will remain in effect as long as automatic payments continue without interruption during the repayment period. The 0.25 interest rate reduction will not lower the monthly payment amount but will instead reduce the interest amount that accrues. The interest rate reduction will be suspended during approved forbearance(s) or if automatic payments are rejected due to insufficient funds. In addition, unlike some lenders, Lela never capitalizes interest during repayment. That means you never pay interest on interest and can mean lower costs if you need to use forbearance to postpone payments at any point.

visit lelachoice.org for more information and to apply.

Lela reserves the right to change the program in any way from time to time without notice.



Explore refinancing your student loans **today!**

Fixed rates from 3.25% to 6.78%[APR]

Advantages & Benefits of refinancing through Lela:

- **Competitive fixed interest rates** and **no origination or hidden upfront fees**
- **Flexible Repayment terms and plans**
- **Zero Capitalized Interest**
- **Easy Application process**
- **Access to Free college planning & financing services**
- **0.25% interest rate reduction by selecting Automatic Payment Option**

[1] *Annual percentage rates (APRs) assume you are enrolled in and maintain auto-debit payments from the date of origination. Enrolling in auto-debit results in a 0.25% interest rate reduction. Without enrolling in auto-debit, the rate will range from 3.50% APR to 7.03% APR. Not all borrowers receive the lowest rate. If you are approved for a loan, the rate offered will depend on your credit profile and the term you select and will be within the ranges shown above assuming the auto-debit interest rate reduction applies.*

www.lelarefihelp.org

Lela RefiHELP℠
HIGHER EDUCATION LOAN PROGRAM

A LOUISIANA NON-PROFIT EDUCATION LOAN REFINANCING PROGRAM

PARTNER WITH A NON PROFIT AND HELP LOUISIANA THRIVE

Who we are

The Louisiana Education Authority (Lela) is a division of the Louisiana Public Facilities Authority (LPFA), a non-profit public trust established to bring financing assistance and advantages to the people of Louisiana. As part of a nonprofit public trust, Lela's mission is to make higher education more accessible and affordable for the people of Louisiana.

How we give back

Together, Lela and the LPFA are committed to **making Louisiana a better place to live, work and raise our families** by furthering education, healthcare, economic development and job creation in the state. Since 1974, the LPFA has **issued over $27 billion in bonds to finance over 600 projects** which has helped to generate **more than 327,110 jobs** in Louisiana! Over the years, Lela has saved students over $23 million by paying the upfront fees for students on their federal student loans and through incentives has offered borrowers the potential to save over $255 million throughout repayment!

www.lpfa.com **asklela.org**

LPFA

ask Lela

Lela RefiHELP offers you competitive, fixed-rate loans with flexible 5-, 10- or 15-year repayment terms.

LOUISIANA'S NON-PROFIT STUDENT LOAN REFINANCING PROGRAM AND TERMS

LOAN TERM	5-YEAR TERM	10-YEAR TERM	15-YEAR TERM
ORIGINATION FEE	0%	0%	0%
FIXED INTEREST RATE	3.25%-5.65% APR.*	4.38%-6.40% APR.*	4.88%-6.78% APR.*
REPAYMENT PERIOD	5 years (60 months)	10 years (120 months)	15 years (180 months)

** Rates reflect a 0.25% interest rate reduction obtained only when you use the automatic payment option. Applicants are subject to credit underwriting approval. For eligibility criteria and other details, please go to www.lelarefihelp.org*

Loan Limits

The Lela RefiHELP loan may only consist of current educational debt and must be:

- At least $5,000.
- No more than $175,000.

Repayment Benefits

Lela RefiHELP borrowers reduce the interest rate on their loans.

- 0.25% rate reduction if select Automatic Payment Option.



apply

Call our Lela representatives toll free at **(800) 228-4755** with any questions or visit **LelaRefiHELP.org** for more information.



Lela RefiHELP™
HIGHER EDUCATION LOAN PROGRAM

Lela RefiHELP loans are private loans and do not have the same repayment terms and offers as federal student loan programs. Lela reserves the right to change the program in any way without notice.
[1] Annual percentage rates (APRs) assume you are enrolled in and maintain auto-debit payments from the date of origination. Enrolling in auto-debit results in a 0.25% interest rate reduction. Without enrolling in auto-debit, the rate will range from 3.50% APR to 7.03% APR. Not all borrowers receive the lowest rate. If you are approved for a loan, the rate offered will depend on your credit profile and the term you select and will be within the ranges shown above assuming the auto-debit interest rate reduction applies.

John Fleming, MD
LOUISIANA STATE TREASURER

(225) 342-0010
latreasury.com

Post Office Box 44154
Baton Rouge, LA 70804

October 28, 2025

Honorable Senator Glen Womack, Chairman
Joint Legislative Committee on the Budget
Post Office Box 44486, Capitol Station
Baton Rouge, LA 70804

Dear Senator Womack:

Attached is a spreadsheet detailing requests for back pay for Deputy Sheriffs' Supplemental pay which has been approved by the Deputy Sheriff Supplemental Pay Board as per Act 110 of 1982. Please place this item on the agenda for the next meeting.

Total requested prior year funds: **$22,194.88**

If we may be of further assistance in this matter, please call me or email Philip Jungeblut at pjungeblut@treasury.la.gov.

Sincerely,

Katie O'Connor
Chairman
Deputy Sheriffs Supplemental Pay Board

KO/pj

Enclosures

FY25 Pending Payments

No.	Parish	Deputy Name	Dates Owed	Amount	Reason	Addl Info
1	East Baton Rouge	Britt, Terry	6/19/2025-6/30/2025	$236.64	Waiting on deputy documentation	Added on October 2025 reconciliation, received October 2, 2025
2	East Baton Rouge	Chatman, Aleya	6/19/2025-6/30/2025	$236.64	Waiting on deputy documentation	Added on October 2025 reconciliation, received October 2, 2025
3	East Baton Rouge	Henderson, Codie	6/19/2025-6/30/2025	$236.64	Waiting on deputy documentation	Added on October 2025 reconciliation, received October 2, 2025
4	East Baton Rouge	Jones, Braylon	6/19/2025-6/30/2025	$236.64	Waiting on deputy documentation	Added on October 2025 reconciliation, received October 2, 2025
5	East Baton Rouge	Pozzi Jr, Paul	6/17/2025-6/30/2025	$276.08	Waiting on deputy documentation	Added on September 2025 reconciliation, received September 18, 2025
6	East Baton Rouge	Zeitler, Michael	4/29/2025-6/30/2025	$1,239.44	Waiting on deputy documentation	Added on September 2025 reconciliation, received September 18, 2025
7	Franklin	Smith, Charles	6/25/2025-6/30/2025	$118.32	Hired after June 2025 reconciliation submitted	Added on July 2025 reconciliation, received September 2, 2025
8	Iberville	Bowie, Theauddues	5/30/2025-6/30/2025	$639.44	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 20, 2025
9	Iberville	New, David	6/11/2025-6/30/2025	$394.40	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 20, 2025
10	Lafourche	Jones, Alyssa	6/16/2025-6/30/2025	$225.32	Waiting on deputy documentation	Added on July 2025 reconciliation, received September 2, 2025
11	Orleans	Anders, Dwanna	4/25/2025-6/30/2025	$1,318.32	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 27, 2025
12	Orleans	Bryant, Reginald	6/1/2024-6/30/2024	$600.00	Waiting on deputy documentation	Added on June 2025 reconciliation, received June 25, 2025
13	Orleans	Coleman, Ashaki	5/20/2025-6/30/2025	$836.64	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 27, 2025
14	Orleans	Harris, Nicole	6/1/2024-6/30/2024	$600.00	Waiting on deputy documentation	Added on June 2025 reconciliation, received June 25, 2025
15	Orleans	Harrison, Quinton I	5/2/2025-6/30/2025	$1,191.60	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 27, 2025
16	Orleans	Johnson, Rayquain Karl	6/1/2024-6/30/2024	$600.00	Waiting on deputy documentation	Added on June 2025 reconciliation, received June 25, 2025
17	Orleans	Madrigal, Loy	5/14/2025-6/30/2025	$954.96	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 27, 2025
18	Orleans	Madrigal, Neil	5/24/2025-6/30/2025	$757.76	Waiting on deputy documentation	Added on September 2025 reconciliation, received September 19, 2025
19	Orleans	Morey, Michael	6/6/2025-6/30/2025	$493.00	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 27, 2025
20	Orleans	Paul, Cretia	5/1/2025-6/30/2025	$1,200.00	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 27, 2025
21	Orleans	Stone, Kenelle	5/20/2025-6/30/2025	$836.64	Waiting on deputy documentation	Added on August 2025 reconciliation, received August 27, 2025
22	Plaquemines	Brown, Latoya	4/8/2025-6/30/2025	$1,661.96	Waiting on deputy documentation	Added on August 2025 reconciliation, received September 9, 2025
23	Pointe Coupee	Lemar, Sarah	5/14/2025-6/30/2025	$954.96	Waiting on deputy documentation	Added on August 2025 reconciliation, received July 30, 2025
24	Rapides	Bardwell, Joshua	5/16/2025-6/30/2025	$915.52	Waiting on deputy documentation	Added on July 2025 reconciliation, received September 5, 2025
25	Rapides	Buch, Ashlee	6/9/2025-6/30/2025	$433.84	Waiting on deputy documentation	Added on July 2025 reconciliation, received September 5, 2025
26	St. Tammany	Dudas, Alexis	6/20/2025-6/30/2025	$216.92	Waiting on deputy documentation	Added on September 2025 reconciliation, received September 19, 2025
27	St. Tammany	Martina, Michael	6/20/2025-6/30/2025	$216.92	Waiting on deputy documentation	Added on September 2025 reconciliation, received September 19, 2025
28	St. Tammany	Muller, Wharton	01/09/2024-6/30/2024	$3,453.56	Change in job duties	Added on January 2025 reconciliation, received January 30, 2025
29	Webster	Sikes, Kerry	5/6/2025-6/30/2025	$1,112.72	Administrative oversight	Added on October 2025 reconciliation, received October 8, 2025
			Grand Total	**$22,194.88**		

November 17, 2025

DOTD REQUESTED JLCB AGENDA ITEM FOR NOVEMBER 20, 2025 MEETING

HB 406/ACT 167 (2022) PRESERVATION ACCOUNT: PARISH PROJECT SELECTION

PARISH	ROUTE	STATE PROJECT NO.	TREATMENT	ACT 167 (2022) ALLOCATION	COMMENTS
Allen	Castor Cotton Gin Road and Musselwhite Road	Local	Bridge Pile Replacement	$750,000	Funding is requested (to match additional Allen Parish Police Jury means of finance if required) so that the Police Jury can bid this work. This will complete the assignment of the $1,250,000 allocated to Allen Parish ($500,000 was approved for use on the Park Road Bridge Replacement by the JLCB on 10/25/2024)

Jeff Landry
Governor

LOUISIANA ECONOMIC DEVELOPMENT

Susan Bonnett Bourgeois
Secretary

November 4, 2025

Senator Glen Womack
Chairman, Joint Legislative Committee on the Budget
P.O. Box 44294
Baton Rouge, Louisiana 70804

Re: Request to be added to November JLCB Meeting Agenda

Dear Chairman Womack:

LA RS 51:2771 establishes the High Impact Jobs Program as the centerpiece of Louisiana Economic Development's (LED's) incentives. We sincerely appreciate the support that you and the entire Legislature provided for this program, as well as the continued support you are providing LED.

LED worked collaboratively with legislative fiscal staff and all eight of our regional economic development organizations in developing the High Impact Jobs Program rules. The rules were first published as an Emergency Rule in July, 2025, and then as a Notice of Intent in the August, 2025 *Louisiana Register*. On October 1, 2025, a public hearing was conducted, and on October 14, 2025, LED formally presented the rules to our oversight committees, the House Commerce Committee and the Senate Committee on Commerce, Consumer Protection and International Affairs.

Please accept this letter as LED's written request to be added to the November Committee Meeting Agenda as we are seeking JLCB approval of the High Impact Jobs Program rules in accordance with LA RS 51:2771(F).

Thank you for your consideration of this request. Should you have any questions, please do not hesitate to contact me or Chris Stelly, Director of Legislative Affairs.

Sincerely,

Susan Bonnett Bourgeois

Susan Bonnett Bourgeois
Secretary
Louisiana Economic Development

Jeff Landry
Governor

LOUISIANA ECONOMIC DEVELOPMENT

Susan Bonnett Bourgeois
Secretary

October 14, 2025

To Whom It May Concern:

Louisiana Economic Development ("LED") hereby announces its plan to proceed with rule-making by finalizing the High Impact Jobs Program Rules, published as an Emergency Rule in the July, 2025 *Louisiana Register* on pages 941-945, then as a Notice of Intent in the August, 2025 *Louisiana Register* on pages 1177-1181.

LED has worked collaboratively with legislative fiscal staff and all 8 regional economic development organizations ("REDO's") in developing the new High Impact Jobs Program and corresponding program rules, beginning with its legislative passage from House Bill 507, to final enactment as Act 372 of the 2025 Regular Session. Such collaboration and informational communications have continued throughout the rule promulgation process to today.

Likewise, LED staff have promoted the new program through informational outreach efforts to key industry stakeholders, addressing program features and benefits, and seeking feedback on proposed rules.

A public hearing was held on October 1, 2025, to discuss and receive comments on the proposed rules. It was attended by representatives from the following organizations: MMR Group, Didier Consultants, Advantous, Ryan, St. Tammany Economic Development Corporation, legislative and LED staff. No written comments have been received by LED in response to the Notice of Intent.

The overall response from public testimony, consultant and REDO feedback has been generally supportive, however, concerns have been raised specifically relating to program funding, to which LED responds as below:

Uncertain funding source and amount:
Act 372 created the High Impact Jobs Fund but did not provide an initial or recurring source of deposits. LED anticipates funding up to $125 Million annually beginning in FY27 and has begun marketing and administration of the program accordingly. Joint Legislative Committee on the Budget ("JLCB") approval of program rules and a legislative appropriation will both be required prior to issuance of any grant payments, which can be no earlier than July 1, 2026.

No cap or maximum grant awards:
There is currently not a total program cap or per company cap. Due to uncertain funding amounts and the new nature of the program, LED believes that award amounts at the discretion of the Secretary, after consideration of all relevant factors, including but not limited to available funding, is in the best interests of the State and program administration at this time.

Uncertainty regarding benefits for retention of workers with advanced degrees:
Due to uncertain funding amounts and the new nature of the program, LED believes that award amounts at the discretion of the Secretary, after consideration of all relevant factors, including but not limited to available funding, is in the best interests of the State and program administration at this time.

LED appreciates the knowledgeable input from all interested parties and recognizes the valid concerns raised, however, meaningful revisions cannot be made to program rules unless and until funding is confirmed. To delay promulgation of rules until such time would result in lost business attraction and economic development expansion opportunities for the State. After consideration of all input, LED therefore proposes to proceed as is with no further changes, and has notified all identified interested parties of its plan to move forward.

Subject to legislative oversight by the House or Senate Committees on Commerce, LED intends to submit for final publication as a Rule in the December 2025 *Louisiana Register*. Such rules to be contingent upon approval of the JLCB. *We therefore respectfully request to be added to the November meeting to formally present the proposed rules to JLCB for their approval.*

As always, we welcome your consideration and I can be reached at ph# 342-5406 with any questions.

Sincerely,



Stephanie Le Grange
Deputy General Counsel

cc: Joint Legislative Committee on the Budget
Senate, Committee on Commerce, Consumer Protection, and International Affairs
House of Representatives, Committee on Commerce

directed to Amy L. McInnis, Department of Agriculture & Forestry, 5825 Florida Blvd., Suite 3000, Baton Rouge, LA 70806 and must be received no later than 4 p.m. on September 10, 2025. All written comments must be signed and dated.

Public Hearing

No public hearing on this proposed Rule has been scheduled. If a public hearing is needed, all interested parties will be afforded an opportunity to submit data, views, or arguments either orally or in writing. Interested parties may submit a written request to conduct a public hearing to Amy L. McInnis, General Counsel, Department of Agriculture & Forestry, 5825 Florida Blvd., Suite 2000, Baton Rouge, LA 70806 or via email to legal@ldaf.state.la.us and must be received no later than 4 p.m. on September 10, 2025.

Mike Strain, DVM
Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Trichomoniasis

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule change is not anticipated to have any costs or savings to the Louisiana Department of Agriculture and Forestry (LDAF), other than the cost of promulgation, which is normally included in the agency's operating budget. There is no anticipated impact on local governmental units

The current rule requires that, within 30 days of purchase, bulls sent to a Trichomoniasis quarantine facility be tested for Trichomoniasis or be resold to slaughter. The proposed rule change eliminates the 30-day requirement for testing or resale.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change is not anticipated to increase or decrease revenue collections of state or local governmental units. The proposed rule change is intended to eliminate the 30-day requirement for testing or resale of bulls in trichomoniasis quarantine facilities, which would not result in any impact on revenue to LDAF or any other state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change could provide direct savings to cattle farmers by decreasing the testing interval for Trichomoniasis in bulls sent to a Trichomoniasis Quarantine Facility, while incurring no added risk of disease spread to other Louisiana cattle farmers.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change is not anticipated to influence competition or employment. The proposed rule change does not result in a competitive advantage to any group, as it merely removes the 30-day testing/resale requirement for all bulls in trichomoniasis quarantine facilities.

Dane Morgan
Assistant Commissioner
2508#029

Patrice Thomas
Deputy Fiscal Officer
Legislative Fiscal Office

RULE

~~NOTICE OF INTENT~~

Louisiana Economic Development
Office of Economic Development

High Impact Jobs Program (LAC 13:I.Chapter 53)

Louisiana Economic Development (LED), as authorized by and pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., R.S. 36:104 and Act 372 of the 2025 Regular Legislative Session, hereby ~~provide notice of their intent to promulgate~~ rules to be used by LED in administration of the High Impact Jobs Program.

Title 13
ECONOMIC DEVELOPMENT
Part I. Financial Incentive Programs
Chapter 53. High Impact Jobs Program
§5301. Purpose

A. The purpose of this Chapter is to implement the High Impact Jobs Program as established by R.S. 51:2771.

B. This Chapter shall be administered to achieve the following purposes:

1. to encourage companies to create jobs that pay above the parish average wage and offer a basic health plan; and

2. to encourage companies to retain highly skilled workers with advanced degrees.

C. Effective date of Act 372 of the 2025 Regular Legislative Session

1. The provisions of Act 372 of the 2025 Regular Legislative Session shall become effective July 1, 2025, however, Louisiana Economic Development shall not issue the first grant until on or after July 1, 2026.

D. Effective date of the program rules

1. Notwithstanding any provision of the Administrative Procedure Act to the contrary, rules promulgated are subject to the approval of the Joint Legislative Committee on the Budget.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5303. Definitions

A. Terms not otherwise defined in this Chapter shall have the same meaning given to them in R.S. 51:2771, unless the context clearly requires otherwise.

B. In this Chapter, the following terms shall have the meanings provided herein, unless the context clearly indicates otherwise.

Advanced Degree—any academic or professional degree earned after a bachelor's degree, such as a master's or doctorate. This term shall not include certifications that demonstrate a professional's proficiency in specific areas such as IT, unless otherwise approved by the secretary.

Applicant—a person requesting a grant award from LED under this program.

Baseline Jobs—the median statewide number of employees of company, including any named subsidiary in the contract, during the payroll periods including the twelfth day of the month, in the last twelve months completed prior

to the application date, or if a later contract effective date is elected and approved, the higher median number of jobs existing either during the payroll periods including the twelfth day of the month, in the last twelve months completed prior to the application date or the contract effective date, as verified on the applicable ES-4 form or equivalent filing form or other documentation as approved by LED. Baseline Jobs must be maintained in any year for which New Job creation benefits are requested.

Baseline Job Payroll—shall mean straight wages excluding overtime, bonus or relocation payments. Partial year employees' wages may be annualized.

Basic Health Benefits Plan—individual coverage for basic hospital care, physician care, and health care, effective no later than the first day of the month 90 days after hiring, that provides the same coverage as that provided to executive, administrative, and professional employees who are exempt from the minimum wage and maximum hour requirements of the federal Fair Labor Standards Act, 29 U.S.C. 2 201 et seq., and which LED determines to be in compliance with federally mandated healthcare requirements, or if no federally mandated healthcare requirements exist, as otherwise approved by LED. For the purposes of this Paragraph, the term "value" shall mean the cost to the company or the cost of equivalent coverage.

Company—an entity authorized to do business in Louisiana pursuant to state law.

Completion—the date on which all required steps for issuance of grant payments have been completed including but not limited to submission of an expenditure verification report and all necessary support documentation, and payment in full of any CPA fees.

Contract Effective Date—may be no earlier than the date that LED received the application and fee, but no later than 180 days after the application date.

Distressed Area—an area that is economically distressed or underdeveloped, which is defined as:

a. lowest 25 percent of parishes by average annual wage according to the Bureau of Labor Statistics (BLS), or

b. areas considered *Deeply Distressed* within the New Market Tax Credit program administered by the U.S. Department of the Treasury's (Treasury) Community Development Financial Institutions Fund (CDFI) in accordance with Internal Revenue Code 26 U.S.C. 45D, and applicable Treasury regulations 26 CFR 1.45D-1, as may be amended, or

c. projects that have a significant community impact, as demonstrated by the associated Regional Economic Development Organization (REDO), or

d. as approved by the secretary.

Expenditure Verification Report—a report of expenses prepared by an independent certified public accountant, selected by LED, paid for by the company, in accordance with R.S. 36:104.1.

Headquarters—the corporate domicile of the company, together with all executive and administrative jobs normally constituting a corporate headquarters, or the regional headquarters support services of the company, together with all executive and administrative jobs normally constituting a regional corporate headquarters.

Jobs—positions of employment that meet all of the following criteria:

a. did not exist in the state for that employer prior to the effective date of the incentive contract entered into pursuant to the provisions of this Chapter.

b. are for full-time, at-will employees. Does not include seasonal or temporary positions.

c. are directly employed by the company or a named subsidiary in the contract.

d. are filled onsite or remotely by Louisiana employees of the company or a named subsidiary in the contract.

e. include a basic health benefits plan.

f. is approved by the secretary.

g. as a general rule, jobs from an acquired Louisiana company shall not be considered a new job for the purposes of this program.

h. jobs shall not mean baseline jobs.

LED—Louisiana Economic Development

Louisiana Employee—a person who qualifies as a resident individual pursuant to R.S. 47:31(1)

New Job Totals—the total number of jobs minus Baseline Jobs

Parish Average Wage—the average wage in a parish as determined annually by the United States Department of Labor, Bureau of Labor Statistics, or its successor agency.

Person—any natural person or legal entity including an individual, corporation, partnership, or limited liability company

Project Site—a physical facility in Louisiana, operating with posted business hours and employing at least one full-time equivalent employee, as identified for a project on the program application

Qualifying Company—a company that is certified by LED as meeting the eligibility requirements of this Section and that has executed a contract with LED providing the terms and conditions for its participation in the program provided for in this Section.

Regional Average Wage—the average wage within the geographic boundaries of the regional economic development organization in which the project is located, as calculated by LED and posted on its website.

Regional Economic Development Organization—any of the following eight state organizations: the Baton Rouge Area Chamber; the Central Louisiana Economic Development Alliance; Greater New Orleans, Inc.; the Northeast Louisiana Economic Alliance; the North Louisiana Economic Partnership; One Acadiana; the South Louisiana Economic Council; the Southwest Louisiana Economic Development Alliance, or any of their successors. Abbreviated and also known as "REDO".

Retain—to keep employees within an organization

Secretary—Secretary of Louisiana Economic Development

Wages—compensation of an employee based on time worked or output of production but does not include overtime compensation, bonuses or relocation payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5305. General Principles

A. The following general principles will direct the administration of the program.

1. Grant awards are not to be considered as an entitlement for companies, and the secretary has the final authority to determine whether or not each particular applicant is eligible and meets the criteria of the grant award, and in all such circumstances, the exercise of that discretion shall be deemed to be a final determination of the applicant's award status.

2. Applications shall be accepted on a year round basis, subject to availability of funding in any given year, or as otherwise determined by LED.

3. As a general rule applicants may apply for more than one statutory benefit program administered by LED, provided that:

a. separate applications are submitted per program; and

b. program applicants do not receive a double benefit on the same expenditure or job.

4. Except that notwithstanding any other provision of law to the contrary, a company seeking the benefits of this High Impact Jobs Program shall not also receive rebates provided for under the Quality Jobs Program as provided for in R.S. 51:2451 through 2461.

B. Program funding.

1. Funding for this program is provided by any money transferred, donated, or appropriated to the High Impact Job Fund ("Fund").

2. LED may not authorize issuance of grant payments exceeding the available monies in the Fund.

3. The issuance of grant payments shall be subject to funding availability in any given fiscal year, and administered based upon a first come, first served basis, as determined by the completion date.

a. Any applicants with completions on the same business day shall be treated as received at the same time, and if the aggregate amount of requests received on a single business day exceed the amount of funding available, payments shall be made on a pro rata basis.

b. In the event the aggregate amount of requests exceed the annual program cap, the excess requests shall be treated as having been applied for on the first day of the subsequent year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5307. General Program Description

A. Companies primarily engaged in the following sectors are ineligible for participation in the program:

1. gaming;
2. retail sales;
3. professional sports teams;
4. state and political subdivision enterprises;
5. automotive rental and leasing;
6. local solid waste disposal;
7. local sewage systems;
8. local water systems;
9. professional service organizations primarily engaged in providing legal services;
10. professional service organizations primarily engaged in providing accounting services;
11. telemarketing and other call centers;
12. solar farms
13. motion picture and video industries, primarily engaged in producing, or producing and distributing, motion pictures, videos, televisions programs or commercials, broadly defined by NAICS Code 5121.
14. live entertainment and performing arts companies, primarily engaged in producing live presentations involving the performance of actors, singers, dancers and other performing artists, broadly defined by NAICS Code 7111.
15. LED may utilize economic impact methodology when evaluating submissions. Using this methodology, industries with a multiplier effect at or below 1.85 may be considered ineligible for program participation. LED shall maintain a listing by NAICS codes of such industries on its website, which may be updated annually.
16. non-profit organizations;
17. organizations primarily involved in political activities;
18. organizations primarily involved in advocacy activities;
19. organizations primarily involved in religious activities;
20. social organizations.

B. To ensure fair and transparent use of funds allocated for this program, sole proprietorships shall be considered ineligible for program participation, and small companies seeking to hire individuals closely connected to the business owner may be subject to heightened scrutiny or restrictions on related party transactions.

C. Companies primarily engaged in the following sectors are eligible for participation in the program:

1. industry sectors identified in LED's strategic plan, as may be amended from time to time;
2. energy and process industries, including but not limited to liquefied natural gas services, nuclear components and carbon ecosystem management;
3. logistics, including but not limited to ports and maritime freight, warehousing and transportation equipment;
4. aerospace and defense, including but not limited to ship building, instrument and propulsion unit manufacturing;
5. agribusiness, including but not limited to fertilizer and food manufacturing, precision and digital agriculture;
6. professional services, including but not limited to data centers and general management operations;
7. life sciences; including but not limited to medical device manufacturing, pharma manufacturing and biotech research and development;
8. technology services, including but not limited to robotics and industrial controls, IoT software and cybersecurity;
9. manufacturing;
10. biomedical or biotechnology industries;
11. corporate headquarters or regional headquarters of a multi-state business;

D. NAICS codes are one factor to be considered by LED in determining program eligibility, however, they shall not be considered dispositive for eligibility purposes.

E. For applications received on or after July 1, 2025, qualifying companies may be eligible for the following incentives:

1. A reimbursable grant based upon the annualized wages paid for qualifying new jobs, not to exceed two hundred thousand dollars per year, per job, based upon the

parish average wage paid where the project is located at the time the incentive contract is executed, subject to the following conditions;

a. eight percent for a project located in a distressed area with wages equal to or greater that one hundred and ten percent but less than one hundred and twenty five percent of the lesser of the parish average wage or the regional average wage;

b. eighteen percent for a project located in a parish with wages equal to or greater than one hundred and twenty five percent but less than one hundred and fifty percent of the parish average wage;

c. twenty-two percent for a project located in a parish with wages equal to or greater than one hundred and fifty percent of the parish average wage.

2. A reimbursable grant to retain highly skilled workers with advanced degrees, at the invitation of, and as approved by the secretary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5309. Application Procedure

A. LED will provide a standard application form which applicants will be required to use to apply for assistance under this program. Applications may be filed through LED's online Fastlane portal, or as otherwise directed by LED.

B. The application shall include, but not be limited to, the following information:

1. business name;
2. contact person and their title;
3. business physical address;
4. business phone number and email address;
5. brief description of the nature of the business;
6. number of existing employees;
7. number of proposed new jobs;
8. Secretary of State registration;
9. any additional information requested by LED;
10. In addition, applicants for projects located in a distressed region shall also provide the following:

a. evidence of the geographic boundaries of the distressed area;

b. letter of project support from the applicable regional economic development organization.

C. A non-refundable application fee shall be submitted with the application in accordance with R.S. 36:104.

D. A refundable expenditure verification report deposit shall also be submitted with the application, in accordance with R.S. 36:104.1. As a general rule, the deposit fee shall be $7,500.00.

1. The expenditure verification report deposit fee may be waived or reduced at the discretion of the secretary for good cause shown. In which case, the applicant will remain liable for payment in full of the actual cost of accounting services, with payment to be made in full at a later date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5311. Selection Criteria

A. LED may consider various discretionary factors when determining which applications will be funded. Among the factors which may be taken into consideration are the following;

1. industry sectors identified in LED's strategic plan, as may be amended from time to time;
2. letters of project support from the applicable regional economic development organization;
3. disbursing of funding statewide;
4. availability of funding; and
5. best interests of the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5313. LED Action—Grant Approval or Denial Provisions

A. In the event LED determines that an applicant is eligible, funding is available and a grant would be appropriate, a contract will be issued, specifying the amount, the terms and conditions of the grant. Companies with project sites located in distressed areas may be subject to in-office work requirements.

1. The initial term of the contract shall be for three years;
2. The contract may be renewed for a single two-year period, if the grant recipient has complied with all terms and conditions of the contract and has not failed to perform any act which would have made the applicant default on any terms of the contract.

a. Applications for renewal shall be filed with LED in the same manner as the original request, not more than six months before, and not later than the expiration of the initial contract, and shall include an application fee and expenditure verification report deposit fee, in accordance with R.S. 36:104 and R.S. 36:104.1.

b. Applications for renewal after the expiration of the initial contract shall be considered late, and may be subject to an additional late filing fee, in accordance with R.S. 36:104.

B. A qualifying company with an executed contract shall make a request for reimbursement as follows:

1. Company shall notify LED that they are ready to proceed and make a cost report of expenses available for inspection by the independent certified accountant assigned by LED, including evidence of basic health plans provided if applicable, and any additional information as may be requested.
2. Requests may be submitted either annually or at the end of the initial or contract renewal periods, as applicable.
3. Upon completion, independent CPA shall submit the expenditure verification report to LED and the applicant, and a final invoice for accounting services rendered.
4. Company shall be refunded any amount in excess of its advance deposit or notified of any final amount due for accounting services.
5. After company payment of any outstanding fees, LED shall review the expenditure verification report and any other applicable support documentation, and upon a determination of qualification, LED shall make payment to the applicant.

C. In the event an application is denied, or if a reimbursement request is denied in whole or part, LED shall issue a written denial, specifying the basis for denial.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5315. Return of Benefits

A. If a company receives a grant award pursuant to this High Impact Jobs Program and it is subsequently determined that the company did not qualify for the benefit then:

1. Future payments to the company shall be reduced by the amount wrongfully received by the company; or,

2. If there are no future payments due the company from which to deduct the amount owed, LED may recover any monies wrongfully obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

Family Impact Statement

The proposed Rule is not anticipated to have an impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

The proposed Rule is not anticipated to have an impact on poverty as described in R.S. 49:973.

Provider Impact Statement

The proposed Rule is not anticipated to have an impact on providers of services as described in HCR 170 of the 2014 Regular Legislative Session.

Small Business Analysis

The proposed Rule is not anticipated to have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic factors has considered and, where possible, utilized regulatory methods in drafting the proposed Rule to accomplish the objectives of applicable statutes while minimizing any anticipated adverse impact on small businesses.

Public Comments

Interested persons should submit written comments on the proposed Rules to Stephanie LeGrange through the close of business on Tuesday, September 30, 2025 at the Louisiana Economic Development, 617 North 3rd Street, 11th Floor, Baton Rouge, LA 70802 or via email to Stephanie.LeGrange@la.gov.

Public Hearing

A meeting for the purpose of receiving the presentation of oral comments will be held at 10 a.m. on Wednesday, October 1, 2025 at the La Salle Building, 617 North Third Street, La Belle Room, Baton Rouge, LA 70802.

Anne G. Villa
Deputy Secretary/CFO

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: High Impact Jobs Program

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule is anticipated to increase statutory dedication expenditures out of the High Impact Jobs Fund by an indeterminable amount beginning in FY 27. The total amount of expenditures within the program will depend upon the applications received, subsequent contracts entered into and fulfilled by participating companies in the program, and a legislative appropriation. No annual limit on the program's expenditures exists. LED estimates programmatic spending will be limited to $125 M annually beginning in FY 27. Existing staff in LED will be able to administer the program. LED is anticipated to increase SGF spending by $100,000 in FY 26 on one-time expenses for software used for applications and tracking.

The proposed rule establishes program guidelines for the High Impact Jobs Program authorized by Act 372 (Act) of the 2025 Regular Session. The Act creates a ten-year High Impact Jobs Program within Louisiana Economic Development (LED), allowing LED to issue program grants beginning in FY 27 to certain businesses for salaries paid above the parish wage (or regional average wage for Distressed Areas) for newly created jobs or the retention of labor with advanced degrees. The rate for grants to reimburse companies that create new jobs is specified in the rules. However, the grant reimbursement rate for labor with advanced degrees retained is unspecified and therefore subjective. No limit exists on the number of new jobs or quantity of labor retained for which a company may be reimbursed.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Act 372 of the 2025 RS creates the High Impact Jobs Fund but does not provide an initial or recurring source of deposits. LED anticipates funding of up to $125 million annually beginning in FY 27. LFO assumes any funds deposited into the new statutory dedication will be appropriated by the Legislature, presumably from a SGF equivalent source.

Beginning July 1, 2025, LED will accept and consider program applications. Application fees received for the program are anticipated to increase self-generated revenue by an indeterminable amount, depending on the number of applications received. However, program rules must first be approved by the Joint Legislative Committee on the Budget (JLCB), and a legislative appropriation will be required prior to issuance of any grant payments, which can be no earlier than July 1, 2026.

The proposed rule will not affect local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS (Summary)

The program will directly benefit businesses that receive awards by providing them with additional grant funding from the state. Applying businesses will be subject to an application fee and compliance requirements, but these requirements should not be significant and should be outweighed by the benefits should a grant award be received.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Companies receiving benefits under this program will gain a competitive advantage over companies that do not receive the program's benefits. Employment may increase in participating businesses that receive grants for new jobs. For businesses that receive grants for retaining labor with advanced degrees, employment is anticipated to remain stable.

Anne G. Villa
Deputy Secretary/CFO
2508#051

Alan M. Boxberger
Legislative Fiscal Officer
Legislative Fiscal Office

OFFICE OF THE STATE REGISTER INSERTION ORDER (eff 08 02)

Claiborne Building 1201 North Third Street Suite 3-220 Post Office Box 94095
Baton Rouge, LA 70804-9095 (225)342-5015 FAX (225)342-0284

(SUBMIT 1 SEPARATE INSERTION ORDER PER DOCUMENT)

☐ EMERGENCY RULE ☒ NOTICE OF INTENT ☐ RULE ☐ POTPOURRI

REFER TO INSTRUCTIONS ON REVERSE SIDE

This is your authority to publish in the (month) August 20 25 *Louisiana Register* the document indicated above

Office of Economic Development
Office Board Commission promulgating this document

Louisiana Economic Development
Department under which office board commission is classified

Anne G. Villa, Deputy Secretary/CFO
(name) (title)
Name and title of person whose signature will appear in the publication (at the end of the document)

S. Le Grange 342-5406
(name) (phone) (fax)
Name, phone number, and FAX number of person to contact regarding this document

Stephanie.LeGrange@la.gov
E-mail address of contact person

High Impact Jobs Program
Short descriptive listing for this document to be used in the *Louisiana Register's* TABLE OF CONTENTS/INDEX

File name

Important: If submitting both an Emergency Rule (ER) and a Notice of Intent (NOI) to be published this month, **AND** if the rule text in the ER is identical to the rule text in the NOI, check here: ☐

Signature of Agency Head or Designee

Anne G. Villa, Deputy Secretary/CFO
Print Name and Title of Agency Head or Designee

CERTIFICATION OF AVAILABLE FUNDS DOCUMENT #_____

LAGOV AGENCY: I certify the availability of fiscal year _____ appropriated funds for the payment of the above referenced publication and authorize the processing of an Interagency Billing with the following coding on the 30th of the month of the publication. Attach supplemental sheet for additional lines of coding

252		2522141400		252000000			
Business Area	**General Ledger**	**Cost Center**	**Grant**	**Fund**	**WBS**	**Internal Order**	**Functional**

NON-LAGOV AGENCY: I certify the availability of fiscal year _____ appropriated funds for the payment of the above referenced publication and agree to place corresponding invoice in line for payment upon receipt.

Signature of Agency Head or Designee - Phone # 342-3000

Billing Contact Information:

Louisiana Economic Development
Agency Name

Taylor Richard
Agency Contact Person for Billing

Taylor.Richard@la.gov
Agency E-Mail Address for Billing

NOTE: Detailed billing information will be provided via a publishing invoice sent to the Billing Contact Information provided.

NOTICE OF INTENT

Louisiana Economic Development
Office of Economic Development

High Impact Jobs Program (LAC 13:I.Chapter 53)

Louisiana Economic Development (LED), as authorized by and pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., R.S. 36:104 and Act 372 of the 2025 Regular Legislative Session, hereby provide notice of their intent to promulgate rules to be used by LED in administration of the High Impact Jobs Program.

Title 13
Economic Development
Part I. Financial Incentive Programs
Chapter 53. High Impact Jobs Program

§5301. Purpose

A. The purpose of this Chapter is to implement the High Impact Jobs Program as established by R.S. 51:2771.

B. This Chapter shall be administered to achieve the following purposes:

1. to encourage companies to create jobs that pay above the parish average wage and offer a basic health plan; and

2. to encourage companies to retain highly skilled workers with advanced degrees.

C. Effective date of Act 372 of the 2025 Regular Legislative Session

1. The provisions of Act 372 of the 2025 Regular Legislative Session shall become effective July 1, 2025, however, Louisiana Economic Development shall not issue the first grant until on or after July 1, 2026.

D. Effective date of the program rules

1. Notwithstanding any provision of the Administrative Procedure Act to the contrary, rules promulgated are subject to the approval of the Joint Legislative Committee on the Budget.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771.

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5303. Definitions

A. Terms not otherwise defined in this Chapter shall have the same meaning given to them in R.S. 51:2771, unless the context clearly requires otherwise.

B. In this Chapter, the following terms shall have the meanings provided herein, unless the context clearly indicates otherwise.

Advanced Degree—any academic or professional degree earned after a bachelor's degree, such as a master's or doctorate. This term shall not include certifications that demonstrate a professional's proficiency in specific areas such as IT, unless otherwise approved by the secretary.

Applicant—a person requesting a grant award from LED under this program.

Baseline Jobs—the median statewide number of employees of company, including any named subsidiary in the contract, during the payroll periods including the twelfth day of the month, in the last twelve months completed prior to the application date, or if a later contract effective date is elected and approved, the higher median number of jobs existing either during the payroll periods including the twelfth day of the month, in the last twelve months completed prior to the application date or the contract effective date, as verified on the applicable UI-4 form or equivalent filing form or other documentation as approved by LED. Baseline Jobs must be maintained in any year for which New Job creation benefits are requested.

Baseline Job Payroll—shall mean straight wages excluding overtime, bonus or relocation payments. Partial year employees' wages may be annualized.

Basic Health Benefits Plan—individual coverage for basic hospital care, physician care, and health care effective no later than the first day of the month 90 days after hiring, that provides the same coverage as that provided to executive, administrative, and professional employees who are exempt from the minimum wage and maximum hour requirements of the federal Fair Labor Standards Act, 29 U.S.C. 2 201 et seq., and which LED determines to be in compliance with federally mandated healthcare requirements, or if no federally mandated healthcare requirements exist, as otherwise approved by LED. For the purposes of this Paragraph, the term "value" shall mean the cost to the company or the cost of equivalent coverage.

Company—an entity authorized to do business in Louisiana pursuant to state law.

Completion—the date on which all required steps for issuance of grant payments have been completed including but not limited to submission of an expenditure verification report and all necessary support documentation, and payment in full of any CPA fees.

Contract Effective Date—may be no earlier than the date that LED received the application and fee, but no later than 180 days after the application date.

Distressed Area—an area that is economically distressed or underdeveloped, which is defined as:

a. lowest 25 percent of parishes by average annual wage according to the Bureau of Labor Statistics (BLS), or

b. areas considered *Deeply Distressed* within the New Market Tax Credit program administered by the U.S. Department of the Treasury's (Treasury) Community Development Financial Institutions Fund (CDFI) in accordance with Internal Revenue Code 26 U.S.C. 45D, and applicable Treasury regulations 26 CFR 1.45D-1, as may be amended, or

c. projects that have a significant community impact, as demonstrated by the associated Regional Economic Development Organization (REDO), or

d. as approved by the secretary.

Expenditure Verification Report—a report of expenses prepared by an independent certified public accountant, selected by LED, paid for by the company, in accordance with R.S. 36:104.1.

Headquarters—the corporate domicile of the company, together with all executive and administrative jobs normally constituting a corporate headquarters, or the regional headquarters support services of the company, together with all executive and administrative jobs normally constituting a regional corporate headquarters.

Jobs—positions of employment that meet all of the following criteria:

a. did not exist in the state for that employer prior to the effective date of the incentive contract entered into pursuant to the provisions of this Chapter.

b. are for full-time, at-will employees. Does not include seasonal or temporary positions.

c. are directly employed by the company or a named subsidiary in the contract.

d. are filled onsite or remotely by Louisiana employees of the company or a named subsidiary in the contract;

e. include a basic health benefits plan;

f. is approved by the secretary;

g. as a general rule, jobs from an acquired Louisiana company shall not be considered a new job for the purposes of this program;

h. jobs shall not mean baseline jobs.

LED—Louisiana Economic Development.

Louisiana Employee—a person who qualifies as a resident individual pursuant to R.S. 47.31(1).

New Job Totals—the total number of jobs minus Baseline Jobs.

Parish Average Wage—the average wage in a parish as determined annually by the United States Department of Labor, Bureau of Labor Statistics, or its successor agency.

Person—any natural person or legal entity including an individual, corporation, partnership, or limited liability company.

Project Site—a physical facility in Louisiana, operating with posted business hours and employing at least one full-time equivalent employee, as identified for a project on the program application.

Qualifying Company—a company that is certified by LED as meeting the eligibility requirements of this Section and that has executed a contract with LED providing the terms and conditions for its participation in the program provided for in this Section.

Regional Average Wage—the average wage within the geographic boundaries of the regional economic development organization in which the project is located, as calculated by LED and posted on its website.

Regional Economic Development Organization—any of the following eight state organizations: the Baton Rouge Area Chamber; the Central Louisiana Economic Development Alliance; Greater New Orleans, Inc.; the Northeast Louisiana Economic Alliance; the North Louisiana Economic Partnership; One Acadiana; the South Louisiana Economic Council; the Southwest Louisiana Economic Development Alliance, or any of their successors. Abbreviated and also known as "REDO".

Retain—to keep employees within an organization.

Secretary—Secretary of Louisiana Economic Development.

Wages—compensation of an employee based on time worked or output of production but does not include overtime compensation, bonuses or relocation payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771.

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5305. General Principles

A. The following general principles will direct the administration of the program.

1. Grant awards are not to be considered as an entitlement for companies, and the secretary has the final authority to determine whether or not each particular applicant is eligible and meets the criteria of the grant award, and in all such circumstances, the exercise of that discretion shall be deemed to be a final determination of the applicant's award status.

2. Applications shall be accepted on a year round basis, subject to availability of funding in any given year, or as otherwise determined by LED.

3. As a general rule applicants may apply for more than one statutory benefit program administered by LED, provided that:

a. separate applications are submitted per program, and

b. program applicants do not receive a double benefit on the same expenditure or job.

4. Except that notwithstanding any other provision of law to the contrary, a company seeking the benefits of this High Impact Jobs Program shall not also receive rebates provided for under the Quality Jobs Program as provided for in R.S. 51:2451 through 2461.

B. Program funding.

1. Funding for this program is provided by any money transferred, donated, or appropriated to the High Impact Job Fund ("Fund").

2. LED may not authorize issuance of grant payments exceeding the available monies in the Fund.

3. The issuance of grant payments shall be subject to funding availability in any given fiscal year, and administered based upon a first come, first served basis, as determined by the completion date.

a. Any applicants with completions on the same business day shall be treated as received at the same time, and if the aggregate amount of requests received on a single business day exceed the amount of funding available, payments shall be made on a pro rata basis.

b. In the event the aggregate amount of requests exceed the annual program cap, the excess requests shall be treated as having been applied for on the first day of the subsequent year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771.

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5307. General Program Description

A. Companies primarily engaged in the following sectors are ineligible for participation in the program:

1. gaming;
2. retail sales;
3. professional sports teams;
4. state and political subdivision enterprises;
5. automotive rental and leasing;
6. local solid waste disposal;
7. local sewage systems;
8. local water systems;
9. professional service organizations primarily engaged in providing legal services;
10. professional service organizations primarily engaged in providing accounting services;
11. telemarketing and other call centers;
12. solar farms;
13. motion picture and video industries, primarily engaged in producing, or producing and distributing, motion pictures, videos, televisions programs or commercials, broadly defined by NAICS Code 5121.
14. live entertainment and performing arts companies, primarily engaged in producing live presentations involving the performance of actors, singers, dancers and other performing artists, broadly defined by NAICS Code 7111.

15. LED may utilize economic impact methodology when evaluating submissions. Using this methodology, industries with a multiplier effect at or below 1.85 may be considered ineligible for program participation. LED shall maintain a listing by NAICS codes of such industries on its website, which may be updated annually.

16. non-profit organizations;

17. organizations primarily involved in political activities;

18. organizations primarily involved in advocacy activities;

19. organizations primarily involved in religious activities;

20. social organizations.

B. To ensure fair and transparent use of funds allocated for this program, sole proprietorships shall be considered ineligible for program participation, and small companies seeking to hire individuals closely connected to the business owner may be subject to heightened scrutiny or restrictions on related party transactions.

C. Companies primarily engaged in the following sectors are eligible for participation in the program:

1. industry sectors identified in LED's strategic plan, as may be amended from time to time;

2. energy and process industries, including but not limited to liquefied natural gas services, nuclear components and carbon ecosystem management;

3. logistics, including but not limited to ports and maritime freight, warehousing and transportation equipment;

4. aerospace and defense, including but not limited to ship building, instrument and propulsion unit manufacturing;

5. agribusiness, including but not limited to fertilizer and food manufacturing, precision and digital agriculture;

6. professional services, including but not limited to data centers and general management operations;

7. life sciences; including but not limited to medical device manufacturing, pharma manufacturing and biotech research and development;

8. technology services, including but not limited to robotics and industrial controls, IoT software and cybersecurity;

9. manufacturing;

10. biomedical or biotechnology industries;

11. corporate headquarters or regional headquarters of a multi-state business;

D. NAICS codes are one factor to be considered by LED in determining program eligibility, however, they shall not be considered dispositive for eligibility purposes.

E. For applications received on or after July 1, 2025, qualifying companies may be eligible for the following incentives:

1. A reimbursable grant based upon the annualized wages paid for qualifying new jobs, not to exceed two hundred thousand dollars per year, per job, based upon the parish average wage paid where the project is located at the time the incentive contract is executed, subject to the following conditions;

a. Eight percent for a project located in a distressed area with wages equal to or greater that one hundred and ten percent but less than one hundred and twenty five percent of the lesser of the parish average wage or the regional average wage;

b. eighteen percent for a project located in a parish with wages equal to or greater than one hundred and twenty five percent but less than one hundred and fifty percent of the parish average wage.

c. twenty-two percent for a project located in a parish with wages equal to or greater than one hundred and fifty percent of the parish average wage.

2. A reimbursable grant to retain highly skilled workers with advanced degrees at the invitation of, and as approved by the secretary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771.

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5309. Application Procedure

A. LED will provide a standard application form which applicants will be required to use to apply for assistance under this program. Applications may be filed through LED's online Fastlane portal, or as otherwise directed by LED.

B. The application shall include, but not be limited to, the following information:

1. business name;
2. contact person and their title;
3. business physical address;
4. business phone number and email address;
5. brief description of the nature of the business;
6. number of existing employees;
7. number of proposed new jobs;
8. Secretary of State registration;
9. any additional information requested by LED;
10. In addition, applicants for projects located in a distressed region shall also provide the following:

a. evidence of the geographic boundaries of the distressed area;

b. letter of project support from the applicable regional economic development organization.

C. A non-refundable application fee shall be submitted with the application in accordance with R.S. 36:104.

D. A refundable expenditure verification report deposit shall also be submitted with the application, in accordance with R.S. 36:104.1. As a general rule, the deposit fee shall be $7,500.00.

1. The expenditure verification report deposit fee may be waived or reduced at the discretion of the secretary for good cause shown. In which case, the applicant will remain liable for payment in full of the actual cost of accounting services, with payment to be made in full at a later date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771.

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5311. Selection Criteria

A. LED ~~will~~ may consider various discretionary factors when determining which applications will be funded. Among the factors which may be taken into consideration are the following;

1. industry sectors identified in LED's strategic plan, as may be amended from time to time;

2. letters of project support from the applicable regional economic development organization;

3. disbursing of funding statewide;

4. availability of funding; and

5. best interests of the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771.

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5313. LED Action—Grant Approval or Denial Provisions

A. In the event LED determines that an applicant is eligible, funding is available and a grant would be appropriate, a contract will be issued, specifying the amount, the terms and conditions of the grant. Companies with project sites located in distressed areas may be subject to in-office work requirements.

1. The initial term of the contract shall be for three years;

2. The contract may be renewed for a single two-year period, if the grant recipient has complied with all terms and conditions of the contract and has not failed to perform any act which would have made the applicant default on any terms of the contract.

a. Applications for renewal shall be filed with LED in the same manner as the original request, not more than six months before, and not later than the expiration of the initial contract, and shall include an application fee and expenditure verification report deposit fee, in accordance with R.S. 36:104 and R.S. 36:104.1.

b. Applications for renewal after the expiration of the initial contract shall be considered late, and may be subject to an additional late filing fee, in accordance with R.S. 36:104.

B. A qualifying company with an executed contract shall make a request for reimbursement as follows:

1. Company shall notify LED that they are ready to proceed and make a cost report of expenses available for inspection by the independent certified accountant assigned by LED, including evidence of basic health plans provided if applicable, and any additional information as may be requested.

2. Requests may be submitted either annually or at the end of the initial or contract renewal periods, as applicable.

3. Upon completion, independent CPA shall submit the expenditure verification report to LED and the applicant, and a final invoice for accounting services rendered.

4. Company shall be refunded any amount in excess of its advance deposit or notified of any final amount due for accounting services.

5. After company payment of any outstanding fees, LED shall review the expenditure verification report and any other applicable support documentation, and upon a determination of qualification, LED shall make payment to the applicant.

C. In the event an application is denied, or if a reimbursement request is denied in whole or part, LED shall issue a written denial, specifying the basis for denial.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

§5315. Return of Benefits

A. If a company receives a grant award pursuant to this High Impact Jobs Program and it is subsequently determined that the company did not qualify for the benefit then:

1. Future payments to the company shall be reduced by the amount wrongfully received by the company; or,

2. If there are no future payments due the company from which to deduct the amount owed, LED may recover any monies wrongfully obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:104 and R.S. 51:2771

HISTORICAL NOTE: Promulgated by Louisiana Economic Development, Office of Economic Development, LR 51:

Family Impact Statement

The proposed Rule is not anticipated to have an impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Statement

The proposed Rule is not anticipated to have an impact on poverty as described in R.S. 49:973.

Provider Impact Statement

The proposed Rule is not anticipated to have an impact on providers of services as described in HCR 170 of the 2014 Regular Legislative Session.

Small Business Statement

The proposed Rule is not anticipated to have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic factors has considered and, where possible, utilized regulatory methods in drafting the proposed rule to accomplish the objectives of applicable statutes while minimizing any anticipated adverse impact on small businesses.

Public Comments

Interested persons should submit written comments on the proposed Rules to Stephanie Le Grange through the close of business on **Tuesday, September 30, 2025** at the Louisiana Economic Development, 617 North 3rd Street, 11th Floor, Baton Rouge, LA 70802 or via email to Stephanie.LeGrange@la.gov.

Public Hearing

A meeting for the purpose of receiving the presentation of oral comments will be held at **10:00 a.m.** on **Wednesday, October 1, 2025** at the La Salle Building, 617 North Third Street, La Belle Room, Baton Rouge, LA 70802.

Anne G. Villa
Deputy Secretary CFO

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

Person Preparing Statement:	Stephanie Le Grange	Dept	Louisiana Economic Development
Phone	225-342-5406	Office	Office of Economic Development
Return Address	617 North Third Street	Rule Title	High Impact Jobs Program
	Baton Rouge, LA 70802		
		Date Rule Takes Effect:	Upon promulgation

SUMMARY
(Use complete sentences)

In accordance with Section 961 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a fiscal and economic impact statement on the rule proposed for adoption, repeal, or amendment. THE FOLLOWING STATEMENTS SUMMARIZE ATTACHED WORKSHEETS I THROUGH IV AND WILL BE PUBLISHED IN THE LOUISIANA REGISTER WITH THE PROPOSED AGENCY RULE.

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule is anticipated to increase statutory dedication expenditures out of the High Impact Jobs Fund by an indeterminable amount beginning in FY 27. The total amount of expenditures within the program will depend upon the applications received, subsequent contracts entered into and fulfilled by participating companies in the program, and a legislative appropriation. No annual limit on the program's expenditures exists. LED estimates programmatic spending will be limited to $125 M annually beginning in FY 27. Existing staff in LED will be able to administer the program. LED is anticipated to increase SGF spending by $100,000 in FY 26 on one-time expenses for software used for applications and tracking.

The proposed rule establishes program guidelines for the High Impact Jobs Program authorized by Act 372 (Act) of the 2025 Regular Session. The Act creates a ten-year High Impact Jobs Program within Louisiana Economic Development (LED), allowing LED to issue program grants beginning in FY 27 to certain businesses for salaries paid above the parish wage (or regional average wage for Distressed Areas) for newly created jobs or the retention of labor with advanced degrees. The rate for grants to reimburse companies that create new jobs is specified in the rules. However, the grant reimbursement rate for labor with advanced degrees retained is unspecified and therefore subjective. No limit exists on the number of new jobs or quantity of labor retained for which a company may be reimbursed.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Act 372 of the 2025 RS creates the High Impact Jobs Fund but does not provide an initial or recurring source of deposits. LED anticipates funding of up to $125 million annually beginning in FY 27. LFO assumes any funds deposited into the new statutory dedication will be appropriated by the Legislature, presumably from a SGF equivalent source.

Beginning July 1, 2025, LED will accept and consider program applications. Application fees received for the program are anticipated to increase self-generated revenue by an indeterminable amount, depending on the number of applications received. However, program rules must first be approved by the Joint Legislative Committee on the Budget (JLCB), and a legislative appropriation will be required prior to issuance of any grant payments, which can be no earlier than July 1, 2026.

The proposed rule will not affect local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NON-GOVERNMENTAL GROUPS (Summary)

The program will directly benefit businesses that receive awards by providing them with additional grant funding from the state. Applying businesses will be subject to an application fee and compliance requirements, but these requirements should not be significant and should be outweighed by the benefits should a grant award be received.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Companies receiving benefits under this program will gain a competitive advantage over companies that do not receive the program's benefits. Employment may increase in participating businesses that receive grants for new jobs. For businesses that receive grants for retaining labor with advanced degrees, employment is anticipated to remain stable.

Signature of Agency Head or Designee

Legislative Fiscal Officer or Designee

Anne G. Villa, Deputy Secretary, OTED

Typed Name & Title of Agency Head or Designee

August 6, 2005

Date of Signature

8/8/05

Date of Signature

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

The following information is required in order to assist the Legislative Fiscal Office in its review of the fiscal and economic impact statement and to assist the appropriate legislative oversight subcommittee in its deliberation on the proposed rule.

A Provide a brief summary of the content of the rule (if proposed for adoption, or repeal) or a brief summary of the change in the rule (if proposed for amendment). Attach a copy of the notice of intent and a copy of the rule proposed for initial adoption or repeal (or, in the case of a rule change, copies of both the current and proposed rules with amended portions indicated).

The proposed rule establishes program rules for the High Impact Jobs Program

B Summarize the circumstances which require this action. If the Action is required by federal regulation, attach a copy of the applicable regulation.

Act 372 of the 2025 RS created the program, to be administered by LED.

C Compliance with Act 11 of the 1986 First Extraordinary Session

(1) Will the proposed rule change result in any increase in the expenditure of funds? If so, specify amount and source of funding.

Yes, the proposed rules may result in an increase in expenditures.

(2) If the answer to (1) above is yes, has the Legislature specifically appropriated the funds necessary for the associated expenditure increase?

(a) _____ Yes. If yes, attach documentation

(b) ___X___ NO. If no, provide justification as to why this rule change should be published at this time

Act 372 created the High Impact Jobs Fund. To date, the Legislature has not specifically appropriated the funds necessary for the associated program costs; however, LED anticipates funding of up to $125 million annually beginning in FY 27. LFO assumes any funds deposited into the new statutory dedication will be appropriated by the Legislature, presumably from a SGF equivalent source.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

I. A. COSTS OR SAVINGS TO STATE AGENCIES RESULTING FROM THE ACTION PROPOSED

1. What is the anticipated increase (decrease) in costs to implement the proposed action?

COSTS	FY 26	FY 27	FY 28
Personal Services	$0	$0	$0
Operating Expenses	$0	$0	$0
Professional Services	$0	$0	$0
Other Charges	$100,000	Increase	Increase
Equipment	$0	$0	$0
Major Repairs & Constr.	$0	$0	$0
TOTAL	$100,000	Increase	Increase
POSITIONS (#)	0	0	0

2. Provide a narrative explanation of the costs or savings shown in "A. 1.", including the increase or reduction in workload or additional paperwork (number of new forms, additional documentation, etc.) anticipated as a result of the implementation of the proposed action. Describe all data, assumptions, and methods used in calculating these costs.

The proposed rule is anticipated to increase statutory dedication expenditures out of the High Impact Jobs Fund by an indeterminable amount beginning in FY 27. The total amount of expenditures within the program will depend upon the applications received, subsequent contracts entered into and fulfilled by participating companies in the program, and legislative appropriation. No annual limit on the program's expenditures exists. LED estimates programmatic spending will be limited to $125 M annually beginning in FY 27. Existing staff in LED will be able to administer the program. LED is anticipated to increase SGF spending by $100,000 in FY 26 on one-time expenses for software used for applications and tracking.

LED will issue program grants beginning in FY 27 to certain businesses for salaries paid above the parish wage (or regional average wage for Distressed Areas) for newly created jobs or the retention of labor with advanced degrees. The rate for grants to reimburse companies that create new jobs is specified in the rules. However, the grant reimbursement rate for labor with advanced degrees retained is unspecified and therefore subjective. No limit exists on the number of new jobs or quantity of labor retained for which a company may be reimbursed.

3. Sources of funding for implementing the proposed rule or rule change.

SOURCE	FY 26	FY 27	FY 28
State General Fund	$100,000	$0	$0
Agency Self-Generated	$0	INCREASE	INCREASE
Dedicated	$0	INCREASE	INCREASE
Federal Funds	$0	$0	$0
Other (Specify)	$0	$0	$0
TOTAL	$100,000	INCREASE	INCREASE

4. Does your agency currently have sufficient funds to implement the proposed action? If not, how and when do you anticipate obtaining such funds?

LED has sufficient funds to cover administrative implementation costs. Going forward, LED anticipates that SGR from program application fees may be utilized to offset any additional administrative costs associated with the program.

LED does not currently have funding for reimbursements paid to companies from the High Impact Jobs Fund. LED anticipates the Legislature will provide such funding and appropriation in FY 27, presumably from a SGF equivalent source, up to a maximum of $125 M.

B. COST OR SAVINGS TO LOCAL GOVERNMENTAL UNITS RESULTING FROM THE ACTION PROPOSED.

1. Provide an estimate of the anticipated impact of the proposed action on local governmental units, including adjustments in workload and paperwork requirements. Describe all data, assumptions and methods used in calculating this impact.

The proposed rule will not affect local governmental units.

2. Indicate the sources of funding of the local governmental unit, which will be affected by these costs or savings.

The proposed rule will not affect local governmental units.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

II EFFECT ON REVENUE COLLECTIONS OF STATE AND LOCAL GOVERNMENTAL UNITS

A What increase (decrease) in revenues can be anticipated from the proposed action?

REVENUE INCREASE/DECREASE	FY 26	FY 27	FY 28
State General Fund	$0	DECREASE	DECREASE
Agency Self-Generated	INCREASE	INCREASE	INCREASE
Dedicated Funds*	$0	SEE BELOW	SEE BELOW
Federal Funds	$0	$0	$0
Local Funds	$0	$0	$0
TOTAL			

*Specify the particular fund being impacted

B. Provide a narrative explanation of each increase or decrease in revenues shown in "A." Describe all data, assumptions, and methods used in calculating these increases or decreases

Act 372 creates the High Impact Jobs Fund but does not provide an initial or recurring source of deposits. LED anticipates funding of up to $125 M annually beginning in FY 27. LFO assumes any funds deposited into the new statutory dedication will be appropriated by the legislature, presumably from a SGF equivalent source.

Beginning July 1, 2025, LED may accept and consider program applications. Application fees received for the program are anticipated to increase SGR by an indeterminable amount, depending on the number of applications received. However, program rules must first be approved by the Joint Legislative Committee on the Budget (JLCB), and a legislative appropriation will be required prior to issuance of any grant payments, which can be no earlier than July 1, 2026.

The proposed rule will not affect local governmental units.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

III. COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS

A. What persons, small businesses, or non-governmental groups would be directly affected by the proposed action? For each, provide an estimate and a narrative description of any effect on costs, including workload adjustments and additional paperwork (number of new forms, additional documentation, etc.), they may have to incur as a result of the proposed action.

The program will directly benefit businesses who receive awards, by providing them with additional grant funding from the State.

B. Also provide an estimate and a narrative description of any impact on receipts and/or income resulting from this rule or rule change to these groups.

Businesses that apply to and receive an award from the High Impact Jobs Program will realize a positive impact on receipts and/or income commensurate with the grant received. The amount of such a grant will be dependent on the number of jobs created or retained and other parameters set forth within the proposed rules.

IV. EFFECTS ON COMPETITION AND EMPLOYMENT

Companies that receive benefits under this program will gain a competitive advantage over companies that do not. Employment may increase in participating businesses that receive grants for new jobs. For businesses that receive grants for retaining labor with advanced degrees, employment is anticipated to remain stable.

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

Person Preparing Statement:	Stephanie Le Grange	Dept.:	Louisiana Economic Development
Phone:	225-342-5406	Office:	Office of Economic Development
Return Address:	617 North Third Street	Rule Title:	High Impact Jobs Program
	Baton Rouge, LA 70802		
		Date Rule Takes Effect:	Upon promulgation

SUMMARY
(Use complete sentences)

In accordance with Section 961 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a fiscal and economic impact statement on the rule proposed for adoption, repeal, or amendment. THE FOLLOWING STATEMENTS SUMMARIZE ATTACHED WORKSHEETS, I THROUGH IV AND WILL BE PUBLISHED IN THE LOUISIANA REGISTER WITH THE PROPOSED AGENCY RULE.

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule is anticipated to increase statutory dedication expenditures out of the High Impact Jobs Fund by an indeterminable amount beginning in FY 27. The total amount of expenditures within the program will depend upon the applications received, subsequent contracts entered into and fulfilled by participating companies in the program, and a legislative appropriation. No annual limit on the program's expenditures exists. LED estimates programmatic spending will be limited to $125 M annually beginning in FY 27. Existing staff in LED will be able to administer the program. LED is anticipated to increase SGF spending by $100,000 in FY 26 on one-time expenses for software used for applications and tracking.

The proposed rule establishes program guidelines for the High Impact Jobs Program authorized by Act 372 (Act) of the 2025 Regular Session. The Act creates a ten-year High Impact Jobs Program within Louisiana Economic Development (LED), allowing LED to issue program grants beginning in FY 27 to certain businesses for salaries paid above the parish wage (or regional average wage for Distressed Areas) for newly created jobs or the retention of labor with advanced degrees. The rate for grants to reimburse companies that create new jobs is specified in the rules. However, the grant reimbursement rate for labor with advanced degrees retained is unspecified and therefore subjective. No limit exists on the number of new jobs or quantity of labor retained for which a company may be reimbursed.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Act 372 of the 2025 RS creates the High Impact Jobs Fund but does not provide an initial or recurring source of deposits. LED anticipates funding of up to $125 million annually beginning in FY 27. LFO assumes any funds deposited into the new statutory dedication will be appropriated by the Legislature, presumably from a SGF equivalent source.

Beginning July 1, 2025, LED will accept and consider program applications. Application fees received for the program are anticipated to increase self-generated revenue by an indeterminable amount, depending on the number of applications received. However, program rules must first be approved by the Joint Legislative Committee on the Budget (JLCB), and a legislative appropriation

will be required prior to issuance of any grant payments, which can be no earlier than July 1, 2026.

The proposed rule will not affect local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NON-GOVERNMENTAL GROUPS (Summary)

The program will directly benefit businesses that receive awards by providing them with additional grant funding from the state. Applying businesses will be subject to an application fee and compliance requirements, but these requirements should not be significant and should be outweighed by the benefits should a grant award be received.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Companies receiving benefits under this program will gain a competitive advantage over companies that do not receive the program's benefits. Employment may increase in participating businesses that receive grants for new jobs. For businesses that receive grants for retaining labor with advanced degrees, employment is anticipated to remain stable.

Signature of Agency Head or Designee

Anne G. Villa, Deputy Secretary / CFO

Typed Name & Title of Agency Head or Designee

Date of Signature

Legislative Fiscal Officer or Designee

Date of Signature

FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES

The following information is required in order to assist the Legislative Fiscal Office in its review of the fiscal and economic impact statement and to assist the appropriate legislative oversight subcommittee in its deliberation on the proposed rule.

A. Provide a brief summary of the content of the rule (if proposed for adoption, or repeal) or a brief summary of the change in the rule (if proposed for amendment). Attach a copy of the notice of intent and a copy of the rule proposed for initial adoption or repeal (or, in the case of a rule change, copies of both the current and proposed rules with amended portions indicated).

The proposed rule establishes program rules for the High Impact Jobs Program.

B. Summarize the circumstances, which require this action. If the Action is required by federal regulation, attach a copy of the applicable regulation.

Act 372 of the 2025 RS created the program, to be administered by LED.

C. Compliance with Act 11 of the 1986 First Extraordinary Session

(1) Will the proposed rule change result in any increase in the expenditure of funds? If so, specify amount and source of funding.

Yes, the proposed rules may result in an increase in expenditures.

(2) If the answer to (1) above is yes, has the Legislature specifically appropriated the funds necessary for the associated expenditure increase?

(a) _____ Yes. If yes, attach documentation.

(b) ___X___ NO. If no, provide justification as to why this rule change should be published at this time

Act 372 created the High Impact Jobs Fund. To date, the Legislature has not specifically appropriated the funds necessary for the associated program costs; however, LED anticipates funding of up to $125 million annually beginning in FY 27. LFO assumes any funds deposited into the new statutory dedication will be appropriated by the Legislature, presumably from a SGF equivalent source.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

I. A. COSTS OR SAVINGS TO STATE AGENCIES RESULTING FROM THE ACTION PROPOSED

1. What is the anticipated increase (decrease) in costs to implement the proposed action?

COSTS	FY 26	FY 27	FY 28
Personal Services	$0	$0	$0
Operating Expenses	$0	$0	$0
Professional Services	$0	$0	$0
Other Charges	$100,000	Increase	Increase
Equipment	$0	$0	$0
Major Repairs & Constr.	$0	$0	$0
TOTAL	$100,000	Increase	Increase
POSITIONS (#)	0	0	0

2. Provide a narrative explanation of the costs or savings shown in "A. 1.", including the increase or reduction in workload or additional paperwork (number of new forms, additional documentation, etc.) anticipated as a result of the implementation of the proposed action. Describe all data, assumptions, and methods used in calculating these costs.

The proposed rule is anticipated to increase statutory dedication expenditures out of the High Impact Jobs Fund by an indeterminable amount beginning in FY 27. The total amount of expenditures within the program will depend upon the applications received, subsequent contracts entered into and fulfilled by participating companies in the program, and legislative appropriation. No annual limit on the program's expenditures exists. LED estimates programmatic spending will be limited to $125 M annually beginning in FY 27. Existing staff in LED will be able to administer the program. LED is anticipated to increase SGF spending by $100,000 in FY 26 on one-time expenses for software used for applications and tracking.

LED will issue program grants beginning in FY 27 to certain businesses for salaries paid above the parish wage (or regional average wage for Distressed Areas) for newly created jobs or the retention of labor with advanced degrees. The rate for grants to reimburse companies that create new jobs is specified in the rules. However, the grant reimbursement rate for labor with advanced degrees retained is unspecified and therefore subjective. No limit exists on the number of new jobs or quantity of labor retained for which a company may be reimbursed.

3. Sources of funding for implementing the proposed rule or rule change.

SOURCE	FY 26	FY 27	FY 28
State General Fund	$100,000	$0	$0
Agency Self-Generated	$0	INCREASE	INCREASE
Dedicated	$0	INCREASE	INCREASE
Federal Funds	$0	$0	$0
Other (Specify)	$0	$0	$0
TOTAL	$100,000	INCREASE	INCREASE

4. Does your agency currently have sufficient funds to implement the proposed action? If not, how and when do you anticipate obtaining such funds?

LED has sufficient funds to cover administrative implementation costs. Going forward, LED anticipates that SGR from program application fees may be utilized to offset any additional

administrative costs associated with the program.

LED does not currently have funding for reimbursements paid to companies from the High Impact Jobs Fund. LED anticipates the Legislature will provide such funding and appropriation in FY 27, presumably from a SGF equivalent source, up to a maximum of $125 M.

B. COST OR SAVINGS TO LOCAL GOVERNMENTAL UNITS RESULTING FROM THE ACTION PROPOSED.

1. Provide an estimate of the anticipated impact of the proposed action on local governmental units, including adjustments in workload and paperwork requirements. Describe all data, assumptions and methods used in calculating this impact.

   The proposed rule will not affect local governmental units.

2. Indicate the sources of funding of the local governmental unit, which will be affected by these costs or savings.

   The proposed rule will not affect local governmental units.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

II. EFFECT ON REVENUE COLLECTIONS OF STATE AND LOCAL GOVERNMENTAL UNITS

A. What increase (decrease) in revenues can be anticipated from the proposed action?

REVENUE INCREASE/DECREASE	FY 26	FY 27	FY 28
State General Fund	$0	DECREASE	DECREASE
Agency Self-Generated	INCREASE	INCREASE	INCREASE
Dedicated Funds*	$0	SEE BELOW	SEE BELOW
Federal Funds	$0	$0	$0
Local Funds	$0	$0	$0
TOTAL			

*Specify the particular fund being impacted.

B. Provide a narrative explanation of each increase or decrease in revenues shown in "A." Describe all data, assumptions, and methods used in calculating these increases or decreases.

Act 372 creates the High Impact Jobs Fund but does not provide an initial or recurring source of deposits. LED anticipates funding of up to $125 M annually beginning in FY 27. LFO assumes any funds deposited into the new statutory dedication will be appropriated by the legislature, presumably from a SGF equivalent source.

Beginning July 1, 2025, LED may accept and consider program applications. Application fees received for the program are anticipated to increase SGR by an indeterminable amount, depending on the number of applications received. However, program rules must first be approved by the Joint Legislative Committee on the Budget (JLCB), and a legislative appropriation will be required prior to issuance of any grant payments, which can be no earlier than July 1, 2026.

The proposed rule will not affect local governmental units.

FISCAL AND ECONOMIC IMPACT STATEMENT
WORKSHEET

III. COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS

A. What persons, small businesses, or non-governmental groups would be directly affected by the proposed action? For each, provide an estimate and a narrative description of any effect on costs, including workload adjustments and additional paperwork (number of new forms, additional documentation, etc.), they may have to incur as a result of the proposed action.

The program will directly benefit businesses who receive awards, by providing them with additional grant funding from the State.

B. Also provide an estimate and a narrative description of any impact on receipts and/or income resulting from this rule or rule change to these groups.

Businesses that apply to and receive an award from the High Impact Jobs Program will realize a positive impact on receipts and/or income commensurate with the grant received. The amount of such a grant will be dependent on the number of jobs created or retained and other parameters set forth within the proposed rules.

IV. EFFECTS ON COMPETITION AND EMPLOYMENT

Companies that receive benefits under this program will gain a competitive advantage over companies that do not. Employment may increase in participating businesses that receive grants for new jobs. For businesses that receive grants for retaining labor with advanced degrees, employment is anticipated to remain stable.

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Office of Group Benefits

November 20, 2025 Meeting of the Joint Legislative Committee on the Budget

CaremarkPCS Health, L.L.C.

Pharmacy Benefit Manager Services
Emergency Contract Amendment No. 2 Overview

CaremarkPCS Health, L.L.C.

Pharmacy Benefit Manager Services Emergency Contract Amendment No. 2 Overview

Contract Purpose	To provide PBM services for certain self-funded health plans offered by OGB.
Eligible Participants	Members who are enrolled in OGB's Magnolia Open Access, Magnolia Local, Magnolia Local Plus, and Pelican HRA1000 plans.
PBM Members as of 11/1/2025[1]	199,041
Emergency Contract Term	01/01/2025 – 12/31/2025
Current Emergency Contract Maximum Payable Amount	$890,909,555.00
Emergency Contract Maximum Payable Amount After this Amendment	$980,909,555.00

[1] Based on 11/1/2025 member participation counts for the Magnolia Open Access, Magnolia Local, Magnolia Local Plus, and Pelican HRA1000 plans.

Purchase Order #2000887026
Amendment #2

Amendment to Contract Between

State of Louisiana
Office of Group Benefits (OGB)

And

CaremarkPCS Health, L.L.C. ("CVS Caremark")
One CVS Drive
Woonsocket, RI 02895

CHANGE FROM:

5.0 Payment Terms

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay the Contractor as follows:

OGB will pay the Contractor a maximum fee of Eight Hundred Ninety Million, Nine Hundred Nine Thousand, Five Hundred Fifty-five Dollars ($890,909,555) for work performed during the term of the Emergency Contract. This fee is inclusive of travel and all Contract-related expenses.

Payments are predicated upon successful completion by the Contractor and written approval by OGB of the described Scope of Work and Deliverables as provided in the Emergency Contract. The Contractor will not be paid more than the maximum amount of the Emergency Contract. OGB will make no payments on banking or State Holidays.

The Contractor may invoice OGB at the billing address designated by the State. Invoices shall include the Emergency Contract and order number, using department and services purchased. Invoices submitted without the referenced documentation will not be approved for payment until the required information is provided.

Payment will be made only upon approval of the Contract Monitor.

CHANGE TO:

5.0 Payment Terms

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay the Contractor as follows:

OGB will pay the Contractor a maximum fee of Nine Hundred Eighty Million, Nine Hundred Nine Thousand, Five Hundred Fifty-five Dollars ($980,909,555) for work performed during the term of the Emergency Contract. This fee is inclusive of travel and all Contract-related expenses.

Payments are predicated upon successful completion by the Contractor and written approval by OGB of the described Scope of Work and Deliverables as provided in the Emergency Contract. The Contractor will not be paid more than the maximum amount of the Emergency Contract. OGB will make no payments on banking or State Holidays.

The Contractor may invoice OGB at the billing address designated by the State. Invoices shall include the Emergency Contract and order number, using department and services purchased.. Invoices submitted without the referenced documentation will not be approved for payment until the required information is provided.

Payment will be made only upon approval of the Contract Monitor.

Effective Date of the Amendment: 11/1/2025

Justification for Amendment:

- **Adjusts the maximum payable amount to reflect the additional Ninety Million Dollars ($90,000,000)**

No Amendment shall be valid until it has been executed by all parties and by the Office of State Procurement, Division of Administration.

All provisions of the existing Contract except as modified herein shall remain in full force and effect. Any conflict between the Contract and this Amendment regarding their subject matter of this Amendment shall be resolved in favor of this amendment

This Amendment contains all revised terms and conditions agreed upon by contracting parties.

*****

IN WITNESS WHEREOF, this Amendment is signed and entered into on the date(s) included below.

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

BY: Heath Williams

NAME: Heath Williams

TITLE: CEO

DATE: 11/7/25

CAREMARKPCS HEALTH, L.L.C.

BY: _____

NAME: Cheryl Byron

TITLE: Vice President, Employer Sales

DATE: 11/6/2025

LEGAL REVIEW

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Office of Group Benefits

November 20, 2025 Meeting of the Joint Legislative Committee on the Budget

HMO Louisiana, Inc.

Fully Insured Medicare Advantage Plan
Emergency Contract Amendment No. 3 Overview

HMO Louisiana, Inc.

Fully Insured Medicare Advantage Plan Emergency Contract Amendment No. 3 Overview

Contract Purpose	To offer a Medicare Advantage plan including Medicare Part D prescription drug benefits for Medicare eligible retirees.
Eligible Enrollees	Retired employees of the State of Louisiana and other OGB-participating entities who are enrolled in Medicare Parts A and B.
Membership Count as of 11/1/2025	2,297
Original Emergency Contract Term	01/01/2024 – 12/31/2024
Emergency Contract Extensions Exercised	12 Months
Current Emergency Contract Term	01-01-2024 – 12/31/2025
Emergency Contract Term After this Amendment	01-01-2024 – 12/31/2026
Original Emergency Contract Maximum Payable Amount	$3,181,000.00
Current Emergency Contract Maximum Payable Amount	$12,379,000.00
Emergency Contract Maximum Payable Amount After this Amendment	$20,503,000.00
Administrative Fee	$10.00 per Primary Plan Participant per Month, Payable to OGB (no change from 2025)
Number of Plans Offered	One (no change from 2025)
Statewide or Regional Premium Rates	Regional Premium Rates (see rates on page 3)

HMO Louisiana, Inc.

Fully Insured Medicare Advantage Plan Emergency Contract Amendment No. 3 Overview

HMO Louisiana Blue Advantage HMO Medicare Advantage Plan	2025 Total Monthly Premiums	2026 Total Monthly Premiums	$ Change	% Change
Region 1				
Enrollee Only	$204.00	$259.00	$55.00	27.0%
Enrollee + Spouse	$408.00	$518.00	$110.00	27.0%
Region 2				
Enrollee Only	$232.00	$246.00	$14.00	6.0%
Enrollee + Spouse	$464.00	$492.00	$28.00	6.0%
Region 3				
Enrollee Only	$208.00	$268.00	$60.00	28.8%
Enrollee + Spouse	$416.00	$536.00	$120.00	28.8%
Region 4				
Enrollee Only	$208.00	$218.00	$10.00	4.8%
Enrollee + Spouse	$416.00	$436.00	$20.00	4.8%
Region 5				
Enrollee Only	$259.00	$334.00	$75.00	29.0%
Enrollee + Spouse	$518.00	$668.00	$150.00	29.0%
Region 6				
Enrollee Only	$259.00	$295.00	$36.00	13.9%
Enrollee + Spouse	$518.00	$590.00	$72.00	13.9%
Region 7				
Enrollee Only	$259.00	$295.00	$36.00	13.9%
Enrollee + Spouse	$518.00	$590.00	$72.00	13.9%
Region 8				
Enrollee Only	$259.00	$295.00	$36.00	13.9%
Enrollee + Spouse	$518.00	$590.00	$72.00	13.9%
Region 9				
Enrollee Only	$244.00	$322.00	$78.00	32.0%
Enrollee + Spouse	$488.00	$644.00	$156.00	32.0%

Region 1: Orleans, Saint Bernard, Plaquemines and Jefferson Parishes
Region 2: East Baton Rouge, West Baton Rouge, Livingston, Ascension, Iberville, Pointe Coupee, East Feliciana and West Feliciana Parishes
Region 3: Lafourche, Saint John, Saint Charles, Saint James, Assumption and Terrebonne Parishes
Region 4: Lafayette, Evangeline, Saint Landry, Acadia, Saint Martin, Iberia, Vermilion and Saint Mary Parishes
Region 5: Beauregard, Allen, Calcasieu, Jefferson Davis and Cameron Parishes
Region 6: Vernon, Sabine, Natchitoches, Winn, Grant, Rapides, LaSalle, Catahoula, Concordia and Avoyelles Parishes
Region 7: Caddo, Bossier, Webster, Claiborne, Bienville, Red River and DeSoto Parishes
Region 8: Ouachita, Union, Lincoln, Jackson, Caldwell, Richland, Morehouse, Franklin, West Carroll, East Carroll, Madison and Tensas Parishes
Region 9: Washington, Saint Tammany, Saint Helena and Tangipahoa Parishes

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Amendment to Contract Between

State of Louisiana
Office of Group Benefits (OGB)

And

HMO Louisiana, Inc.
Subsidiary of Blue Cross and Blue Shield of Louisiana
5525 Reitz Avenue, Baton Rouge, LA 70809

CHANGE FROM:

3.1 TERM OF EMERGENCY CONTRACT

This Emergency Contract shall begin on or about January 1, 2024, and is anticipated to end on December 31, 2025, subject to written extension(s) of this Emergency Contract by agreement of the parties and as provided by the Office of State Procurement. Notwithstanding any other provision of this Emergency Contract, this Emergency Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana. Prior to any extension of the Emergency Contract, at the same administrative fee, terms and conditions, prior approval from OSP to extend the Emergency Contract further shall be obtained. Rates charged by Contractor may be revised each twelve (12) month period. As provided in Section 4.3, the continuation of this Emergency Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Emergency Contract.

CHANGE TO:

3.1 TERM OF EMERGENCY CONTRACT

This Emergency Contract shall begin on or about January 1, 2024, and is anticipated to end on December 31, 2026, subject to written extension(s) of this Emergency Contract by agreement of the parties and as provided by the Office of State Procurement. Notwithstanding any other provision of this Emergency Contract, this Emergency Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana. Prior to any extension of the Emergency Contract, at the same administrative fee, terms and conditions, prior approval from OSP to extend the Emergency Contract further shall be obtained. Rates charged by Contractor may be revised each twelve (12) month period. As provided in Section 4.3, the continuation of this Emergency Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Emergency Contract.

CHANGE FROM:

3.4 PAYMENT TERMS

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay to Contractor a maximum fee of $12,379,000.00 (Twelve Million Three Hundred Seventy Nine

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Thousand Dollars) for work performed during the term of this Emergency Contract. This fee is inclusive of travel and all Emergency Contract-related expenses. Payments are predicated upon successful completion by Contractor and written approval by OGB of the described services and deliverables as provided in the Emergency Contract. Contractor will not be paid more than the maximum amount of the Emergency Contract. No payments will be made by OGB on banking or State holidays.

With respect to Plan Participants who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their Plan participation due to the selection of the Louisiana HMO. OGB shall impose on Contractor a monthly administrative fee of $10.00 for each HMO Primary Plan Participant. The administrative fee will be paid directly to OGB for each Primary Plan Participant and shall not be included in the premium charged. Should OGB make retroactive changes to the covered HMO Primary Plan Participants, OGB shall refund to Contractor any administrative fees paid by Contractor to OGB for those Primary Plan Participants. Plan Participants selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other health coverage options provided by OGB.

The Contractor will invoice OGB on the 1st day of each month for payment of premiums for services provided pursuant to the resulting Emergency Contract. The invoice should include, at a minimum, the time period covered, total billed amount detailed by class of coverage, and assessed administrative fee based on total number of Primary Plan Participants. Payments will be made to the Contractor after written acceptance and approval of the invoice by the State. Upon approval of each submitted invoice by OGB's Chief Executive Officer or designee, OGB/State will render payment of undisputed amounts within thirty (30) days.

CHANGE TO:

3.4 PAYMENT TERMS

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay to Contractor a maximum fee of $20,503,000.00 (Twenty Million Five Hundred Three Thousand Dollars) for work performed during the term of this Emergency Contract. This fee is inclusive of travel and all Emergency Contract-related expenses. Payments are predicated upon successful completion by Contractor and written approval by OGB of the described services and deliverables as provided in the Emergency Contract. Contractor will not be paid more than the maximum amount of the Emergency Contract. No payments will be made by OGB on banking or State holidays.

With respect to Plan Participants who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their Plan participation due to the selection of the Louisiana HMO. OGB shall impose on Contractor a monthly administrative fee of $10.00 for each HMO Primary Plan Participant. The administrative fee payment will be delivered directly to OGB by the last day of the month for each Primary Plan Participant for the previous month, and shall not be included in the premium charged. Should OGB make retroactive changes to the covered HMO Primary Plan Participants, OGB shall refund to Contractor any administrative fees paid by Contractor to OGB for those Primary Plan Participants. Plan Participants selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other health coverage options provided by OGB.

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

The Contractor will invoice OGB before close of business on the fifth business day of the month for which premiums apply for services provided pursuant to the resulting Emergency Contract. The invoice should include, at a minimum, the time period covered, total billed amount detailed by class of coverage, and assessed administrative fee based on total number of Primary Plan Participants. Payments will be made to the Contractor after written acceptance and approval of the invoice by the State. Upon approval of each submitted invoice by OGB's Chief Executive Officer or designee, OGB/State will render payment of undisputed amounts within thirty (30) days.

CHANGE FROM:

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis on a quarterly basis. OGB and Contractor shall mutually agree to any modifications to the performance guarantees each Contract year. The amount at risk shall not exceed 6.25%, or cumulatively 25% of fifteen (15%) percent (representing the administrative and margin portion) of total annual premium at risk. Contractor will be subject to per day and per occurrence fees for certain performance guarantees. All guarantees must be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit. OGB agrees to provide Contractor with sixty (60) days advance written notice prior to commencement of the performance guarantee audit.

Measurement Period: January 1, 2024 through December 31, 2024. Additional measurement periods will be incorporated, as applicable, upon extension of this Emergency Contract, subject to any option approval required by law. If performance guarantees are effective for less than a full calendar year, the payment amounts will be prorated for the portion of the measurement period.

Additional Measurement Period: January 1, 2025 – December 31, 2025

CHANGE TO:

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis on a quarterly basis. OGB and Contractor shall mutually agree to any modifications to the performance guarantees each Contract year. The amount at risk shall not exceed 6.25%, or cumulatively 25% of fifteen (15%) percent (representing the administrative and margin portion) of total annual premium at risk. Contractor will be subject to per day and per occurrence fees for certain performance guarantees. All guarantees must be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit. OGB agrees to provide Contractor with sixty (60) days advance written notice prior to commencement of the performance guarantee audit.

Measurement Period: January 1, 2024 through December 31, 2024. Additional measurement periods will be incorporated, as applicable, upon extension of this Emergency Contract, subject to any option approval required by law. If performance guarantees are effective for less than a full calendar year, the payment amounts will be prorated for the portion of the measurement period.

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Additional Measurement Period: January 1, 2025 – December 31, 2025

Additional Measurement Period: January 1, 2026 – December 31, 2026

CHANGE FROM:

4.3 FISCAL FUNDING

The continuation of this contract is contingent upon the appropriation of funds to fulfill the requirement of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the Emergency Contract, or if such appropriation is reduced by the veto of the Governor or any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the Emergency Contract, the Emergency Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

CHANGE TO:

4.3 TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Emergency Contract is contingent upon the appropriation of funds to fulfill the requirements of this Emergency Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of this Emergency Contract or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act or Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of this Emergency Contract, this Emergency Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

When funds are not appropriated or otherwise made available to support continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, this Emergency Contract for the remaining term shall be cancelled and the Contractor shall be reimbursed in accordance with the terms of this Emergency Contract for the reasonable value of any nonrecurring costs incurred but not amortized in the price of services delivered pursuant to this Emergency Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or from unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for a penalty to the state for cancellation or early payment of this Emergency Contract.

CHANGE FROM:

20 INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. Independent assurances may be in the form of a Service

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Organization Control ("SOC") 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 18 engagement of the operations. The SSAE 18 engagement will be performed at least annually during the term of the Emergency Contract by an audit firm that will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. These audits and/or assurances will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the indicated audit. The audit firm that will conduct the SSAE 18 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe.

As an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, if approved by OGB on or before January 15, 2025, Contractor may provide a quality control plan [such as third party Quality Assurance (QA), an Independent Verification and Validation (IV & V)], or any other independent Contractor project or performance review or independent internal audit report.

The cost of such independent assurances will be borne solely by Contractor. Contractor may review any audit report before delivery to the State and include with the report a supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. The Contractor shall supply the State/OGB with an exact copy of the report within (30) calendar days of receipt of the audit. Contractor shall implement recommendations as suggested by the program review, audit, and/or SSAE 18 engagement within three (3) months of report issuance and at no cost to the State.

CHANGE TO:

20 INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. Independent assurances may be in the form of a Service Organization Control ("SOC") 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 18 engagement of the operations. The SSAE 18 engagement will be performed at least annually during the term of the Emergency Contract by an audit firm that will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. These audits and/or assurances will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the indicated audit. The audit firm that will conduct the SSAE 18 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe.

As an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, if approved by OGB on or before January 15, 2026, Contractor may provide a quality control plan [such as third party Quality Assurance (QA), an Independent Verification and Validation (IV & V)], or any other independent Contractor project or performance review or independent internal audit report. If any of these alternatives reviews are used in lieu of a SSAE 18 engagement, the review(s) must occur within the period that the Emergency Contract is in effect,

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

and it must be documented in the resulting report and evident that scope of the independent review included the specific controls and processes for which the Contractor is providing for OGB.

The cost of such independent assurances will be borne solely by Contractor. Contractor may review any audit report before delivery to the State and include with the report a supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. The Contractor shall supply the State/OGB with an exact copy of the report within (30) calendar days of receipt of the audit. Contractor shall implement recommendations as suggested by the program review, audit, and/or SSAE 18 engagement within three (3) months of report issuance and at no cost to the State.

CHANGE FROM:

21 NOTICE

Any notice required or permitted by this Emergency Contract, unless otherwise specifically provided for in this Emergency Contract, shall be in writing and shall be deemed given upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or, (ii) registered or certified mail return receipt requested, and addressed as follows:

To HMO Louisiana, Inc.: Sheldon Faulk, SVP and COO
HMO Louisiana, Inc.
5825 Reitz Avenue
Baton Rouge, LA 70809

and

Lou Patalano, SVP and CLO
HMO Louisiana, Inc.
5825 Reitz Avenue
Baton Rouge, LA 70809

To OGB: David W. Couvillon, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

or

David W. Couvillon, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

The U.S. Postal Service does not make deliveries to OGB's physical location.

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

CHANGE TO:

21 NOTICE

Any notice required or permitted by this Emergency Contract, unless otherwise specifically provided for in this Emergency Contract, shall be in writing and shall be deemed given upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or, (ii) registered or certified mail return receipt requested, and addressed as follows:

To HMO Louisiana, Inc.: Paul Gray, Vice President MA Performance &Business Process
HMO Louisiana, Inc.
5825 Reitz Avenue
Baton Rouge, LA 70809
and
Lou Patalano, SVP and CLO
HMO Louisiana, Inc.
5825 Reitz Avenue
Baton Rouge, LA 70809

To OGB: Heath Williams, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

or

Heath Williams, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

The U.S. Postal Service does not make deliveries to OGB's physical location.

At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

CHANGE FROM:

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

ATTACHMENT I: SCOPE OF WORK/SERVICES; Section 1.2 Deliverables

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance identified by OGB to include, but not be limited to, the following:

- **Financial Experience:** Premium Income and Claims Utilization Experience.
- **Average Speed to Answer:** Average lag time to answer by live voice percentage of Plan Participants who wait over 60 seconds to speak with a live customer service representative.
- **Abandon Call Rate:** Percentage of calls where the caller hangs up before speaking to a live voice.
- **Inquiry Timeliness**: Percentage of inquiries answered within 7 business days.
- **Claims Financial Accuracy:** Percentage of claims paid correctly – dollar amount only.
- **Claims Accuracy:** Percentage of claims paid correctly the first time.
- **Claims Process Time:** Percentage of electronic and non-electronic claims paid within 30 days of receipt.
- **Eligibility Posting Timeliness**: Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
- **ID Card Timeliness**: Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
- **PCP Turnover Rate**: Percentage of PCPs leaving the network voluntarily or involuntarily during the month.
- **Open PCP/Participant Ratio:** Ratio of open PCPs accepting new plan participants to actual plan participants.

- Submit annual Service Organization Control (SOC1), Type II report resulting from SSAE 18 engagement no later than September 30 of each year of the Emergency Contract and/or other independent assurances approved by OGB by January 15 preceding the report deadline.
- Submit quarterly report that captures operational performance guarantees on a client-specific basis and report OGB's data within forty-five (45) calendar days after close of each quarter. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of calendar year 2024 and calendar year 2025, respectively.
- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance and health outcomes of OGB's Plan Participants.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.
- One hundred and twenty days (120) prior to January 1, 2025, January 1, 2026, and for any renewal option period, the Contractor shall provide OGB with a renewal report that shows

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, premiums at current rates, and the indicated rate adjustment.

CHANGE TO:

ATTACHMENT I: SCOPE OF WORK/SERVICES; Section 1.2 Deliverables

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance identified by OGB to include, but not be limited to, the following:

- **Financial Experience:** Premium Income and Claims Utilization Experience.
- **Average Speed to Answer:** Average lag time to answer by live voice percentage of Plan Participants who wait over 60 seconds to speak with a live customer service representative.
- **Abandon Call Rate:** Percentage of calls where the caller hangs up before speaking to a live voice.
- **Inquiry Timeliness**: Percentage of inquiries answered within 7 business days.
- **Claims Financial Accuracy:** Percentage of claims paid correctly – dollar amount only.
- **Claims Accuracy:** Percentage of claims paid correctly the first time.
- **Claims Process Time:** Percentage of electronic and non-electronic claims paid within 30 days of receipt.
- **Eligibility Posting Timeliness**: Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
- **ID Card Timeliness**: Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
- **PCP Turnover Rate**: Percentage of PCPs leaving the network voluntarily or involuntarily during the month.
- **Open PCP/Participant Ratio:** Ratio of open PCPs accepting new plan participants to actual plan participants.

- Submit annual Service Organization Control (SOC1), Type II report resulting from SSAE 18 engagement no later than September 30 of each year of the Emergency Contract and/or other independent assurances approved by OGB by January 15 preceding the report deadline.
- Submit quarterly report that captures operational performance guarantees on a client-specific basis and report OGB's data within forty-five (45) calendar days after close of each quarter. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of calendar years 2024, 2025, and 2026, respectively.

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance and health outcomes of OGB's Plan Participants.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.
- One hundred and twenty days (120) prior to January 1, 2025, January 1, 2026 and for any renewal option period, the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, premiums at current rates, and the indicated rate adjustment.

ADDITION:

ADDENDUM TO EMERGENCY CONTRACT: ADDITIONAL PROVISION

Prohibition of Companies That Discriminate Against Firearm and Ammunition Industries

In accordance with La. R.S. 39:1602.2, the following applies to any competitive sealed bids, competitive sealed proposals, or contract(s) with a value of $100,000 or more involving a for-profit company with at least 50 full-time employees:

Unless otherwise exempted by law, by submitting a response to this solicitation or entering into this contract, the Bidder, Proposer or Contractor certifies the following:

1. The company does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association based solely on the entity's or association's status as a firearm entity or firearm trade association;

2. The company will not discriminate against a firearm entity or firearm trade association during the term of the contract based solely on the entity's or association's status as a firearm entity or firearm trade association.

The State reserves the right to reject the response of the Bidder, Proposer or Contractor if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response or if the certification is no longer true.

REPLACE:

ATTACHMENT II: ADMINISTRATIVE FEE AND PREMIUM RATE SCHEDULE

ATTACHMENT V: RECORDS RETENTION SCHEDULE

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Effective Date of Amendment: October 1, 2025

Justification for Amendment:

- Extends the term of the Emergency Contract for an additional twelve (12) months, at the same terms and conditions of the initial contract, to December 31, 2026.
- Increases the maximum payable amount to $20,503,000.
- Provides additional measurement periods for Performance Guarantees for calendar year 2026.
- Provides date to submit request to OGB for submission of alternative independent assurance report for calendar year 2026.
- Provides due date for submission of independent assurance report for calendar year 2026.
- Provides date for submission of rate renewal report and actuarial certification for calendar year 2026.
- Provides administrative fee and premium rates for calendar year 2026.

No Amendment shall be valid until it has been executed by all parties and approved by the Office of State Procurement, Division of Administration.

All other provisions of the Emergency Contract shall remain in full force and effect. Any conflict between the Emergency Contract and this Amendment regarding the subject matters of this Amendment shall be resolved in favor of this Amendment.

This Amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this Amendment is signed and entered into on the date(s) included below.

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

BY: Signed by: Heath Williams 21C3CF4BDC4F403...

NAME: Heath Williams

TITLE: Chief Executive Officer

DATE: November 12, 2025 | 11:33 AM CST

HMO LOUISIANA, INC.

BY: Signed by: Paul Gray 201CF67A54844CA...

NAME: Paul Gray

TITLE: VP of Medicare Advantage Performance & Business Process

DATE: October 29, 2025 | 11:22 AM CDT

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

ATTACHMENT II: ADMINISTRATIVE FEE AND PREMIUM RATE SCHEDULE (REVISED)

All pricing is fully burdened and inclusive of travel and all Emergency Contract-related expenses. Commissions or finder's fees are not payable under this Emergency Contract.

Administrative Fee

Monthly Administrative Fee Per Primary Plan Participant Per Month
$10.00

Regional Premium

Premium rates proposed for each twelve (12)-month period must be approved by the Centers for Medicare and Medicaid Services (CMS). Additionally, for each twelve (12)-month period, the Contractor must document, through a written certification from its actuary, that the proposed rates for each twelve (12)-month period are calculated on the basis of sound actuarial principles, reasonable in relation to the benefits provided and the population anticipated to be covered, and are neither excessive nor deficient.

Parishes Included in OGB Region 1	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$174.00
1/1/2025 – 12/31/2025	$204.00
1/1/2026 – 12/31/2026	$259.00

Parishes Included in OGB Region 2	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$217.00
1/1/2025 – 12/31/2025	$232.00
1/1/2026 – 12/31/2026	$246.00

Parishes Included in OGB Region 3	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$197.00
1/1/2025 – 12/31/2025	$208.00
1/1/2026 – 12/31/2026	$268.00

Parishes Included in OGB Region 4	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$197.00
1/1/2025 – 12/31/2025	$208.00
1/1/2026 – 12/31/2026	$218.00

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Parishes Included in OGB Region 5	**Fixed Monthly Premium, Per Plan Participant Per Month**
1/1/2024 – 12/31/2024	$227.00
1/1/2025 – 12/31/2025	$259.00
1/1/2026 – 12/31/2026	$334.00

Parishes Included in OGB Regions 6, 7, and 8	**Fixed Monthly Premium, Per Plan Participant Per Month**
1/1/2024 – 12/31/2024	$227.00
1/1/2025 – 12/31/2025	$259.00
1/1/2026 – 12/31/2026	$295.00

Parishes Included in OGB Region 9	**Fixed Monthly Premium, Per Plan Participant Per Month**
1/1/2024 – 12/31/2024	$212.00
1/1/2025 – 12/31/2025	$244.00
1/1/2026 – 12/31/2026	$322.00

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

ATTACHMENT V: RECORDS RETENTION SCHEDULE

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Page 1 of 15 R-2025-349 JO

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Executive

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Internal Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued.*
2	LLA Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued. *
3	Group Benefits Policy and Planning Board Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created. *
4	Group Benefits Policy & Planning Board Reports	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	
5	Group Benefits Policy & Planning Board Meeting Minutes	PERM	0	PERM	M	R	N	V	
6	Group Benefits Estimating Conference Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created. *
7	Group Benefits Estimating Conference Meeting Minutes	PERM	0	PERM	M	R	N	V	
8	OGB 5-year Strategic Plan	ACT + 5 FY	0	ACT + 5 FY	P	S	N	V	ACT = until the end of the FY in which the Strategic plan was drafted. *

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
LLA = Louisiana Legislative Auditor
OGB = Office of Group Benefits

Heath Williams — Agency Approval
6/9/25 — Date Signed
Lettice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_x_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration -- Finance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Budget Request Documents/Records	ACT + 5 FY	0	ACT + 5 FY	P	S	N	V	ACT = until the end of the FY in which created*
2	Actuarial Revenue/Expenditure Line-item Projections	ACT + 5 FY	0	ACT + 5 FY	M	S	N	V	ACT = until the end of the FY in which received*
3	Actuarial Premium Rate Schedules	ACT + 5 CY	0	ACT + 5 CY	P	S	N	V	ACT = until the end of the FY in which received*
4	Official Premium Rate Schedules	LOA + 10 CY	0	LOA + 10 CY	P	R	N	V	
5	Monthly OTS Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*
6	Annual IAT Agreements & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*
7	Miscellaneous/One-time Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*
8	OGB Fiscal Note Worksheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created*
9	DOA Analysis Sheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created*
10	Fuel Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA—Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB – Office of Group Benefits
OTS – Office of Technology Services
IAT- Inter Agency Transfers
DOA – Division of Administration

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration -- Communications

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Annual Enrollment Member Guides	LOA + 10 CY	0	LOA+10 CY	P	R	N	V	
2	Annual Enrollment Member Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created*
3	Annual Enrollment HR Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created*
4	Agency/Member Memos on OGB Policies/Procedures Changes	LOA + 10 CY	0	LOA+ 10 CY	P	R	N	V	
5	Medicare Part D Creditable Coverage Notices	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = until the end of the CY in which the notices were created*
6	Publications	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	
7	Designation Forms (OGB Coordinator, OGB Additional Agency Contacts) (GB-74, GB-76)	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
HR – Human Resources
OGB – Office of Group Benefits

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration – General

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Employee Driver Authorization Forms	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the employee separates from agency*
2	OGB Employee Safety Meetings Training Materials & Sign-in Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
3	OGB Employee PES Evaluations and Planning Session Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which supervision ends*
4	OGB Employee Time & Attendance Reports	ACT + 2 CY	3 CY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the CY in which the reports were created or received*
5	Vehicle Logs & Supporting Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
6	SOF & Supporting Documents	ACT + 2 FY	1 FY	ACT + 3 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
7	Daily Documents/Mail Assignments Logs	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created*
8	**Records Management Files:** Retention Schedules, disposal requests, Transmittals, Surveys and Exceptions)	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
SOF –Special order Form
OGB= Office of Group Benefits
PES = Personnel Evaluation System

Agency Approval — 6/9/25 Date Signed — Secretary of State, State Archives & Records Services — JUN 11 2025 Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Contracts Management

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Contracts, Contract Amendments, & Supporting Documents	ACT + 3 CY	7 CY	ACT + 10 CY	M	S	Y	V	ACT = Until the end of the CY in which the contract expires or is terminated*
2	OGB Contract Solicitations (RFP, ITB, RFI) & Supporting Documents	ACT + 3 CY	0	ACT + 3 CY	M	S	Y	V	ACT = Until the end of the CY in which the solicitations deadline ends*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
RFP = Request for Proposal
ITB = Intent to Bid
RFI = Request for Information

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_x_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Agency Services

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Member Participation Schedules	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
2	OGB Member Collections Notices & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
3	OGB Member Appeals & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
4	OGB-participating Agency Administrative Error Appeals & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
5	Enrollment Change Forms & Supporting Eligibility Documents (GB-01)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
6	Designation Forms (Agency Master User, Eligibility/eEnrollment Contact) (GB-75, GB-78)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Hebert — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_x_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Customer Service

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Member Correspondence	LOA + 10 CY	0	LOA + 10 CY	C	A	N	V	
2	**Daily Work Papers**: includes printed copies of imaged documents and non-essential notes with PHI or OGB member contact info, produced by OGB Customer Service section staff	ACT	0	ACT	M	S	N	U	ACT = until the end of the day in which the work papers were created *
3	OGB Visitor Logs/Sign-in Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
PHI = Personal Health Information

Heath Willis — Agency Approval
6/9/25 — Date Signed
Lotrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Health Insurance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Self-funded Health Plan Medical TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
2	Self-funded Health Plan Pharmacy TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
3	Fully Insured Health Plan Vendors Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
4	Capitated Primary Care Network Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
5	IMMEHRA Vendor Invoices and Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
6	Health Plan Vendors Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the report or deliverable was received *
7	Health Savings Account Enrollment & Payroll Deduction Election/Changes (GB-79 Forms)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
8	TPA Health and Pharmacy Claims (including supplemental Claims)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase). OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
TPA = Third party administrator
IMMEHRA = Individual Medicare Market Exchange with Health Reimbursement Arrangements
OGB = Office of Group Benefits

Heath Willis — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Life Insurance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Fully Insured Basic and Supplemental Life Insurance Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the document was received *
2	Fully Insured Basic and Supplemental Life Insurance Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the document was received *
3	Fully Insured Basic and Supplemental Life Insurance Member Beneficiary Designation/Change Forms	LOA + 10 CY	0	LOA+ 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Willis — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved
as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Flexible Benefits & COBRA

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	FSA & COBRA TPA Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
2	FSA & COBRA TPA Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
3	Flexible Spending Arrangement Enrollment/Stop Form (GB-2)	LOA + 10 CY	0	LOA+ 10 CY	M	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits
TPA = Third Party Administrator

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits/Invoicing

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Reconciled Invoices with Payment Record	PERM	0	PERM	M	R	N	V	*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations

Heath Williams — Agency Approval
6/9/25 — Date Signed
Lotrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits/Compliance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Section 111 Reporting Documents and Reports: mandated by the Centers for Medicare and Medicaid Services (CMS). Includes research, communication with CMS, internal communication, reports, working files	PERM	0	PERM	M	R	N	V	
2	Administrative Procedures Act Documents and Reports	PERM	0	PERM	P	R	N	V	
3	Mandated Legislative Reports and Regulations	ACT + 5 CY	0	ACT + 5 CY	P	S	N	V	ACT = Until end of CY report is submitted (*Regulations that become OGB policy and procedure may become permanent records*)
4	OGB HIPAA Compliance Records	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = until the end of the CY in which the records were created or received.*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits
HIPAA = Health Insurance Portability and Accessibility Act

Heath Williams — Agency Approval
6/9/25 — Date Signed
Letrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Filing Deadline Mail Records	ACT + 3 CY	0	ACT + 3 CY	M	S	N	I	ACT = until the end of the CY in which the document was created or received. *
2	Live and Event Claims Records	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
3	Field and Audit Reports	ACT + 5 CY	0	ACT + 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued. *
4	Health Claims (including Supplemental Claims)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
5	Explanation of Benefits (EOBs)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
6	Medical Records	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
7	Pre-determinations	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
8	Case Management	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
9	Medical Necessities	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Wilkins — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
10	Paid in Vouchers	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
11	Flexible Benefit Master File	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
12	Hospital Audits, Statistical Reports and Work Papers	ACT + 5 CY	0	ACT + 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued.*
13	Fraud and Abuse Case Files and Logs	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
14	Health Claim Audits and Work Papers: (including over $500 plan Member check Audits)	ACT + 5 CY	0	ACT + 5 CY	C	S	N	I	ACT = until the end of the CY in Audit is completed.*
15	Special Reports (Outlier, Check Cycle)	ACT + 10 CY	0	ACT + 10 CY	M	S	N	I	ACT = until the end of the CY in which report is run.*
16	Reviews (Medical and Chiropractic)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
17	Preferred Provider Option/Exclusive Provider Option Contracts	LOA + 5 CY	0	LOA + 5 CY	M	R	N	V	
18	Logic Approvals	ACT + 3 CY	7 CY	ACT + 10CY	M	S	N	V	ACT = until the end of the CY in which plan expires.*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Wilson — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Docusign Envelope ID: 1A966A50-E60B-44AC-9EB7-B6F342950D1F

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
19	Adjusted Batch Listings	ACT + 7 CY	0	ACT + 7 CY	M	S	N	I	ACT = until the end of the CY in which plan expires. *
20	**Fully Insured Basic and Supplemental Life Insurance:** all claims documents received, requested and sent (Employer Statements, Beneficiary Statements, Explanation of Benefits, Beneficiary Information, Enrollment Information), Notes, Calls and Payments	ACT + 70 CY	0	ACT + 70 CY	M	S	N	V	ACT = until end of CY in which employee separates from the agency

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Agency Approval — 6/9/25 Date Signed

Secretary of State, State Archives & Records Services — JUN 11 2025 Date Approved

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Office of Group Benefits

November 20, 2025 Meeting of the Joint Legislative Committee on the Budget

Humana Health Benefits Plan of Louisiana, Inc.

Fully Insured Medicare Advantage Plan
Emergency Contract Amendment No. 2 Overview

Humana Health Benefits Plan of Louisiana, Inc.

Fully Insured Medicare Advantage Plan Emergency Contract Amendment No. 2 Overview

Contract Purpose	To offer a Medicare Advantage plan including Medicare Part D prescription drug benefits for Medicare eligible retirees.
Eligible Enrollees	Retired employees of the State of Louisiana and other OGB-participating entities who are enrolled in Medicare Parts A and B.
Membership Count as of 11/1/2025	557
Original Emergency Contract Term	01/01/2024 – 12/31/2024
Emergency Contract Extensions Exercised	12 Months
Current Emergency Contract Term	01-01-2024 – 12/31/2025
Emergency Contract Term After this Amendment	01-01-2024 – 12/31/2026
Original Emergency Contract Maximum Payable Amount	$981,000.00
Current Emergency Contract Maximum Payable Amount	$2,073,000.00
Emergency Contract Maximum Payable Amount After this Amendment	$3,479,000.00
Administrative Fee	$12.50 per Primary Plan Participant per Month, Payable to OGB (no change from 2025)
Number of Plans Offered	One (no change from 2025)
Statewide or Regional Premium Rates	Regional Premium Rates (see rates on page 3)

Humana Health Benefits Plan of Louisiana, Inc.

Fully Insured Medicare Advantage Plan Emergency Contract Amendment No. 2 Overview

Humana HMO Medicare Advantage Plan	2025 Total Monthly Premiums	2026 Total Monthly Premiums	$ Change	% Change
Region 1				
Enrollee Only	$82.78	$94.53	$11.75	14.2%
Enrollee + Spouse	$165.56	$189.06	$23.50	14.2%
Region 2				
Enrollee Only	$228.84	$240.59	$11.75	5.1%
Enrollee + Spouse	$457.68	$481.18	$23.50	5.1%
Region 3				
Enrollee Only	$193.29	$205.04	$11.75	6.1%
Enrollee + Spouse	$386.58	$410.08	$23.50	6.1%
Region 4				
Enrollee Only	$194.04	$205.79	$11.75	6.1%
Enrollee + Spouse	$388.08	$411.58	$23.50	6.1%
Region 5				
Enrollee Only	$190.47	$202.22	$11.75	6.2%
Enrollee + Spouse	$380.94	$404.44	$23.50	6.2%
Region 6				
Enrollee Only	$241.57	$253.32	$11.75	4.9%
Enrollee + Spouse	$483.14	$506.64	$23.50	4.9%
Region 7				
Enrollee Only	$251.74	$263.49	$11.75	4.7%
Enrollee + Spouse	$503.48	$526.98	$23.50	4.7%
Region 8				
Enrollee Only	$251.56	$263.31	$11.75	4.7%
Enrollee + Spouse	$503.12	$526.62	$23.50	4.7%
Region 9				
Enrollee Only	$227.01	$238.76	$11.75	5.2%
Enrollee + Spouse	$454.02	$477.52	$23.50	5.2%

Region 1: Orleans, Saint Bernard, Plaquemines and Jefferson Parishes
Region 2: East Baton Rouge, West Baton Rouge, Livingston, Ascension, Iberville, Pointe Coupee, East Feliciana and West Feliciana Parishes
Region 3: Lafourche, Saint John, Saint Charles, Saint James, Assumption and Terrebonne Parishes
Region 4: Lafayette, Evangeline, Saint Landry, Acadia, Saint Martin, Iberia, Vermilion and Saint Mary Parishes
Region 5: Beauregard, Allen, Calcasieu, Jefferson Davis and Cameron Parishes
Region 6: Vernon, Sabine, Natchitoches, Winn, Grant, Rapides, LaSalle, Catahoula, Concordia and Avoyelles Parishes
Region 7: Caddo, Bossier, Webster, Claiborne, Bienville, Red River and DeSoto Parishes
Region 8: Ouachita, Union, Lincoln, Jackson, Caldwell, Richland, Morehouse, Franklin, West Carroll, East Carroll, Madison and Tensas Parishes
Region 9: Washington, Saint Tammany, Saint Helena and Tangipahoa Parishes

Purchase Order #2000791844
Amendment #2

Amendment to Contract Between

State of Louisiana
Office of Group Benefits (OGB)

And

Humana Health Benefits Plan of Louisiana, Inc.
101 East Main Street, WTS03-CO41, Louisville, KY 40202

CHANGE FROM:

3.1 TERM OF EMERGENCY CONTRACT

This Emergency Contract shall begin on or about January 1, 2024, and is anticipated to end on December 31, 2025, subject to written extension(s) of this Emergency Contract by agreement of the parties and as provided by OSP. Notwithstanding any other provision of this Emergency Contract, this Emergency Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana. Prior to the extension of the Emergency Contract beyond the term, prior approval from OSP to extend the Emergency Contract beyond the term shall be obtained. As provided in Section 4.3, the continuation of this Emergency Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Emergency Contract.

CHANGE TO:

3.1 TERM OF EMERGENCY CONTRACT

This Emergency Contract shall begin on or about January 1, 2024, and is anticipated to end on December 31, 2026, subject to written extension(s) of this Emergency Contract by agreement of the parties and as provided by OSP. Notwithstanding any other provision of this Emergency Contract, this Emergency Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana. Prior to any extension of the Emergency Contract, at the same administrative fee, terms and conditions, prior approval from OSP to extend the Emergency Contract beyond the term shall be obtained. Rates charged by Contractor may be revised each twelve (12) month period. As provided in Section 4.3, the continuation of this Emergency Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Emergency Contract.

CHANGE FROM:

3.4 PAYMENT TERMS

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay to Contractor a maximum fee of $2,073,000.00 (Two Million Seventy Three Thousand Dollars) for work performed during the term of this Emergency Contract. This fee is inclusive of travel and all Emergency Contract-related expenses. Payments are predicated upon successful completion by Contractor and written approval by OGB of the described services and deliverables as provided in the Emergency Contract. Contractor will not be paid more than the maximum amount of the Emergency Contract. No payments will be made by OGB on banking or State holidays.

With respect to Plan Participants who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their Plan participation due to the selection of the Louisiana HMO. OGB shall impose on Contractor a monthly administrative fee of [redacted] for each HMO Primary Plan Participant. The administrative fee will be paid directly to OGB for each Primary Plan Participant and shall not be included in the premium charged. Plan Participants selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other health coverage options provided by OGB.

The Contractor will invoice OGB on the 1st day of each month for payment of premiums for services provided pursuant to the resulting Emergency Contract. The invoice should include, at a minimum, the time period covered, total billed amount detailed by class of coverage, and assessed administrative fee based on total number of Primary Plan Participants. Payments will be made to the Contractor after written acceptance by the State and approval of the invoice by the State. Upon approval of each submitted invoice by OGB's Chief Executive Officer or designee, OGB/State will render payment of undisputed amounts within thirty (30) days.

CHANGE TO:

3.4 PAYMENT TERMS

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay to Contractor a maximum fee of $3,479,000 (Three Million Four Hundred Seventy Nine Thousand Dollars) for work performed during the term of this Emergency Contract. This fee is inclusive of travel and all Emergency Contract-related expenses. Payments are predicated upon successful completion by Contractor and written approval by OGB of the described services and deliverables as provided in the Emergency Contract. Contractor will not be paid more than the maximum amount of the Emergency Contract. No payments will be made by OGB on banking or State holidays.

With respect to Plan Participants who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their Plan participation due to the selection of the Louisiana HMO. OGB shall impose on Contractor a monthly administrative fee of [redacted] for each HMO Primary Plan Participant. The administrative fee payment will be issued and sent to OGB by the last day of the month for each Primary Plan Participant for the previous month, and shall not be included in the premium charged. Plan Participants selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other health coverage options provided by OGB.

The Contractor will invoice OGB before close of business on the fifth business day of the month for which premiums apply for services provided pursuant to the resulting Emergency Contract. The invoice should include, at a minimum, the time period covered, total billed amount detailed by class of coverage, and assessed administrative fee based on total number of Primary Plan Participants. Payments will be made to the Contractor after written acceptance by the State and approval of the invoice by the State. Upon approval of each submitted invoice by OGB's Chief Executive Officer or designee, OGB/State will render payment of undisputed amounts within thirty (30) days.

CHANGE FROM:

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis on a quarterly basis. In the event that this Emergency Contract is to be extend3d further by amendments, OGB shall have the ability to modify the performance guarantees for each subsequent Contract year, however, twenty-five (25%) percent of Contractor's fees will remain at risk, and Contractor will be subject to per day and per occurrence fees for certain performance guarantees. All guarantees must be reconciled at the end of the term of the Emergency Contract and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Performance Guarantees: The Contractor will be subject to negotiated performance standards subject to a penalty of twenty-five (25%) percent of the total contracted cost, plus per day and occurrence fees for certain performance guarantees.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit. Any auditor must agree to follow Contractor's security procedures and protect confidentiality of Contractor's information.

Measurement Period: January 1, 2024 through December 31, 2024. Additional measurement periods will be incorporated, as applicable, upon extension of this Emergency Contract, subject to any option approval required by law. If performance guarantees are effective for less than a full calendar year, the payment amounts will be prorated for the portion of the measurement period.

Additional Measurement Period: January 1, 2025 – December 31, 2025.

CHANGE TO:

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis on a quarterly basis. In the event that this Emergency Contract is to be extended further by amendments, OGB shall have the ability to modify the performance guarantees for each subsequent Contract year, however, twenty-five (25%) percent of Contractor's fees will remain at risk, and Contractor will be subject to per day and per occurrence fees for certain performance guarantees. All guarantees must be reconciled at the end of the term of the Emergency Contract and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Performance Guarantees: The Contractor will be subject to negotiated performance standards subject to a penalty of twenty-five (25%) percent of the total contracted cost, plus per day and occurrence fees for certain performance guarantees.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit. Any auditor must agree to follow Contractor's security procedures and protect confidentiality of Contractor's information.

Measurement Period: January 1, 2024 through December 31, 2024. Additional measurement periods will be incorporated, as applicable, upon extension of this Emergency Contract, subject to any option approval required by law. If performance guarantees are effective for less than a full calendar year, the payment amounts will be prorated for the portion of the measurement period.

Additional Measurement Period: January 1, 2025 – December 31, 2025.

Additional Measurement Period: January 1, 2026 – December 31, 2026

CHANGE FROM:

4.3 FISCAL FUNDING

The continuation of this contract is contingent upon the appropriation of funds to fulfill the requirement of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the Emergency Contract, or if such appropriation is reduced by the veto of the Governor or any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the Emergency Contract, the Emergency Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

CHANGE TO:

4.3 TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Emergency Contract is contingent upon the appropriation of funds to fulfill the requirements of this Emergency Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of this Emergency Contract or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act or Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of this Emergency Contract, this Emergency Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

When funds are not appropriated or otherwise made available to support continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, this Emergency Contract for the remaining term shall be cancelled and the Contractor shall be reimbursed in accordance with the terms of this Emergency Contract for the reasonable value of any nonrecurring costs incurred but not amortized in the price of services delivered pursuant to this Emergency Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or from unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for a penalty to the state for cancellation or early payment of this Emergency Contract.

CHANGE FROM:

20 INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. Independent assurances may be in the form of a Service Organization Control ("SOC") 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 18 engagement of the operations. The SSAE 18 engagement will be performed at least annually during the term of the Emergency Contract by an audit firm that will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. These audits and/or assurances will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the indicated audit. The audit firm that will conduct the SSAE 18 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe.

As an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, if approved by OGB on or before January 15, 2025, Contractor will provide the resulting reports from any quality control reviews [such as a third party Quality Assurance (QA) review, Independent Verification and Validation (IV & V)], or any other independent Contractor project or performance reviews or independent internal audit reports. If any of these alternatives reviews are used in lieu of a SSAE 18 engagement, the review(s) must occur within the period that the Emergency Contract is in effect, and it must be documented in the resulting report and evident that scope of the independent review included the specific controls and processes for which the Contractor is providing for OGB.

The cost of such independent assurances will be borne solely by Contractor. Contractor may review any audit report before delivery to the State and include with the report a supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. Contractor shall implement recommendations as suggested by the program review, audit, and/or SSAE 18 engagement within three (3) months of report issuance and at no cost to the State.

CHANGE TO:

20 INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. Independent assurances may be in the form of a Service Organization Control ("SOC") 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 18 engagement of the operations. The SSAE 18 engagement will be performed at least annually during the term of the Emergency Contract by an audit firm that will

conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. These audits and/or assurances will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the indicated audit. The audit firm that will conduct the SSAE 18 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe.

As an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, if approved by OGB on or before January 15, 2026, Contractor will provide the resulting reports from any quality control reviews [such as a third party Quality Assurance (QA) review, Independent Verification and Validation (IV & V)], or any other independent Contractor project or performance reviews or independent internal audit reports. If any of these alternatives reviews are used in lieu of a SSAE 18 engagement, the review(s) must occur within the period that the Emergency Contract is in effect, and it must be documented in the resulting report and evident that scope of the independent review included the specific controls and processes for which the Contractor is providing for OGB.

The cost of such independent assurances will be borne solely by Contractor. Contractor may review any audit report before delivery to the State and include with the report a supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. Contractor shall implement recommendations as suggested by the program review, audit, and/or SSAE 18 engagement within three (3) months of report issuance and at no cost to the State.

CHANGE FROM:

21 NOTICE

Any notice required or permitted by this Emergency Contract, unless otherwise specifically provided for in this Emergency Contract, shall be in writing and shall be deemed given upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or, (ii) registered or certified mail return receipt requested, and addressed as follows:

To Humana: Michael P. Tilton
Humana Health Benefit Plan of Louisiana, Inc.
101 East Main Street, WTS03-CO41
Louisville, KY 40202

To OGB: David W. Couvillon, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

or

David W. Couvillon, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

The U.S. Postal Service does not make deliveries to OGB's physical location. At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

CHANGE TO:

21 NOTICE

Any notice required or permitted by this Emergency Contract, unless otherwise specifically provided for in this Emergency Contract, shall be in writing and shall be deemed given upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or, (ii) registered or certified mail return receipt requested, and addressed as follows:

To Humana: Gilbert Alan Stewart
Humana Health Benefit Plan of Louisiana, Inc.
101 East Main Street, WTS03-CO41
Louisville, KY 40202

To OGB: Heath Williams, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

or

Heath Williams, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

The U.S. Postal Service does not make deliveries to OGB's physical location. At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

CHANGE FROM:

ATTACHMENT I: SCOPE OF WORK/SERVICES; Section 1.2 Deliverables

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance identified by OGB to include, but not be limited to, the following:

- Financial Experience: Premium Income and Claims Utilization Experience.
- Average Speed to Answer: Average lag time to answer by live voice percentage of Plan Participants who wait over 60 seconds to speak with a live customer service representative.
- Abandon Call Rate: Percentage of calls where the caller hangs up before speaking to a live voice.
- Inquiry Timeliness: Percentage of inquiries answered within 7 business days.
- Claims Financial Accuracy: Percentage of claims paid correctly – dollar amount only.
- Claims Accuracy: Percentage of claims paid correctly the first time.
- Claims Process Time: Percentage of electronic and non-electronic claims paid within 30 days of receipt.
- Eligibility Posting Timeliness: Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
- ID Card Timeliness: Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
- PCP Turnover Rate: Percentage of PCPs leaving the network voluntarily or involuntarily during the month.
- Open PCP/Participant Ratio: Ratio of open PCPs accepting new plan participants to actual plan participants.

- Submit annual Service Organization Control (SOC1), Type II report resulting from SSAE 18 engagement no later than September 30 of each year of the Emergency Contract and/or other independent assurances approved by OGB by January 15 preceding the report deadline.
- Submit quarterly report that captures operational performance guarantees on a client specific basis and report OGB's data within forty-five (45) calendar days after close of each quarter. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of calendar year 2024 and calendar year 2025, respectively.
- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance and health outcomes of OGB's Plan Participants.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.

- In the event that this Emergency Contract is to be extended by amendment beyond the termination date of December 31, 2024, then one hundred and twenty days (120) prior to January 1, 2025, January 1, 2026, and for any renewal option period, the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, premiums at current rates, and the indicated rate adjustment.

CHANGE TO:

ATTACHMENT I: SCOPE OF WORK/SERVICES; Section 1.2 Deliverables

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance identified by OGB to include, but not be limited to, the following:

  - Financial Experience: Premium Income and Claims Utilization Experience.
  - Average Speed to Answer: Average lag time to answer by live voice percentage of Plan Participants who wait over 60 seconds to speak with a live customer service representative.
  - Abandon Call Rate: Percentage of calls where the caller hangs up before speaking to a live voice.
  - Inquiry Timeliness: Percentage of inquiries answered within 7 business days.
  - Claims Financial Accuracy: Percentage of claims paid correctly – dollar amount only.
  - Claims Accuracy: Percentage of claims paid correctly the first time.
  - Claims Process Time: Percentage of electronic and non-electronic claims paid within 30 days of receipt.
  - Eligibility Posting Timeliness: Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
  - ID Card Timeliness: Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
  - PCP Turnover Rate: Percentage of PCPs leaving the network voluntarily or involuntarily during the month.
  - Open PCP/Participant Ratio: Ratio of open PCPs accepting new plan participants to actual plan participants.

- Submit annual Service Organization Control (SOC1), Type II report resulting from SSAE 18 engagement no later than September 30 of each year of the Emergency Contract and/or other independent assurances approved by OGB by January 15 preceding the report deadline.
- Submit quarterly report that captures operational performance guarantees on a client specific basis and report OGB's data within forty-five (45) calendar days after close of each

quarter. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of calendar year 2024, calendar year 2025, and calendar year 2026 respectively.

- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance and health outcomes of OGB's Plan Participants.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.
- In the event that this Emergency Contract is to be extended by amendment beyond the termination date of December 31, 2024, then one hundred and twenty days (120) prior to January 1, 2025, January 1, 2026, and for any renewal option period, the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, premiums at current rates, and the indicated rate adjustment.

ADDITION:

ADDENDUM TO EMERGENCY CONTRACT: ADDITIONAL PROVISION

Prohibition of Companies That Discriminate Against Firearm and Ammunition Industries

In accordance with La. R.S. 39:1602.2, the following applies to any competitive sealed bids, competitive sealed proposals, or contract(s) with a value of $100,000 or more involving a for-profit company with at least 50 full-time employees:

Unless otherwise exempted by law, by submitting a response to this solicitation or entering into this contract, the Bidder, Proposer or Contractor certifies the following:

1. The company does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association based solely on the entity's or association's status as a firearm entity or firearm trade association;

2. The company will not discriminate against a firearm entity or firearm trade association during the term of the contract based solely on the entity's or association's status as a firearm entity or firearm trade association.

The State reserves the right to reject the response of the Bidder, Proposer or Contractor if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response or if the certification is no longer true.

REPLACE:

ATTACHMENT II: ADMINISTRATIVE FEE AND PREMIUM RATE SCHEDULE

ATTACHMENT V: RECORDS RETENTION SCHEDULE

Effective Date of Amendment: November 12, 2025

Justification for Amendment:

- Extends the term of the Emergency Contract for twelve (12) months, at the same terms and conditions of the initial contract, to December 31, 2026.
- Increases the maximum payable amount to $3,479,000.00.
- Provides additional measurement periods for Performance Guarantees for calendar year 2026.
- Provides date to submit request to OGB for submission of alternative independent assurance report for calendar year 2026.
- Provides due date for submission of independent assurance report for calendar year 2026.
- Provides date for submission of rate renewal report and actuarial certification for calendar year 2026.
- Provides administrative fee and premium rates for calendar year 2026.

No Amendment shall be valid until it has been executed by all parties and approved by the Office of State Procurement, Division of Administration.

All other provisions of the Emergency Contract shall remain in full force and effect. Any conflict between the Emergency Contract and this Amendment regarding the subject matters of this Amendment shall be resolved in favor of this Amendment.

This Amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this Amendment is signed and entered into on the date(s) included below.

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

BY: Heath Williams

NAME: Heath Williams

TITLE: Chief Executive Officer

DATE: 11/17/25

Humana Health Benefits Plan of Louisiana, Inc.

BY:

NAME: Alan Stewart

TITLE: Senior Vice President and Division Leader

DATE: 11/14/2025

ATTACHMENT II: ADMINISTRATIVE FEE AND PREMIUM RATE SCHEDULE (REVISED)

All pricing is fully burdened and inclusive of travel and all Emergency Contract-related expenses. Commissions or finder's fees are not payable under this Emergency Contract.

Administrative Fee

Monthly Administrative Fee Per Primary Plan Participant Per Month
[redacted]

Regional Premium

In the event that this Emergency Contract is to be extended by amendment beyond the termination date of December 31, 2026, the Contractor will submit proposed rates for such extension no later than August 1, 2026. Premium rates proposed for each twelve (12)-month period must be approved by the Centers for Medicare and Medicaid Services (CMS). Additionally, for each twelve (12)-month period, the Contractor must document, through a written certification from its actuary, that the proposed rates for each twelve (12)-month period are calculated on the basis of sound actuarial principles, reasonable in relation to the benefits provided and the population anticipated to be covered, and are neither excessive nor deficient.

Parishes Included in OGB Region 1	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$34.11
1/1/2025 – 12/31/2025	$82.78
1/1/2026 – 12/31/2026	$94.53

Parishes Included in OGB Region 2	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$178.83
1/1/2025 – 12/31/2025	$228.84
1/1/2026 – 12/31/2026	$240.59

Parishes Included in OGB Regions 3	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$145.36
1/1/2025 – 12/31/2025	$193.29
1/1/2026 – 12/31/2026	$205.04

Parishes Included in OGB Regions 4	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$157.83
1/1/2025 – 12/31/2025	$194.04
1/1/2026 – 12/31/2026	$205.79

Parishes Included in OGB Region 5	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$157.84
1/1/2025 – 12/31/2025	$190.41
1/1/2026 – 12/31/2026	$202.22

Parishes Included in OGB Region 6	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$208.01
1/1/2025 – 12/31/2025	$241.57
1/1/2026 – 12/31/2026	$253.32

Parishes Included in OGB Region 7	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$224.08
1/1/2025 – 12/31/2025	$251.74
1/1/2026 – 12/31/2026	$263.49

Parishes Included in OGB Region 8	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$213.86
1/1/2025 – 12/31/2025	$251.56
1/1/2026 – 12/31/2026	$263.31

Parishes Included in OGB Region 9	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	$203.95
1/1/2025 – 12/31/2025	$227.01
1/1/2026 – 12/31/2026	$238.76

ATTACHMENT V: RECORDS RETENTION SCHEDULE

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125 Baton Rouge, LA 70804

Page 1 of 15 R-2025-349 JO

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Decimal Dispositions

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Executive

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Internal Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued *
2	LLA Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued *
3	Group Benefits Policy and Planning Board Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created *
4	Group Benefits Policy & Planning Board Reports	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	
5	Group Benefits Policy & Planning Board Meeting Minutes	PERM	0	PERM	M	R	N	V	
6	Group Benefits Estimating Conference Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created *
7	Group Benefits Estimating Conference Meeting Minutes	PERM	0	PERM	M	R	N	V	
8	OGB 5-year Strategic Plan	ACT + 5 FY	0	ACT + 5 FY	P	S	N	V	ACT = until the end of the FY in which the Strategic plan was drafted *

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY – Fiscal Year (July 1 – June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Days
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
LLA = Louisiana Legislative Auditor
OGB = Office of Group Benefits

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (05/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_x_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Administration -- Finance

Item Number	Records Series Title	Retention Period: In Office	In Storage	Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	OGB Budget Request Documents/Records	ACT + 5 FY	0	ACT + 5 FY	P	S	N	V	ACT = until the end of the FY in which created
2	Actuarial Revenue/Expenditure Line-item Projections	ACT + 5 FY	0	ACT + 5 FY	M	S	N	V	ACT = until the end of the FY in which received
3	Actuarial Premium Rate Schedules	ACT + 5 CY	0	ACT + 5 CY	P	S	N	V	ACT = until the end of the FY in which received
4	Official Premium Rate Schedules	LOA + 10 CY	0	LOA + 10 CY	P	R	N	V	
5	Monthly OTS Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received
6	Annual IAT Agreements & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received
7	Miscellaneous/One-time Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received
8	OGB Fiscal Note Worksheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created
9	DOA Analysis Sheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created
10	Fuel Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA—Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB – Office of Group Benefits
OTS – Office of Technology Services
IAT- Inter Agency Transfers
DOA – Division of Administration

Heath Willis — Agency Approval
6/5/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration – Communications

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Annual Enrollment Member Guides	LOA + 10 CY	0	LOA+10 CY	P	R	N	V	
2	Annual Enrollment Member Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created*
3	Annual Enrollment HR Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created*
4	Agency/Member Memos on OGB Policies/Procedures Changes	LOA + 10 CY	0	LOA+ 10 CY	P	R	N	V	
5	Medicare Part D Creditable Coverage Notices	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = until the end of the CY in which the notices were created*
6	Publications	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	
7	Designation Forms (OGB Coordinator, OGB Additional Agency Contacts) (GB-74, GB-76)	LOA + 10 CY	0	LOA – 10 CY	M	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Days)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to CaBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
HR – Human Resources
OGB – Office of Group Benefits

Agency Approval — Date Signed — Secretary of State, State Archives & Records Services — Date Approved

6/9/25

JUN 11 2025

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration – General

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Employee Driver Authorization Forms	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the employee separates from agency*
2	OGB Employee Safety Meetings Training Materials & Signed Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
3	OGB Employee PES Evaluations and Planning Session Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which supervis on ends*
4	OGB Employee Time & Attendance Reports	ACT + 2 CY	3 CY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the CY in which the reports were created or received*
5	Vehicle Logs & Supporting Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
6	SOF & Supporting Documents	ACT + 2 FY	1 FY	ACT + 3 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
7	Daily Documents/Mail Assignments Logs	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created*
8	Records Management Files: Retention Schedules, disposal requests, Transmittals Surveys and Exceptions)	LOA + 10 CY	0	LOA + 10 CY	M	A	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY– Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
SOF –Special order Form
OGB= Office of Group Benefits
PES = Personnel Evaluation System

Agency Approval — 4/9/25 Date Signed — Secretary of State, State Archives & Records Services — JUN 1 1 2025 Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Contracts Management

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Contracts, Contract Amendments, & Supporting Documents	ACT + 3 CY	7 CY	ACT + 10 CY	M	S	Y	V	ACT = Until the end of the CY in which the contract expires or is terminated*
2	OGB Contract Solicitations (RFP, ITB, RFI) & Supporting Documents	ACT + 3 CY	0	ACT + 3 CY	M	S	Y	V	ACT = Until the end of the CY in which the solicitations deadline ends*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex Scanned to CrBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
RFP = Request for Proposal
ITB = Intent to Bid
RFI = Request for Information

Heath Williams — Agency Approval
6/9/25 — Date Signed
Lettice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

Records Retention Schedule

SSARC-932 (09/22)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Agency Services

Indicate Use of Form
__ORIGINAL SUBMISSION
_x_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	OGB Member Participation Schedules	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
2	OGB Member Collections Notices & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
3	OGB Member Appeals & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
4	OGB-participating Agency Administrative Error Appeals & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
5	Enrollment Change Forms & Supporting Eligibility Documents (GB-01)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
6	Designation Forms (Agency Master User, Eligibility/eEnrollment Contact) (GB-75, GB-78)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Williams — Agency Approval — 6/9/25 — Date Signed

Latrice Davis — Secretary of State, State Archives & Records Services — JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
records@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_x_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Customer Service

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	OGB Member Correspondence	LOA + 10 CY	0	LOA + 10 CY	C	A	N	V	
2	Daily Work Papers: Includes printed copies of imaged documents and non essential notes with PHI or OGB member contact info, produced by OGS Customer Service section staff	ACT	0	ACT	M	S	N	U	ACT = until the end of the day in which the work papers were created *
3	OGB Visitor Logs/Sign-In Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
PHI = Personal Health Information

Heath Wilkins — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Health Insurance

Item Number	Records Series Title	Retention Period: In Office	In Storage	Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Self-funded Health Plan Medical TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
2	Self-funded Health Plan Pharmacy TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
3	Fully Insured Health Plan Vendors Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
4	Capitated Primary Care Network Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
5	IMMEHRA Vendor Invoices and Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
6	Health Plan Vendors Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the report or deliverable was received *
7	Health Savings Account Enrollment & Payroll Deduction Elections/Changes (GB-79 Forms)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
8	TPA Health and Pharmacy Claims (including supplemental Claims)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define terms in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase) OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
TPA = Third party administrator
IMMEHRA = Individual Medicare Market Exchange with Health Reimbursement Arrangements
OGB = Office of Group Benefits

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005

Agency / Division / Section: Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Life Insurance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Fully Insured Basic and Supplemental Life Insurance Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the document was received *
2	Fully Insured Basic and Supplemental Life Insurance Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the document was received *
3	Fully Insured Basic and Supplemental Life Insurance Member Beneficiary Designation/Change Forms	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Willis — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Flexible Benefits & COBRA

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	FSA & COBRA TPA Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
2	FSA & COBRA TPA Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
3	Flexible Spending Arrangement Enrollment/Stop Form (GB-2)	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits
TPA = Third Party Administrator

Heath Williams — Agency Approval
6/9/25 — Date Signed
Letrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits/Invoicing

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Reconciled Invoices with Payment Record	PERM	0	PERM	M	R	N	V	*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency

NOTE Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations

Heath Williams — Agency Approval — 6/9/25 — Date Signed

Lottrice Davis — Secretary of State, State Archives & Records Services — JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Agency No. | Agency / Division / Section

003.005 Division of Administration / Office of Group Benefits/Compliance

Indicate Use of Form
_ORIGINAL SUBMISSION
X RENEWAL
_REPLACEMENT PAGE
_ADDENDUM PAGE

Item Number	Records Series Title	Retention Period: In Office	In Storage	Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Section 111 Reporting Documents and Reports: mandated by the Centers for Medicare and Medicaid Services (CMS). Includes research, communication with CMS, internal communication, reports, working files	PERM	0	PERM	M	R	N	V	
2	Administrative Procedures Act Documents and Reports	PERM	0	PERM	P	R	N	V	
3	Mandated Legislative Reports and Regulations	ACT + 5 CY	0	ACT + 5 CY	P	S	N	V	ACT = Until end of CY report is submitted (Regulations that become OGB policy and procedure may become permanent records)
4	OGB HIPAA Compliance Records	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = Until the end of the CY in which the records were created*

Permitted Retention Period Abbreviations
ACT = Active Period (When used define term in remarks column)
FY = Fiscal Year (July 1 – June 30)
CY = Calendar Year (Jan 1 – Dec 31)
AY = Academic Year (Aug 1 – July 31)
FFY = Federal Fiscal Year (Oct 1 – Sept 30)
MO = Months WK = Weeks (Mon-Sun) DY = Days
PERM = Permanent Life of State LOA = Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex: Scanned to OnBase)

Security Status Codes
P = Public Record
M = May Contain Confidential Information
C = Confidential Information

Archival Processing Codes
A = Transfer to State Archives
R = Retain in Agency Archives
S = Review by State Archives
O = Other (Specify in Remarks)

State Records Center Use
Y = Yes
N = No

Vital Record Identification Code
V = Vital
I = Important
U = Useful

Agency Abbreviations
OGB = Office of Group Benefits
HIPAA = Health Insurance Portability and Accessibility Act

Heath Williams 6/9/25
Agency Approval Date Signed

Latrice Davis JUN 11 2025
Secretary of State, State Archives & Records Services Date Approved

Records Retention Schedule

SSARC-932 (03/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Filing Deadline Mail Records	ACT + 3 CY	0	ACT + 3 CY	M	S	N	I	ACT = until the end of the CY in which the document was created or received. *
2	Live and Event Claims Records	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
3	Field and Audit Reports	ACT + 5 CY	0	ACT + 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued *
4	Health Claims (including Supplemental Claims)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
5	Explanation of Benefits (EOBs)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
6	Medical Records	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
7	Pre-determinations	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
8	Case Management	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
9	Medical Necessities	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY– Fiscal Year (July 1– June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Wellin — Agency Approval
6/9/25 — Date Signed
Patrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (03/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Agency No | Agency / Division / Section

003.005 Division of Administration / Office of Group Benefits / Discontinued Programs

Indicate Use of Form
__ORIGINAL SUBMISSION
X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Item Number	Records Series Title	Retention Period: In Office	In Storage	Total Retention	Security	Archival	State Records Center	Vital	Remarks
10	Paid in Vouchers	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
11	Flexible Benefit Master File	LOA + 10 CY	0	LOA - 10 CY	C	R	N	V	
12	Hospital Audits Statistical Reports and Work Papers	ACT + 5 CY	0	ACT + 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued *
13	Fraud and Abuse Case Files and Logs	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
14	Health Claim Audits and Work Papers (including over $500 plan Member check Audits)	ACT + 5 CY	0	ACT + 5 CY	C	S	N	I	ACT = until the end of the CY in Audit is completed *
15	Special Reports (Outer Check Cycle)	ACT + 10 CY	0	ACT + 10 CY	M	S	N	I	ACT = until the end of the CY in which report is run *
16	Reviews (Medical and Chiropractic)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
17	Preferred Provider Option/Exclusive Provider Option Contracts	LOA + 5 CY	0	LOA + 5 CY	M	R	N	V	
18	Legal Approvals	ACT + 3 CY	7 CY	ACT + 10CY	M	S	N	V	ACT = until the end of the CY in which plan expires *

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No. | Agency / Division / Section

003.005 Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
19	Adjusted Batch Listings	ACT + 7 CY	0	ACT + 7 CY	M	S	N	I	ACT = until the end of the CY in which plan expires
20	Fully Insured Basic and Supplemental Life Insurance: all claims documents received, requested and sent (Employer Statements, Beneficiary Statements, Explanation of Benefits, Beneficiary Information, Enrollment Information) Notes, Calls and Payments	ACT + 70 CY	0	ACT + 70 CY	M	S	N	V	ACT = until end of CY in which employee separates from the agency

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY – Fiscal Year (July 1 – June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Weeks (Mon-Sun) DY – Days)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Agency Approval

4/9/25
Date Signed

Secretary of State, State Archives & Records Services

JUN 11 2025
Date Approved

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Office of Group Benefits

November 20, 2025 Meeting of the Joint Legislative Committee on the Budget

New Orleans Regional Physician Hospital Organization, LLC, d/b/a Peoples Health

Fully Insured Medicare Advantage Plan
Emergency Contract Amendment No. 2 Overview

New Orleans Regional Physician Hospital Organization, LLC, d/b/a Peoples Health

Fully Insured Medicare Advantage Plan Emergency Contract Amendment No. 3 Overview

Contract Purpose	To offer a Medicare Advantage plan including Medicare Part D prescription drug benefits for Medicare eligible retirees.
Eligible Enrollees	Retired employees of the State of Louisiana and other OGB-participating entities who are enrolled in Medicare Parts A and B.
Membership Count as of 11/1/2025	2,206
Original Emergency Contract Term	01/01/2024 – 12/31/2024
Emergency Contract Extensions Exercised	12 Months
Current Emergency Contract Term	01-01-2024 – 12/31/2025
Emergency Contract Term After this Amendment	01-01-2024 – 12/31/2026
Original Emergency Contract Maximum Payable Amount	$5,586,000.00
Current Emergency Contract Maximum Payable Amount	$10,219,000.00
Emergency Contract Maximum Payable Amount After this Amendment	$20,318,000.00
Administrative Fee	$10.00 per Primary Plan Participant per Month, Payable to OGB (no change from 2025)
Number of Plans Offered	One (no change from 2025)
Statewide or Regional Premium Rates	Statewide Premium Rates (see below)

Peoples Health HMO-POS Medicare Advantage Plan	2025 Total Monthly Premiums	2026 Total Monthly Premiums	$ Change	% Change
Statewide				
Enrollee Only	$175.00	$378.04	$203.04	116.0%
Enrollee + Spouse	$350.00	$756.08	$406.08	116.0%

Amendment to Contract Between

State of Louisiana
Office of Group Benefits (OGB)

And

New Orleans Regional Physician Hospital Organization, LLC, d/b/a Peoples Health
3838 N. Causeway Blvd., Suite 2500, Metairie, LA 70002

CHANGE FROM:

3.1 TERM OF EMERGENCY CONTRACT

This Emergency Contract shall begin on or about January 1, 2024, and is anticipated to end on December 31, 2025, subject to written extension(s) of this Emergency Contract by agreement of the parties and as provided by the Office of State Procurement. Notwithstanding any other provision of this Emergency Contract, this Emergency Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana. Prior to the extension of the Emergency Contract beyond the term, prior approval from OSP to extend the Emergency Contract beyond the term shall be obtained. As provided in Section 4.3, the continuation of this Emergency Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Emergency Contract.

CHANGE TO:

3.1 TERM OF EMERGENCY CONTRACT

This Emergency Contract shall begin on or about January 1, 2024, and is anticipated to end on December 31, 2026, subject to written extension(s) of this Emergency Contract by agreement of the parties and as provided by the Office of State Procurement. Notwithstanding any other provision of this Emergency Contract, this Emergency Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana. Prior to the extension of the Emergency Contract beyond the term, prior approval from OSP to extend the Emergency Contract shall be obtained. As provided in Section 4.3, the continuation of this Emergency Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Emergency Contract.

CHANGE FROM:

3.4 PAYMENT TERMS

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay to Contractor a maximum fee of $10,219,000.00 (Ten Million Two Hundred Nineteen Thousand Dollars) for work performed during the term of this Emergency Contract. This fee is inclusive of travel and all Contract-related expenses. Payments are predicated upon successful completion by Contractor and written approval by OGB of the described services and deliverables as provided in

the Emergency Contract. Contractor will not be paid more than the maximum amount of the Emergency Contract. No payments will be made by OGB on banking or State holidays.

With respect to Plan Participants who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their plan participation due to the selection of the Louisiana HMO. OGB shall impose on Contractor a monthly administrative fee of $10.00 for each HMO Primary Plan Participant. The administrative fee will be paid directly to OGB for each Primary Plan Participant and shall not be included in the premium charged. Plan Participants selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other health coverage options provided by OGB.

The Contractor will invoice OGB on the 1st day of each month for payment of premiums for services provided pursuant to the resulting Emergency Contract. The invoice should include, at a minimum, the time period covered, total billed amount detailed by class of coverage, and assessed administrative fee based on total number of Primary Plan Participants. Payments will be made to the Contractor after written acceptance and approval of the invoice by the State. Upon approval of each submitted invoice by OGB's Chief Executive Officer or designee, OGB/State will render payment of undisputed amounts within thirty (30) days.

CHANGE TO:

3.4 PAYMENT TERMS

In consideration of the services required by this Emergency Contract, OGB hereby agrees to pay to Contractor a maximum fee of $20,381,000 (Twenty Million Three Hundred Eighty One Thousand Dollars) for work performed during the term of this Emergency Contract. This fee is inclusive of travel and all Contract-related expenses. Payments are predicated upon successful completion by Contractor and written approval by OGB of the described services and deliverables as provided in the Emergency Contract. Contractor will not be paid more than the maximum amount of the Emergency Contract. No payments will be made by OGB on banking or State holidays.

With respect to Plan Participants who select a Louisiana HMO for their coverage, OGB shall impose no extraordinary restrictions on their plan participation due to the selection of the Louisiana HMO. OGB shall impose on Contractor a monthly administrative fee of $10.00 for each HMO Primary Plan Participant. The administrative fee payment will be delivered directly to OGB by the last day of the month for each Primary Plan Participant for the previous month, and shall not be included in the premium charged. Plan Participants selecting the Louisiana HMO option shall receive the same employer contributions provided under La. R.S. 42:851, and the regulations issued thereunder, as participants who choose other health coverage options provided by OGB.

The Contractor will invoice OGB before close of business on the fifth business day of the month for which premiums apply for services provided pursuant to the resulting Emergency Contract. The invoice should include, at a minimum, the time period covered, total billed amount detailed by class of coverage, and assessed administrative fee based on total number of Primary Plan Participants. Payments will be made to the Contractor after written acceptance and approval of the invoice by the State. Upon approval of each submitted invoice by OGB's Chief Executive Officer or designee, OGB/State will render payment of undisputed amounts within thirty (30) days.

CHANGE FROM:

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis on a quarterly basis. OGB shall have the ability to modify the performance guarantees each Contract year; however, twenty-five (25%) percent of Contractor's fees will remain at risk, and Contractor will be subject to per day and per occurrence fees for certain performance guarantees. All guarantees must be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Performance Guarantees: The Contractor will be subject to negotiated performance standards subject to a penalty of twenty-five (25%) percent of the total contracted cost, plus per day and per occurrence fees for certain performance guarantees.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit.

Measurement Period: January 1, 2024 through December 31, 2024. Additional measurement periods will be incorporated, as applicable, upon extension of this Emergency Contract, subject to any option approval required by law.

Additional Measurement Period: January 1, 2025 – December 31, 2025

CHANGE TO:

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis on a quarterly basis. OGB shall have the ability to modify the performance guarantees each Contract year; however, twenty-five (25%) percent of Contractor's fees will remain at risk, and Contractor will be subject to per day and per occurrence fees for certain performance guarantees. All guarantees must be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of the calendar year.

Performance Guarantees: The Contractor will be subject to negotiated performance standards subject to a penalty of twenty-five (25%) percent of the total contracted cost, plus per day and per occurrence fees for certain performance guarantees.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit.

Measurement Period: January 1, 2024 through December 31, 2024. Additional measurement periods will be incorporated, as applicable, upon extension of this Emergency Contract, subject to any option approval required by law.

Additional Measurement Period January 1, 2025 – December 31, 2025.

Additional Measurement Period January 1, 2026 – December 31, 2026.

CHANGE FROM:

4.3 FISCAL FUNDING

The continuation of this contract is contingent upon the appropriation of funds to fulfill the requirement of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the Emergency Contract, or if such appropriation is reduced by the veto of the Governor or any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the Emergency Contract, the Emergency Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

CHANGE TO:

4.3 TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Emergency Contract is contingent upon the appropriation of funds to fulfill the requirements of this Emergency Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of this Emergency Contract or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act or Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of this Emergency Contract, this Emergency Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

When funds are not appropriated or otherwise made available to support continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, this Emergency Contract for the remaining term shall be cancelled and the Contractor shall be reimbursed in accordance with the terms of this Emergency Contract for the reasonable value of any nonrecurring costs incurred but not amortized in the price of services delivered pursuant to this Emergency Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or from unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for a penalty to the state for cancellation or early payment of this Emergency Contract.

CHANGE FROM:

20. INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. Independent assurances may be in the form of a Service Organization Control ("SOC") 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 18 engagement of the operations. The SSAE 18 engagement will be performed at least annually during the term of the Emergency Contract by an audit firm that will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. These audits and/or assurances will require the Contractor to provide

any assistance, records access, information system access, staff access, and space access to the party selected to perform the indicated audit. The audit firm that will conduct the SSAE 18 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe.

As an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, if approved by OGB on or before January 15, 2025, Contractor may provide a quality control plan [such as third party Quality Assurance (QA), an Independent Verification and Validation (IV & V)], or any other independent Contractor project or performance review or independent internal audit report.

The cost of such independent assurances will be borne solely by Contractor. Contractor may review any audit report before delivery to the State and include with the report a supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. The Contractor shall supply the State/OGB with an exact copy of the report within (30) calendar days of receipt of the audit. Contractor shall implement recommendations as suggested by the program review, audit, and/or SSAE 18 engagement within three (3) months of report issuance and at no cost to the State.

CHANGE TO:

20. INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. Independent assurances may be in the form of a Service Organization Control ("SOC") 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 18 engagement of the operations. The SSAE 18 engagement will be performed at least annually during the term of the Emergency Contract by an audit firm that will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. These audits and/or assurances will require the Contractor to provide any assistance, records access, information system access, staff access, and space access to the party selected to perform the indicated audit. The audit firm that will conduct the SSAE 18 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe.

As an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, if approved by OGB on or before January 15, 2026, Contractor may provide a quality control plan [such as third party Quality Assurance (QA), an Independent Verification and Validation (IV & V)], or any other independent Contractor project or performance review or independent internal audit report. If any of these alternatives reviews are used in lieu of a SSAE 18 engagement, the review(s) must occur within the period that the Emergency Contract is in effect, and it must be documented in the resulting report and evident that scope of the independent review included the specific controls and processes for which the Contractor is providing for OGB.

The cost of such independent assurances will be borne solely by Contractor. Contractor may review any audit report before delivery to the State and include with the report a supplementary

statement containing facts that Contractor considers pertinent to the audit or engagement. The Contractor shall supply the State/OGB with an exact copy of the report within (30) calendar days of receipt of the audit. Contractor shall implement recommendations as suggested by the program review, audit, and/or SSAE 18 engagement within three (3) months of report issuance and at no cost to the State.

CHANGE FROM:

21 NOTICE

Any notice required or permitted by this Emergency Contract, unless otherwise specifically provided for in this Emergency Contract, shall be in writing and shall be deemed given upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or, (ii) registered or certified mail return receipt requested, and addressed as follows:

To Peoples Health:
Suzi Swoop O'Brien, CEO
Peoples Health
3838 N. Causeway Blvd., Suite 2200
Metairie, LA 70002

To OGB:
David W. Couvillon, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804
or
David W. Couvillon, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

The U.S. Postal Service does not make deliveries to OGB's physical location.

At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

CHANGE TO:

21 NOTICE

Any notice required or permitted by this Emergency Contract, unless otherwise specifically provided for in this Emergency Contract, shall be in writing and shall be deemed given upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or, (ii) registered or certified mail return receipt requested, and addressed as follows:

To Peoples Health:
Suzi Swoop O'Brien, CEO
Peoples Health
3838 N. Causeway Blvd., Suite 2500
Metairie, LA 70002

To OGB:

Heath Williams, CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

or

Heath Williams, CEO
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802

The U.S. Postal Service does not make deliveries to OGB's physical location.

At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

CHANGE FROM:

ATTACHMENT I: SCOPE OF WORK/SERVICES; Section 1.2 Deliverables

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance identified by OGB to include, but not limited to, the following:

- **Financial Experience:** Premium Income and Claims Utilization Experience.
- **Average Speed to Answer:** Average lag time to answer by live voice percentage of Plan Participants who wait over 60 seconds to speak with a live customer service representative.
- **Abandon Call Rate:** Percentage of calls where the caller hangs up before speaking to a live voice.
- **Inquiry Timeliness**: Percentage of inquiries answered within 7 business days.
- **Claims Financial Accuracy:** Percentage of claims paid correctly – dollar amount only.
- **Claims Accuracy:** Percentage of claims paid correctly the first time.
- **Claims Process Time:** Percentage of electronic and non-electronic claims paid within 30 days of receipt.
- **Eligibility Posting Timeliness**: Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
- **ID Card Timeliness**: Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
- **PCP Turnover Rate**: Percentage of PCPs leaving the network voluntarily or involuntarily during the month.

- **Open PCP/Participant Ratio:** Ratio of open PCPs accepting new plan participants to actual plan participants.

- Submit annual Service Organization Control (SOC1), Type II report resulting from SSAE 18 engagement no later than September 30, 2024 and/or other independent assurances approved by OGB by January 15 preceding the report deadline.
- Submit quarterly report that captures operational performance guarantees on a client-specific basis and report OGB's data within forty-five (45) calendar days after close of each quarter. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of calendar year 2024 and calendar year 2025, respectively.
- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance and health outcomes of OGB's Plan Participants.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.
- One hundred and twenty days (120) prior to January 1, 2025, January 1, 2026, and for any renewal option period, the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, premiums at current rates, and the indicated rate adjustment.

CHANGE TO:

ATTACHMENT I: SCOPE OF WORK/SERVICES; Section 1.2 Deliverables

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance identified by OGB to include, but not limited to, the following:

- **Financial Experience:** Premium Income and Claims Utilization Experience.
- **Average Speed to Answer:** Average lag time to answer by live voice percentage of Plan Participants who wait over 60 seconds to speak with a live customer service representative.
- **Abandon Call Rate:** Percentage of calls where the caller hangs up before speaking to a live voice.
- **Inquiry Timeliness**: Percentage of inquiries answered within 7 business days.
- **Claims Financial Accuracy:** Percentage of claims paid correctly – dollar amount only.
- **Claims Accuracy:** Percentage of claims paid correctly the first time.

- **Claims Process Time:** Percentage of electronic and non-electronic claims paid within 30 days of receipt.
- **Eligibility Posting Timeliness**: Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
- **ID Card Timeliness**: Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
- **PCP Turnover Rate**: Percentage of PCPs leaving the network voluntarily or involuntarily during the month.
- **Open PCP/Participant Ratio:** Ratio of open PCPs accepting new plan participants to actual plan participants.

- Submit annual Service Organization Control (SOC1), Type II report resulting from SSAE 18 engagement no later than September 30 of each year of the Emergency Contract and/or other independent assurances approved by OGB by January 15 preceding the report deadline.
- Submit quarterly report that captures operational performance guarantees on a client-specific basis and report OGB's data within forty-five (45) calendar days after close of each quarter. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of calendar year 2024, calendar year 2025, and calendar year 2026 respectively.
- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor's operating performance and health outcomes of OGB's Plan Participants.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.
- One hundred and twenty days (120) prior to January 1, 2025, January 1, 2026, January 1, 2027, and for any renewal option period, the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, premiums at current rates, and the indicated rate adjustment.

ADDITION:

ADDENDUM TO EMERGENCY CONTRACT: ADDITIONAL PROVISION

Prohibition of Companies That Discriminate Against Firearm and Ammunition Industries

In accordance with La. R.S. 39:1602.2, the following applies to any competitive sealed bids, competitive sealed proposals, or contract(s) with a value of $100,000 or more involving a for-profit company with at least 50 full-time employees:

Unless otherwise exempted by law, by submitting a response to this solicitation or entering into this contract, the Bidder, Proposer or Contractor certifies the following:

1. The company does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association based solely on the entity's or association's status as a firearm entity or firearm trade association;

2. The company will not discriminate against a firearm entity or firearm trade association during the term of the contract based solely on the entity's or association's status as a firearm entity or firearm trade association.

The State reserves the right to reject the response of the Bidder, Proposer or Contractor if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response or if the certification is no longer true.

REPLACE:

ATTACHMENT II: ADMINISTRATIVE FEE AND PREMIUM RATE SCHEDULE

ATTACHMENT V: RECORDS RETENTION SCHEDULE

Effective Date of Amendment: October 1, 2025

Justification for Amendment:

- Extends the term of the Emergency Contract for twelve (12) months, at the same terms and conditions of the initial contract, to December 31, 2026.
    - Increases the maximum payable amount to $20,381,000.
- Provides additional measurement periods for Performance Guarantees for calendar year 2026.
- Provides date to submit request to OGB for submission of alternative independent assurance report for calendar year 2026.
- Provides due date for submission of independent assurance report for calendar year 2026.
- Provides date for submission of rate renewal report and actuarial certification for calendar year 2026.
- Provides administrative fee and premium rates for calendar year 2026.

No Amendment shall be valid until it has been executed by all parties and approved by the Office of State Procurement, Division of Administration.

All other provisions of the Emergency Contract shall remain in full force and effect. Any conflict between the Emergency Contract and this Amendment regarding the subject matters of this Amendment shall be resolved in favor of this Amendment.

This Amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this Amendment is signed and entered into on the date(s) included below.

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS

NEW ORLEANS REGIONAL PHYSICIAN HOSPITAL ORGANIZATION, LLC d/b/a PEOPLES HEALTH

BY: Heath Williams	**BY:** Suzi Swoop O'Brien
NAME: Heath Williams	**NAME:** Suzi Swoop O'Brien
TITLE: Chief Executive Officer	**TITLE:** President and Chief Executive Officer
DATE: 11/17/25	**DATE:** 11/17/2025

ATTACHMENT II: ADMINISTRATIVE FEE AND PREMIUM RATE SCHEDULE

All pricing is fully burdened and inclusive of travel and all Contract-related expenses. Commissions or finder's fees are not payable under this Emergency Contract.

Administrative Fee

Monthly Administrative Fee Per Primary Plan Participant Per Month
$10.00

Regional Premium

In the event that this Emergency Contract is to be extended by amendment beyond the termination date of December 31, 2026, the Contractor will submit proposed rates for such extension no later than August 1, 2026. **Premium rates proposed for each twelve (12)-month period must be approved by the Centers for Medicare and Medicaid Services (CMS). Additionally, for each twelve (12)-month period, the Contractor must document, through a written certification from its actuary, that the proposed rates for each twelve (12)-month period are calculated on the basis of sound actuarial principles, reasonable in relation to the benefits provided and the population anticipated to be covered, and are neither excessive nor deficient.**

Parishes Included in all OGB Regions (i.e., statewide)	Fixed Monthly Premium, Per Plan Participant Per Month
1/1/2024 – 12/31/2024	**$160.00**
1/1/2025 – 12/31/2025	**$175.00**
1/1/2026 – 12/31/2026	**$378.04**

ATTACHMENT V: RECORDS RETENTION SCHEDULE

Records Retention Schedule

SSARC-933 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125 Baton Rouge, LA 70804

recmgt.Does.fa.gov

Page 1 of 15 2.2025-3490

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Executive

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Internal Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued *
2	LLA Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued *
3	Group Benefits Policy and Planning Board Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created *
4	Group Benefits Policy & Planning Board Reports	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	
5	Group Benefits Policy & Planning Board Meeting Minutes	PERM	0	PERM	M	R	N	V	
6	Group Benefits Estimating Conference Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created *
7	Group Benefits Estimating Conference Meeting Minutes	PERM	0	PERM	M	R	N	V	
8	OGB 5-year Strategic Plan	ACT + 5 FY	0	ACT + 5 FY	P	S	N	V	ACT = until the end of the FY in which the Strategic plan was drafted *

Permitted Retention Period Abbreviations
ACT = Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY - Calendar Year (Jan 1 - Dec 31)
AY - Academic Year (Aug 1 - July 31)
FFY - Federal Fiscal Year (Oct 1 - Sept 30)
MO - Months WK - Week (Mon-Sun) DY - Days
PERM - Permanent (Life of State) LOA - Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase).

Security Status Codes
P - Public Record
M - May Contain Confidential Information
C - Confidential Information

Archival Processing Codes
A - Transfer to State Archives
R - Retain - Agency Archives
S - Review by State Archives
O - Other (Specify in Remarks)

State Records Center Use
Y - Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
LLA = Louisiana Legislative Auditor
OGB = Office of Group Benefits

Heath Wilson — Agency Approval
6/9/25 — Date Signed
Lettice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

SSARC-932 (05/20)

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Administration -- Finance

Item Number	Records Series Title	Retention Period: In Office	In Storage	Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	OGB Budget Request Documents/Records	ACT + 5 FY	0	ACT + 5 FY	P	S	N	V	ACT = until the end of the FY in which created*
2	Actuarial Revenue/Expenditure Line-Item Projections	ACT + 5 FY	0	ACT + 5 FY	M	S	N	V	ACT = until the end of the FY in which received*
3	Actuarial Premium Rate Schedules	ACT + 5 CY	0	ACT + 5 CY	P	S	N	V	ACT = until the end of the FY in which received*
4	Official Premium Rate Schedules	LOA + 10 CY	0	LOA + 10 CY	P	R	N	V	
5	Monthly OTS Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*
6	Annual IAT Agreements & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*
7	Miscellaneous/One-time Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*
8	OGB Fiscal Note Worksheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created*
9	DOA Analysis Sheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created*
10	Fuel Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA—Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex: Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB – Office of Group Benefits
OTS – Office of Technology Services
IAT- Inter Agency Transfers
DOA – Division of Administration

Heath Wilson — Agency Approval
6/3/25 — Date Signed
Lottrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Journal Page Ref. No.

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005

Agency / Division / Section: Division of Administration / Office of Group Benefits / Administration – Communications

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Annual Enrollment Member Guides	LOA + 10 CY	0	LOA+10 CY	P	R	N	V	
2	Annual Enrollment Member Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created"
3	Annual Enrollment HR Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created"
4	Agency/Member Memos on OGB Policies/Procedures Changes	LOA + 10 CY	0	LOA+ 10 CY	P	R	N	V	
5	Medicare Part D Creditable Coverage Notices	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = until the end of the CY in which the notices were created"
6	Publications	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	
7	Designation Forms (OGB Coordinator, OGB Additional Agency Contacts) (GB-74, GB-75)	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Days)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to CaBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
HR – Human Resources
OGB – Office of Group Benefits

Heath Hill — Agency Approval
6/9/25 — Date Signed
Patrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (03/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Format Established by

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration – General

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Employee Driver Authorization Forms	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the employee separates from agency*
2	OGB Employee Safety Meetings Training Materials & Signed Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
3	OGB Employee PES Evaluations and Planning Session Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which supervisor ends*
4	OGB Employee Time & Attendance Reports	ACT + 2 CY	3 CY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the CY in which the reports were created or received*
5	Vehicle Logs & Supporting Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
6	SOF & Supporting Documents	ACT + 2 FY	1 FY	ACT + 3 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received*
7	Daily Documents/Mail Assignments Logs	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created*
8	Records Management Files: Retention Schedules, disposal requests, Transmittals, Surveys and Exceptions)	LOA + 10 CY	0	LOA + 10 CY	M	A	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY – Fiscal Year (July 1 – June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY – Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
SOF –Special order Form
OGB= Office of Group Benefits
PES = Personnel Evaluation System

Agency Approval — 4/9/25 Date Signed — Secretary of State, State Archives & Records Services — JUN 11 2025 Date Approved

as amended

Records Retention Schedule

SSARC-932 (08/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Contracts Management

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Contracts, Contract Amendments, & Supporting Documents	ACT + 3 CY	7 CY	ACT + 10 CY	M	S	Y	V	ACT = Until the end of the CY in which the contract expires or is terminated*
2	OGB Contract Solicitations (RFP, ITB, RFI) & Supporting Documents	ACT + 3 CY	0	ACT + 3 CY	M	S	Y	V	ACT = Until the end of the CY in which the solicitations deadline ends*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain at Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
RFP = Request for Proposal
ITB = Intent to Bid
RFI = Request for Information

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_x_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Agency Services

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Member Participation Schedules	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
2	OGB Member Collections Notices & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
3	OGB Member Appeals & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
4	OGB-participating Agency Administrative Error Appeals & Supporting Documents	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
5	Enrollment Change Forms & Supporting Eligibility Documents (GB-01)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
6	Designation Forms (Agency Master User, Eligibility/eEnrollment Contact) (GB-75 CB-78)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Wilkinson — Agency Approval
6/9/25 — Date Signed
Patrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125 Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Customer Service

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Member Correspondence	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
2	Daily Work Papers: Includes printed copies of imaged documents and non-essential notes with PHI or OGB member contact info, produced by OGB Customer Service section staff	ACT	0	ACT	M	S	N	U	ACT = until the end of the day in which the work papers were created *
3	OGB Visitor Logs/Sign-in Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created*

Permitted Retention Period Abbreviations
ACT – Active Period (When used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex: Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
PHI = Personal Health Information

Heath Willis — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Internal Schedule No.

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Health Insurance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Self-Funded Health Plan Medical TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
2	Self-Funded Health Plan Pharmacy TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
3	Fully Insured Health Plan Vendors Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
4	Capitated Primary Care Network Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
5	IMMEHRA Vendor Invoices and Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
6	Health Plan Vendors Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the report or deliverable was received *
7	Health Savings Account Enrollment & Payroll Deduction Elections/Changes (GB-79 Forms)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
8	TPA Health and Pharmacy Claims (including supplemental Claims)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase) OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
TPA = Third party administrator
IMMEHRA = Individual Medicare Market Exchange with Health Reimbursement Arrangements
OGB = Office of Group Benefits

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Life Insurance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Fully Insured Basic and Supplemental Life Insurance Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the document was received *
2	Fully Insured Basic and Supplemental Life Insurance Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the document was received *
3	Fully Insured Basic and Supplemental Life Insurance Member Beneficiary Designation/Change Forms	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Willis — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-032 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmgt@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Flexible Benefits & COBRA

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	FSA & COBRA TPA Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
2	FSA & COBRA TPA Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received *
3	Flexible Spending Arrangement Enrollment/Stop Form (OB-2)	LOA + 10 CY	0	LOA + 10 CY	M	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits
TPA = Third Party Administrator

Heath Williams — Agency Approval
6/9/25 — Date Signed
Latrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

format 8 pos to .doc

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits/Invoicing

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Reconciled Invoices with Payment Record	PERM	0	PERM	M	R	N	V	*

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations

Heath Williams — Agency Approval
6/9/25 — Date Signed
Lottrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
_ORIGINAL SUBMISSION
X RENEWAL
_REPLACEMENT PAGE
_ADDENDUM PAGE

Agency No. | Agency / Division / Section

003.005 Division of Administration / Office of Group Benefits/Compliance

Item Number	Records Series Title	Retention Period: In Office	In Storage	Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Section 111 Reporting Documents and Reports: mandated by the Centers for Medicare and Medicaid Services (CMS); includes research, communication with CMS, internal communication, reports, working files	PERM	0	PERM	M	R	N	V	
2	Administrative Procedures Act Documents and Reports	PERM	1	PERM	P	R	N	V	
3	Mandated Legislative Reports and Regulations	ACT + 5 CY	0	ACT + 5 CY	P	S	N	V	ACT = Until end of CY report is submitted (Regulations that become OGB policy and procedure may become permanent records)
4	OGB HIPAA Compliance Records	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = until the end of the CY in which the records were created or received *

Permitted Retention Period Abbreviations
ACT – Active Period (when used on the form in remarks column)
FY – Fiscal Year (July 1 – June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY – Days
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex: Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U = Useful

Agency Abbreviations
OGB = Office of Group Benefits
HIPAA = Health Insurance Portability and Accessibility Act

Heath Williams 6/9/25
Agency Approval Date Signed

Lotrice Davis JUN 11 2025
Secretary of State, State Archives & Records Services Date Approved

Records Retention Schedule

SSARC-932 (03/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
1	Filing Deadline Mail Records	ACT + 3 CY	0	ACT + 3 CY	M	S	N	I	ACT = until the end of the CY in which the document was created or received. *
2	Live and Event Claims Records	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
3	Field and Audit Reports	ACT + 5 CY	0	ACT + 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued *
4	Health Claims (including Supplemental Claims)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
5	Explanation of Benefits (EOBs)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
6	Medical Records	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
7	Pre-determinations	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
8	Case Management	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
9	Medical Necessities	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology. (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Heath Wellin — Agency Approval
6/9/25 — Date Signed
Lottrice Davis — Secretary of State, State Archives & Records Services
JUN 11 2025 — Date Approved

as amended

Records Retention Schedule

SSARC-932 (05/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period: In Office	In Storage	Total Retention	Security	Archival	State Records Center	Vital	Remarks
10	Paid in Vouchers	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
11	Flexible Benefit Master File	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
12	Hospital Audits Statistical Reports and Work Papers	ACT + 5 CY	0	ACT + 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued *
13	Fraud and Abuse Case Files and Logs	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
14	Health Claim Audits and Work Papers (including over $500 plan Member check Audits)	ACT + 5 CY	0	ACT + 5 CY	C	S	N	-	ACT = until the end of the CY in Audit is completed *
15	Special Reports (Outside Check Cycle)	ACT + 10 CY	0	ACT + 10 CY	M	S	N	I	ACT = until the end of the CY in which report is run *
16	Reviews (Medical and Chiropractic)	LOA + 10 CY	0	LOA + 10 CY	C	R	N	V	
17	Preferred Provider Option/Exclusive Provider Option Contracts	LOA + 5 CY	0	LOA + 5 CY	M	R	N	V	
18	Logic Approvals	ACT + 3 CY	7 CY	ACT + 10CY	M	S	N	V	ACT = until the end of the CY in which plan expires *

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY - Fiscal Year (July 1 - June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase)

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V = Vital
I = Important
U = Useful

Agency Abbreviations
OGB = Office of Group Benefits

Agency Approval

6/9/25
Date Signed

Secretary of State, State Archives & Records Services

JUN 11 2025
Date Approved

as amended

Records Retention Schedule

SSARC-932 (09/20)

Louisiana State Archives—Records Management
Louisiana Secretary of State
Post Office Box 94125, Baton Rouge, LA 70804
recmail@sos.la.gov

Indicate Use of Form
__ORIGINAL SUBMISSION
_X_RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Agency No: 003.005
Agency / Division / Section: Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period: In Office	Retention Period: In Storage	Retention Period: Total Retention	Security	Archival	State Records Center	Vital	Remarks
19	Adjusted Batch Listings	ACT + 7 CY	0	ACT + 7 CY	M	S	N	I	ACT = until the end of the CY in which plan expires *
20	Fully Insured Basic and Supplemental Life Insurance: all claims documents received, requested and sent (Employer Statements, Beneficiary Statements, Explanation of Benefits, Beneficiary Information, Enrollment Information) Notes, Calls and Payments	ACT + 70 CY	0	ACT + 70 CY	M	S	N	V	ACT = until end of CY in which employee separates from the agency

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY: Fiscal Year (July 1 – June 30)
CY – Calendar Year (Jan 1 – Dec 31)
AY – Academic Year (Aug 1 – July 31)
FFY – Federal Fiscal Year (Oct 1 – Sept 30)
MO – Months WK – Week (Mon-Sun) DY – Days)
PERM – Permanent (Life of State) LOA – Life of Agency
NOTE: Please put an asterisk (*) in the Remarks section for any record series that contains born-digital or imaged records. Include brief description of the technology (Ex. Scanned to OnBase).

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

Agency Approval — Date Signed: 4/9/25

Secretary of State, State Archives & Records Services — Date Approved: JUN 11 2025

Office of State Procurement
State of Louisiana
Division of Administration

JEFF LANDRY
Governor

TAYLOR F. BARRAS
Commissioner of Administration

August 14, 2025

TO: Kimberly Sullivan, JD
Medicaid Executive Director
Louisiana Department of Health

FROM: Pamela Bartfay Rice, Esq., CPPO
Assistant Director, Professional Contracts

RE: OSP Pre-Approval for JLCB
Amendment #2 to contract – Health Services Advisory Group Consultants, LLC
LaGov PO: 2000773152

The above-referenced contract amendment has been reviewed by the Office of State Procurement. The documents comply with the State Procurement Code and are ready for submission to the Joint Legislative Committee on the Budget. Upon approval of the contract amendment in accordance with La. R.S. 39:1615 (J), please return the "**Agency Memo to OSP After JLCB Approval,**" along with the stamped contract from the JLCB.

The contract amendment will not receive final approval by OSP until all appropriate approvals are received and each is submitted to OSP in LaGov and/or LESA, as applicable.

If you should have any further questions/comments, please do not hesitate to contact me.

Health Services Advisory Group (HSAG) Contract Extension

LDH LEGISLATIVE FACT SHEET

LOUISIANA DEPARTMENT OF HEALTH

CONTRACT SUMMARY:

Start Date	**March 1, 2023**
End Date	**February 28, 2026**
Requested Extension (Amendment 1) 2 year extension	**March 1, 2026 through February 28, 2028**
Extension Amount	**$4,400,000.00 ($2.2M per year; $1.65M Fed/$550K SGF)**
Total Contract Amount	**$11,182,194.00 (FY 23-26; FY 26-28 $4,400,000)**

BACKGROUND:

- The Louisiana Department of Health is requesting permission to extend the current contract with the Health Services Advisory Group (HSAG) for the term of two years (24 months). The current HSAG contract provides an option to extend the services for the same rate, with the expectation of adhering to the "new" CMS Access Rule.

- HSAG currently serves as the External Quality Review Organization (EQRO**)** for the Louisiana Department of Health to perform independent external quality review (EQR) of Louisiana Medicaid mandatory and optional services in the Code of Federal Regulations (CFR) Title 42 CFR § 438 Subpart E.

- Since March 1, 2023, HSAG has been serving in the EQRO capacity, analyzing data to evaluate the quality, accessibility and timeliness of services provided to eligible Medicaid members through Louisiana's contracted managed care organizations (MCO), dental prepaid ambulatory health plan (PAHP) and behavioral health prepaid inpatient health plan (PIHP). The work is expected to continue until February 28, 2026.

- LDH is actively drafting a new request for proposal (RFP) to secure EQRO services through a competitive process. A draft is anticipated in December 2025, but the process from publication to final contract can reasonably span months.

JUSTIFICATION:

- The contract is necessary to remain in compliance with federal regulations governing the Medicaid program through the completion of the project.

- According to Section 1932(c)(2) of the Social Security Act, each state that contracts with a managed care plan, including a Medicaid and/or CHIP MCO, PIHP, or PAHP, must ensure that an annual External

Quality Review (EQR) is performed by a qualified External Quality Review Organization (EQRO) (42 CFR § 438.350 for Medicaid and § 457.1250 for CHIP).

- Medicaid and CHIP managed care programs must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state regulations governing patient privacy and disclosure. HSAG ensures that we remain in compliance with HIPAA.

- CMS provides an oversight role with a few specific federal responsibilities. Section 1932 of the Act prescribes the managed care enrollment process, beneficiary protections, and requirements governing information and communication, but establishes only two direct oversight and monitoring requirements:

    - (1) A state must develop, implement and update a managed care quality assessment and improvement strategy that includes access standards and procedures for monitoring and evaluating the quality and appropriateness of care and services, meets the standards set by CMS, and is subject to monitoring by CMS;
    - (2) A state must conduct an annual external independent review of the quality of and access to services under each managed care contract.

IMPACT:

- Failure to approve the contract extension would result in suspension of payments; rejection of Medicaid State Plan Amendments (SPAs); and reduction of federal funding (FFP). Not adhering to federal regulations set forth in 42 CFR § 438 Subpart E to conduct external quality reviews for each contracted Medicaid Managed Care Entity (MCE) greatly impacts range of sanctions on the State of Louisiana by CMS. The specific consequences that a state could face include:

    - **Suspension of payments:** CMS can suspend federal payments for new enrollees until the state corrects the non-compliance.
    - **Rejection of Medicaid State Plan Amendments (SPAs):** CMS may deny a state's Medicaid SPA if it does not include a study demonstrating that the modification complies with federal requirements. For instance, a payment rate change must be supported by a quality-of-care analysis to be approved by CMS.
    - **Reduction of federal funding:** If a state fails to meet the federal standards for its Medicaid managed care program, it risks having its federal financial participation (FFP) reduced or withheld. This is especially crucial under managed care regulations, which are predicated on the state's agreement to operate its program in accordance with CMS guidelines.

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 2

LAGOV#: 2000773152

LDH #:

Agency Name... Bureau of Health Services Financing

(Regional/ Program/ Facility)

Original Contract Amount 6,782,194.00

AND

Original Contract Begin Date 03/01/2023

Health Services Advisory Group (HSAG)

Contractor Name

Original Contract End Date 02/28/2026

RFP Number: 3000017943

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: 6,782194.00 Current Contract Term: 3/1/2023-02/28/2026

1. Page 1 of CF-1, Item 11 Termination Date: 2/28/2026
2. Page 1 of CF-1, Item 12 Maximum Contract Amount: $6,782,194
3. Page 1 of CF-1, Item 13 Estimated Amounts By Fiscal Years: FY23 $677,915.00; FY24 $2,102,577.67; FY 25 $2,329,564.00; FY26 $1,672,137.33

Change Contract To: To Maximum Amount: 11,182,194.00 Changed Contract Term: 3/1/2023-02/28/2028

1. Page 1 of CF-1, Item 11 Termination Date: 2/28/2028
2. Page 1 of CF-1, Item 12 Maximum Contract Amount: $11,182,194
3. Page 1 of CF-1, Item 13 Estimated Amounts By Fiscal Years: FY23 $677,915.00; FY24 $2,102,577.67; FY 25 $2,329,564.00; FY26 $2,072,137.33; FY27 $2,200,000; FY28 $1,800,000
4. Page 1 of CF-1, Item 15 List All Required Attachments: Attachment D CF-1 Addendum

Justifications for amendment:

LDH is utilizing their option to extend the EQRO contract for an additional twenty-four (24) months at the same rates, terms, and conditions of the initial contract terms, in order to perform independent external quality review (EQR) services that consist of mandatory and optional activities as outlined in the Code of Federal Regulations (CFR) Title 42 CFR § 438 Subpart E.

This Amendment Becomes Effective: 03/01/2026

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

CONTRACTOR SIGNATURE **DATE**

PRINT NAME: Joellen Tenison

CONTRACTOR TITLE: Chief Executive Officer

SIGNATURE **DATE**

NAME: Bruce D. Greenstein

TITLE: LDH Secretary

OFFICE:

PROGRAM SIGNATURE **DATE**

NAME:

ADDENDUM TO CF-1

The following language shall supplement the language contained in the CF-1:

TERMINATION FOR NONAPPROPRIATION OF FUNDS.
When funds are not appropriated or otherwise made available to support continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, the contract for the remaining term shall be canceled, and the Contractor shall be reimbursed in accordance with the terms of the Contract for the reasonable value of any non-recurring costs incurred but not amortized in the price of the services being delivered pursuant to the Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for penalty to the state for cancellation or early payment of the Contract.

PROHIBITION OF COMPANIES THAT DISCRIMINATE AGAINST FIREARM AND AMMUNITION INDUSTRIES.
In accordance with LSA R.S. 39:1602.2, the following applies to any competitive sealed bids, competitive sealed proposals, or contract(s) with a value of $100,000.00 or more involving a for-profit company with at least fifty full-time employees:

Unless otherwise exempted by law, by submitting a response to this solicitation or entering into this Contract, the Bidder, Proposer or Contractor certifies the following:

1. The company does not have a practice, policy guidance or directive that discriminates against a firearm entity or firearm trade association based solely on the entity's or association's status as a firearm entity or firearm trade association.

2. The company will not discriminate against a firearm entity or firearm trade association during the term of the Contract based solely on the entity's or association's status as a firearm entity or firearm trade association.

The State reserves the right to reject the response of the Bidder, Proposer or Contractor if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response or if the certification is no longer true.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

August 22, 2023

Ms. Pamela Bartfay Rice, Esq.
Assistant Director, Professional Contracts
DOA-Office of State Procurement
P. O. Box 94095
Baton Rouge, Louisiana 70804-9095

Dear Ms. Rice:

The following contract(s) is/are being submitted to your office this date for review and approval in accordance with Louisiana Revised Statutes 39:1481 et seq. and the rules and regulations adopted pursuant thereto:

Submitting Agency – Bureau of Health Services Financing (BHSF)

Contractor – Health Services Advisory Group, Inc. (HSAG)

Amount – $6,782,194.00 (FY23 $677,915.00; FY24 $2,102,577.67; FY25 $2,329,564.00;FY26 $1,672,137.33)

Your cooperation in this regard is greatly appreciated. If additional information is needed, please call Deonne Bailey at (225) 342-5042.

Sincerely,

Deonne T. Bailey

Deonne Bailey
Medicaid Program Manager 1B

CONTRACT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

LaGov # 2000773152

BHSF

Bureau of Health Services Financing (BHSF) Agency # 305

Medical Vendor Administration (MVA)

AND

Health Services Advisory Group, Inc. (HSAG)

FOR

Personal Service ☐ Professional Service ☐ Consulting Services ☑ Social Services ☐ Governmental (State/Agency) ☐ Governmental (Local) ☐

RFP NUMBER (if applicable) 3000017943 Emergency ☐ Sole Source ☐

1) **Contractor (Registered Legal Name)** Health Services Advisory Group, Inc

5) **Vendor Supplier #** 310049989-01 5a) **State LDR Account #(if applicable)** 7638059-001

2) **Street Address** 3133 East Camelback Road Suite 140

6) **Parish(es) Served** (List all that apply) Statewide

City Phoenix **State** AZ **Zip Code** 85016

7) **License or Certification #** N/A

3) **Telephone Number**

8) **Contractor Status**

Subrecipient:	☐ Yes	☑ No
Corporation:	☑ Yes	☐ No
For Profit:	☑ Yes	☐ No
Publicly Traded:	☐ Yes	☑ No

4) **Mailing Address (if different)** "SAME"

City **State** **Zip Code**

8a) **CFDA#(Federal Grant#)**

9) **Brief Description Of Services To Be Provided:**

The Contractor will serve as the External Quality Review Organization (EQRO) for the Louisiana Department of Health to perform independent external quality review (EQR) services that consist of mandatory and optional activities as outlined in the Code of Federal Regulations (CFR) Title 42 CFR § 438 Subpart E. The Contractor will provide analysis and evaluation of aggregated data and information on quality, accessibility, and timeliness of services provided by contracted Medicaid Managed Care Organizations (MCO), a Dental Prepaid Ambulatory Health Plan (PAHP), and a Behavioral Health Prepaid Inpatient Health Plan (PIHP) for eligible Medicaid enrollees.

10) **Effective Date** 03/01/2023

11) **Termination Date** 02/28/2026

12) **Maximum Contract Amount** $ 6,782,194.00

13) **Estimated Amounts by Fiscal Year** FY23 $677,915.00; FY24$2,102,577.67; FY 25 $2,329,564.00; FY26 $1,672,137.33

14) **Terms of Payment**

If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows:

Payments will be made to the Contractor after the State approves in writing the work performed and the submitted invoice. Payment will be made only after the LDH BHSF designee approves the invoice and deliverables. The Contractor shall submit invoices by the fifteenth (15th) of each month with the appropriate documentation including separation of administrative and professional activities for purposes of Federal Match Identification. The Contract Year Payment will be calculated according to the number of contracted managed care entities and the appropriate Unit Cost outlined in the Fee Schedule (please see Attachment B for Fee Schedule and Additional Terms of Payment). A retainage fee of ten percent (10%) shall be withheld from each approved invoice

Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

14a) **PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:**

First Name Kolynda **Last Name** Parker

Title Medicaid Deputy Director **Phone Number** 225-342-7439

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

List all required Attachments

Attachment A Scope of Work
Attachment B Contract Budget, Fee Schedule and Additional terms of payment
Attachment C Diversity and Inclusion Statement

List all required Exhibits

Exhibit 1: Board Resolution/Signatory Authority Letter
Exhibit 2: Resumes
Exhibit 3: Licenses and Certificates

Types of Attachments and Exhibits

ATTACHMENTS
- Statement of work
- Fee Schedule/Budget
- Special Provisions
- Standard Provisions
- Diversity and Inclusion Statement
- OIG Addendum

EXHIBITS
- Board Resolution/Signature Authority
- Resume
- License

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. **Discrimination Clause:** Contractor hereby agrees to abide by the requirements of the following, as applicable: Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. §18116); Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d, et seq.); Title VII of the Civil Rights Act of 1964 (42 U.S.C. §2000e, et seq.); Title IX of the Education Amendments of 1972 (20 U.S.C. §1681, et seq.); the Age Discrimination Act of 1975 (42 U.S.C. §6101, et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. §794d); the Americans with Disabilities Act of 1990 (42 U.S.C. §12101, et seq.); the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. §4212); the Fair Housing Act of 1968 (42 U.S.C. §3601, et seq.); and Federal Executive Order 11246; and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services.

   Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, sexual orientation, age, national origin, disability, political affiliation, veteran status, or any other non-merit factor. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable, shall be grounds for termination of this Contract.

2. **Confidentiality:** Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and patient/client confidentiality. Information obtained under this Contract shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. **Right to Audit:** The Louisiana Legislative Auditor, Office of the Governor, Division of Administration, and Department auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this Contract during the Contract and for a period of five (5) years following final payment. Contractor grants to the State of Louisiana, through the Office of the Louisiana Legislative Auditor, Louisiana Department of Health, and State Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or Department policy requiring an audit of Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the term of this contract, for any period, four (4) copies of the audit report shall be sent to the Louisiana Department of Health, Attention: Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797 and one (1) copy of the audit shall be sent to the originating office within the Department.

4. **Record Retention:** Contractor agrees to retain all books, records, and other documents relevant to the Contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 75.361, whichever is longer.

   Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit, or copy records at Contractor's site, without expense to the Department.

5. **Record Ownership:** All records, reports, documents, and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this Contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract.

6. **Nonassignability:** Contractor shall not assign any interest in this Contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this Contract may be assigned to a bank, trust company, or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of State Procurement.

7. **Taxes:** Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this Contract shall be Contractor's. Contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

8. **Insurance:** Contractor shall obtain and maintain during the term of this Contract all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect Contractor, the Louisiana Department of Health, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the Contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

9. **Travel:** In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The Contract contains a maximum compensation that shall be inclusive of all charges including fees and travel expenses.

10. **Political Activities:** No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the Legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

11. **State Employment:** Should Contractor become an employee of the classified or unclassified service of the State of Louisiana during the term of the contract, Contractor must notify his/her appointing authority of any existing Contract with the State of Louisiana and notify the contracting office with the Department of any additional State employment. This is applicable only to contracts with individuals.

12. **Ownership of Proprietary Data:** All non-third party software and source code, records, reports, documents, and other material delivered or transmitted to Contractor by the State shall remain the property of the State, and shall be returned by Contractor to the State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this Contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the State, and shall be returned by Contractor to the State, at Contractor's expense, at termination or expiration of this contract.

13. **Subcontracting:** Contractor shall not enter into any subcontract for work or services contemplated under this Contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by Contractor of items and services that are incidental but necessary for the performance of the work required under this contract.

    No subcontract shall relieve Contractor of the responsibility for the performance of contractual obligations described herein.

14. **Conflict of Interest:** Contractor acknowledges that the Code of Governmental Ethics, La. R.S. 42:1101, et seq., applies to Contractor in the performance of services under this contract. Contractor warrants that no person and no entity providing services pursuant to this Contract on behalf of Contractor or any subcontractor is prohibited from providing such services by the provisions of La. R.S. 42:1113. Contractor agrees to immediately notify the Department if potential violations of the Code of Governmental Ethics arise at any time during the term of the contract.

15. **Unauthorized Services:** No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs that have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to offset and withhold said amounts from any amount due to Contractor under this Contract for costs that are allowable.

16. **Fiscal Funding:** This Contract is subject to and conditioned upon the availability and appropriation of federal and/or state funds; and no liability or obligation for payment will develop between the parties until the Contract has been approved by required authorities of the Department; and, if Contract exceeds $2,000, the Division of Administration, Office of State Procurement.

    The continuation of this Contract is contingent upon the appropriation of funds from the Legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. **State and Federal Funding Requirements:** Contractor shall comply with all applicable requirements of state or federal laws or regulations relating to Contractor's receipt of state or federal funds under this contract.

    If Contractor is a “subrecipient” of federal funds under this contract, as defined in 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), Contractor shall comply with all applicable requirements of 2 CFR Part 200, including but not limited to the following:

    - Contractor must disclose any potential conflict of interest to the Department and the federal awarding agency as required by 2 CFR §200.112.
    - Contractor must disclose to the Department and the federal awarding agency, timely and in writing, all violations of federal criminal laws that may affect the federal award, as required by 2 CFR §200.113.
    - Contractor must safeguard protected personally identifiable information and other sensitive information, as required by 2 CFR §200.303.
    - Contractor must have and follow written procurement standards and procedures in compliance with federally approved methods of procurement, as required by 2 CFR §§200.317 - 200.326.
    - Contractor must comply with the audit requirements set forth in 2 CFR §§200.501 - 200.521, as applicable, including but not limited to:
        - Electronic submission of data and reports to the Federal Audit Clearinghouse (FAC) (2 CFR §200.512(d)).
        - Ensuring that reports do not include protected personally identifiable information (2 CFR §200.512(a)(2)).

    Notwithstanding the provisions of paragraph 3 (Auditors) of these Terms and Conditions, copies of audit reports for audits conducted pursuant to 2 CFR Part 200 shall not be required to be sent to the Department.

18. **Amendments:** Any alteration, variation, modification, or waiver of provisions of this Contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if the Contract exceeds $5,000, by the Division of Administration, Office of State Procurement. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

19. **Non-Infringement:** Contractor will warrant all materials, products, and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against the Department, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in the Department's name, but at Contractor's expense and shall indemnify and hold the Department harmless against any loss, expense, or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists, or other allied health providers solely for medical services.

20. **Purchased Equipment:** Any equipment purchased under this Contract remains the property of Contractor for the period this Contract and future continuing contracts for the provision of the same services. Contractor must submit a vendor invoice with the reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of one thousand dollars ($1,000.00) or more. Contractor has the responsibility to submit to the Contract Monitor an inventory list of equipment items when acquired under the Contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of the contracted services, the equipment purchased under this Contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within thirty (30) days of termination of services.

21. **Indemnity:** Contractor agrees to protect, indemnify, and hold harmless the State of Louisiana and the Department from all claims for damages, costs, expenses, and attorney fees arising in Contract or tort from this Contract or from any acts or omissions of Contractor's agents, subcontractors, employees, officers, or clients, including, but not limited to, premises liability and any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which La. R.S. 40:1237.1, *et seq*. provides malpractice coverage to Contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (La. R.S. 13:5108.1(E)). Further, it does not apply to premises liability when the services are being performed on premises owned and operated by the Department.

22. **Severability**: Any provision of this Contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in state or federal law, or applicable state or federal regulations.

23. **Entire Agreement**: Contractor agrees that the current Contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of this contract.

24. **E-Verify**: Contractor acknowledges and agrees to comply with the provision of La. R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under this contract.

25. **Remedies for Default**: Any claim or controversy arising out of this Contract shall be resolved by the provisions of La. R.S. 39:1672.2-1672.4.
    Other Remedies: If the Contractor fails to perform in accordance with the terms and conditions of this Contract, or if any lien or claim for damages, penalties, cost and the like is asserted by or against the State, then, upon notice to the Contractor, the State may pursue all remedies available to it at law or equity, including retaining monies from amounts due the Contractor and proceeding against any surety of the Contractor.

26. **Governing Law**: This Contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to La. R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, and specifications listed in the Request for Proposals (RFP), if applicable; and this contract.

27. **Contractor's Cooperation**: Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the State, when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, Contractor shall not limit or impede the State's right to audit or shall not withhold State-owned documents.

28. **Continuing Obligation**: Contractor has a continuing obligation to disclose to the Department any suspension or debarment by any government entity, including, but not limited to, the General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracts.

29. **Eligibility Status**: Contractor and each tier of subcontractors, shall certify that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving Federal funds or grants from the Federal Government. Contractor and each tier of subcontractors shall certify that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with Executive Orders 12549 and 12689, and "NonProcurement Debarment and Suspension" set forth at 2 CFR Part 376.

30. **Act 211 Taxes Clause**: In accordance with La. R.S. 39:1624(A)(10), the Louisiana Department of Revenue must determine that Contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the Louisiana Department of Revenue prior to the approval of this Contract by the Office of State Procurement. Contractor hereby attests to its current and/or prospective compliance, and agrees to provide its seven-digit LDR Account Number to the Department so that Contractor's tax payment compliance status may be verified. Contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of this Contract by the Office of State Procurement. The Department reserves the right to withdraw its consent to this Contract without penalty and proceed with alternate arrangements should Contractor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) business days of such notification.

31. **Termination for Cause:** The Department may terminate this Contract for cause based upon the failure of Contractor to comply with the terms and/or conditions of the contract; provided that the Department shall give Contractor written notice specifying Contractor's failure. If within thirty (30) days after receipt of such notice, Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the Department may, at its option, place Contractor in default and the Contract shall terminate on the date specified in such notice. Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the Department to comply with the terms and conditions of this contract; provided that Contractor shall give the Department written notice specifying the Department's failure and a reasonable opportunity for the State to cure the defect.

32. **Termination for Convenience**: The Department may terminate this Contract at any time by giving thirty (30) days written notice to Contractor. Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

33. **Confidentiality:** Contractor shall protect from unauthorized use and disclosure all information relating to the State's operations and data (e.g. financial, statistical, personal, technical, etc.) that becomes available to the Contractor in carrying out this Contract. Contractor shall use protecting measures that are the same or more effective than those used by the State. Contractor is not required to protect information or data that is publicly available outside the scope of this Contract; already rightfully in the Contractor's possession; independently developed by the Contractor outside the scope of this Contract; or rightfully obtained from third parties. Under no circumstance shall the Contractor discuss and/or release information to the media concerning this project without prior express written approval of the State.

34. **Prohibition of Discriminatory Boycotts of Israel:** In accordance with La. R.S. 39:1602.1, any Contract for $100,000 or more and for any contractor with five (5) or more employees, Contractor, and any subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this Contract, refrain from a boycott of Israel. The State reserves the right to terminate this Contract if Contractor, or any subcontractor, engages in a boycott of Israel during the term of the contract.

35. **Cybersecurity Training:** In accordance with La. R.S. 42: 1267 (B)(3) and the State of Louisiana's Information Security Policy, if the Contractor, any of its employees, agents, or subcontractors will have access to State government information technology assets, the Contractor's employees, agents, or subcontractors with such access must complete cybersecurity training annually, and the Contractor must present evidence of such compliance annually and upon request. The Contractor may use the cybersecurity training course offered by the Louisiana Department of State Civil Service without additional cost.

    For purposes of this Section, "access to State government information technology assets" means the possession of credentials, equipment, or authorization to access the internal workings of State information technology systems or networks. Examples would include but not be limited to State-issued laptops, VPN credentials to credentials to access the State network, badging to access the State's telecommunications closets or systems, or permissions to maintain or modify IT systems used by the State. Final determination of scope inclusions or exclusions relative to access to State government information technology assets will be made by the Office of Technology Services.

36. **Code of Ethics:** The Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (R.S. 42:1101 et. seq., Code of Governmental Ethics) applies to the Contracting Party in the performance of services called for in this Contract. The Contractor agrees to immediately notify the state if potential violations of the Code of Governmental Ethics arise at any time during the term of this Contract.

37. **Countersignature**: This Contract may be executed in two or more counterparts, each of which shall be deemed an original, but all of which, taken together, shall constitute one and the same instrument.

38. **No Employment Relationship**: Nothing in this Contract shall be construed to create an employment or agency relationship, partnership, or joint venture between the employees, agents, or subcontractors of Contractor and the State of Louisiana.

39. **Venue**: Venue for any action brought with regard to this Contract shall be in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

40. **Commissioner's Statements**: Statements, acts, and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this contract, Contractor, and/or any subcontractor of Contractor shall not be deemed a conflict of interest when the Commissioner is discharging his duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

41. **Order of Precedence Clause**: In the event of any inconsistent or incompatible provisions in a Contract which resulted from an RFP, this signed Contract (excluding the RFP and Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of Contractor's proposal. *This Order of Precedence Clause applies only to contracts that resulted from an RFP.*

42. **Contractor must comply with the Office of Technology Services (OTS) Information Security Policy,** https://www.doa.la.gov/Pages/ots/InformationSecurity.aspx.

    a. Contractor must report to the State any known breach of security no later than forty-eight (48) hours after confirmation of the event. Notify the Information Security Team (“IST”) by calling the Information Security Hotline at 1-844-692-8019 and emailing the security team at infosecteam@la.gov.

    b. Contractor must follow OTS Information Security Policy for Data Sanitization requirements for any equipment replaced during the Contract and at the end of the contract, for all equipment which house confidential/restricted data provided by the State.

    c. Contractor must ensure appropriate protections of data is in accordance with HIPAA Rules and HITECH Acts.

    d. If Contractor will have access to data originating from the Centers for Medicare and Medicaid Services (CMS), then Contractor must ensure their computer system is in compliance with CMS latest version of the Minimum Acceptable Risk Standards for Exchanges (MARS-E) Document Suite, currently MARS-E 2.0. The CMS MARS-E 2.0 requirements include but are not limited to the below listed requirements:

        - Multi-factor authentication is a CMS requirement for all remote users, privileged accounts and non-privileged accounts. In this context, a “remote user” is referencing staff accessing the network from offsite, normally with a client virtual private network with the ability to access CMS data.

        - Perform criminal history check for all staff prior to granting access to CMS data. All employees and contractors requiring access to Patient Protection and Affordable Care Act (PL 111-148) sensitive information must meet personnel suitability standards. These suitability standards are based on a valid need-to-know, which cannot be assumed from position or title, and favorable results from a background check. The background checks for prospective and existing employees (if not previously completed) should include, at a minimum, contacting references provided by the employee as well as the local law enforcement agency or agencies.

43. **HIPAA Business Associate Provisions**

    If Contractor is a Business Associate of the Department, as that term is defined herein, because Contractor either: (a) creates, receives, maintains, or transmits protected health information (PHI) for or on behalf of the Department; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for the Department involving the disclosure of PHI, the following provisions will apply:

    a. Definitions: As used in these provisions -

        i. The term “HIPAA Rules” refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 CFR Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (DHHS) pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”) of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health (“HITECH”) Act of the American Recovery and Reinvestment Act of 2009.

        ii. The terms “Business Associate”, “Covered Entity”, “disclosure”, “electronic protected health information” (“electronic PHI”), “health care provider”, “health information”, “health plan”, “protected health information” (“PHI”), “subcontractor”, and “use” have the same meaning as set forth in 45 CFR §160.103.

        iii. The term “security incident” has the same meaning as set forth in 45 CFR §164.304.

        iv. The terms “breach” and “unsecured protected health information” (“unsecured PHI”) have the same meaning as set forth in 45 CFR §164.402.

    b. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this Contract as required by the HIPAA Rules and by this Contract.

    c. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule, regulation (including the HIPAA Rules), or as otherwise required or permitted by this Contract.

    d. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this Contract, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Department.

    e. In accordance with 45 CFR §164.502(e)(1)(ii) and (if applicable) §164.308(b)(2), Contractor shall ensure that any agents, employees, subcontractors, or others that create, receive, maintain, or transmit PHI on behalf of Contractor agree to the same restrictions, conditions, and requirements that apply to Contractor with respect to such information, and it shall

ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees', or subcontractors' actions or omissions do not cause Contractor to violate this Contract.

f. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this Contract, report such disclosure in writing to the person(s) named in Terms of Payment on page 1 of this document. Disclosures which must be reported by Contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La. R.S. 51:3071 *et seq*. At the option of the Department, any harm or damage resulting from any use or disclosure which violates this Contract shall be mitigated, to the extent practicable, either: (a) by Contractor at its own expense; or (b) by the Department, in which case Contractor shall reimburse the Department for all expenses that the Department is required to incur in undertaking such mitigation activities.

g. To the extent that Contractor is to carry out one or more of the Department's obligations under 45 CFR Part 164, Subpart E, Contractor shall comply with the requirements of Subpart E that apply to the Department in the performance of such obligation(s).

h. Contractor shall make available such information in its possession which is required for the Department to provide an accounting of disclosures in accordance with 45 CFR §164.528. In the event that a request for accounting is made directly to Contractor, Contractor shall forward such request to the Department within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR §164.528 for at least six (6) years after the date of the last such disclosure.

i. Contractor shall make PHI available to the Department upon request in accordance with 45 CFR §164.524.

j. Contractor shall make PHI available to the Department upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR §164.526.

k. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by Contractor on behalf of the Department available to the Secretary of the DHHS for purposes of determining the Department's compliance with the HIPAA Rules.

l. Contractor shall indemnify and hold the Department harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this provision by Contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.

m. The parties agree that the legal relationship between the Department and Contractor is strictly an independent contractor relationship. Nothing in this Contract shall be deemed to create a joint venture, agency, partnership, or employer- employee relationship between the Department and Contractor.

n. Notwithstanding any other provision of the contract, the Department shall have the right to terminate the Contract immediately if the Department determines that Contractor has violated any provision of the HIPAA Rules or any material term of this contract.

o. At the termination of the contract, or upon request of the Department, whichever occurs first, Contractor shall return or destroy (at the option of the Department) all PHI received or created by Contractor that Contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, Contractor shall extend the confidentiality protections of the Contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

SIGNATURES TO FOLLOW ON THE NEXT PAGE

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

CONTRACTOR	STATE OF LOUISIANA, LOUISIANA DEPARTMENT OF HEALTH
DocuSigned by: Mary Ellen Dalton 988AB6FBCE484BA...	
SIGNATURE	SIGNATURE
8/24/2023	
DATE	DATE
Mary Ellen Dalton PHD,MBA, RN	
NAME	NAME
President and Chief Executive Officer	Secretary, Louisiana Department of Health or Designee
TITLE	TITLE
	Bureau of Health Services Financing (BHSF)
	DocuSigned by: Tara A. LeBlanc 338F7ABF393C405...
SIGNATURE	SIGNATURE
DATE	8/25/2023
	DATE
NAME	Tara A. LeBlanc
	NAME
TITLE	Medicaid Director
	TITLE

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

LOUISIANA DEPARTMENT OF HEALTH

Bureau of Health Services Financing

Scope of Work

For

External Quality Review Organization (EQRO)

Health Services Advisory Group, Inc. (HSAG)

RFP #: 3000017943
PO# 2000773152

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

GLOSSARY AND ACRONYMS

Glossary

Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in payment for services that are not medically necessary, or that fail to meet professionally recognized standards for health care.
Addendum	A modification issued by LDH to modify the original solicitation document.
Agency	Any department, commission, council, board, office, bureau, committee, institution, agency, government, corporation, or other establishment of the executive branch of this State authorized to participate in any Contract resulting from this solicitation.
Agent	An entity or individual that Contracts with LDH or the EQRO to perform administrative functions, including but not limited to, fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.
Breach	The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule, which compromises the security, or privacy of the protected health information.
Bureau of Health Services Financing (BHSF)	The Agency within the Louisiana Department of Health, Office of Management and Finance, that has been designated as Louisiana's single State Medicaid agency to administer the Medicaid and CHIP programs.
Business Day	Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m., unless the context clearly indicates otherwise.
CAHPS	The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of enrollees' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).
Calendar Day	Each of the seven (7) days of the week. Unless otherwise specified, the term "days" in the Contract refers to calendar days/day.
Can	Denotes a preference but not a requirement.
Centers for Medicare and Medicaid Services (CMS)	The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the State Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).
CFR	Code of Federal Regulations.
CHIP	Children's Health Insurance Program created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as LaCHIP.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Claim	A claim is either: (1) A bill for services, (2) a line item of service, or (3) all services for one enrollee within a bill.
Contract	Written and signed agreement between LDH and the Contractor, which will include, by reference, the RFP, any and all addenda, appendices, attachments, or amendments thereto, and the terms of the Contractor's Proposal.
Contract Execution	When all parties to the Contract have executed the Contract thereby putting its terms and conditions into effect.
Contract Term	The period during which the Contract is in effect.
Contractor	Any person having a contract with a governmental body; the selected Proposer.
Coordinated System of Care (CSoC)	A program designed to help children and youth, from ages 5 through 20, who have significant emotional and/or behavioral health challenges and are in, or at risk of out-of-home placement. It offers services and supports that help these youth return to or remain at home while they are being helped. This name also refers to Louisiana's Contracting Prepaid Inpatient Health Plan (PIHP).
Corrective Action Plan (CAP)	A plan developed by the Contractor that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency. Use of the CAP will be at the discretion of LDH.
Covered Services	Those health care services to which an eligible Medicaid Beneficiary is entitled under the Louisiana Medicaid State Plan.
Deliverable	Anything submitted to LDH by the Contractor to fulfill requirements of the Contract, which include, but is not limited to the following, a document, manual, file, plan, or report.
Department	The Louisiana Department of Health also referred to as LDH throughout this RFP. The State Agency responsible for promoting and protecting health and ensuring access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana.
Disclosure	The release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.
Eligible	An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.
Encounter Data	Healthcare encounter data include: (i) all data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the enrollee receiving services during the encounter; (ii) the identification of the enrollee receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) a unique, i.e. unduplicated, identifier for the single encounter.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Enrollment Broker	The State's contracted or designated agent that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees and enrollees into an MCO.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes based on evidence produced from several research studies designed to assist consumers in achieving their desired goals of health and wellness.
External Quality Review (EQR)	The analysis and evaluation by a Contractor, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their providers furnish to Medicaid beneficiaries.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354, and performs external quality review and other EQR-related activities as set forth in 42 CFR § 438.358, or both.
Fiscal Intermediary (FI)	Designee or agent responsible in the current FI delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.
Fiscal Year (FY):	The budget year - Federal Fiscal Year: October 1 through September 30; State fiscal year: July 1 through June 30.
Fraud	As relates to Medicaid Program Integrity, fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain payment or certification; or claiming payment for services which were never delivered or received.
Full Time	Forty (40) hours per week.
Quality Measure Steward	The measure steward is responsible for making necessary updates to the measure, and for informing the validating entity about any changes made to the measure on an annual basis. In addition, the measure steward is responsible for providing the required measure information during the measure maintenance process.
Health Information	Any information, including genetic information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse, and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care.
Health Plan	An individual or group plan that provides, or pays the cost of, medical care.
HIPAA Privacy Rule	Health Insurance Portability and Accountability Act (HIPAA) federal standards for the privacy of individually identifiable health information, found at 45 CFR Part 164, Subpart E.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

HIPAA Security Rule	Health Insurance Portability and Accountability Act (HIPAA) federal standards for the security of individually identifiable health information, found at 45 CFR Part 164, Subpart C.
Immediately	Without delay, but not more than twenty-four (24) hours.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Liquidated Damages	Damages that may be assessed whenever the Contractor or its Subcontractors fail to achieve certain performance standards and other required items as detailed in the terms and conditions of the Contract.
Louisiana Children's Health Insurance Program (LaCHIP)	Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides health care coverage for uninsured children up to age 19 through a Medicaid expansion program for children at or below 200% FPL and a separate State CHIP program for the unborn prenatal option and for children with income from 200% up to and including 250% FPL.
Louisiana Department of Health (LDH)	The State Agency responsible for promoting and protecting health and ensuring access to medical, preventive, and rehabilitative services for all citizens in the State of Louisiana.
Louisiana Medicaid State Plan	The binding written agreement between Louisiana's Department of Health and CMS that describes how the Medicaid program is administered and determines the services for which LDH will receive federal financial participation.
Managed Care Entity (MCE)	Denotes either a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, or primary care case management that has, or is seeking to qualify for, a comprehensive risk Contract that meets the requirements of 42 CFR § 438.2.
Managed Care Organization (MCO)	An entity that has, or is seeking to qualify for, a comprehensive risk Contract that meets the requirements of 42 CFR §438.2.
Managed Care Program	Louisiana Medicaid program providing Medicaid covered services to enrollees through select MCOs with the goal of effectively utilizing resources to promote the health and well-being of Louisianans in LDH's Medicaid Managed Care Program.
May / Can	The terms "may" and "can" denote an advisory or permissible action(s).
Measurable	Applies to a Contractor objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.
Measurement Year	The timeframe during which health care services are provided. For example, for most HEDIS® measures, the previous calendar year is the standard measurement year. The health care quality measure steward defines the measurement year (or period) in the technical specifications for each measure.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving covered individuals.
Medicaid Beneficiary	An individual who has been determined eligible, pursuant to federal and State law, to receive medical care, goods, or services for which LDH may make payments under the Medicaid or LaCHIP programs.
Medicaid Managed Care Plan	Denotes either a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, or primary care case management as defined in this Glossary.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and State law, to receive medical care, goods or services for which LDH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.
Medical Record	A single complete record kept at the site of the enrollee's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical health care services whether provided by the MCO, its Subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible, and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR § 456.111 and § 456.211.
Member	A Medicaid enrollee.
Monetary Penalty	Financial assessment that may be enforced whenever a Contractor and/or its Subcontractors fail to meet the requirements of this Contract.
Must	The term “must” denotes a requirement(s).
Network	As utilized in the RFP, “network” may be defined as a group of participating providers linked through provider agreements or Contracts with the MCEs to supply a range of medical services. Also called a provider network.
Network Adequacy	A network of providers for the managed care entities that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to enrollees without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.
Original Signature	Denotes that a document must be signed in ink.
Performance Improvement Projects (PIP)	Projects designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care, and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Performance Measures	Criteria that quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.
Plan	An individual or group that provides, or pays the cost of, medical care.
Policies	The general principles, which guide decisions and outcomes; high-level overall plans embracing general goals and acceptable procedure. As used herein in reference to LDH, policies are the general principles by which LDH is guided in its management of the Title XIX program.
Prepaid Ambulatory Health Plan (PAHP)	An entity Contracting with the State that meets the requirements contained in 42 CFR § 438.2.
Prepaid Inpatient Health Plan (PIHP)	An entity Contracting with the State that meets the requirements contained in 42 CFR § 438.2.
Proposer	A firm or individual who responds to this RFP.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Provider	Any Medicaid service provider contracted with a Health Plan and/or enrolled in the Medicaid Program.
Provider Directory	A listing of health care service providers within the Contractor's provider network that is prepared by the MCO as a reference tool to assist enrollees in locating providers that are available to provide services.
Quality	The degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Companion Guide	Written instructional document for performance improvement projects, performance measure specifications and validation processes.
Quality Strategy	Establishes a planned, systematic, organization wide approach to ongoing Quality Improvement processes to continually improve and monitor Medicaid/Children's Health Insurance Program (CHIP) care and services.
Readiness Review	Assessment prior to implementation of the MCE's ability to fulfill the RFP requirements. Such review may include, but is not be limited to, the review of proper licensure, operational protocols, review of MCE standards, and review of systems. The review may be done as a desk review, on-site review, or combination of both and may include interviews with pertinent personnel so that LDH can make an informed assessment of the MCE's ability and readiness to render services.
Redacted Proposal	The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes.
Relationship	Relationship is described as follows for the purposes of any business affiliations discussed in Section 5: A director, officer, or partner of the Contractor; a person with beneficial ownership of five percent or more of the Contractor's equity; or a person with an employment, consulting, or

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

	other arrangement (e.g., providers) with the Contractor's obligations under its Contract with the State.
Reliability	The internal consistency of a study instrument, and the reproducibility of study results when the survey or intervention is administered under different conditions (*e.g.*, by different people, or at different times).
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative or AR.
Request for Proposals (RFP)	As it relates to the EQRO, the process by which LDH invites proposals from interested parties for the procurement of specified services.
Sample	A subset selected from a population.
Secure File Transfer Protocol (SFTP)	Software protocol for transferring data files from one computer to another with added encryption.
Shall / Will	The terms "shall" and "will" denote mandatory requirements.
Should	The term "should" denotes a desirable action.
Significant	As utilized in this RFP, except where specifically defined, shall mean important in effect or meaning.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C. §301 et seq.), which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Solvency	The minimum standard of financial health for a Contractor where assets exceed liabilities and timely payment requirements can be met.
Standard	A reference point, generally the ideal, against which other things can be evaluated; the model of authority or excellence.
State	The term "State" shall mean the State of Louisiana and its departments, agencies (including the Using Agency), boards, and commissions as well as their officers, agents, servants, employees, and volunteers.
State Plan	Refers to the Louisiana Medicaid State Plan.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Subcontractor	A person, agency, or organization with which the Contractor has subcontracted or delegated some of its management functions or other Contractual responsibilities to comply with the terms and provisions of the Contract.
Subsidiary	An affiliate controlled by such person or entity directly or indirectly through one or more intermediaries.
Timely	Existing or taking place within the designated period; within the time required by statue or rules and regulations, Contract terms, or policy requirements.
Title XIX	Title of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid Program.
Title XXI	Title of the Social Security Act of 1935, as amended, that encompasses and governs the Children's Health Insurance Program (CHIP).
Transition Phase	Includes all activities the EQRO is required to perform between the date the Contract is signed by all parties and the operational start date as defined in this RFP.
Transition Plan	Written plan developed by the Contractor, approved by LDH, to be employed during the Transition Phase, which includes all activities the

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

	Contractor is required to perform in conjunction with the end of the Contract.
Using Agency	The term "Using Agency" shall mean the governmental body of the State (including any authorized users) which is procuring any supplies, services, or major repairs, or any professional, personal, consulting, or social services under this Contract pursuant to the Louisiana Procurement Code, La. R.S. 39:1551-1755.
Utilization	The rate patterns of service usage or types of service occurring within a specified period.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias, and in accord with standards for data collection and analysis.
Variable	A characteristic or condition that changes or has different values for different individuals.
Week	The seven-day week, Monday through Sunday.
Will	Denotes a requirement.

Acronyms

BAFO	Best and Final Offers
BHSF	Bureau of Health Services Financing
CFR	Code of Federal Regulations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAHPS-A	Consumer Assessment of Healthcare Providers and Systems-Health Plan Survey 5.0H, Adult
CAHPS-C	Consumer Assessment of Healthcare Providers and Systems-Health Plan Survey 5.0H, Child
CAP	Corrective Action Plan
CAQH	Council for Affordable Quality Healthcare
CCC	Children with Chronic Conditions
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare and Medicaid Services
CSoC	Coordinated System of Care
CY	Calendar Year
DOA	Division of Administration
EFT	Electronic Funds Transfer
EQR	External Quality Review
EQRO	External Quality Review Organization
FPL	Federal Poverty Level
FTP	File Transfer Protocol
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health
IDSS	Interactive Data Submission System
IS	Information Systems

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

JLCB	Joint Legislative Committee on the Budget
LaCHIP	Louisiana Children's Health Insurance Program
LDH	Louisiana Department of Health
LDR	Louisiana Department of Revenue
MARS-E	Minimum Acceptable Risk Standards for Exchanges
MCE	Managed Care Entity
MCO	Managed Care Organization
MMIS	Medicaid Managed Information System
NCQA	National Committee for Quality Assurance
NON-CCC	Children with non-chronic conditions
NR	Not Reported
OAAS	Office of Aging and Adult Services
OBH	Office of Behavioral Health
OCDD	Office for Citizens with Developmental Disabilities
OMF	Office of Management and Finance
OPH	Office of Public Health
OS	Office of the Secretary
OSP	Office of State Procurement
OTS	Office of Technology Services
PAHP	Prepaid Ambulatory Health Plan
PDSA	Plan Do Study Act
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PII	Personally Identifiable Information
PIP	Performance Improvement Project
PM	Performance Measure
QRS	Quality Rating System
RFP	Request for Proposals
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
TA	Technical Assistance
USC	United States Code
VPN	Virtual Private Network

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

PART 6: SCOPE OF WORK

6.1 Scope of Work

The Contractor will be required to perform the EQR activities as outlined in 42 CFR § 438.358 and § 438.360 for the Louisiana Medicaid managed care delivery system. Specifically, the Contractor will be required to: 1) develop evaluation methodologies for the EQR activities; 2) perform data collection and analysis; 3) prepare reports presenting evaluation findings and recommendations; and 4) provide technical assistance to LDH and its contracted MCEs. Contractor will need to complete the deliverables in accordance with the frequencies and expectations specified in this RFP for the State to comply with federal requirements and to assure adequate oversight of Louisiana's Medicaid managed care delivery system.

The Contractor will be responsible for the deliverables as described in Section 6.2, including all preparatory and intervening steps, whether or not LDH has explicitly specified or delineated them within the RFP.

The services to be provided under the resulting Contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for managed care entities such as MCOs, PIHPs and PAHPs. The specifications for deliverables required under the RFP may evolve from year to year in response to program changes. Such modifications would be implemented through an allowable Contract amendment which requires approval by the Office of State Procurement.

The Contractor shall have assigned staff who are, or have a subcontract with a qualified organization that is, designated as a National Committee for Quality Assurance (NCQA) certified Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Auditor.

The Contractor shall have the designation as, or subcontract with a qualified organization that is designated as, an NCQA-certified HEDIS Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Vendor.

6.1.1 The Contractor shall have the following at a minimum:

6.1.1.1 Staff with demonstrated experience, knowledge and/or skills of:

a. Serving Medicaid beneficiaries, handling Medicaid policies, data systems and processes;
b. Managed care delivery systems, organizations, and financing;
c. Quality assessment and improvement methods;
d. Research design and methodology, including statistical analysis; and
e. Practical or clinical health care experience.

6.1.1.2 Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.

6.1.1.3 Other clinical and non-clinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any Subcontractors.

6.1.1.4 The Contractor and its Subcontractors must be independent from the State Medicaid agency and from the MCOs, PIHPs, or PAHPs entities (described in 42 CFR § 438.310(c)(2)) that they review. To qualify as "independent":

6.1.1.4.1 If a State agency, department, university, or other State entity:

a. May not have Medicaid purchasing or managed care licensing authority; and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

b. Must be governed by a Board or similar body whose majority of members are not government employees.

6.1.1.4.2 The Contractor **MAY NOT**:

6.1.1.4.2.1 Review any managed care entity, or a competitor operating in the State, over which the Contractor exerts control or which exerts control over the Contractor (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through:
a. Stock ownership;
b. Stock options and convertible debentures;
c. Voting trusts;
d. Common management, including interlocking management; and
e. Contractual relationships.

6.1.1.4.2.2 Deliver any health care services to Medicaid beneficiaries;

6.1.1.4.2.3 Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PIHP, or PAHP services, except for the related activities specified in 42 CFR § 438.358;

6.1.1.4.2.4 Review any MCO, PIHP, or PAHP entity for which it is conducting or has conducted an accreditation review within the previous three (3) years; or

6.1.1.4.2.5 Have a present, or known future, direct, or indirect financial relationship with an MCO, PIHP, or PAHP entity that it will review as a Contractor.

6.2 Deliverables and Performance Standards

The Contractor must perform the external quality review activities as outlined in 42 CFR § 438.358 and 438.360 for the Louisiana Medicaid managed care delivery system.

The federal Centers for Medicare and Medicaid Services (CMS) issued protocols for Contractors to use as guidance when undertaking the mandatory and optional tasks for external quality reviews. Included are protocols for validating performance measures, calculating performance measures, validating performance improvement projects, administering consumer or provider surveys of quality of care, validating consumer and provider surveys, and validating encounter data. The Contractor shall comply with federal rules and CMS protocols.

The Contractor shall produce a monthly activity/status report of all deliverables and services completed for the prior month as well as planned activities for the next month. The report shall include the deliverable, activity performed, status, date completed or timeline to completion and any anticipated project risks or issues. The report shall be submitted to LDH no later than the fifteenth (15^{th}) of each month.

The Contractor shall participate in monthly meetings to review the monthly activity report.

The Contractor shall participate in meetings as needed to address any issues with the deliverables of this Contract.

6.2.1 Performance Evaluation and Improvement

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.1.1 HEDIS Performance Measure (PM) Validation

LDH currently uses MCE self-reported, audited HEDIS performance measures as a component of the Quality Strategy to evaluate MCE performance, monitor MCE compliance with LDH's performance standards, meet federal requirements for the mandatory activity of validation of performance measures as specified in 42 CFR § 438.358, and complete a comparative review of quality process and outcome measures based on HEDIS. MCEs employ their own certified HEDIS auditor to complete the data collection and submission of the measures to NCQA and as required in the Medicaid Managed Care Program and Medicaid Managed Care Provider Agreements. The measures must have received a "report" designation from the HEDIS-certified auditor and must be specific to the Medicaid population under evaluation and as specified in the Provider Agreement.

The Contractor must complete the following tasks:

6.2.1.1.1 Review the health plans' final audit reports to identify any potential data collection or reporting issues that may impact the final audited rates;

6.2.1.1.2 Evaluate the reason any self-reported measures received an audit designation of "Not Reported" (NR);

6.2.1.1.3 Based on the review of the final audit reports and any NR designations for reported measures, provide a report summarizing the final audit reports to include documentation of any findings that impact LDH's evaluation of managed care delivery system performance, determination of the managed care delivery system's compliance with minimum performance standards, evaluation of performance related to the award of performance incentives, and recommendations to LDH related to potential corrective actions or quality improvement;

6.2.1.1.4 Develop, maintain, and update LDH's specifications documents for health plans' self-reported, audited results;

6.2.1.1.5 Validate that the HEDIS measures reported by the health plans are consistent with the protocols established by CMS for performance measure validation; and use the results for evaluation of the Louisiana Medicaid Program; and

6.2.1.1.6 Maintain a data repository for the health plans' National Committee for Quality Assurance (NCQA) Interactive Data Submission System (IDSS) self-reported, audited HEDIS results and final audit reports, facilitating access to the files for LDH and provide an industry-standard data exchange mechanism (e.g., secure file transfer protocol (FTP)).

Frequency: Annually

Deliverable tied to payment: The Contractor must:

1. Produce one (1) final audit review summary report annually for the Louisiana Medicaid Managed Care Program. The report must contain MCE-specific findings.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

2. Produce one (1) specifications document annually for the Louisiana Medicaid Managed Care Program delivery system that describes methods for the submission of the MCE self-reported, HEDIS audited data to LDH.

Payment: Each report and specification document shall be compensated at a fixed price.

6.2.1.2 HEDIS Performance Measure Calculation and Reporting

6.2.1.2.1 The Contractor must produce reports using the MCEs' self-reported, audited HEDIS data that include MCE-specific and Statewide results, and national benchmarks, per program, and MCE compliance with performance standards per LDH's specifications and timelines. Report formats will be developed in consultation with, and approved by, LDH.

Frequency: Annually

Deliverable tied to payment: The Contractor will be responsible for producing one (1) report annually for the Louisiana Medicaid Managed Care Program that contains MCE-specific and Statewide results.

Payment: Each report shall be compensated at a fixed price.

6.2.1.3 Technical Assistance for Health Plan Performance Measures (HEDIS, CAHPS, non- HEDIS and LDH-specific measures)

6.2.1.3.1 The Contractor will assist LDH, as needed, in establishing performance measures and standards for the Louisiana Medicaid Managed Care Program and by making research-driven recommendations based on industry standards and best practices of other states, CMS, and national organizations. The following tasks pertain to the current Louisiana Medicaid Managed Care Program.

6.2.1.3.2 The Contractor shall assist LDH in the identification and selection of performance measures and/or measurement sets that are used to monitor the compliance of health plans with minimum performance standards and/or to award performance incentives to plans that meet LDH specified criteria. LDH has used criteria such as the following when selecting measures:

6.2.1.3.2.1 Are clinically appropriate for the specific population(s) being monitored;

6.2.1.3.2.2 Align with and support the goals of LDH's Quality Strategy;

6.2.1.3.2.3 Produce meaningful and robust results for Louisiana's key areas of focus;

6.2.1.3.2.4 Integrate new measures as industry measurement sets evolve (e.g., CHIPRA, Adult Medicaid Core Set, etc.);

6.2.1.3.2.5 Ensure reliability, availability, standardization, and accuracy of data sources (e.g. claims, vital statistics, etc.) required for calculation of measures; and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.1.3.2.6 May be trended over time to measure changes in performance, comparisons to other Louisiana Medicaid plans, and comparisons with national benchmarks.

6.2.1.3.3 The Contractor shall recommend and/or evaluate methodologies for establishing minimum performance standards used to monitor plan compliance and set performance incentive levels used to award performance incentives to health plans using criteria specified by LDH. LDH has used criteria such as the following when selecting minimum performance standards:

6.2.1.3.3.1 Are based on research and knowledge of other states', organizations', and CMS' approaches to setting performance expectations for providers and MCEs;

6.2.1.3.3.2 Use national benchmarks and/or other industry-based standards when available and appropriate;

6.2.1.3.3.3 Drive performance improvement for Louisiana's Medicaid Managed Care Program;

6.2.1.3.3.4 May be adjusted if there are changes in methodologies after the performance expectations are set; and

6.2.1.3.3.5 Use statistical analyses, or other sound methodology for setting standards, when national benchmarks are not available.

6.2.1.3.4 The Contractor shall identify and inform LDH of updates in HEDIS, CAHPS, and nationally recognized non-HEDIS measure methodology within seven (7) calendar days of the release of published updates;

6.2.1.3.5 The Contractor shall quantify the potential impact on HEDIS results from methodology changes to specific HEDIS measures using sound analytical techniques, in accordance with LDH's timeline;

6.2.1.3.6 The Contractor shall recommend a methodology for adjusting performance standards if a measure's methodology changes after LDH performance standards are set;

6.2.1.3.7 The Contractor shall perform ad hoc analyses related to questions raised by LDH and/or health plans regarding performance measure result calculations;

6.2.1.3.8 The Contractor shall act as a liaison between LDH and NCQA and/or CMS with respect to specific questions on HEDIS or CAHPS measures and methodologies;

6.2.1.3.9 The Contractor shall ensure data collaboration, consistency, and coordination calculating HEDIS and CAHPS performance measure results with CMS for the duration of the Louisiana Medicaid Managed Care Program; and

6.2.1.3.10 For the CSoC PIHP, the Contractor will validate select performance measures in accordance with CMS EQR Protocol 2, Validation of Performance Measures, which may include non-HEDIS performance metrics.

6.2.1.3.11 The Contractor shall provide technical assistance to managed care entities and LDH, as needed, related to HEDIS and health plan self-reported data issues and their resolution.

Frequency: As needed by LDH.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Deliverable tied to payment:

1. For every LDH technical assistance request, the Contractor will be responsible for providing a written summary for the Louisiana Medicaid managed care program that summarizes results and other information as requested by LDH.

2. Produce one (1) final audit review summary report annually for the CSoC Program. The report must contain MCE-specific findings.

Payment:

1. The Contractor shall be compensated at an hourly rate for activities related to technical assistance deliverable(s).

2. The Contractor shall be compensated at a fixed price for the CSoC report.

6.2.2 Consumer Surveys: Consumer Assessment of Healthcare Providers & Systems (CAHPS-A and CAHPS-C)

Louisiana Medicaid uses CAHPS surveys to monitor the performance of the Louisiana Medicaid Managed Care Program and to evaluate MCO compliance with program requirements. Louisiana Medicaid requires MCOs to administer annual adult and child CAHPS surveys to their Louisiana Medicaid membership and to submit their survey data to LDH, NCQA, and the Contractor.

The Contractor will be required to receive, validate, and analyze each MCO's CAHPS survey data and produce reports of survey findings for the State.

6.2.2.1 Data Receipt and Validation

Louisiana's managed care organizations are required to administer the NCQA HEDIS CAHPS Adult Medicaid Health Plan Survey and the NCQA HEDIS CAHPS Child Medicaid Health Plan Survey (with the chronic conditions measurement set) and to submit the items listed below to LDH on an annual basis. The plans are required to submit to the State member-level data according to CAHPS Submission Member-Level Data File Layout specifications. The documents submitted to the Contractor on behalf of LDH are:

6.2.2.1.1 NCQA Summary-Level Reports (three (3) pdf files)

6.2.2.1.2 NCQA CAHPS Member-Level Data File Layout

6.2.2.1.3 CAHPS Survey Instruments

6.2.2.1.4 Adult and Child raw data files from each managed care plan

6.2.2.1.5 Letter of validation from Contractor

6.2.2.1.6 Survey Supplier(s) Contact Information

The Contractor must perform the following requirements:

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

1. Establish and maintain a secure file transfer protocol (SFTP) site to allow for receipt of data;

2. Receive, maintain, and process the data;

3. Validate the data in accordance with the most current HEDIS Specifications for Survey Measures; NCQA's Quality Assurance Plan for HEDIS Survey Measures; NCQA data file layouts; and NCQA Summary Reports (for LDH's Contracting plans); and

4. Inform LDH that all required data files were received and confirmed with all data submission specifications.

6.2.2.2 Data Analysis

The Contractor must perform the following general requirements:

6.2.2.2.1 Analyze data using Medicaid CAHPS Health Plan Survey data files imported from LDH's contracted MCOs;

6.2.2.2.2 Analyze data in accordance with the most current HEDIS Specifications for Survey Measures, NCQA's Quality Assurance Plan for HEDIS Survey Measures, and the NCQA Summary-Level Reports (from LDH's contracted MCOs); and

6.2.2.2.3 Analyze adult and general child member (general population and chronic conditions) data at the Statewide level for each managed care plan.

The Contractor must perform the following specific analyses if not provided by the contracted managed care organizations:

6.2.2.2.3.1 Calculate response rates;

6.2.2.2.3.2 Prepare adult, general child, children with chronic conditions (CCC), and children without chronic conditions demographic (non-CCC) profiles;

6.2.2.2.3.3 Prepare general child, CCC, and non-CCC respondent profiles;

6.2.2.2.3.4 Prepare a profile of members classified as children with chronic conditions (i.e., responses to the CCC screener questions);

6.2.2.2.3.5 Conduct a respondent/non-respondent analysis and test for statistically significant differences between respondents and non-respondents at the MCO and Louisiana Medicaid Managed Care Program levels, with respect to member age, gender, race, and ethnicity;

6.2.2.2.3.6 Conduct a comparative analysis of MCO, Louisiana Medicaid Managed Care Program, and national Medicaid three point means, and test for statistically significant differences between MCO level and Louisiana Medicaid Managed Care Program level scores;

6.2.2.2.3.7 Conduct a trending analysis of MCO, Louisiana Medicaid Managed Care Program, and national Medicaid three point means, and test for statistically

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

significant differences between current and prior years' scores for each managed care plan and the Louisiana Medicaid Managed Care Program;

6.2.2.2.3.8 Produce star ratings tables for adult and general child members that compare MCO and Louisiana Medicaid Managed Care Program three point means for the core measures (i.e., global ratings and composite measures) to national Medicaid benchmarks provided in NCQA CAHPS Benchmarks and Thresholds for Accreditation;

6.2.2.2.3.9 Conduct a key drivers analysis for approximately three (3) of the CAHPS core measures (to be determined) which includes a review of MCOs and Louisiana Medicaid Managed Care Program performance on the key drivers to identify strengths and weaknesses and present findings using an analytic diagram or model (e.g., a priority matrix, opportunity);

6.2.2.2.3.10 Develop cross tabulations of specific survey data (e.g., responses to each survey question stratified by certain demographic variables), for the adult and general child populations, as specified by LDH;

6.2.2.2.3.11 Conduct a comparative analysis of CCC and non-CCC three point means, and test for statistically significant differences between CCC and non-CCC level scores;

6.2.2.2.3.12 Conduct a trending analysis of CCC and non-CCC three point means, and test for statistically significant differences between current and prior year's scores for each population; and

6.2.2.2.3.13 Develop cross tabulations of specific survey data (e.g., responses to each survey question stratified by certain demographic variables), for the CCC population only, as specified by LDH.

Frequency: Annually

Deliverable tied to payment: The Contractor must produce the following reports each Contract year, for a total of four (4) reports.

1. One (1) Dashboard Report (this is a static report, approximately five (5) pages in length, that contains initial summary findings for the core measures, in graphical displays), submitted to LDH at the commencement of data analysis);

2. One (1) Executive Summary Report;

3. One (1) Full Report (to include an introduction, survey methodology, findings, conclusions and recommendations); and

4. One (1) Survey Methodology Report.

The Contractor will work with LDH to further define analytical and reporting expectations (e.g., report outlines, data analysis plans).

Payment: Each report shall be compensated at a fixed price.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.3 MCE Quality Rating System (QRS)

Pending final guidance from CMS, the Contractor will assist LDH with adopting a Medicaid managed care Quality Rating System (QRS) developed by CMS to evaluate and apply a rating to measure the quality of care provided by Louisiana Medicaid MCEs. LDH will utilize the CMS framework, methodology and identified performance measures in accordance with 42 CFR § 438.334 that align with the summary indicators of the qualified health plan QRS developed per 45 CFR § 156.1120. LDH reserves the right to add additional performance measures to the QRS to ensure alignment with the Louisiana quality strategy.

Following the issuance of final CMS guidance, technical specifications and protocols, and at the request of LDH, the Contractor will:

6.2.3.1 Establish a work plan for producing the Louisiana Medicaid Quality Rating System, considering applicable national requirements from CMS including compliance with new CMS guidelines and innovative approaches used by other State Medicaid programs and/or the health care industry;

6.2.3.3 Support as necessary any data collection from MCEs and data submission to CMS as required for specified QRS performance measures;

6.2.3.4 Produce any associated reference materials (e.g., score calculation and data source documentation), as specified and approved by LDH, on an annual basis;

6.2.3.5 Develop and maintain the Louisiana Medicaid QRS methodology documents and revise annually in collaboration with LDH;

6.2.3.6 Integrate new measures as CMS and industry measurement sets evolve and as requested by LDH;

6.2.3.7 Modify/enhance the MCE Quality Rating System as specified by LDH in response to and in alignment with LDH's changing business requirements (e.g., LDH branding, changes in federal regulations, revisions to the Contracts between LDH and the Managed care entities) and/or changes to report card measure specifications (e.g., HEDIS, CAHPS);

6.2.3.8 Modify and/or enhance the QRS tools (analytics, reporting, and/or reference materials) as needed, to align with LDH's changing business requirements; and

6.2.3.9 Provide assistance to the plans on how to read, interpret, and use the system as part of a performance improvement strategy.

Frequency: Annually (subject to CMS finalization of QRS guidance and related technical specifications and protocols).

Deliverables tied to payment:

1. Following the issuance of final CMS technical specifications and protocols, the Contractor must establish a work plan for producing the Louisiana Medicaid QRS to assist LDH in evaluating the performance of the Louisiana Medicaid contracted MCEs. The work plan shall be updated annually as required.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

2. Once the Louisiana Medicaid QRS becomes available, the Contractor must produce and evaluate the electronic scores and produce individual plan and summary results on an annual basis.

Payment: Each deliverable shall be compensated at a fixed price.

6.2.4 Provider Satisfaction Surveys

Louisiana Medicaid uses Provider Satisfaction Surveys to monitor the performance of its Medicaid Managed Care Program. The Contractor will be required to select and/or develop a survey instrument, administer the survey, validate and analyze the survey data, and prepare reports of survey findings for the State.

The Contractor must perform the following general requirements in collaboration with LDH:

6.2.4.1 Identify study populations and indicators;

6.2.4.2 Recommend, select, and/or develop survey methodology and instrument(s), with preference given to nationally-accepted, publicly-available survey measures and instruments;

6.2.4.3 Develop and follow a sampling plan that uses a representative sample, allows data to be analyzed per plan, and uses a ninety-five percent (95%) confidence level with a five percent (5%) margin of error;

6.2.4.4 Develop and follow a detailed work plan approved by LDH;

6.2.4.5 Develop and follow reporting expectations and report outlines in consultation with LDH;

6.2.4.6 Use survey administration protocols designed to achieve high response rates;

6.2.4.7 Use data collection procedures that ensure data are valid and reliable; and

6.2.4.8 Validate data by:

a. Validating that the number of records and completes match final disposition report;

b. Ensuring disposition codes and questions are coded according to project specifications;

c. Validating that all data elements have valid values; and

d. Calculating results in accordance with a data analysis plan approved by LDH.

Frequency: Administer the survey annually for each Contract year. The timeframe for administering the survey (i.e., month/CY) during each Contract year will be determined in collaboration with LDH.

Deliverable tied to payment: The Contractor must produce the following two (2) reports each Contract year:

1. One (1) Executive Summary (this is a static report, approximately two-five (2-5) pages in length, that contains narrative summary findings and graphical displays), submitted to LDH when data analyses are complete; and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

2. One (1) Full Report (to include an introduction, methodology, findings, conclusions and recommendations).

Payment: Each report shall be compensated at a fixed price.

6.2.5 Performance Improvement Project Validation

LDH defines quality improvement as assessing and continually improving healthcare, operations, and services within a planned, systematic, collaborative, interdisciplinary process. This is accomplished through intra-departmental quality measurement, interdisciplinary committees, interdepartmental teams, and ongoing evaluation of performance. Quality, a standard of service excellence, is based upon the Institute for Healthcare Improvement's Triple Aim framework: 1) Improve the health of populations, 2) Enhance the patient experience of care (including quality and satisfaction, and 3) Reduce the per capita cost of health care. LDH Leadership has directed that continuous Quality Improvement be an ongoing, organization-wide activity aimed at achieving the goals of LDH's mission, values, and vision. Every member is entitled to quality health care and all providers, MCEs, vendors, and employees are individually accountable for contributing to improving patient care.

During each Contract year, each MCE will be required to conduct performance improvement projects (PIP) as outlined in their Contract. Each PIP will be validated by the Contractor. All PIPs must achieve, through periodic measurements and interventions, significant and sustained improvement in clinical and non-clinical areas which are expected to have a favorable effect on health outcomes and satisfaction. MCEs must adhere to LDH improvement project content and format specifications. All LDH-specified improvement projects span a minimum of twelve (12) months which includes planning and implementation activities, as well as putting processes in place for sustainability and further testing and refinement of interventions during the project period.

MCEs must submit the status and results of each improvement project to LDH on a schedule determined by LDH. The status and results of each phase of the PIP must be submitted to LDH and the Contractor on a schedule determined collaboratively by LDH and the MCE. LDH will work with the Contractor to identify which phases of the PIP shall be included in each year's validation process.

The Contractor must:

6.2.5.1 Provide technical assistance to MCEs in development, implementation, and administration of the LDH approved PIP(s), following CMS guidance on a Model for Improvement and focused on an LDH population stream;

6.2.5.2 Develop a standardized tool that incorporates CMS' PIP protocol with the Model for Improvement and rapid cycle improvement tools, such as process mapping, Pareto charts, run charts, key driver diagrams, the Plan Do Study Act (PDSA), and statistical process control methods. The standard tool should establish objective criteria that will be used to document the design, implementation, and outcomes of the PIP;

6.2.5.3 Using the standardized tool developed in 6.2.5.2, develop a scoring methodology that will be used to determine if the PIPs are valid and to rate the percentage of compliance with CMS' PIP protocols. Refer to the External Quality Review Protocols dated September 2012

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

located at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html;

6.2.5.4 Calculate percentage scores in accordance with the scoring methodology developed in 6.2.5.2 above;

6.2.5.5 Assign a validation status of 'Met', 'Partially Met', or 'Not Met' based on the calculation of an overall percentage score;

6.2.5.6 Provide a written assessment and/or technical report of what must be changed for the health plan to achieve a status of 'Met';

6.2.5.7 The technical report should include an assessment of the overall validity and reliability of study results and include any threats to accuracy and/or confidence in reporting; and

6.3.5.8 Ensure that the technical report includes a description of PIP interventions and outcomes information associated with each State-required PIP topic for the current EQR review cycle.

Frequency: Annually

Deliverable tied to payment: The Contractor must produce one (1) report per MCE and PIP topic (i.e., individual reports should be produced for each PIP topic conducted by each plan). LDH anticipates up to five (5) PIP topics for each MCO and up to two (2) PIP topics for each PIHP and PAHP on an annual basis.

Payment: Each report shall be compensated at a fixed price.

6.2.6 Network Adequacy and Availability Validation

6.2.6.1 Validation of MCE Provider Network Adequacy and Availability

MCEs must ensure access to medically necessary Medicaid covered services and must meet network adequacy requirements as set forth by 42 CFR § 438.68, 42 CFR § 438.206, and 42 CFR § 438.207. The EQRO will validate these MCE requirements according to CMS protocols when applicable. Additional requirements may be added related to Network Adequacy Standards when CMS releases new protocols related to 42 CFR § 438.358(b)(1)(iv), as indicated in Section 6.2.11.

6.2.6.1.1 Evaluation of Provider Directory Accuracy

MCEs are required to submit provider directory information in a manner specified by LDH to ensure accuracy of provider information listed in directories that are used by Medicaid recipients. The Contractor will evaluate the accuracy of provider directory information submitted by MCEs

This evaluation must include, but may not be limited to, the following:

6.2.6.1.1.1 An audit of online provider directories to validate that the data elements are correct.

For the audits described above, the Contractor must do the following as approved by LDH:

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

a. Develop a study methodology that describes the evaluation approach;

b. Develop a standardized data collection tool;

c. Develop a sampling methodology;

d. Collect and analyze data; and

e. Prepare reports containing MCE-specific findings, and deliver all raw data to LDH.

Frequency: ~~The audit must be conducted quarterly.~~ **The audit must be conducted weekly through March 31st for Year 1 and quarterly thereafter.**

Deliverable tied to payment: For each audit conducted, the Contractor must submit a final report as described in item (e) above.

Payment: Each report shall be compensated at a fixed price.

6.2.6.1.2 Provider Access Surveys

To ensure MCEs' enrollees are able to appropriately access providers, the Contractor must conduct quarterly telephone surveys among a sample of providers to determine appointment availability information for new and existing enrollees.

6.2.6.1.2.1 Telephone Surveys

The Contractor must conduct the following:

6.2.6.1.2.1.1 Develop and/or update a study methodology describing the evaluation approach;

6.2.6.1.2.1.2 Develop a standardized data collection tool;

6.2.6.1.2.1.3 Develop a sampling methodology;

6.2.6.1.2.1.4 Collect and analyze data; and

6.2.6.1.2.1.5 Prepare a report containing MCE-specific findings, and deliver all raw data to LDH.

Frequency: Quarterly **or Semi-annual**

Deliverable tied to payment: After each survey, the Contractor will provide LDH with:

1. A final report that includes data tables with aggregate and MCE-specific results as described in 6.2.6.1.2.1.5.

2. One (1) excel file with MCE-specific worksheets containing provider-level survey data results.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Payment: Each report and results data shall be compensated at a fixed price.

6.2.6.1.3 Performance Measure Calculation and Reporting

The Contractor will be required to calculate, for each MCE, a performance measure that uses results from the telephone surveys. This must include:

6.2.6.1.3.1 Developing and updating a measure methodology document with LDH's input;

6.2.6.1.3.2 Recommending a strategy for setting and adjusting a performance standard;

6.2.6.1.3.3 Producing a report of MCE-specific rates in a format specified by LDH; and

6.2.6.1.3.4 Providing technical assistance to the each plan in each line of business and LDH related to the measure.

Frequency: Annually.

Deliverable tied to payment: The Contractor must create one (1) Statewide report with results listed by each MCE.

Payment: Each report shall be compensated at a fixed price.

6.2.7 Readiness Reviews

The Contractor will conduct Readiness Reviews, as detailed below, as requested by LDH, to determine if there is the ability to enroll and provide the necessary level of access to and quality of Medicaid services. The Contractor shall evaluate each prospective MCE's compliance with LDH MCE Contract requirements. The number of reviews will depend on the number of MCEs contracted by LDH.

6.2.7.1 The Contractor shall:

6.2.7.1.1 Collaborate with LDH to determine the scope of and the dates for the Readiness Review;

6.2.7.1.2 Readiness Reviews shall be conducted before the plan begins to enroll potential enrollees. It will contain two (2) components, including:

6.2.7.1.2.1 Desk Reviews
A review of all prospective MCE's policies and procedures, program descriptions, committee meeting minutes, manuals, handbooks and quality data; and

6.2.7.1.2.2 On–Site Visits
A visit in the Medicaid MCE's office to review credentialing files, medical records, conduct staff interviews, review other areas not covered in the desk review, and provide feedback.

6.2.7.1.3 Collaborate with LDH on developing an electronic tool based on readiness review standards and requirements that shall be a means of gathering information and documentation.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.7.1.3.1 The Contractor shall share approved criteria and/or tools in advance with each Medicaid MCE to ensure adequate preparation and discussion.

6.2.7.1.3.3 The Contractor shall schedule a conference call or discussion with each Medicaid MCE in conjunction with LDH to describe the process (both document review and on-site review) and detail the topics of the upcoming review, no later than (30) calendar days after receiving department's approval.

6.2.7.1.4 Have capabilities to review and assess MCE's information system.

6.2.7.1.4.1 Use criteria and tools approved by LDH to conduct on-site information systems reviews assessing each MCE's:

6.2.7.1.4.1.1 Data management processes;

6.2.7.1.4.1.2 Data integration and control procedures, including:

- Reviewing completed assessment tools and supporting documentation; and interviewing staff responsible for leading certain operational and/or functional aspects of the plans' information systems.
- Assessing the ability to link data from multiple sources.
- Examining processes for data transfers.
- Evaluating data warehouse structures and reporting capabilities.
- Reviewing processes, documentation and data files to ensure compliance with State specifications for encounter data submissions.
- Assessing the claims adjudication process and capabilities.

6.2.7.1.4.1.3 Evaluate the MCEs' information systems capabilities and identify any potential problem areas that may impact LDH's ability to monitor performance in key operational areas.

6.2.7.1.5 Provide LDH with a tracking report of progress on the readiness reviews. This tracking report shall include review progress of each Medicaid MCE and areas of concern in the form of a brief summary with dates and expectations for completing specified activities. This report shall be initiated at the time of the initial outreach to the Medicaid managed care entities and updated bi-weekly. This report shall be submitted electronically.

6.2.7.1.6 Submit a complete readiness review report within three (3) weeks after completion of the Medicaid MCE site visit. This report shall be submitted electronically.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Frequency: As needed.

Deliverable tied to payment: The final written readiness report as described above.

Payment: Each report shall be compensated at a fixed price.

6.2.8 Compliance Reviews

MCEs are required to comply with federal and State program requirements specified in the Code of Federal Regulations, the Louisiana Revised Statutes, the Louisiana Administrative Code, LDH policies and procedures, as applicable, Provider Agreements, and 1915 (b) and (c) waivers. The Contractor must conduct an assessment of each plan's compliance with the requirements that are in effect during the time period under review. The assessment must include, but not be limited to, a review of the following areas: 1) availability of services; 2) assurance of adequate capacity and services; 3) coordination and continuity of care; 4) coverage and authorization of services; 5) credentialing and re-credentialing of services; 6) subcontracted relationships and delegation; 7) enrollee information and enrollee rights; 8) confidentiality of health information; 9) enrollment and disenrollment; 10) the grievance and complaint process; 11) practice guidelines; 12) quality assessment and performance improvement program; 13) health information systems; and 14) fraud and abuse.

6.2.8.1 The Contractor must conduct each of the following tasks:

6.2.8.1.1 In consultation with LDH, identify the topic areas and administrative standards that will be reviewed;

6.2.8.1.2 Develop an evaluation methodology and standardized data collection tool, in consultation with LDH that will be used for each MCE review. This will include, but is not limited to, a review of policies and procedures, staff interviews, and file reviews;

6.2.8.1.5 Conduct a desk review and/or on-site review;

6.2.8.1.6 Aggregate and analyze the data and information collected in order to communicate findings of compliance with the administrative standards;

6.2.8.1.7 Prepare MCE-specific reports of findings that include the completed data collection tool with cited references, as appropriate; and

6.2.8.1.8 Prepare program-specific reports if needed, as requested by LDH.

Frequency: The Contractor must conduct each of the following:

1. A comprehensive review of MCE's compliance with federal regulations described in 42 CFR § 438, conducted every three (3) years. The Proposer may be required to conduct partial reviews as determined by LDH; and

2. Targeted reviews must be conducted per as follows:

    a. Case Management desk reviews annually. All MCOs are included in this review; and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

b. Select additional operational topics (e.g., claims adjudication, non-emergency transportation, grievances and appeals) at intervals to be determined by LDH. The number of MCEs subject to a review will vary depending on the topic selected.

Deliverable tied to payment: For each review**:**

a. The Contractor must provide to LDH one (1) report per MCE that contains an executive summary, introduction, summary of findings, conclusion and recommendations for improvement. The completed data collection tool and the information sources used must be made available to LDH.

b. One (1) Executive Summary (this is a static report, approximately two-five (2-5) pages in length, that contains narrative summary findings and graphical displays), that summarizes how all MCEs performed in the compliance audit submitted to LDH.

Payment: Each report shall be compensated at a fixed price.

6.2.9 External Quality Review Annual Technical Report

The Contractor must produce a detailed technical report to ensure LDH's compliance with 42 CFR § 438.364, and ensure that a finalized annual technical report is submitted to LDH and CMS by April 30th of each year. The most recent report can be viewed on the following website: http://www.ldh.la.gov/inde.cfm/page/3176.

6.2.9.1 The Contractor must produce a detailed technical report that includes the following components:

6.2.9.1.1 A description of the manner in which the data from all EQR activities conducted in accordance with 42 CFR § 438.358 were aggregated and analyzed, and conclusions that were drawn with regard to the quality, timeliness and access to health care services furnished to health plans' members;

6.2.9.1.2 A description of the objectives; technical methods of data collection and analysis; description of data obtained, including validated performance data for each activity conducted in accordance with 42 CFR § 438.358(b) and (c); conclusions that were drawn from the data for each activity included in the report; and problems encountered in performing the review;

6.2.9.1.3 An assessment of each MCE's strengths and weaknesses for the quality, timeliness and access to health care services furnished to Medicaid managed care members;

6.2.9.1.4 Recommendations for improving the quality of services furnished by each MCE including how the State can target goals and objects in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid managed care members;

6.2.9.1.5 Methodologically appropriate, comparative information about all Medicaid MCEs operating within Louisiana, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR § 438.352(e); and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.9.1.6 An assessment of the degree to which a Medicaid MCE has effectively addressed recommendations for quality improvement made by the Contractor during the previous year's EQR.

6.2.9.2 LDH may not substantively revise the content of the final EQR technical report without evidence of error or omission.

6.2.9.3 The Contractor shall provide LDH with a tracking report of progress on annual reviews. This tracking report will include review of progress by Medicaid MCEs and areas of concern. The tracking report will consist of a brief summary with dates and expectations for completing specified activities. This report shall be transmitted electronically and updated bi-weekly.

6.2.9.4 The Contractor must electronically submit the Annual Technical Reports to LDH after the completion of the annual review of each Medicaid MCE and it must be submitted by March 1st of each calendar year prior to the CMS deadline of April 30th.

Frequency: Annually, by March 1st

Deliverable tied to payment: Produce a detailed report in compliance with 42 CFR § 438.364.

Payment: Each report shall be compensated at a fixed price.

6.2.10 Medicaid Managed Care Quality Strategy Evaluation

6.2.10.1 The Contractor must assist LDH in evaluating the effectiveness of the Louisiana Medicaid Quality Strategy.

The Contractor will, in consultation with LDH, develop an evaluation methodology and tools required to evaluate the effectiveness of the Medicaid Managed Care Quality Strategy as required by 42 CFR 438 Subpart E, that may be refined on an annual basis to reflect lessons learned from the prior year's evaluation.

The Contractor will conduct the evaluation and prepare a written report of review findings to be submitted to LDH within thirty (30) business days after completion of the evaluation.

Frequency: Annually.

Deliverables tied to payment:

1. Evaluation methodology and tool(s).
2. The final evaluation written report.

Payment: Each report shall be compensated at a fixed price.

6.2.11 Additional Technical Assistance (TA) and Optional Activities

The Contractor may be required to provide technical assistance and/or optional activities described in 42 CFR § 438.358(c) or comparable activities that assess the quality or utilization of services in the participating MCOs, PAHP, and PIHP during the Contract period.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.11.1 The specific nature of the technical assistance will be defined on a case-by-case basis, and shall include, but not be limited to, performance improvement project development and implementation, performance measure support, educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of healthcare initiatives.

6.2.11.3 The Contractor shall provide ad-hoc technical assistance to LDH and all Medicaid managed care entities upon request and approval of LDH.

6.2.11.4 Optional activities as described in 42 CFR § 438.358(c).

The Louisiana Medicaid managed care population optional activities include:

6.2.11.4.1 Conduct additional focus studies. Conduct a specific focus study to evaluate peer support services or other services/programs from a member and/or provider perspective.

6.2.11.4.2 Validation of encounter data

6.2.11.4.3 Administration or Validation of Consumer or Provider Surveys

6.2.11.4.4 Conduct and facilitate performance improvement projects

6.2.11.4.5 Calculation of performance measures

6.2.11.4.6 Developing and monitoring Corrective Action Plans

6.2.11.4.7 Produce additional reports at the request of LDH

6.2.11.4.8 Validation of Network Adequacy

6.2.11.4.9 Validation of MCO Quality Reports for Behavioral Health

6.2.11.4.10 Behavioral Health Provider Sample Selection for Quality Monitoring Audits

6.2.11.4.11 MCE Independent Assessments

Frequency: As requested by LDH.

Deliverable tied to payment: For every LDH request for technical assistance or optional activity, the Contractor will be responsible for adhering to both LDH and CMS specifications. The Contractor and LDH will agree on an appropriate format for reporting or delivering activities for the Louisiana Medicaid managed care program.

Payment: The Contractor shall be compensated at an hourly rate for activities related to technical assistance and optional activity deliverable(s).

6.2.12 Quality Companion Guide

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.12.1 The Contractor will develop a Quality Companion Guide in consultation with LDH that focuses on core quality improvement activities, assisting managed care entities with LDH Contract requirements, Contractor activities and processes outlined in 42 CFR 438 Subpart E, 438.358 and 438.364. The timeframes for each activity may be modified at the discretion of LDH.

6.2.12.2 The Quality Companion Guide shall be submitted to LDH for approval within sixty (60) days of Contract effective date and annually thereafter.

Frequency: Annually.

Deliverable tied to payment: The Contractor must produce a comprehensive guide in consultation with LDH. The Quality Companion Guide shall include, but is not limited to, written instruction for performance improvement projects, performance measure specifications and validation processes.

Payment: The Quality Companion Guide shall be compensated at a fixed price.

6.2.13 Behavioral Health Member Satisfaction Survey

Louisiana uses behavioral health member satisfaction survey data to monitor access, quality of care, and member interaction with the Medicaid managed care organizations and the Coordinated System of Care (CSoC) Contractor. The Contractor will be required to select and/or develop a survey instrument, administer the survey, validate and analyze the survey data, and prepare reports of survey findings for each MCO and CSoC. The Contractor must perform the following general requirements in collaboration with LDH:

6.2.13.1 Identify study populations and indicators;

6.2.13.2 Recommend, select, and/or develop survey methodology and instrument(s), with preference given to nationally-accepted, publicly-available survey measures and instruments, and in consideration of applicable privacy laws;

6.2.13.3 Develop and follow a sampling plan that uses a representative sample, allows data to be analyzed per plan, and uses a ninety-five percent (95%) confidence level with a five percent (5%) margin of error for each program, Louisiana Medicaid managed care and CSoC;

6.2.13.4 Translate member surveys and accompanying material in prevalent non-English languages, including Spanish and Vietnamese.

6.2.13.5 Use survey administration protocols designed to achieve high response rates;

6.2.13.6 Use data collection procedures that ensure data are valid and reliable; and

6.2.13.7 Stratify data by age group, race, and region.

Frequency: Administer surveys annually, effective SFY 2020. The timeframe for administering the survey (i.e., month/CY) during each SFY will be determined in collaboration with LDH.

Deliverable tied to payment: The Contractor must produce the following two (2) reports each Contract year:

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

1. One (1) Executive Summary (this is a static report, approximately two-five (2-5) pages in length, that contains narrative summary findings and graphical displays), submitted to LDH when data analyses are complete; and

2. One (1) Full Report (to include an introduction, methodology, findings, conclusions and recommendations).

Payment: Each report shall be compensated at a fixed price.

6.2.14 Health Disparities Studies (Focused Studies)

6.2.14.1 Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report

6.2.14.1.1 Upon direction and approval by LDH, the Contractor must conduct health disparities analyses throughout the Contract term, including:

a. Developing methodologies;
b. Producing final health disparities data spreadsheets that evaluate health disparities among the LDH Medicaid contracted MCEs with recommendations for quality improvement. The data can include, but is not limited to, CMS Adult and Child Core Sets and MCO HEDIS data;
c. Summary report of data analyses; and
d. Pilot studies, if requested by LDH.

6.2.14.2 Health Disparities Study Supplemental Activity-Pilot Study

6.2.14.2.1 LDH may direct the Contractor to conduct pilot studies. The purpose of Conducting pilot studies may include, but are not limited to:

a. Testing completeness and accuracy of data elements and/or data calculation methods;
b. Testing whether the data and calculation methods produce the type of results needed;
c. Testing viability of proposed interventions;
d. Identifying unforeseen gaps, overlaps, or other complications in either the source data or calculation methods;
e. Identifying unknown causal factors for a healthcare issue; and/or
f. Conducting information-gathering activities to reveal root causes.

The Contractor must collaborate with LDH in determining the level of data analysis and LDH may elect to require the Contractor to expand a health disparity pilot study into an extensive study.

Frequency:

1. **Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report:** Annually
2. **Health Disparities Study Supplemental Activity-Pilot Study Final Report:** As requested by LDH

Deliverable tied to payment:

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

1. **Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report**:
    a. Data spreadsheets must include all sources of data, denominators, numerators and methods of calculation for both the aggregate as well as subsections of each work product (i.e. charts, graphs, tables, etc.).
    b. One (1) Full Report (to include an introduction, methodology, findings, conclusions and recommendations).

2. **Health Disparities Study Supplemental Activity-Pilot Study Final Report:** The Contractor must produce a final report of the extensive study on a health disparity topic in any Contract year.

Payment: The Contractor shall be compensated at an hourly rate for activities related to health disparities studies deliverable(s).

~~**1.2.15 Assessment and Evaluation Activities for 1115 Demonstration Waivers**~~

~~LDH currently has an agreement with CMS to operate a Section 1115 demonstration waiver titled the Healthy Louisiana Substance Use Disorder (SUD) 1115 Demonstration. Section 1115 demonstration waivers require an independent party to conduct assessment and evaluation activities per 42 CFR § 431.424. Additionally, CMS may require other activities as outlined in each waiver's Special Terms and Conditions (*LA 1115 SUD Approval is incorporated herein and made part hereof by reference.* A copy of the current Terms and Conditions for the SUD 1115 Demonstration will be available at the following website:~~

~~https://ldh.la.gov/index.cfm/newsroom/detail/6369~~

~~The Contractor shall serve as the independent assessor/evaluator and complete all assessment and evaluation activities for each of LDH's 1115 demonstration waivers in accordance with their Special Terms and Conditions. The Contractor shall complete each of the following deliverables:~~

~~**1.2.15.1** Evaluation Design – the Contractor shall complete the Evaluation Design in accordance with the Special Terms and Conditions of each waiver and in consultation with LDH. The Evaluation Design will provide the basis for the evaluation of each Demonstration and shall include at a minimum general background information, evaluation questions and hypotheses, methodology, and methodological limitations.~~

~~**1.2.15.2** Mid-Point Assessment – the Contractor shall conduct a Mid-Point Assessment for each Demonstration that includes LDH's progress toward meeting demonstration milestones, performance measure targets, a determination of factors that affected achievement of or barriers to achieving milestones, and a status update on budget neutrality requirements.~~

~~**1.2.15.3** Interim and Summative Evaluation Report – the Contractor shall complete an Interim and Summative Evaluation Report as required in each Demonstration's Special Terms and Conditions and will discuss evaluation progress and present findings to date per the approved Evaluation Design for each waiver.~~

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

~~**Frequency:** Each deliverable listed above will be required once during each waiver's five-year life cycle~~

~~**Deliverable tied to payment:** The final document or report received and approved by LDH.~~

~~**Payment:** Each document or report shall be compensated at a fixed price.~~

6.2.16 Case Management Performance Evaluation

6.2.16.1 MCEs are required to offer Case Management services, for Medicaid Managed Care enrollees that have opted to accept case management services. LDH requires MCE reporting of data on Case Management services to determine the number of individuals, the types of conditions, and the impact that Case Management services have on members receiving those services.

6.2.16.2 Contractor shall facilitate the annual collection and validation of data submitted by MCEs regarding Case Management services.

6.2.16.3 Contractor shall evaluate the MCE's compliance with the Case Management provisions of its Contract with LDH.

6.2.16.4 Contractor shall evaluate the rates of engagement in Case Management, the specific services offered to enrollees receiving Case Management, and the effectiveness of Case Management in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

6.2.16.5 Contractor shall develop a draft and final report of its results and findings for each MCE. The Contractor shall collaborate with LDH to determine the strategy, approach, timing, and report format.

6.2.16.6 Contractor shall participate with LDH in an annual, formal webinar or in-person meeting with the MCEs to review results from the Case Management data, identify opportunities for improvement, and determine efficient application of Case Management services to positively impact outcomes.

Frequency: Annually by February 28th

Deliverable tied to payment: The Contractor must produce the following for each.

Deliverable tied to payment: The Contractor must produce the following for each MCE:

1. One (1) Full report (to include an introduction, methodology, findings, conclusions and recommendations) for each MCE.

Payment: Each report shall be compensated at a fixed price.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.3 Technical Requirements

The Contractor will be required to transmit all non-proprietary data which is relevant for analytical purposes to LDH on a regular schedule in XML format or format compatible with LDH operations. Final determination of relevant data will be made by LDH based on collaboration between both parties. The schedule for transmission of the data will be established by LDH and dependent on the needs of the Department related to the data being transmitted. XML or compatible files for this purpose will be transmitted via SFTP to the Department. Both parties must approve any other data or method of transmission used for this purpose via written agreement.

6.3.1 General Provisions

6.3.1.1 The Contractor must maintain hardware and software compatible with LDH requirements that are secure and sufficient to successfully perform the services detailed in the Contract as the service level specified, which are as follows:

6.3.1.1.1 The Contractor shall adhere to State and federal regulations and guidelines, as well as industry standards and best practices for systems and/or functions required to support the requirements of the Contract.

6.3.1.1.2 The Contractor shall clearly identify any systems or portions of systems outlined in the proposal which are considered to be proprietary in nature.

6.3.1.1.3 The Contractor is responsible for all expenses required to obtain access to LDH systems and/or resources which are relevant to successful completion of the requirements of the Contract. The Contractor is also responsible for expenses required for LDH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of the Contract. Such expenses include, but are not limited to, hardware, software, network infrastructure and any licensing costs.

6.3.1.1.4 Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.

6.3.1.1.5 Contractor owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164).

6.3.1.1.6 Any Contractor use of flash drives or external hard drives for storage of LDH data must first receive written approval from LDH and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

6.3.1.1.7 All Contractor utilized computers and devices must:

6.3.1.1.7.1 Be protected by industry standard virus protection software that is automatically updated on a regular schedule;

6.3.1.1.7.2 Have installed all security patches that are relevant to the applicable operating system and any other system software; and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.3.1.1.7.3 Have encryption protection enabled at the Operating System level.

6.3.1.2 The Contractor shall ensure appropriate protections of shared Personally Identifiable Information ("PII"), in accordance with 45 CFR §155.260.

6.3.1.2.1 The Contractor shall ensure that its system is operated in compliance with the Centers for Medicare and Medicaid Services' ("CMS") latest version of the Minimum Acceptable Risk Standards for Exchanges (MARS-E) Document Suite, currently MARS-E version 2.0.

6.3.1.2.2 Multi-factor authentication is a CMS requirement for all remote users, privileged accounts, and non-privileged accounts. In this context, "remote user" refers to staff accessing the network from offsite, normally with a client VPN ("Virtual Private Network") with the ability to access CM, specifically Medicaid, data.

6.3.1.2.3 A site-to-site tunnel is an extension of LDH's network. For Contractors that are utilizing a VPN site-to-site tunnel and also have remote users who access CMS data, the Contractor is responsible for providing and enforcing multi-factor authentication. Contractors that do not utilize a VPN site-to-site tunnel will be charged for dual authentication licensing and hardware tokens as necessary. Costs associated with the purchase and any replacement of lost hardware tokens will be charged to the Contractor.

6.3.2 Electronic Messaging

6.3.2.1 The Contractor shall provide a continuously available electronic mail communication link (email system) to facilitate communication with LDH. This email system shall be capable of attaching and sending documents created using software compatible with LDH's installed version of Microsoft Office 2016 and any subsequent upgrades as adopted.

6.3.2.2 The Contractor shall comply with national standards for submitting protected health information (PHI) electronically and shall set up a secure email system that is password protected for both sending and receiving any protected health information.

6.3.3 Information Security and Access Management

6.3.3.1 The Contractor's system shall:

6.3.3.1.1 Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

6.3.3.1.1.1 Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only will not be permitted to modify information;

6.3.3.1.1.2 Restrict access to specific SFTP or system functions and information based on an individual user profile, including inquiry only capabilities; access to all functions shall be restricted to specified staff jointly agreed to by LDH and the Contractor; and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.3.3.1.1.3 Restrict unsuccessful attempts to access system functions to three (3) attempts with a system function that automatically prevents further access attempts and records these occurrences.

6.3.3.2 Records Retention:

6.3.3.2.1 Contractor shall retain all books, records and other documents relevant to the Contract and funds expended there under for at least ten (10) years after final payment. Contractor shall make available to LDH such records within thirty (30) days of LDH's written request and shall deliver such records to LDH's central office in Baton Rouge, Louisiana, all without expense to LDH. Contractor shall allow LDH to inspect, audit or copy records at the Contractor's site, without expense to LDH.

6.4 Contract Management Approach

6.4.1 The Contractor must describe how it will accomplish required tasks and deliverables, as deemed necessary to deliver the required scope of work including, but not limited to:

6.4.1.1 Project management approach and structure;

6.4.1.2 Communication protocols between LDH and Contractor;

6.4.1.3 Interaction with other LDH Proposers;

6.4.1.4 Schedule for key activities and milestones; and

6.4.1.5 Approach to managing project risks and issues.

6.4.2 An updated and detailed plan will be due to LDH within thirty (30) calendar days of Contract start date by the Contractor. The Contractor's Contract management work plan will be due annually thereafter.

6.5 Additional Reporting Requirements

6.5.1 The Contractor must be able to design, develop, and implement reports using the electronic formats, instructions, and timeframes specified by LDH. The Contractor shall maintain flexible reporting capabilities and must be able to respond to the reporting requests of LDH and its designees.

6.5.2 The Contractor shall certify all submitted data and reports, including, but not limited to, routine HEDIS performance reports, CAHPS, non-HEDIS, and PIPs. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The Contractor must submit the certification concurrently with the certified data and reports.

6.5.3 Louisiana Medicaid Transparency Report

6.5.3.1 The Contractor shall designate one (1) staff member to serve as the single point of contact for all requests related to the Transparency Report required by La. R.S. 40:1253.2. The Contractor shall comply with all LDH instructions and definitions related to this report.

6.5.3.2 The Contractor shall comply with all data requests and surveys from LDH or its designee.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.5.4 Ad Hoc Reports:

The Contractor shall prepare and submit any other reports as required and requested by LDH, any LDH designee, and/or CMS, that is related to the Contractor's duties and obligations under the Contract. Ad Hoc reports shall be submitted within five (5) business days from request.

6.5.5 Submission Process and Timeframes

6.5.5.1 The Contractor shall ensure that all required reports or files are submitted to LDH in a timely manner for review and approval. The Contractor's failure to submit the reports or files as specified may result in the assessment of monetary penalties in the form of Liquidated Damages.

6.5.5.2 Unless otherwise specified, deadlines for submitting files and reports are as follows:

6.5.5.2.1 Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of the reporting month;

6.5.5.2.2 Quarterly reports and files shall be based on a calendar quarter and be submitted within thirty (30) calendar days of the end of the reporting quarter; and

6.5.5.2.3 Annual reports and files shall be based on a calendar year and shall be submitted within thirty (30) days of the end of the reporting year.

6.5.5.2.4 Annual reports and files based on State fiscal year shall be submitted within thirty (30) days of the end of the reporting year.

6.5.6 If the due date occurs on a weekend or Louisiana designated holiday, the report shall be due the following business day.

6.5.7 Regardless of the due date, all reports shall be submitted by close of business. For purposes of this section, close of business is defined as 5:00 p.m. Central Time.

6.5.8 The Contractor agrees to prepare complete and accurate reports for submission to LDH. If after preparation and submission, an error is discovered, the Contractor shall submit accurate reports in a timeframe directed by LDH. Failure of the Contractor to submit accurate reports may result in the assessment of monetary penalties in the form of Liquidated Damages.

6.5.9 The Contractor shall provide LDH with written reports that are clear, concise and useful for the audience for whom they are intended. The report shall be composed in a manner consistent with LDH specifications and with the Contractor's stated criteria. All reports shall be provided in electronic formats compatible with software applications in use by LDH (e.g., Microsoft Word, Excel) as well as in hard copy, as specified by LDH. The Contractor shall be responsible for assuring that it completely understands the specifications and requirements for all reporting and other activities under the Contract. Where required, the Proposer shall provide supporting documents such as report appendices.

6.5.10 By January 1st of each year, perform analysis and submit a report of existing and new Federal and State policies, procedures, and regulations to determine their impact on the EQRO components of the Louisiana Medicaid program and related State and Contractor-performed functions. The analysis

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

shall include a review of portions of the Federal Register that would impact the Louisiana Medicaid Program.

6.6 Additional Staffing Requirements

6.6.1 Substitution of Personnel

6.6.1.1 The Contractor's Key Personnel assigned to the Contract shall not be replaced without the prior written consent of LDH. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any of the Contractor's personnel becomes unavailable due to resignation, illness, or other factors 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 shall make every reasonable attempt to assign the personnel listed in their proposal in the positions specified in the Proposal.

6.6.2 Written Policies, Procedures, and Position Descriptions

6.6.2.1 The Contractor shall develop and maintain written policies, procedures, and job descriptions for each functional area, consistent in format and style.

6.6.2.1.1 The Contractor shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions.

6.6.2.1.2 All policies and procedures shall be reviewed at least annually by the Contractor to ensure that the Contractor's written policies reflect current practices.

6.6.2.1.3 Job descriptions shall be reviewed at least annually by the Contractor to ensure that current duties performed by the employee reflect written requirements.

6.6.2.2 The Contractor must submit to LDH the following items annually:

6.6.2.2.1 An updated organization chart complete with the key personnel positions. The chart must include the person's name, title, email address, and telephone number.

6.6.2.2.2 A functional organization chart of the key program areas, responsibilities and the areas of the organization that report to that position.

6.6.3 Staff Training and Meeting Attendance

6.6.3.1 The Contractor shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill their requirements of their position prior to the beginning of work.

6.6.3.2 The Contractor must provide initial and ongoing staff training that includes an overview of Louisiana Medicaid Policy, Contract, and State and federal requirements specific to individual job functions.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.6.3.3 The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by LDH. All meetings shall be considered mandatory for assigned Key Personnel unless otherwise indicated. Staff shall attend in person as directed by LDH. At a minimum, this includes an annual Contract review and quarterly performance improvement project meetings.

6.6.3.4 LDH reserves the right to attend any and all training programs and seminars conducted by the Contractor. The Contractor shall provide LDH a list of any training dates, time, and location, at least fourteen (14) calendar days prior to the actual date of training.

6.7 Transition Plan

6.7.1 In the event of written notification of termination of the Contract by either party, the Contractor shall submit a Transition Plan ("the Plan") within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the Contractor and LDH. The Plan shall address the turnover of records and information maintained by the Proposer. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the transition tasks. The Transition Plan must be approved by LDH.

6.7.2 If the Contract is not terminated by written notification as provided in above, the Contractor shall propose a Transition Plan three (3) months prior to the end of the Contract period, including any extensions to such period. The Plan shall address the possible turnover of the records and information maintained to either LDH or a third party designated by LDH. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Transition Plan must be approved by LDH.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

PART 7: PERFORMANCE MONITORING, NON-COMPLIANCE, AND MONETARY PENALTIES/LIQUIDATED DAMAGES

7.1 Performance Monitoring

7.1.1 All work performed by the Contractor will be monitored by the Medicaid Director or his/her designee.

7.1.2 LDH or its designee will monitor the operation of the Contractor for compliance with the provisions of the Contract, and applicable federal and State laws and regulations.

7.1.3 The Contractor shall provide access to documentation, records, premises, and staff as deemed necessary by LDH to monitor performance.

7.2 Non-Compliance

7.2.1 The Contractor shall be prepared to demonstrate compliance with any deliverable outlined in the Contract upon request by LDH.

7.2.2 Administrative Actions

7.2.2.1 Administrative actions exclude the assessment of monetary penalties, Liquidated Damages, and intermediate sanctions, but may include at a minimum the following:

7.2.2.1.1 A written Notice of Action when it is determined the Contractor is deficient or non-compliant with requirements or deliverables of the Contract;

7.2.2.1.2 Remedial education requirement regarding program policies and practices;

7.2.2.1.4 Referral for review by appropriate professional organizations; and/or

7.2.2.1.5 Referral to the Office of the Attorney General for fraud investigation.

7.3 Monetary Penalties/Liquidated Damages

7.3.1 In the event the Contractor fails to meet the performance standards specified within the Contract, the monetary penalties in the form of Liquidated damages defined below may be assessed. If assessed, the monetary penalties will be used to reduce the LDH's payments to the Proposer or if the monetary penalties exceed amounts due from LDH, the Proposer will be required to make cash payments for the amount in excess.

a. Late submission of any required report five hundred dollars ($800) per working day, per report.

b. For each day that any other Contract deliverable is late, incorrect or deficient, the Contractor shall be liable to LDH for monetary penalties in an amount not to exceed fifteen hundred dollars ($1500) per business day per deliverable.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

7.3.2 LDH may also delay the assessment of monetary penalties if it is in the best interest of the Department to do so. LDH may give notice to the Contractor of a failure to meet performance standards but delay the assessment of monetary penalties in order to give the Contractor an opportunity to remedy the deficiency; if the Contractor subsequently fails to remedy the deficiency to the satisfaction of LDH, the Department may reassert the assessment of monetary penalties, even following Contract termination.

7.3.3 Attorney's Fees

7.3.3.1 In the event LDH should prevail in any legal action arising out of the performance or non-performance of the Contract, the Contractor shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

7.4 Fraud and Abuse

7.4.1 The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

7.4.2 Such policies and procedures must be in accordance with State and federal regulations. Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

PROPOSED Total COST by Contract Year & Function			
		Health Services Advisory Group, Inc. (HSAG)	LDH- HSAG Agreed Changes
Year 1 - Fixed		$ 1,613,000.00	$ 1,591,200.00
Year 1 - Hourly		$ 442,545.00	$ 442,545.00
Year 2 - Fixed		$ 1,946,080.00	$ 1,784,388.00
Year 2 - Hourly		$ 455,855.00	$ 455,855.00
Year 3 - Fixed		$ 2,070,327.00	$ 2,038,636.00
Year 3 - Hourly		$ 469,570.00	$ 469,570.00
TOTAL Proposed Cost		$ 6,997,377.00	$ 6,782,194.00

LDH- HSAG Agreed Total Contract Budget by SFY

	SFY 23	SFY 24	SFY 25	SFY 26
Contract Dates				
03/23- 06/23	$ 677,915.00			
07/23-2/24		$ 1,355,830.00		
03/24-06/24		$ 746,747.67		
07/24-2/25			$ 1,493,495.33	
03/25-06/25			$ 836,068.67	
07/25-2/26				$ 1,672,137.33
Totals	**$ 677,915.00**	**$ 2,102,577.67**	**$ 2,329,564.00**	**$ 1,672,137.33**

Maximum Amount: $ 6,782,194

HSAG Proposed Total Cost by SFY

	SFY 23	SFY 24	SFY 25	SFY 26
Contract Dates				
03/23- 06/23	$685,182			
07/23-2/24		$1,370,363		
03/24-06/24		$ 800,645.00		
07/24-2/25			$1,601,290	
03/25-06/25			$846,632	
07/25-2/26				$1,693,265
Totals	**$685,182**	**$2,171,008**	**$2,447,922**	**$1,693,265**

Maximum Amount: $6,997,377

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Fixed Rate Deliverables

Year One: March 1, 2023 to February 29, 2024

Deliverable Tied to Payment (from Scope of Work/Services)	Unit Cost (per deliverable tied to payment)	Unit Factor (# of units to satisfy deliverable tied to payment)	HSAG Proposed Total Cost (unit cost x factor)	Total Cost (Agreed) (unit cost x factor)
Performance Evaluation and Improvement –HEDIS Performance Measures (PMs) Validations				
Final Audit Review Summary Report	$ 12,000.00	1	$ 12,000.00	$ 12,000.00
Specification Document	$ 5,000.00	1	$ 5,000.00	$ 5,000.00
HEDIS Performance Measure Calculation and Reporting				
Statewide Report	$ 30,000.00	1	$ 30,000.00	$ 30,000.00
CSOC Performance Measures (PMs) Validations				
Final Audit Review Summary Report	$ 15,000.00	1	$ 15,000.00	$ 15,000.00
CAHPS-A and CAHPS-C Assessment of Healthcare Providers & Systems				
Dashboard Report	$ 14,000.00	1	$ 14,000.00	$ 14,000.00
Executive Summary Report	$ 15,000.00	1	$ 15,000.00	$ 15,000.00
Full Report	$ 75,000.00	1	$ 75,000.00	$ 75,000.00
Survey Methodology Report	$ 10,000.00	1	$ 10,000.00	$ 10,000.00
MCE Quality Rating System (QRS)				
Work Plan	$ 3,000.00	1	$ 3,000.00	$ 3,000.00
MCE's Electronic Score(s) Evaluation	$ 6,000.00	6	$ 36,000.00	$ 36,000.00
Individual Plan and Summary Results	$ 6,000.00	2	$ 12,000.00	$ 12,000.00
Provider Satisfaction Survey (For evaluation purposes only, assume a sample size of 7,000 providers)				
Executive Summary Report	$ 5,000.00	1	$ 5,000.00	$ 5,000.00
Full Report of Findings	$ 95,000.00	1	$ 95,000.00	$ 95,000.00
Performance Improvement Project (PIP) Validation(s)				
PIP Report(s)	$ 5,000.00	36	$ 155,000.00	$ 180,000.00
*Network Adequacy and Availability Validation - Provider Directory Accuracy *equates to conducting weekly surveys or quarterly Surveys**				
Final Audit Report(s) rev	$ 26,400.00	4	$ 48,000.00	$ 105,600.00
*Network Adequacy and Availability -Provider Access Survey(s) *equates to conducting 2 semi-annual surveys or 4 quarterly surveys**				
Report(s) of Survey Findings	$ 28,800.00	4	$ 96,000.00	$ 115,200.00
Survey Raw Data	$ 600.00	4	$ 2,000.00	$ 2,400.00
Network Adequacy and Availability –Performance Measures Calculation and Reporting				
Statewide Report	$ 12,000.00	1	$ 10,000.00	$ 12,000.00
Readiness Review(s)				
Final Readiness Report(s)	$ 37,000.00	6	$ 259,000.00	$ 222,000.00
Compliance Review(s)				
Targeted Reviews	$ 18,000.00	9	$ 144,000.00	$ 162,000.00
Executive Summary Report	$ 4,000.00	3	$ 12,000.00	$ 12,000.00
EQR Technical Report				
Annual Technical Report	$ 9,000.00	11	$ 81,000.00	$ 99,000.00
Medicaid Managed Care Quality Strategy Evaluation				
Evaluation Methodology Tool	$ 5,000.00	1	$ 5,000.00	$ 5,000.00
Final Evaluation Report	$ 26,000.00	1	$ 26,000.00	$ 26,000.00
Quality Companion (QC) Guide				
Comprehensive Guide	$ 6,000.00	1	$ 6,000.00	$ 6,000.00
Behavioral Health Member Satisfaction Survey (For evaluation purposes only, assume a sample size of 1,800 adults and 1,800 children from each				
Executive Summary Report	$ 9,000.00	1	$ 9,000.00	$ 9,000.00
Full Report of Findings	$ 188,000.00	1	$ 188,000.00	$ 188,000.00
~~*Assessment and Evaluation Activities for 1115 Demonstration Waivers*~~				
~~Evaluation Design~~	~~$ 40,000.00~~	~~0~~	~~$ 40,000.00~~	~~$ -~~
~~Mid-Point Assessment~~	~~$ 10,000.00~~	~~0~~	~~$ 10,000.00~~	~~$ -~~
~~Interim and Summative Evaluation Report~~	~~$ 75,000.00~~	~~0~~	~~$ 75,000.00~~	~~$ -~~
Case Management Performance Evaluation				
Full Report	$ 15,000.00	8	$ 120,000.00	$ 120,000.00
COST AMOUNT (sum of total cost above)=		**$ 1,613,000.00**		**$ 1,591,200.00**

Year Two: March 1, 2024 to February 28, 2025

Deliverable Tied to Payment (from Scope of Work/Services)	Unit Cost (per deliverable tied to payment)	Unit Factor (# of units to satisfy deliverable tied to payment)	HSAG Proposed Total Cost (unit cost x factor)	Total Cost (Agreed) (unit cost x factor)
Performance Evaluation and Improvement –HEDIS Performance Measures (PMs) Validations				
Final Audit Review Summary Report	$ 14,688.00	1	$ 12,240.00	$ 14,688.00
Specification Document	$ 6,120.00	1	$ 5,100.00	$ 6,120.00
HEDIS Performance Measure Calculation and Reporting				
Statewide Report	$ 36,720.00	1	$ 30,600.00	$ 36,720.00
CSOC Performance Measures (PMs) Validations				
Final Audit Review Summary Report	$ 15,300.00	1	$ 15,300.00	$ 15,300.00
CAHPS-A and CAHPS-C Assessment of Healthcare Providers & Systems				
Dashboard Report	$ 15,708.00	1	$ 14,280.00	$ 15,708.00
Executive Summary Report	$ 16,830.00	1	$ 15,300.00	$ 16,830.00
Full Report	$ 84,150.00	1	$ 76,500.00	$ 84,150.00
Survey Methodology Report	$ 11,220.00	1	$ 10,200.00	$ 11,220.00
MCE Quality Rating System (QRS)				
Work Plan	$ 3,060.00	1	$ 3,060.00	$ 3,060.00
MCE's Electronic Score(s) Evaluation	$ 6,120.00	6	$ 36,720.00	$ 36,720.00
Individual Plan and Summary Results	$ 6,120.00	2	$ 12,240.00	$ 12,240.00
Provider Satisfaction Survey (For evaluation purposes only, assume a sample size of 7,000 providers)				
Executive Summary Report	$ 5,100.00	1	$ 5,100.00	$ 5,100.00
Full Report of Findings	$ 96,900.00	1	$ 96,900.00	$ 96,900.00
Performance Improvement Project (PIP) Validation(s)				
PIP Report(s)	$ 5,100.00	36	$ 158,100.00	$ 183,600.00
*Network Adequacy and Availability Validation - Provider Directory Accuracy *equates to conducting weekly surveys or quarterly Surveys**				
Final Audit Report(s)	$ 26,928.00	4	$ 48,960.00	$ 107,712.00
Network Adequacy and Availability -Provider Access Survey(s)				
Report(s) of Survey Findings	$ 29,376.00	4	$ 97,920.00	$ 117,504.00
Survey Raw Data	$ 612.00	4	$ 2,040.00	$ 2,448.00
Network Adequacy and Availability –Performance Measures Calculation and Reporting				
Statewide Report	$ 12,240.00	1	$ 10,200.00	$ 12,240.00
Readiness Review(s)				
Final Readiness Report(s)	$ 37,740.00	6	$ 264,180.00	$ 226,440.00
Compliance Review(s)				
Targeted Reviews	$ 18,360.00	14	$ 257,040.00	$ 257,040.00
Executive Summary Report	$ 4,080.00	5	$ 20,400.00	$ 20,400.00
EQR Technical Report				
Annual Technical Report (s)	$ 9,180.00	11	$ 82,620.00	$ 100,980.00
Medicaid Managed Care Quality Strategy Evaluation				
Evaluation Methodology Tool	$ 5,100.00	1	$ 5,100.00	$ 5,100.00
Final Evaluation Report	$ 26,520.00	1	$ 26,520.00	$ 26,520.00
Quality Companion (QC) Guide				
Comprehensive Guide	$ 6,120.00	1	$ 6,120.00	$ 6,120.00
Behavioral Health Member Satisfaction Survey (For evaluation purposes only, assume a sample size of 1,800 adults and 1,800 children from each				
Executive Summary Report	$ 11,016.00	1	$ 9,180.00	$ 11,016.00
Full Report of Findings	$ 230,112.00	1	$ 191,760.00	$ 230,112.00
~~*Assessment and Evaluation Activities for 1115 Demonstration Waivers*~~				
~~Evaluation Design~~	~~$ 10,000.00~~	~~0~~	~~$ 10,000.00~~	~~$ -~~
~~Mid-Point Assessment~~	~~$ 50,000.00~~	~~0~~	~~$ 50,000.00~~	~~$ -~~
~~Interim and Summative Evaluation Report~~	~~$ 250,000.00~~	~~0~~	~~$ 250,000.00~~	~~$ -~~
Case Management Performance Evaluation				
Full Report	$ 15,300.00	8	$ 122,400.00	$ 122,400.00
COST AMOUNT (sum of total cost above)=		**$ 1,946,080.00**		**$ 1,784,388.00**

Year Three: March 1, 2025 to February 28, 2026

Deliverable Tied to Payment (from Scope of Work/Services)	Unit Cost (per deliverable tied to payment)	Unit Factor (# of units to satisfy deliverable tied to payment)	Total Cost (unit cost x factor)	Total Cost (Agreed) (unit cost x factor)
Performance Evaluation and Improvement –HEDIS Performance Measures (PMs) Validations				
Final Audit Review Summary Report	$ 14,982.00	1	$ 12,485.00	$ 14,982.00
Specification Document	$ 6,242.00	1	$ 5,202.00	$ 6,242.00
HEDIS Performance Measure Calculation and Reporting				
Statewide Report	$ 37,455.00	1	$ 31,212.00	$ 37,455.00
CSOC Performance Measures (PMs) Validations				
Final Audit Review Summary Report	$ 15,606.00	1	$ 15,606.00	$ 15,606.00
CAHPS-A and CAHPS-C Assessment of Healthcare Providers & Systems				
Dashboard Report	$ 16,023.00	1	$ 14,566.00	$ 16,023.00
Executive Summary Report	$ 17,167.00	1	$ 15,606.00	$ 17,167.00
Full Report	$ 85,833.00	1	$ 78,030.00	$ 85,833.00
Survey Methodology Report	$ 11,444.00	1	$ 10,404.00	$ 11,444.00
MCE Quality Rating System (QRS)				
Work Plan	$ 3,121.00	1	$ 3,121.00	$ 3,121.00
MCE's Electronic Score(s) Evaluation	$ 6,242.00	8	$ 49,936.00	$ 49,936.00
Individual Plan and Summary Results	$ 6,242.00	3	$ 18,726.00	$ 18,726.00
Provider Satisfaction Survey (For evaluation purposes only, assume a sample size of 7,000 providers)				
Executive Summary Report	$ 5,202.00	1	$ 5,202.00	$ 5,202.00
Full Report of Findings	$ 98,838.00	1	$ 98,838.00	$ 98,838.00
Performance Improvement Project (PIP) Validation(s)				
PIP Report(s)	$ 5,202.00	36	$ 161,262.00	$ 187,272.00
*Network Adequacy and Availability Validation - Provider Directory Accuracy *equates to conducting weekly surveys or quarterly Surveys**				
Final Audit Report	$ 27,467.00	4	$ 49,940.00	$ 109,868.00
*Network Adequacy and Availability -Provider Access Survey(s) *equates to conducting 2 semi-annual surveys or 4 quarterly surveys**				
Report(s) of Survey Findings	$ 29,964.00	4	$ 99,880.00	$ 119,856.00
Survey Raw Data	$ 624.00	4	$ 2,080.00	$ 2,496.00
Network Adequacy and Availability –Performance Measures Calculation and Reporting				
Statewide Report	$ 12,485.00	1	$ 10,404.00	$ 12,485.00
Readiness Review(s)				
Final Readiness Report(s)	$ 38,495.00	6	$ 269,465.00	$ 230,970.00
Compliance Review(s)				
Comprehensive Reviews	$ 37,000.00	9	$ 296,000.00	$ 333,000.00
Targeted Reviews	$ 18,727.00	6	$ 149,816.00	$ 112,362.00
Executive Summary Report	$ 4,162.00	9	$ 24,972.00	$ 37,458.00
EQR Technical Report				

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Annual Technical Report (s)	$ 9,364	11	$ 84,276.00	$ 103,004.00
Medicaid Managed Care Quality Strategy Evaluation				
Evaluation Methodology Tool	$ 5,202.00	1	$ 5,202.00	$ 5,202.00
Final Evaluation Report	$ 27,050.00	1	$ 27,050.00	$ 27,050.00
Quality Companion (QC) Guide				
Comprehensive Guide	$ 6,239.00	1	$ 6,239.00	$ 6,239.00
Behavioral Health Member Satisfaction Survey (For evaluation purposes only, assume a sample size of 1,800 adults and 1,800 children from each				
Executive Summary Report	$ 11,237.00	1	$ 9,364.00	$ 11,237.00
Full Report of Findings	$ 234,714.00	1	$ 195,595.00	$ 234,714.00
~~*Assessment and Evaluation Activities for 1115 Demonstration Waivers*~~				
~~Evaluation Design~~	~~$ 10,000.00~~	~~0~~	~~$ 10,000.00~~	$ -
~~Mid-Point Assessment~~	~~$ 50,000.00~~	~~0~~	~~$ 50,000.00~~	$ -
~~Interim and Summative Evaluation Report~~	~~$ 135,000.00~~	~~0~~	~~$ 135,000.00~~	$ -
Case Management Performance Evaluation				
Full Report	$ 15,606.00	8	$ 124,848.00	$ 124,848.00
COST AMOUNT (sum of total cost above)=		**$ 2,070,327.00**		**$ 2,038,636.00**

Year One: March 1, 2023 to February 29, 2024

Deliverable Tied to Payment	Position	Hourly Rate	Anticipated Hours per Year	Position Description	Total Cost
6.2.11.3 AD-HOC Technical Assistance	VP Managed Care, Director, Medical Director, Asst. Director, Sr. Analyst, Sr. Research	$ 177.00	200	QI and performance measurement expertise including certified HEDIS auditor, subject matter expert – performance measurement	$35,400.00
6.2.11.4.1 Conduct Focus Studies	VP Managed Care, Director, Medical Director, Asst. Directors, Clinical Analyst, Project Manager, Technical Writer	$ 157.00	300	Clinicians, QI and performance measurement expertise, statistical and analytic support	$ 47,100.00
6.2.11.4.2 Validation of Encounter Data	Director, Asst. Director, Project Manager	$ 175.00	250	Data management, validation and reporting expertise, analytic support, programmers	$ 43,750.00
6.2.11.4.3 Administration or Validation of Consumer or Provider Survey	Director, Medical Director, Asst. Director	$ 157.00	120	Clinicians, subject matter expert – survey management, certified HEDIS auditor	$ 18,840.00
6.2.11.4.4 Conduct and Facilitate performance improvement projects	VP Managed Care, Director, Medical Director, Asst. Directors, Project Manager	$ 157.00	225	Clinicians, QI and performance measurement expertise, statistical and analytic support	$ 35,325.00
6.2.11.4.5 Calculation of Performance Measures	Directors, Medical Director, Asst. Director, Project Manager	$ 175.00	100	Clinicians, QI and performance measurement expertise, programmers	$ 17,500.00
6.2.11.4.6 Developing and Monitoring Corrective Action Plans	VP Managed Care, Director, Medical Director, Asst. Director	$ 140.00	60	QI expertise, administrative support	$ 8,400.00
6.2.11.4.7 Produce Additional reports at the request of LDH	Director, Asst. Directors, Project Manager	$ 137.00	70	QI expertise, analytic support, programmers	$ 9,590.00
6.2.11.4.8 Validation of Network Adequacy	Directors, Asst. Director, Project Manager	$ 157.00	50	Subject matter expert – provider network measurement and validation, statistical and analytic support, programmers	$ 7,850.00
6.2.11.4.9 Validation of MCO Quality Reports for Behavioral Health	VP Managed Care, Director, Medical Director, Asst. Directors, Project Managers, Technical Writer	$ 127.00	270	Subject matter expert – behavioral health, clinicians, QI expertise, statistical and analytic support	$ 34,290.00
6.2.11.4.10 Behavioral Health Provider Sample Selection for QM Audits	Director, Medical Director, Asst. Directors, Project Managers, Technical Writer	$ 150.00	40	Clinicians, QI expertise, statistical and analytic support	$ 6,000.00
6.2.11.4.11 MCE Independent Assessments	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 175.00	270	Staff with expertise in data management, program design and evaluation, methodology development/study design, data analysis, reporting, and analytic support	$ 47,250.00
6.2.14.1 Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 175.00	500	Staff with expertise in data management, program design and evaluation, methodology development/study design, summary report of data analysis, reporting, and analytic support	$ 87,500.00
6.2.14.2 Health Disparities Study Supplemental Activity- Pilot Study	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 175.00	250	Staff with expertise in calculation methods, pilot studies, data management, program design and evaluation, data analysis, reporting, and analytic support	$ 43,750.00
COST AMOUNT (sum of total cost above)	**$**		**442,545.00**		

Year Two: March 1, 2024 to February 28, 2025

Deliverable Tied to Payment	Position	Hourly Rate	Anticipated Hours per Year	Position Description	Total Cost
6.2.11.3 AD-HOC Technical Assistance	VP Managed Care, Director, Medical Director, Asst. Director, Sr. Analyst, Sr. Research	$ 182.30	200	QI and performance measurement expertise including certified HEDIS auditor, subject matter expert – performance measurement	$ 36,460.00
6.2.11.4.1 Conduct Focus Studies	VP Managed Care, Director, Medical Director, Asst. Directors, Clinical Analyst, Project Manager, Technical Writer	$ 161.70	300	Clinicians, QI and performance measurement expertise, statistical and analytic support	$ 48,510.00
6.2.11.4.2 Validation of Encounter Data	Director, Asst. Director, Project Manager	$ 180.30	250	Data management, validation and reporting expertise, analytic support, programmers	$ 45,075.00
6.2.11.4.3 Administration or Validation of Consumer or Provider Survey	Director, Medical Director, Asst. Director	$ 161.70	120	Clinicians, subject matter expert – survey management, certified HEDIS auditor	$ 19,404.00
6.2.11.4.4 Conduct and Facilitate performance improvement projects	VP Managed Care, Director, Medical Director, Asst. Directors, Project Manager	$ 161.60	225	Clinicians, QI and performance measurement expertise, statistical and analytic support	$ 36,360.00
6.2.11.4.5 Calculation of Performance Measures	Directors, Medical Director, Asst. Director, Project Manager	$ 180.30	100	Clinicians, QI and performance measurement expertise, programmers	$ 18,030.00
6.2.11.4.6 Developing and Monitoring Corrective Action Plans	VP Managed Care, Director, Medical Director, Asst. Director	$ 144.20	60	QI expertise, administrative support	$ 8,652.00
6.2.11.4.7 Produce Additional reports at the request of LDH	Director, Asst. Directors, Project Manager	$ 141.10	70	QI expertise, analytic support, programmers	$ 9,877.00
6.2.11.4.8 Validation of Network Adequacy	Directors, Asst. Director, Project Manager	$ 161.70	50	Subject matter expert – provider network measurement and validation, statistical and analytic support, programmers	$ 8,085.00
6.2.11.4.9 Validation of MCO Quality Reports for Behavioral Health	VP Managed Care, Director, Medical Director, Asst. Directors, Project Managers, Technical Writer	$ 130.80	270	Subject matter expert – behavioral health, clinicians, QI expertise, statistical and analytic support	$ 35,316.00
6.2.11.4.10 Behavioral Health Provider Sample Selection for QM Audits	Director, Medical Director, Asst. Directors, Project Managers, Technical Writer	$ 154.50	40	Clinicians, QI expertise, statistical and analytic support	$ 6,180.00
6.2.11.4.11 MCE Independent Assessments	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 180.30	270	Staff with expertise in data management, program design and evaluation, methodology development/study design, data analysis, reporting, and analytic support	$ 48,681.00
6.2.14.1 Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 180.30	500	Staff with expertise in data management, program design and evaluation, methodology development/study design, summary report of data analysis, reporting, and analytic support	$ 90,150.00
6.2.14.2 Health Disparities Study Supplemental Activity- Pilot Study	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 180.30	250	Staff with expertise in calculation methods, pilot studies, data management, program design and evaluation, data analysis, reporting, and analytic support	$ 45,075.00
COST AMOUNT (sum of total cost above)	**$**		**455,855.00**		

Year Three: March 1, 2025 to February 28, 2026

Deliverable Tied to Payment	Position	Hourly Rate	Anticipated Hours per Year	Position Description	Total Cost
6.2.11.3 AD-HOC Technical Assistance	VP Managed Care, Director, Medical Director, Asst. Director, Sr. Analyst, Sr. Research	$ 187.80	200	QI and performance measurement expertise including certified HEDIS auditor, subject matter expert – performance measurement	$ 37,560.00
6.2.11.4.1 Conduct Focus Studies	VP Managed Care, Director, Medical Director, Asst. Directors, Clinical Analyst, Project Manager, Technical Writer	$ 166.60	300	Clinicians, QI and performance measurement expertise, statistical and analytic support	$ 49,980.00
6.2.11.4.2 Validation of Encounter Data	Director, Asst. Director, Project Manager	$ 185.70	250	Data management, validation and reporting expertise, analytic support, programmers	$ 46,425.00
6.2.11.4.3 Administration or Validation of Consumer or Provider Survey	Director, Medical Director, Asst. Director	$ 166.60	120	Clinicians, subject matter expert – survey management, certified HEDIS auditor	$ 19,992.00
6.2.11.4.4 Conduct and Facilitate performance improvement projects	VP Managed Care, Director, Medical Director, Asst. Directors, Project Manager	$ 166.60	225	Clinicians, QI and performance measurement expertise, statistical and analytic support	$ 37,485.00
6.2.11.4.5 Calculation of Performance Measures	Directors, Medical Director, Asst. Director, Project Manager	$ 185.70	100	Clinicians, QI and performance measurement expertise, programmers	$ 18,570.00
6.2.11.4.6 Developing and Monitoring Corrective Action Plans	VP Managed Care, Director, Medical Director, Asst. Director	$ 148.50	60	QI expertise, administrative support	$ 8,910.00
6.2.11.4.7 Produce Additional reports at the request of LDH	Director, Asst. Directors, Project Manager	$ 145.30	70	QI expertise, analytic support, programmers	$ 10,171.00
6.2.11.4.8 Validation of Network Adequacy	Directors, Asst. Director, Project Manager	$ 166.60	50	Subject matter expert – provider network measurement and validation, statistical and analytic support, programmers	$ 8,330.00
6.2.11.4.9 Validation of MCO Quality Reports for Behavioral Health	VP Managed Care, Director, Medical Director, Asst. Directors, Project Managers, Technical Writer	$ 134.70	270	Subject matter expert – behavioral health, clinicians, QI expertise, statistical and analytic support	$ 36,369.00
6.2.11.4.10 Behavioral Health Provider Sample Selection for QM Audits	Director, Medical Director, Asst. Directors, Project Managers, Technical Writer	$ 159.10	40	Clinicians, QI expertise, statistical and analytic support	$ 6,364.00

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

6.2.11.4.11 MCE Independent Assessments	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 185.70	270	Staff with expertise in data management, program design and evaluation, methodology development/study design, data analysis, reporting, and analytic support	$ 50,139.00
6.2.14.1 Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 185.70	500	Staff with expertise in data management, program design and evaluation, methodology development/study design, summary report of data analysis, reporting, and analytic support	$ 92,850.00
6.2.14.2 Health Disparities Study Supplemental Activity- Pilot Study	Executive Technical Director; Director, DSAA Analytics; Senior Data Scientist; Senior Analyst; Analyst; Analytics Manager	$ 185.70	250	Staff with expertise in calculation methods, pilot studies, data management, program design and evaluation, data analysis, reporting, and analytic support	$ 46,425.00
COST AMOUNT (sum of total cost above)	**$**			**469,570.00**	

HSAG Proposed Total Cost for all 3 years (Fixed Rate Deliverables + Technical Assistance and Optional Activities Hourly Rate) $ 6,997,377.00

LDH-HSAG Agreed Changes Total Cost = $ 6,782,194.00

TOTAL CONTRACT COST (Not to Exceed) $6,782,194.00

Additional Terms of Payment

LDH reserves the right to adjust the Contract Year Payment based on the number and type of managed care entity in effect at the time. The Contract payments will be determined by multiplying the unit of deliverables times the unit cost for each deliverable. The base monthly contract amount will be paid upon submission of invoice and required work plan showing status and satisfactorily meeting deliverables. The Contractor is responsible for all travel costs. Contractor shall submit all invoices electronically to LDH Designee.

Retainage

The Department shall secure a retainage of 10% from all billings under the contract as surety for performance. On successful completion of contract deliverables, the retainage amount may be released on an annual basis. Within sixty (60) days of the termination of the contract, if the contractor has performed the contract services to the satisfaction of the Department and all invoices appear to be correct, the Department shall release all retained amounts to the contractor.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Attachment C: Diversity and Inclusion
Contractor: EQRO RFP # 3000017943 HSAG
PO#: 2000773152

Equity, Diversity and Inclusion Statement

The Louisiana Department of Health (LDH) characterizes equity, diversity and inclusion as representing the differences and similarities of all individuals while creating a work environment in which those same individuals are treated fairly and respectfully, have equal access to opportunities and resources, and can contribute fully to the work of LDH in a safe and welcoming environment.

LDH values diversity in its workplace, vendor network, customers, and communities. As a state agency, LDH believes that diversity contributes to the success of Louisiana and society. LDH values the unique contributions of individuals with wide ranging backgrounds and experiences. and believes an inclusive culture allows our employees to contribute their best. Because of this, LDH is committed to equal opportunity and fair treatment for all.

This agency prohibits discrimination on the basis of age, race, color, gender, religion, ethnicity, disability, marital or family status, national origin, sexual orientation, veteran status, genetic information, medical condition, or any other non-merit factor. LDH is fully committed to being a model for equity, diversity, inclusion, belonging, and accessibility, where all team members are treated with dignity and respect. This principle extends to all decisions relating to recruitment, hiring, contracting, training, placement, advancement, compensation, benefits, and termination. By signing this contract, contractor acknowledges the following:

a. That LDH values diversity in the workplace and that contractor agrees to value diversity in its workplace, further;
b. That contractor is subject to uphold this Diversity and Inclusion Statement in actions related to the execution and/or fulfillment of this contract; and
c. That subject to federal and/or state laws, contractor agrees not to discriminate on the basis of age, race, color, gender, religion, ethnicity, disability, marital or family status, national origin, sexual orientation, veteran status, genetic information, or medical condition, in any action related to the execution and/or fulfillment of this contract.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Exhibit 1 Signatory Authority Letter
Contractor: EQRO HSAG
PO#:2000773152

January 4, 2022

Deonne Bailey
Louisiana Department of Health
Bureau of Health Services Financing
628 N. 4th Street, 7th Floor
Baton-Rouge, Louisiana 70802

Subject: Request For Proposals For External Quality Review Organization (EQRO); RFP #: 3000017943

Dear Ms. Bailey:

Health Services Advisory Group, Inc. (HSAG), is pleased to submit its proposal to the State of Louisiana Department of Health, Bureau of Health Services Financing, Request for Proposals For External Quality Review Organization (EQRO).

In accordance with RFP Section 2.15.4.1 Cover Letter, this Transmittal Letter provides the following required information:

Requirement	Response		
1. Location of administrative office with full time personnel:	Phoenix Office (Corporate) 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016	Florida Office 3000 Bayport Drive, Suite 300 Tampa, FL 33607	Hawaii Office Campbell Square 1001 Kamokila Blvd. Kapolei, HI 96707
2. Name and address of corporate principal officer registered with the Secretary of State:	Mary Ellen Dalton, PhD, MBA, RN President and Chief Executive Officer 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016		
3. Name and address for purposes of issuing checks and/or drafts:	Joellen Tenison, MBA, CPA, BS Chief Financial Officer 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016		
4. Names and addresses of principle owners who hold five percent (5%) interest or more in the corporation:	Mary Ellen Dalton, PhD, MBA, RN President and Chief Executive Officer 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016	Joellen Tenison, MBA, CPA, BS Chief Financial Officer 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016	
5. Name and address of local representative:	HSAG does not have a local representative		
6. If any of the planned personnel is a current Louisiana State employee, or was employed within the	None of the personnel proposed by HSAG for this contract are currently nor have they been a Louisiana State employee within the past two (2) years.		

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Requirement	Response
past two (2) years, provide a listing to include the employee name, State agency, and last date of employment:	
7. Proposer's state and federal tax identification numbers, LaGov vendor number, and Louisiana Department of Revenue number:	Arizona State Tax ID Number: 01495496 Federal Tax ID Number: 86-0440007 LaGov Vendor Number: V31004998901 Louisiana Department of Revenue (LDR) Number: 7638059-001
8. A summary of whether Proposer meets mandatory and preferred qualifications to propose;	HSAG meets all the mandatory and preferred qualifications to propose as listed in Section 1.5 of the RFP. HSAG has over 20 years of experience performing EQRO functions for MCOs/MCEs, PIHPs, and PAHPs. CMS recognizes HSAG as an EQRO as confirmed in *CMS' Table 1. External Quality Review Organizations with State Medicaid or CHIP Contracts, 2020-2021 Reporting Cycle*, shown in Appendix 1. HSAG is the largest, most experienced EQRO in the nation with expert staff who have years of experience working with Medicaid programs. We are knowledgeable about all of the CMS mandatory and optional EQRO requirements and are ready to begin work upon contract award.

HSAG's proposal is valid for a period of ninety (90) calendar days from the date of receipt.

HSAG has reviewed and agrees to comply with the Contract terms as defined in the RFP and has no exceptions or modifications to the Contract.

HSAG acknowledges Addendum #1 posted 11/19/2021; and Addendum #2 including Answers to Questions posted 12/14/2021.

Please do not hesitate to contact me, the authorized person for contract negotiations, if you have any questions or require any additional information regarding this proposal. I can be reached at 602.801.6701 or mdalton@hsag.com.

Sincerely,

Mary Ellen Dalton

Mary Ellen Dalton, PhD, MBA, RN
President and Chief Executive Officer

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

HSAG HEALTH SERVICES ADVISORY GROUP

Health Services Holdings, Inc.
Corporate Resolution of Signing Authority

Resolution that Mary Ellen Dalton, PhD, MBA, RN, President and Chief Executive Officer, be hereby authorized to sign, initial, accept or execute all documents in connection with conducting business on behalf of Health Services Advisory Group, Inc., a wholly owned subsidiary of Health Services Holdings, Inc.

The undersigned hereby certifies that the undersigned is the duly elected, qualified, acting and hereunto authorized secretary of the Corporation and that the above resolution is true and correct.

Certification

The undersigned hereby certifies that the undersigned is the duly elected, qualified, acting and hereunto authorized secretary of the Corporation and that the above resolution is true and correct.

IN WITNESS WHEREOF, the undersigned has signed this certificate as of December 15, 2021

J. Tenison

Joellen Tenison, Secretary

3133 East Camelback Road, Suite 140, Phoenix, AZ 85016-4545 | Phone: 602.801.6600 | Fax: 602.801.6051 | www.hsag.com

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Appendix 9: HSAG Key Personnel Resumes

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Thomas Miller, MA, BS, CHCA
Practice Leader & Executive Director, Audit Operations

Qualification Highlights

Mr. Miller has more than 20 years of experience in healthcare operations, data analysis, healthcare information technology, and auditing across a variety of healthcare delivery systems and payers. He serves as a subject matter expert on Medicaid managed care and fee-for-service programs, pharmacy operations and pharmacy benefit management, disease management, claims and encounter processing, and healthcare auditing services. Mr. Miller is experienced in managing external quality review (EQR) services and working with federal and state agencies, health plans, and community stakeholders to evaluate, measure, and improve healthcare services and programs. His expertise includes overall contract and client management, business development, and management of EQR and non-EQR activities including compliance and operational readiness reviews, information systems capabilities assessments (ISCA), program evaluations, quality strategy development and assessment, performance measure validation audits and calculation (Healthcare Effectiveness Data and Information Set [HEDIS®],[1] Adult and Child Medicaid Core Measures), performance improvement projects (PIPs), healthcare surveys, provider profiles, and data mining and analysis.

He is adept at translating quantitative and qualitative research into operational goals, standards, and improvement activities. Mr. Miller is also a National Committee for Quality Assurance (NCQA) Certified HEDIS Compliance Auditor (CHCA).

Relevant Experience

HSAG, Executive Director, State & Corporate Services (S&CS): Mr. Miller is currently responsible for managing HSAG's EQR services for the State of Oregon. His responsibilities include overall contract and client management, and oversight of all EQR and non-EQR activities including compliance monitoring and readiness reviews, ISCAs, delivery system network evaluations, mental health parity evaluations, and production of the annual technical report. Mr. Miller also provides subject matter expertise and technical assistance to the Oregon Health Authority in performance measure validation and calculation (HEDIS, Adult and Child Medicaid Core Measures), PIPs, healthcare surveys, compliance monitoring reviews, program evaluations, provider profiles, and data mining.

Mr. Miller was previously responsible for managing EQR and Medicaid analytic services as the executive director of HSAG's Hawaii EQRO (2017–2019) and Arkansas' Data Mining and Program Evaluation (2011–2017) contracts. He was also instrumental in the implementation and management of several special projects.

HSAG, Practice Leader & Executive Director, Audit Operations: Mr. Miller recently served as HSAG's Audits Team operational lead, accountable for the management and oversight of all audit lines of business including HEDIS Compliance Audit™,[2] services, AMP (Align. Measure. Perform.) Audit Review™,[3] audit services, performance measure validation, CMS data

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] HEDIS Compliance Audit™ is a trademark of NCQA.
[3] AMP Audit Review™ is a registered trademark of NCQA.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

validation for Medicare Part C and Part D, and information systems assessment/readiness reviews for EQR and private clients. His responsibilities included contract and client management along with being the technical lead and division trainer for HSAG's auditing services. Mr. Miller worked with Audits Team staff members to enhance operations, incorporate process improvements, and develop and implement a comprehensive training program.

HSAG, Executive Director, S&CS: Previously, Mr. Miller also served as the executive director of HSAG's State Analytics Team, where he provided oversight of EQR Medicaid evaluation and analytic activities and was responsible for the oversight of HSAG analysis activities and staff members, including coordinating all analytic activities; implementing quality control processes; as well as training, mentoring, and oversight of analysis. This included presenting findings and analytic interpretations in reports, graphs, and charts. Mr. Miller continues to provide research leadership, analytical expertise, technical interpretive writing, and mentoring for the analytic staff members at HSAG.

HSAG, Director, S&CS Analysis: Mr. Miller was responsible for coordinating HSAG analytic activities, including study design, analysis, and interpretations. He was also responsible for oversight and training of S&CS analysts and quality control process implementation.

HSAG, Senior Healthcare Analyst, Surveys, Research, and Analysis: Mr. Miller was responsible for the scientific soundness of study design, analysis, and interpretations of a variety of healthcare studies.

AdvancePCS, Senior Research Analyst: As a member of the Customer & Quality Research Division, Mr. Miller designed, implemented, and managed sampling protocols for internal and external customer satisfaction projects. He performed all aspects of the survey process including sampling, data management, analysis, and reporting. Mr. Miller also conducted cross-sectional and longitudinal retrospective database analyses using pharmaceutical and medical claims data and provided analytical, methodological, and statistical consulting and support for internal and external research projects.

Professional History

HSAG, Phoenix, Arizona: Practice Leader & Executive Director, Audit Operations (10/2019–present); Executive Director, S&CS (11/2007–09/2019); Director, S&CS Analysis (03/2004–11/2007); Senior Healthcare Analyst, Surveys, Research, and Analysis (12/2003–03/2004); 12/2003–present

AdvancePCS, Scottsdale, Arizona: Senior Research Analyst; 02/2001–12/2003

Southwest Catholic Health Network, Phoenix, Arizona: Research Analyst, Department of Research and Evaluation; 02/1999–02/2001

Education

Master of Arts, Sociology, University of Cincinnati, Cincinnati, Ohio, 1999

Bachelor of Science, Sociology and Psychology, Northern Arizona University, Flagstaff, Arizona, 1996

Certifications

NCQA Certified HEDIS Compliance Auditor (CHCA)

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Medicaid Projects of Similar Scope and Size:

As the Executive Director in support of HSAG's EQRO contracts in Hawaii and Oregon, Mr. Miller's responsibilities include the implementation, oversight, and leadership of EQRO activities, including direct management of mandatory and optional EQR activities for a variety of health plan types (e.g., MCOs, PIHPs, and PAHPs). Mr. Miller also serves as a subject matter expert on Medicaid programs, health plan operations and regulatory compliance, performance measurement, and quality improvement; providing ongoing technical assistance to state Medicaid agents, health plans, and community stakeholders.

Below are references who can attest to Mr. Miller's competence and skill level for the cited projects.

Reference #1			
Contract:	**State of Oregon, EQRO**		
Related EQR Task(s)	EQRO Contract Management, Compliance Reviews, Readiness Reviews, Network Adequacy and Delivery System Network Evaluation, Information Systems Capabilities Assessments, and Technical Assistance		
Name: **Title:**	Veronica Guerra, Quality Assurance and Contract Oversight Manager		
Company*:	Oregon Health Authority, Health Systems Division		
Email:	Veronica.Guerra@dhoha.state.or.us	**Phone #:**	503.437.5614
Reference #2			
Contract:	**State of Hawaii, EQRO**		
Related EQR Task(s)	EQRO Contract Management, Compliance Reviews, HEDIS Audits and Performance Measure Validation, and Technical Assistance		
Name: **Title:**	Priscilla Thode CMCS Administrator, Contract Speciality		
Company*:	Department of Human Services, Med-QUEST Division		
Email:	pthode@dhs.hawaii.gov	**Phone #:**	808.692.8129

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Georgia Wilkison, BSN, RN, CPC
Project Manager II, State & Corporate Services

Qualification Highlights

Ms. Wilkison has 25 years of experience in clinical nursing and leadership, including hospice and palliative care, internal and external auditing, and regulatory compliance. She has experience working with state Medicaid and Children's Health Insurance Program managed care programs and health plans on external quality review (EQR) activities to improve healthcare services and programs. Her expertise includes overall client and contract management and conducting EQR activities, including performance improvement project (PIP) reviews, compliance reviews, clinical focus studies, encounter data validation (EDV), and medical record review (MRR). Ms. Wilkison is also certified as a professional coder by the American Academy of Professional Coders.

Relevant Experience

HSAG, Project Manager II, State & Corporate Services (S&CS): Ms. Wilkison is responsible for daily project management of contractual requirements for EQR services for the State of Oregon. She maintains working knowledge of customer requirements and facilitates process changes, as necessary. Her responsibilities include coordination of Oregon EQR activities, including compliance monitoring reviews, network adequacy and delivery system network evaluations, PIPs, EDV, mental health parity evaluations, and annual technical report production. Ms. Wilkison analyzes and evaluates health plan compliance with federal and State requirements during annual compliance monitoring reviews and provides subject matter expertise and technical assistance to the Oregon Health Authority and health plans in meeting and sustaining compliance with regulatory standards.

Qlarant Quality Solutions, Inc., Project Manager II, EQR: Ms. Wilkison provided daily oversight and management of contractual requirements with the Department of Health Care Finance (DHCF) in the District of Columbia. She maintained working knowledge of customer needs, deliverables, resource requirements, and budget management. Ms. Wilkison provided technical oversight to all phases of project planning, implementation, and management of deliverables. She monitored and adhered to cost projections and continuously explored operational efficiencies. Ms. Wilkison worked directly with the DHCF client administrator to ensure all aspects of the contract were met as specified in the scope of work. She collaborated with DHCF to design and adapt processes and deliverables to meet changing needs. Ms. Wilkison also facilitated biweekly meetings with the DHCF client administrator to provide project updates and submitted monthly written reports outlining completed and upcoming tasks. She developed subcontractor agreements consistent with contract requirements and provided oversight of all subcontractor work performed. Ms. Wilkison analyzed and evaluated managed care organization (MCO) compliance with federal and state requirements during annual on-site reviews. She provided ongoing guidance and education to MCOs regarding policy revisions and development to meet and maintain regulatory compliance and identify program vulnerabilities. Ms. Wilkison assisted MCOs with development of corrective action plans and monitored MCO progress with meeting and maintaining sustained compliance with regulatory standards. She conducted PIP validation, EDV, network adequacy validation, and clinical quality focus studies. Ms. Wilkison developed technical reports for all EQR activities to meet contract deliverables and

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

customer requirements. She responded to requests for technical assistance and provided technical support to customers and MCOs across all external quality review organization (EQRO) contracts while maintaining a collaborative relationship with customers and MCOs to achieve meaningful results. Ms. Wilkison served as a clinical consultant for the EQRO contract with skilled nursing facilities (SNFs), conducting mock surveys to assess facility compliance. She provided education to SNF staff at the administrative and departmental levels. Ms. Wilkison participated in new business proposal development. Additionally, Ms. Wilkison provided direct supervision, coaching, coordination, and evaluation of EQRO staff and subcontractors.

Qlarant Quality Solutions, Inc., Claims Analyst II, Audit Medicaid Integrity Contractor (MIC): Ms. Wilkison reviewed Explanation of Benefits cases; beneficiary, provider, and pharmacy cases for drug seeking, drug selling, beneficiary, and other potential overpayment; and fraud, waste, and abuse. She completed desk reviews and field audits to meet applicable contract requirements and to identify evidence of potential overpayment or fraud. Ms. Wilkison provided guidance to providers during field audits regarding policy development to identify program vulnerabilities and ensure proper billing practices. She effectively identified and resolved claims issues and determined root causes. Ms. Wilkison participated in internal and external focus groups and other projects. She identified potential fraud and reported findings to audit and management teams. Ms. Wilkison developed an audit test plan and methodology used for general inpatient hospice facility audits. She presented clinical and data analysis findings to state representatives. Additionally, Ms. Wilkison developed a formal mentoring process for newly hired claims analysts to increase their knowledge of the medical review process/criteria and ensure consistency among reviewers.

Compass Regional Hospice, Quality Manager/Clinical Staff Development Specialist: Ms. Wilkison monitored patient clinical records concurrently and retrospectively to collect and report quality measure data required to maintain compliance with the Centers for Medicare & Medicaid Services Hospice Quality Reporting Program. She led the Quality Assessment Performance Improvement Committee and was influential in major organizational decisions through senior management team participation and coordinated data collection used for benchmarking. Ms. Wilkison assessed, planned, implemented, and evaluated the organization's performance improvement programs and facilitated performance improvement studies. She assisted department leads in identifying the needs of and resources for Compass Regional Hospice and in formulating and developing organizational goals and plans; she also served as the compliance officer, privacy officer, and risk manager. Ms. Wilkison reviewed, revised, and implemented policies and procedures to maintain compliance with State and federal regulations and The Joint Commission standards, and she coordinated staff training and education activities throughout the organization. She assured policy and regulatory compliance with the conversion of the hospice center's residential beds from routine level of care to general inpatient level of care. Additionally, Ms. Wilkison participated on the Regulatory Committee for the Hospice and Palliative Care Network of Maryland.

Compass Regional Hospice, Director of Clinical Services: Ms. Wilkison was responsible for ensuring the quality and safe delivery of hospice services that reflected the hospice's philosophy and standard of care. She planned, developed, implemented, and evaluated hospice services, programs, and activities. Ms. Wilkison negotiated required contracts and provided oversight to

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

contract provisions. She promoted an agency environment that was compliant with federal, State, and local regulatory health and safety standards. Ms. Wilkison maintained appropriate staffing levels of qualified personnel to meet the highest standards of quality. She provided direct oversight to the planning, building, staffing, and provision of care for the six-bed residential hospice center. Ms. Wilkison reviewed, revised, and implemented policies and procedures to maintain compliance with State and federal regulations and The Joint Commission standards. She participated in public relations and community activities building awareness and increasing access to hospice care in the community. Additionally, Ms. Wilkison established collaborative relationships with assisted living facilities and long-term care facilities, increasing resident access to hospice care.

Hospice of the Chesapeake, Nurse Case Manager: Ms. Wilkison was responsible for the caseload of terminally ill patients in a home hospice setting. She provided direct care and support to patients and families. Ms. Wilkison developed and implemented care plans, which included short- and long-term goals. Additionally, Ms. Wilkison coordinated other disciplines as appropriate.

Johns Hopkins Bayview Medical Center, Newborn/Neonatal Care Nursery Nurse: Ms. Wilkison provided direct care to healthy, premature, and critically ill neonates. She educated parents regarding care of healthy as well as premature/special needs infants. Additionally, she gained extensive experience caring for withdrawing neonates and performing neonatal abstinence scoring.

Johns Hopkins Bayview Medical Center, Medical Surgical Nurse: Ms. Wilkison provided direct care to acutely ill patients within a busy medical/surgical unit, with a caseload of approximately 10 to 12 patients. She assumed charge nurse responsibilities.

Professional History

HSAG, Phoenix, Arizona: Project Manager II, S&CS; 06/2021–present

Qlarant Quality Solutions, Inc., Easton, Maryland: Project Manager II, EQR (02/2017–06/2021); Claims Analyst II, Audit Medicaid Integrity Contractor (MIC) (05/2015–02/2017); 05/2015–06/2021

Compass Regional Hospice, Centreville, Maryland: Quality Manager/Clinical Staff Development Specialist (11/2008–05/2015); Director of Clinical Services (09/2002–11/2008); 09/2002–05/2015

Hospice of the Chesapeake, Pasadena, Maryland: Nurse Case Manager; 03/2001–09/2002

Johns Hopkins Bayview Medical Center, Baltimore, Maryland: Newborn/Neonatal Intensive Care Nursery Nurse (11/1997–03/2001); Medical Surgical Nurse (11/1996–11/1997); 11/1996–03/2001

Education & Training

Bachelor of Science, Nursing, Villa Julie College, Stevenson, Maryland, 1996

Licenses

Registered Nurse, State of Maryland, 1996

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Certifications

Certified Professional Coder, 2016–present

Professional Organizations

American Academy of Professional Coders, 2016

Hospice Administrator Certificate Program, 2005

National Healthcare Association for Healthcare Quality Training Program, 2012

Certified Professional in Healthcare Quality, 2021

Medicaid Projects of Similar Scope and Size:

As the project manager for the Oregon EQRO contract, Ms. Wilkison's responsibilities include day-to-day coordination and oversight of mandatory and optional EQR activities for the health plans contracted with the Oregon Health Authority (OHA). Ms. Wilkison also provides subject matter expertise and technical assistance to the OHA and health plans in meeting compliance with regulatory standards.

Ms. Wilkison was previously responsible for managing EQR services as the project manager for the District of Columbia EQRO (2017–2021).

Below are references who can attest to Ms. Wilkison's competence and skill level for the cited projects.

Reference #1			
Contract:	**State of Oregon, EQRO**		
Related EQR Task(s)	EQRO Contract Management, Compliance Reviews, Network Adequacy and Delivery System Network Evaluation, and Technical Assistance		
Name: **Title:**	Veronica Guerra Quality Assurance and Contract Oversight Manager		
Company*:	Oregon Health Authority, Health Systems Division		
Email:	Veronica.Guerra@dhoha.state.or.us	**Phone #:**	503.437.5614
Reference #2			
Contract:	**District of Columbia, EQRO**		
Related EQR Task(s)	EQRO Contract Management, Compliance Reviews, Readiness Reviews, Network Adequacy and Delivery System Network Evaluation, Information Systems Capabilities Assessments, and Technical Assistance		
Name: **Title:**	Serina Kavanaugh Management Analyst, Division of Quality and Health Outcomes		
Company:	Department of Health Care Finance, 441 4th St. NW, Washington, DC 20001		
Email:	Serina.Kavanaugh@dc.gov	**Phone #:**	707.365.4839

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Elisabeth Hunt, MHA, CPCS, CHCA, BS
Executive Director, Data Science & Advanced Analytics Management

Qualification Highlights

Ms. Hunt has over 20 years of healthcare industry experience, with expertise in senior management and operations of healthcare delivery systems. She has 14 years of experience in healthcare auditing and evaluation; is skillful in healthcare credentialing, quality improvement, compliance, and contracting; and is an expert in review and interpretation of state and federal regulations, Centers for Medicare & Medicaid Services (CMS) policies, Medicare and Medicaid programs, and National Committee for Quality Assurance (NCQA) requirements.

Relevant Experience

HSAG, Executive Director, Data Science & Advanced Analytics (DSAA) Management: Ms. Hunt provides oversight for the DSAA Audits Team and the NORC subcontract, coordinating internal and external resources to achieve contract goals, objectives, and activities. She is the regulatory subject matter expert (SME) providing leadership and direction for related activities consistent with overall company objectives, and she is responsible for accurate and timely deliverables and day-to-day operational activities. Ms. Hunt is responsible and accountable for tracking and monitoring the progress of projects and tracking project-specific expenses and revenues. She leads performance measure validation, independent assessments, and program evaluations, and serves as the Audits Team SME for a variety of performance measures associated with healthcare policy and health plan operations leading Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audits™[2] and AMP [Align. Measure. Perform.] Audit Reviews™[3]. She interviews, hires, evaluates, and counsels staff members; develops staff training based on needs assessments; develops reports, proposals, and project budgets; and acts as a liaison between customer representatives and HSAG project staff members, ensuring that reports are reliable, valid, and appropriate for the intended audience.

HSAG, Executive Director, State & Corporate Services (S&CS): Ms. Hunt was responsible for the external quality review organization (EQRO) contract in Ohio, coordinating internal and external resources to achieve the contract goals and objectives. Contracted activities included leading and supporting activities for the Ohio Department of Medicaid and managed care plans that provided both physical and behavioral healthcare to members. She provided leadership and direction for related activities consistent with overall company objectives and was responsible for accurate and timely deliverables and day-to-day operational activities. Ms. Hunt oversaw staff members and developed staff training, reports, proposals, and project budgets and acted as a liaison between customer representatives and HSAG project staff members.

HSAG, Director, S&CS: Ms. Hunt was responsible for the EQRO contract in Ohio, coordinating internal and external resources to achieve the contract goals, objectives, and activities. She provided leadership and direction for related activities consistent with overall

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] HEDIS® Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

[3] AMP Audit Review™ is a trademark of the National Committee for Quality Assurance (NCQA).

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

company objectives and was responsible for accurate and timely deliverables and day-to-day operational activities.

Molina Healthcare of Ohio, Inc., Associate Vice President, Healthcare Services Operations: Ms. Hunt directed a team of 500+ employees who performed clinical auditing, care coordination,case management, and utilization management of over 330,000 Ohio beneficiaries across all government-funded healthcare programs.

Molina Healthcare of Ohio, Inc., Interim Vice President, Healthcare Services: Ms. Hunt led health plan teams in achieving multiple program improvements in 2014, 2015, and 2016 and led the integration of new populations into managed care, while overseeing clinical auditing.

Molina Healthcare of Ohio, Inc., Compliance Director/Officer: Ms. Hunt was responsible for all aspects of Molina's compliance program, based on the Office of Inspector General effective elements of a compliance program. Ms. Hunt led all internal audits whose standards were based on CMS policies and regulations and Medicare and Medicaid program requirements and assisted with implementation of the Health Insurance Exchange.

Molina Healthcare of Ohio, Inc., Quality Improvement Manager: Ms. Hunt was responsible for all health plan provider credentialing processes, policies, and procedures and all quality of care and quality of service provider investigations, including medical record review processes and credentialing audits.

Molina Healthcare of Ohio, Inc., Delegation Oversight/Subcontracts Manager: Ms. Hunt created and implemented the Delegation Oversight Program in its entirety, managing and auditing 15 delegated entities.

Molina Healthcare of Ohio, Inc., Lead Credentialing Specialist: Ms. Hunt implemented process efficiencies that ensured 100 percent compliance with NCQA credentialing standards.

Professional History

HSAG, Columbus, Ohio: Executive Director, DSAA Management (02/2019–present); Executive Director/Director, S&CS (07/2018–02/2019); Director, S&CS (08/2017–06/2018); 08/2017–present

Molina, Columbus, Ohio: Associate Vice President, Healthcare Services Operations (09/2013–08/2017); Interim Vice President, Healthcare Services (10/2015–03/2017); Compliance Director/Officer (11/2011–10/2013); Quality Improvement Manager (02/2010–11/2011); Delegation Oversight/Subcontracts Manager (02/2008–02/2010); Lead Credentialing Specialist (10/2006–02/2008); 10/2006–08/2017

Nationwide Health Plans, Dublin, Ohio: Senior Credentialing/Team Lead (03/2004–10/2006); Business Analyst (02/2002–03/2004); Administrative Assistant (10/2000–02/2002); 10/2000–10/2006

Education

Master of Health Administration, summa cum laude, Trident University International, Cypress, California, 2018

Bachelor of Science, magna cum laude, The Ohio State University, Columbus, Ohio, 1998

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Certifications

Certified Provider Credentialing Specialist, 2010

Certified HEDIS Compliance Auditor, 2020

Medicaid Projects of Similar Scope and Size:

As the Executive Director overseeing the Audits Department within DSAA, Ms. Hunt's responsibilities include leading large-scale performance measure validation (PMV) and reporting for a variety of managed care entities (e.g., MCOs, PAHPs, PIHPs, and MMPs). Ms. Hunt specifically leads PMV audits of HEDIS and non-HEDIS measures in support of HSAG's EQRO contracts in Arizona and Michigan. In Arizona, Ms. Hunt project manages PMV of HEDIS and non-HEDIS measures for nine MCOs. Her project management in Arizona includes leading PMV audits and overseeing auditors to ensure consistency in application of audit processes, completion of rate review, identification of audit findings, and summation of results within final audit reports. In Michigan, Ms. Hunt oversees annual PMV of non-HEDIS measures for 10 PIHPs and seven Integrated Care Organizations (Michigan MMPs), and oversees performance measure reporting for two PAHPs and 10 MCOs.

Below are references who can attest to Ms. Hunt's competence and skill level for the cited projects.

Reference #1			
Contract:	**State of Arizona, EQRO**		
Related EQR Task(s)	**Performance Measure Validation**		
Name: **Title:**	Jamie Robin Quality Improvement Manager		
Company*:	Arizona Health Care Cost Containment System		
Email:	Jamie.robin@azahcccs.gov	**Phone #:**	602.417.4717
Reference #2			
Contract:	**State of Michigan, EQRO**		
Related EQR Task(s)	**Performance Measure Validation and Reporting**		
Name: **Title:**	Katarzyna Roelant Quality Analyst – MI Health Link		
Company*:	Michigan Department of Health and Human Services		
Email:	RoelantK@michigan.gov	**Phone #:**	517.241.8033

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Kari Pikus, BS
Analytics Manager III, Data Science & Advanced Analytics

Qualification Highlights

Ms. Pikus has more than 13 years of experience managing day-to-day analytic and project-related activities on HSAG's external quality review organization (EQRO) contracts, including Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1] surveys and performance measure rate reporting for several states. Ms. Pikus coordinates and manages several EQRO projects that evaluate aggregated information on timeliness, access, and quality of healthcare services furnished to Medicaid enrollees. She assists with the day-to-day management, reporting, and data validation of various activities. Through this work, Ms. Pikus has gained a deep understanding of key areas of state Medicaid programs.

Relevant Experience

HSAG, Analytics Manager III, Data Science & Advanced Analytics (DSAA): Ms. Pikus is responsible for day-to-day activities for the CAHPS and other member and provider surveys for several states and brings strong management and coordination skills to the survey activities. Her responsibilities include participation in collaborative team meetings (both internal and external), subcontractor management, contract management, report development, appropriate and accurate reporting of results, ensuring strict adhere to customer timelines, validating reports for accuracy, and ensuring timely receipt of deliverables. She assists customers with designing and conducting surveys using a methodologically sound approach. Ms. Pikus also coordinates receipt of data and analytical activities for the CAHPS surveys. She is responsible for coordinating the receipt of data, secure file transfer and storage, analytical oversight, and reporting of results. Additionally, Ms. Pikus is experienced in creating summary reports containing health plan and program findings.

HSAG, Analytics Manager II, Data Science & Advanced Analytics (DSAA): Ms. Pikus was responsible for day-to-day activities for the CAHPS surveys for several states and brought strong management and coordination skills to the CAHPS activities. Her responsibilities included participation in collaborative team meetings (both internal and external), subcontractor management, report development, appropriate and accurate reporting of results, establishing internal and external timelines, validating reports for accuracy, and ensuring timely receipt of deliverables. She assisted clients with designing and conducting surveys using a methodologically sound approach. Ms. Pikus also coordinated receipt of data and analytical activities for the CAHPS surveys. She was responsible for coordinating the receipt of data, secure file transfer and storage, analytical oversight, and reporting of results. Ms. Pikus had experience creating summary reports containing health plan and program findings.

Additionally, Ms. Pikus oversaw the California Department of Public Health (CDPH) Skilled Nursing Facility (SNF) Quality and Accountability Supplemental Program (QASP) project and the production of an annual report that contained scores of select quality measures at the facility level that the California Department of Health Care Services (DHCS) used to issue incentive payments.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

HSAG, Analytics Manager I, Analytics & Informatics (A&I): Ms. Pikus coordinated activities for the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Organization Privacy Protection Center (PSOPPC) contract and brought strong management and coordination skills to the project. She provided assistance and project oversight for several key tasks for the AHRQ PSOPPC contract, including Common Formats development and maintenance and expert and stakeholder meeting support. Her responsibilities included participation in collaborative team meetings, appropriate and accurate reporting of results, establishing internal and external timelines, validating reports for accuracy, and ensuring timely receipt of deliverables. Ms. Pikus also coordinated analytical activities for the Quality Improvement Organization (QIO) contract. She was responsible for the day-to-day coordination of data requests and reporting of results for several Centers for Medicare & Medicaid Services (CMS) evaluation metrics, such as reducing healthcare-associated infections and reducing adverse drug events.

HSAG, Informatics Project Coordinator, Informatics: Ms. Pikus directed survey projects, including implementation, project management, reports, and assisting in the development of project timelines. She was also responsible for communicating with subcontractors, project partners, and clients.

Ms. Pikus also coordinated a quality of life (QoL) study for the Aged, Blind, and Disabled (ABD) population that assessed populations' burden of disease and measured the health-related QoL for its members. This study provided the State of Ohio with actionable recommendations for consumers on the health-related QoL. Additionally, Ms. Pikus was responsible for day-to-day activities for the AHRQ PSOPPC contract and provided assistance and project oversight for several key tasks including Common Formats development and maintenance and expert and stakeholder meetings support.

Professional History

HSAG, Phoenix, Arizona: Analytics Manager III, DSAA (07/2020–present); Analytics Manager II, DSAA (07/2016–06/2020); Analytics Manager I, A&I (10/2012–06/2016); Informatics Project Coordinator, Informatics (05/2008–10/2012); 05/2008–present

Bear Stearns Residential Mortgage, Scottsdale, Arizona: Analyst; 11/2006–05/2008

Universal American Mortgage Company, Tempe, Arizona: Loan Processor II, New Home Purchase, Home Equity, & Refinance; 07/2005–11/2006

LoanPro, Horsham, Pennsylvania: Loan Processor, First Mortgage and Home Equity Loans; 07/2004–07/2005

Education & Training

Bachelor of Science, Computer Information Systems, Arizona State University, Tempe, Arizona, 2004

Skills

Microsoft Office: Word, Excel, Visio, PowerPoint, Access, Project, and SharePoint
Programming: SAS

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Medicaid Projects of Similar Scope and Size:

As Analytics Manager in support of HSAG's EQRO contracts for Colorado and Hawaii, Ms. Pikus' responsibilities include managing day-to-day activities for the CAHPS and other member and provider surveys. Ms. Pikus provides support to state Medicaid agents with designing and conducting surveys using a methodologically sound approach. In addition, Ms. Pikus handles subcontractor management and is proficient in report development, appropriate and accurate reporting of results, ensuring strict adherence to customer timelines, validating reports for accuracy, and ensuring timely receipt of deliverables. Ms. Pikus also coordinates receipt of data and analytical activities for all survey activities.

Below are references who can attest to Ms. Pikus' competence and skill level for the cited projects.

Reference #1			
Contract:	**State of Colorado, EQRO**		
Related EQR Task(s)	CAHPS Surveys, ECHO Survey		
Name: **Title:**	Russell Kennedy Quality Program Manager		
Company*:	Department of Health Care Policy & Financing		
Email:	Russell.kennedy@state.co.us	**Phone #:**	303.866.3954
Reference #2			
Contract:	**State of Hawaii, EQRO**		
Related EQR Task(s)	CAHPS Surveys, Provider Survey		
Name: **Title:**	Diana Jane Cassidy Quality and Member Relations Improvement Section		
Company*:	Department of Human Services, Med-QUEST Division		
Email:	dcassidy@dhs.hawaii.gov	**Phone #:**	808.692.8178

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Erin Knorr, MPH, BS
Associate Director, Data Science & Advanced Analytics

Qualification Highlights

Ms. Knorr has more than nine years of healthcare experience performing analytics activities using a variety of data sources, including claims and encounters, minimum data set, and chart-based data. She has expertise in validating data, developing predictive models, conducting exploratory analyses, and performing Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measure calculations. Over the last eight years, Ms. Knorr has worked with several state Medicaid agencies as part of HSAG's external quality review (EQR) contracts to assess their beneficiaries' access to quality care. She has experience in developing methodology to link disparate data sources that lack a common unique key. She also is well-versed in national hospital quality reporting programs and the data reported as a result of those initiatives.

Relevant Experience

HSAG, Associate Director, Data Science & Advanced Analytics (DSAA): Ms. Knorr provides analytic oversight of various activities in support of EQR contracts for Hawaii, California, Georgia, Illinois, Iowa, Michigan, and Virginia. These activities include methodology development and analysis to support consumer decision support tools as well as analysis of HEDIS data to support states' aggregate and technical reporting needs. For the State of Hawaii contract, she is responsible for production of the rate spreadsheet which contains both Community Care Service and QUEST Integration health plan rates for both HEDIS and non-HEDIS measures along with statewide weighted averages. Additionally, Ms. Knorr assists with the analysis and evaluation of several states' 1115 waiver demonstrations.

HSAG, Senior Data Scientist, DSAA: Ms. Knorr was a lead analyst on the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) 11th and 12th scope of work (SOW) while also providing oversight for the Centers for Medicare & Medicaid Services (CMS) Hospital Outpatient Quality Reporting (OQR) and Inpatient Quality Reporting (IQR) programs. She assisted in the collection and analysis of information for an environmental scan and data report with baseline rates to support the transition to the 12th SOW and also provided analytic oversight to the Hospital Quality Improvement Contract.

HSAG, Senior Healthcare Analyst, DSAA: Ms. Knorr led work on the QIN-QIO 11th SOW. She assisted in creating an annual report summarizing the results for the most recent year of the 11th SOW evaluation metrics. Additionally, Ms. Knorr led the analysis and provided analytic oversight of the CMS Hospital OQR and IQR programs. Ms. Knorr used her knowledge of the Medicaid program to oversee the development of state-specific HEDIS aggregate reports for multiple states as part of HSAG's external quality review organization (EQRO) contracts.

She also conducted statistical analyses for the Standards for Quality Improvement Reporting Excellence reports, as required by CMS, to assess the success of interventions put in place by the QIN-QIO. Ms. Knorr linked information on Medicare beneficiaries who received the intervention provided by external partners to Medicare fee-for-service data based on available common data elements to assess outcomes.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

HSAG, Informatics Analyst III, DSAA: Ms. Knorr served as the analytic lead and support for various tasks within the QIN-QIO 11th SOW. She specifically focused on metrics related to admissions, readmissions, and emergency department visits for Medicare beneficiaries, as well as on monitoring hospital-acquired infection rates for recruited facilities using National Healthcare Safety Network data. Additionally, Ms. Knorr assisted in calculating performance metrics for adverse drug events.

Ms. Knorr was involved in developing a QIN-QIO metrics database to allow better tracking of metrics and benchmarks. She has extensive knowledge of Medicaid and the Children's Health Insurance Program (CHIP) and assisted with several analytic activities, including the calculation of performance measures for Ohio's Medicaid and dual-eligible populations. Additionally, Ms. Knorr developed measure code for several EQRO contracts, including code for HEDIS measures, adult Medicaid quality grant measures, and Agency for Healthcare Research and Quality indicators.

HSAG, Informatics Analyst II, Analytics & Informatics (A&I): Ms. Knorr performed data monitoring and analyses for several state and national hospital performance evaluations and public reporting program activities aimed at improving the quality, safety, transparency, and efficiency of healthcare provided to all beneficiaries. Ms. Knorr worked with the Ohio Department of Medicaid (ODM) to develop a methodology and SAS program linking Ohio's Vital Statistics records to the Medicaid encounters and enrollment information to assist in identifying high-risk mothers and assess the rate of low birth weight infants within ODM's managed care population.

Arizona Department of Health Services (ADHS), Intern: Ms. Knorr used Link Plus and SAS to probabilistically link records from two different data sources. Before beginning analyses, she performed literature reviews to investigate instances wherein other organizations linked data from different sources in addition to the processes implemented to accomplish this linking. She developed predictive models and presented the results to ADHS employees.

Professional History

HSAG, Phoenix, Arizona: Associate Director (06/2021–present); Senior Data Scientist (07/2019–06/2021); Senior Healthcare Analyst (07/2017–06/2019); Informatics Analyst III (05/2016–07/2017); Informatics Analyst II (01/2015–04/2016); Informatics Analyst I (06/2013–01/2015); 06/2013–present

ADHS, Phoenix, Arizona: Intern, Department of Epidemiology and Biostatistics; 08/2012–05/2013

University of Arizona, Tucson, Arizona: Student Researcher/Graduate Assistant; 08/2010–05/2011

Education

Master of Public Health, Biostatistics, University of Arizona, Tucson, Arizona, 2013

Bachelor of Science, Biochemistry with a minor in Mathematics, University of Arizona, Tucson, Arizona, 2011

Certifications

Incident Command System 100 Certified, April 2012

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Professional Organizations

Mel and Enid Zuckerman College of Public Health Student Affairs Committee representative, February 2012–May 2013

American Society for Biochemistry and Molecular Biology member, 2009–2012

Publications

Campbell E. The role of decreased levels of Niemann-Pick C1 intracellular cholesterol transport on obesity is reversed in the C57BL/6J, metabolic syndrome mouse strain: a metabolic or an inflammatory effect? *Journal of Applied Genetics*. August 2012.

Skills

SAS and R programming languages, basic knowledge of Stata statistical software

Medicaid Projects of Similar Scope and Size:

As an Associate Director within the DSAA department, Ms. Knorr's responsibilities include the implementation and oversight of quality reporting systems, commonly referred to as consumer report cards to evaluate MCE performance as part of the EQRO contracts in Illinois, Iowa, Michigan and Virginia.

Below are references who can attest to Ms. Knorr's competence and skill level for the cited projects.

Reference #1			
Contract:	**State of Illinois, EQRO**		
Related EQR Task(s)	Quality Rating System		
Name: **Title:**	Dawn Wells, RN, BSN Bureau Chief		
Company*:	Illinois Department of Healthcare and Family Services		
Email:	Dawn.R.Wells@Illinois.gov	**Phone #:**	217.782.2314
Reference #2			
Contract:	**State of Michigan, EQRO**		
Related EQR Task(s)	Quality Rating System		
Name: **Title:**	Sandhya Swarnavel Department Analyst		
Company*:	Michigan Department of Health and Human Services Managed Care Plan Division		
Email:	Swarnavels@michigan.gov	**Phone #:**	517.284.1149

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Christi L. Melendez, ASN, RN, CPHQ
Executive Director, Performance Improvement Projects, State & Corporate Services

Qualification Highlights

Ms. Melendez has more than 35 years of experience in the healthcare industry, with expertise in quality improvement (QI), performance improvement projects (PIPs), technical assistance, on-site training, healthcare policy and processes, clinical case management, and in working directly with Medicaid and Medicare populations. She works closely with state Medicaid agencies and their contracted managed care organizations (MCOs) to ensure PIPs are structured in a methodologically sound manner, follow industry-recognized practices, and have the potential to bring about real and sustained improvement and better health outcomes for beneficiaries. Ms. Melendez is a subject matter expert in QI science and in using rapid-cycle technique improvement. She spearheaded the development and implementation of HSAG's innovative rapid-cycle approach for implementing and validating PIPs, and she led the process to obtain Centers for Medicare & Medicaid Services' (CMS') approval and endorsement of the rapid-cycle approach.

Relevant Experience

HSAG, Executive Director, PIPs, State & Corporate Services (S&CS): Ms. Melendez has over 20 years of experience with HSAG working in the external quality review (EQR) industry. Ms. Melendez plans, directs, and manages the overall operations for PIP activities related to analytics projects that support EQR and PIP validation activities. She is responsible for using internal and external resources to achieve corporate, departmental, and project goals and objectives, including working with the project director to ensure deliverables are on time and of high quality. Ms. Melendez provides research leadership, analytics expertise, technical interpretive writing, and mentoring to her staff members, and she ensures the scientific soundness of study design, analysis, and interpretation of a variety of healthcare studies. She represents HSAG as needed at regional and national levels and in planning technical assistance meetings, teleconferences, and webinars with state and health plan staff and assigned clients. Ms. Melendez is responsible for the PIP Team staff and project deliverables and provides technical assistance to health plans throughout the PIP process, including on-site and virtual training for health plans and individual states. She is accountable for developing and adhering to project timelines and task schedules.

HSAG, Project Manager, PIP Team: Ms. Melendez provided day-to-day management of the PIP Team and developed in-service trainings for the team. She provided technical assistance to health plans throughout the PIP process and created presentations to train states about the process. Ms. Melendez also assisted an S&CS executive director in writing the PIP Reviewer's Guide and the MCO guides for the PIP process. Ms. Melendez performed validation of physical and behavioral health PIPs and wrote PIP validation reports, explaining the validity and reliability of the PIP findings. In addition, she supported writing PIP annual summary reports and EQR technical reports.

HSAG, PIP Reviewer II, S&CS: Ms. Melendez performed validation of physical and behavioral health PIPs by assessing the implications of the validity and reliability of findings. She was responsible for providing technical assistance to states, as needed.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

HSAG, Review Coordinator/Abstractor, S&CS: Ms. Melendez performed review and abstraction of medical records to assess quality of care, practice guidelines, and variation in care and outcome, and to substantiate review findings. She worked on a variety of projects, including the RAND Cost of Cancer Treatment Study, and she assisted in training other registered nurse (RN) abstractors, providing on-site medical reviews for Healthcare Effectiveness Data and Information Set (HEDIS®) auditing.[1]

Banner Home Health, Case Manager: Ms. Melendez performed case management for pregnant, pediatric, and adult home health patients, including infusion patients, and coordinated care with a multidisciplinary team. She was a nurse preceptor and performed new employee preceptor duties. Ms. Melendez performed chart audits for multiple teams, including Medicare/Medicaid.

Gentiva Health Services, Manager of Clinical Practice: Ms. Melendez managed a team of 40 nurses and performed case management for long-term, chronically ill children. She prepared quality assurance and treatment plans and performed medical record/documentation audits. Ms. Melendez was also a member of the Performance Improvement Committee.

Integrated Health Services (IHS) Home Care, Senior Case Manager: Ms. Melendez performed case management for pregnant and pediatric patients, coordinating their care with a multidisciplinary team. She served as the performance improvement coordinator for the pediatric team. Ms. Melendez also performed chart audits for multiple teams, including Medicare and Medicaid.

Professional History

HSAG, Phoenix, Arizona: Executive Director, PIPs, S&CS (07/2021–present); Associate Executive Director, PIPs, S&CS (09/2011–07/2021); EQRO Project Manager, PIP Team (10/2008–09/2011); Project Leader, PIP Team (01/2007–10/2008); PIP Reviewer II (01/2006–01/2007); Review Coordinator/Abstractor (01/2001–01/2006); 01/2001–present

Banner Home Health, Phoenix, Arizona: Case Manager; 09/2004–11/2007

Centrum Healthcare, Phoenix, Arizona: Pediatric Field Nurse; 05/2002–08/2004

Gentiva Health Services, Phoenix, Arizona: Manager of Clinical Practice; 01/2000–12/2000

Children's Home Care, Phoenix, Arizona: Intermittent Visit Nurse; 03/1999–12/1999

IHS Home Care, Phoenix, Arizona: Senior Case Manager; 02/1991–03/1999

Desert Samaritan Medical Center, Mesa, Arizona: Staff RN; 02/1990–02/1991

Whittier Presbyterian, Whittier, California: Staff RN; 03/1986–12/1989

Education

Associate of Science in Nursing, Cypress College, Cypress, California, 1986

Licenses

Registered Nurse, Arizona, 1986–present

Nurse Licensure Compact: Active, Unencumbered, Multi-state, 1990–present

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Certifications

Certified Professional in Healthcare Quality by the Healthcare Quality Certification Board, 2009

Medicaid Projects of Similar Scope and Size:

As the Executive Director in support of HSAG's EQRO PIP contracts for California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, Nebraska, Nevada, New Hampshire, North Carolina, Oregon, Utah, Vermont, and Virginia, Ms. Melendez's responsibilities include the implementation, oversight, and leadership of all PIP EQRO activities, including direct management of mandatory and optional PIP activities for a variety of health plan types (e.g., MCOs, PIHPs, and PAHPs). Ms. Melendez also serves as a subject matter expert on Medicaid QI, providing ongoing technical assistance to state Medicaid agents, health plans, and community stakeholders.

Below are references who can attest to Ms. Melendez's competence and skill level for the cited projects.

Reference #1			
Contract:	**State of Colorado, EQRO**		
Related EQR Task(s)	Performance Improvement Projects (Implementation and Validation)		
Name: **Title:**	Russ Kennedy Quality Program Manager, Cost Control and Quality Improvement Office		
Company*:	Colorado Department of Health of Health Care Policy and Financing		
Email:	Russell.kennedy@state.co.us	**Phone #:**	303.866.3340
Reference #2			
Contract:	**State of Nevada, EQRO**		
Related EQR Task(s)	Performance Improvement Projects (Implementation and Validation)		
Name: **Title:**	Theresa Carsten Social Services Chief III		
Company*:	Division of Health Care Financing and Policy/Managed Care and Quality Assurance		
Email:	Theresa.Carsten@dhcfp.nv.gov	**Phone #:**	775.684.3655

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Leslie Arendell, MS, BA
Associate Director, Data Science & Advanced Analytics
Qualification Highlights

Ms. Arendell has more than 20 years of experience working in epidemiological research and data analysis, with expertise in study design, analysis planning, statistical analysis, and report writing. She has expertise and experience with Medicare and Medicaid programs and data systems. Ms. Arendell has substantial data management and data analysis experience, which includes working with large data sets. She is experienced in delivering both written and verbal presentations to the scientific and non-scientific communities.

Relevant Experience

HSAG, Associate Director, Data Science & Advanced Analytics (DSAA): Ms. Arendell provides overight for the team responsible for conducting secret shopper surveys in, Illinois, Iowa, Utah, and Virginia. The secret shopper work includes evaluating the accuracy and completeness of health plan provider data according to state-specific standards. Ms. Arendell is also responsible for planning and conducting analytic activities including study design, analysis, and interpretation. This involves preparing methodology; creating analytic plans; conducting analysis; and presenting results and conclusions in spreadsheets, reports, and presentations. Ms. Arendell works on a variety of external quality review organization (EQRO) projects including network analysis studies in California, Illinois, Iowa, Oregon, Nevada, Tennessee, Utah, and Virginia, and focused studies in California.

HSAG, Senior Measures Analyst, Research & Analysis Team: Ms. Arendell provided analytic support for a three-year project assessing the impact of Centers for Medicare & Medicaid Services (CMS) quality and efficiency measures. She was responsible for obtaining and tracking data from several governmental sources and systems including claims, survey and quality measure data from hospitals, nursing homes, home health agencies, physicians, and Medicare Advantage plans. Ms. Arendell maintained communication with clients and the data owners. She prepared methodologies, created analytic plans, and conducted statistical analysis for research assessing the impact of CMS quality measures. Ms. Arendell assisted with literature review and environmental scans to review previously published literature, as well as presented on the topic of information gathering and risk adjustment at the Measures Development Information Series for CMS measure developers.

University of Arizona, Mel and Enid Zuckerman College of Public Health, Research Specialist Senior: Ms. Arendell managed the Healthy Aging Laboratory, mentoring and advising students and staff working on projects for the lab. She developed research protocols and data management and quality control procedures, and ensured protocol implementation. Ms. Arendell also prepared Institutional Review Board (IRB) annual reports, protocols, and updates; analyzed questionnaire and laboratory data; and prepared research progress reports. Ms. Arendell evaluated the validity of data obtained from experimental procedures and recommended additional tests and/or modifications, as well as facilitated program objectives through interaction with university faculty, staff, students, and outside agencies.

Pima Community College, Adjunct Faculty, Business and Mathematics Departments: Ms. Arendell taught classes of up to 35 students on course topics including business statistics, basic math, and introductory statistics. She was responsible for all aspects of the class, including

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

preparing the syllabus, lecturing, grading, creating and administering exams, as well as classroom and time management.

Professional History

HSAG, Phoenix, Arizona: Associate Director, DSAA (06/2014–present); Sr. Measures Analyst, Research & Analysis Team (06/2012–06/2014); 06/2012–present

Pima Community College, Tucson, Arizona: Adjunct Faculty, Business and Mathematics Departments; 06/2007–12/2011

University of Arizona, Tucson, Arizona: Research Specialist Senior, Healthy Aging Laboratory at the Mel and Enid Zuckerman College of Public Health; 01/2000–06/2012

Education

Master of Science, Epidemiology, University of Arizona, Tucson, Arizona, 2001

Bachelor of Arts, Biology, Spanish, Wittenberg University, Springfield, Ohio, 1999

Selected Publications

Thomson, C.A., Stanaway, J.D., Neuhouser, M.L., Snetselaar, L.G., Stefanick, M.L., Arendell. L., Chen, Z. Nutrient intake and anemia risk in the women's health initiative observational study. *J Am Diet Assoc*. 2011 Apr; 111(4):532–41.

Chen, Z., Maricic, M., Aragaki, A.K., Mouton, C., Arendell, L., Lopez, A.M., Bassford, T., Chlebowski, R.T. Fracture risk increases after diagnosis of breast or other cancers in postmenopausal women: results from the Women's Health Initiative. *Osteoporos Int*. 2009 Apr; 20(4):527–36.

Chen, Z., Arendell, L.A., Aickin, M., Cauley, J.A., Lewis, C.E., Chlebowski, R. Hip bone density predicts breast cancer risk independently of Gail score: results from the Women's Health Initiative. *Cancer*. 2008 Sep 1; 113(5) 907–15.

Caire–Juvera, G., Arendell, L.A., Maskarinec, G., Thomson, C.A., Chen, Z. Associations between mammographic density and body composition in Hispanic and non–Hispanic white women by menopause status. *Menopause*. 2008 Mar–Apr;15(2):319–25.

Maskarinec, G., Takata, Y., Chen, Z., Gram, I.T., Nagata, C., Pagano, I., Hayashi, K., Arendell, L., Skeie G, Rinaldi, S., Kaaks, R. IGF–I and mammographic density in four geographic locations: a pooled analysis. *Int J Cancer*. 2007 Oct 15;121 (8) 1786–92.

Presentations

Magness (Arendell), L., Miller, T.D. Risk Adjustment. Presented at CMS Measure Development Informational Series. April 4, 2013.

Gupta, A., Magness (Arendell), L., Marinelarena, M. Sifting through the details: Information Gathering in the Information Age—Literature Review, Evidence Grading, Clinical Guidelines. Presented at CMS Measure Development Informational Series. October 25, 2012.

Skills

SAS, Stata, SPSS, Quest Analytics, and other statistical programs. Biostatistics, Program Evaluation, Public Health. MS Office (including Word, Excel, PowerPoint, Outlook, and Access with Visual Basic, Publisher).

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Medicaid Projects of Similar Scope and Size:

As an Associate Director in support of HSAG's EQRO's contracts, Ms. Arendell's responsibilities include leading network adequacy projects in Iowa and Utah. Ms. Arendell is also responsible for planning and conducting analytic activities including study design, analysis, and interpretation. This involves preparing methodology; creating analytic plans; conducting analysis; and presenting results and conclusions in spreadsheets, reports, and presentations.

Below are references who can attest to Ms. Arendell's competence and skill level for the cited projects.

Reference #1			
Contract:	**State of Iowa, EQRO**		
Related EQR Task(s)	Network Adequacy Validation		
Name: **Title:**	Jason Holst Quality Improvement Analyst		
Company*:	Department of Health and Human Services (DHS)		
Email:	jholst@dhs.state.ia.us	**Phone #:**	515.974.3070
Reference #2			
Contract:	**State of Utah, EQRO**		
Related EQR Task(s)	Network Adequacy Validation		
Name: **Title:**	Cameron Gunderson Quality Program Manager		
Company*:	Utah Department of Health and Human Services (UDOH)		
Email:	crgunderson@utah.gov	**Phone #:**	801.538.6943

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Raymond Berens, BA
Associate Director, Data Science & Advanced Analytics

Qualification Highlights

Mr. Berens has 10 years of experience performing, designing, and overseeing analyses of healthcare performance measure data and calculating performance measures using administrative and medical record review data. He also has experience developing custom performance measures specifications for state clients to assess quality of care for specific conditions or populations when national measures do not exist. Additionally, he has overseen the development and implementation of analyses of health disparities for multiple state Medicaid agencies. He has developed state Medicaid quality rating systems (QRSs) and pay-for-performance (P4P) program algorithms. He has also evaluated programs across a myriad of evaluation units, including analyses performed at the statewide, health plan, nursing home, and hospital levels.

Relevant Experience

HSAG, Associate Director, Data Science & Advanced Analytics (DSAA): Mr. Berens is responsible for providing process oversight, analytical expertise, technical interpretive writing, and project management support within DSAA. In his role leading performance measure calculation activities, Mr. Berens has provided oversight of the calculation of Healthcare Effectiveness Data and Information Set (HEDIS®)[1] and HEDIS-like performance measures for multiple state Medicaid agencies including Arizona, Arkansas, California, Colorado, Iowa, Nevada, New Hampshire, Ohio, and Virginia. He has overseen performance measure calculation requiring the use of administrative claims/encounter data, supplemental registry data, medical record review data, and minimum data set (MDS) 3.0 data. Mr. Berens also has experience developing measure specifications for state Medicaid agencies in instances where national measures are not available for a specific focus area. For the commonwealth of Virginia, Mr. Berens oversaw the development of eight custome measures to assess the Addiction and Recover Treatment Services (ARTS) program and three custome measures to assess the quality of care for the Virginia Medicaid population with identified prediabetes. Additionally, he developed the Health Disparities Focus Study methodology for the California Department of Healthcare Services (DHCS) to identify health disparities at a statewide and managed care level. This activity has expanded to also involve developing a methodology to identify priority focus areas for managed care plans in California to develop quality improvement initiatives to eliminate disparities statewide. Mr. Berens is also working with the North Carolina Division of Health Benefits (DHB) to develop an analysis of health equity. Additionally, he assists in the day-to-day project management and analytic activities related to the California Department of Public Health (CDPH) Skilled Nursing Facility (SNF) Quality and Accountability Supplemental Payment (QASP) Program, and the Office of Personnel Management (OPM) Federal Employee Health Benefits (FEHB) Plan Performance Assessment (PPA) activity. For the CDPH SNF QASP Program activities, Mr. Berens researches, evaluates, and recommends new measures for inclusion in the program; assists in the development of online quality improvement tools that are provided to SNFs participating in the QASP Program; and oversees the final evaluation of SNFs participating in the program for the determination of incentive payments. For the OPM FEBH PPA activity, Mr. Berens provides oversight of the collection and aggregation of HEDIS and

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] data from the 87 FEHB contractors. The HEDIS and CAHPS results are then used to calculate overall performance scores based on quality of care, customer service, and resource use (QCR), which are factored in as one component of a P4P program. He also makes recommendations to OPM regarding methodology changes and measure inclusion for future PPA activities. Previously, Mr. Berens provided oversight of DSAA state reporting activities, including the use of performance measure data in the creation of QRSs, HEDIS aggregate reports, and external quality review (EQR) technical reports.

HSAG, Senior Analyst, DSAA: Mr. Berens was responsible for overseeing activities associated with performance measure calculation for the Medicaid agencies in Arizona, Arkansas, Colorado, Iowa, Nevada, New Hampshire, Ohio, and Virginia,. He evaluated Medicaid survey data for many state Medicaid agencies including Arizona, Colorado, Hawaii, Michigan, New Hampshire, Ohio, and Washington. Mr. Berens used HEDIS performance measure rates and CAHPS survey results to develop QRSs that are issued by states to assist Medicaid beneficiaries in selecting a health plan.

HSAG, Informatics Analyst III, Analytics & Informatics (A&I): Mr. Berens was responsible for leading informatics activities associated with performance measure calculation for various state Medicaid agencies. He calculated performance measure rates and produced reports in a format suitable to meet client's needs. Mr. Berens was responsible for assisting CDPH in calculating performance measures rates for the implementation of the statutorily required SNF QASP Program.

HSAG, Informatics Analyst II/Lead Analyst, A&I: Mr. Berens wrote code to calculate HEDIS and CMS Adult Core measure rates for Ohio's Adult Medicaid Quality Grant and external quality review organization (EQRO) contracts. He performed analyses for the Arkansas EQRO contract using the New York University algorithm to analyze nonemergent emergency department use in the State. He also worked on CAHPS and provider survey activities for Hawaii's Department of Human Services, Med-QUEST Division.

HSAG, Informatics Analyst I, A&I: As part of the CMS Partnership for Patients (PfP) project evaluation contract, Mr. Berens worked with CMS to evaluate the PfP initiative, which encompassed approximately 4,000 hospitals. He aggregated the most recently available hospital data to aid in evaluating national trends in both adverse event and readmission rates.

HSAG, Informatics Analytic Specialist, A&I: Mr. Berens assisted the lead analyst on the Colorado and Hawaii CAHPS survey activities to validate their results.

Professional History

HSAG, Phoenix, Arizona: Associate Director, DSAA (10/2017–present); Senior Analyst, DSAA (05/2016–10/2017); Informatics Analyst III, A&I (05/2015–05/2016); Informatics Analyst II/Lead Analyst, A&I (06/2013–04/2015); Informatics Analyst I, A&I (08/2012–06/2013); Informatics Analytic Specialist, A&I (08/2011–08/2012); 08/2011–present

University of Phoenix, Phoenix, Arizona: Finance Advisor; 04/2009–08/2011

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Mesa Unified School District, Mesa, Arizona: Substitute Teacher; 08/2008–04/2009

King's Ridge Middle School, Phoenix, Arizona: Math Teacher, 8th Grade; 07/2005–05/2008

Education

Bachelor of Arts, Mathematics, magna cum laude, Arizona State University, Tempe, Arizona, 2004

Skills

Experienced SAS user; proficient in calculating and evaluating performance measures and in using Microsoft operating systems.

Medicaid Projects of Similar Scope and Size:

As an Associate Director in HSAG's DSAA division, Mr. Berenes has overseen in the development and implementation of health disparities focus studies as part of the California EQRO contract. Mr. Berens also oversees performance measure calculations activities in support of the Arizona, California, Iowa, and Virginia EQRO contracts.

Below are references who can attest to Mr. Berens' competence and skill level for the cited projects.

Reference #1			
Contract:	**State of California, EQRO**		
Related EQR Task(s)	Health Disparities Focus Study, Quality Improvement Health Disparities Focus Study, Skilled Nursing Facility/Intermediate Care Facility Distance and Experience, Preventive Services Utilization		
Name: **Title:**	Estelle Champlain Policy and Medical Monitoring Branch, Contract Manager		
Company*:	Department of Health Care Services		
Email:	Estelle.Champlain@dhcs.ca.gov	**Phone #:**	916.345.7998
Reference #2			
Contract:	**State of Virginia, EQRO**		
Related EQR Task(s)	Task Q: Addiction and Recovery Treatment Services Performance Measure Calculations; Task K: Calculate Performance Measures; Task J.1 Birth Outcomes Focus Study; Task J.2 Foster Care Focus Study; Task S: Dental Utilization Brief		
Name: **Title:**	Dr. Laura Boutwell, DM, MPH Director, Quality and Population Health		
Company*:	Department of Medical Assistance Services		
Email:	Laura.Boutwell@dmas.virginia.com	**Phone #:**	804.371.4070

* See HSAG's EQR State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Paul Niemann, PhD, MA, BA, BS
Director, Data Science & Advanced Analytics

Qualification Highlights

Dr. Niemann has more than 14 years of experience in the healthcare industry, with expertise in data and cost analysis, providing access to care analyses compliant with federal requirements, risk mitigation, and statistical and impact evaluations relating to Medicare and Medicaid healthcare reform. Dr. Niemann has expertise in Medicaid network adequacy and access to care analysis and validation, including utilization and network saturation, spatial relationship, and time and distance analysis. He is experienced in designing waiver evaluations, and conducting analyses and evaluations of 1115, substance use disorder (SUD), Medicaid expansion, special programs for mental and behavioral health, and programs serving individuals with intellectual and developmental disabilities. Dr. Niemann also has expertise in designing Medicaid value-based payment programs.

Relevant Experience

HSAG, Director/Associate Director, Data Science & Advanced Analytics (DSAA): Dr. Niemann provides analytical and research management oversight of evaluations of multiple Medicaid Section 1115 waivers including SUD waivers, waivers providing coverage for Medicaid expansion populations through a private insurance exchange, special programs for persons with intellectual and developmental disabilities, mental and behavioral health waivers, and more. In addition, he has provided oversight and guidance for the development of multiple Section 1115 waiver evaluation designs. Dr. Niemann has directed, coordinated, and provided oversight for network adequacy/access to care analyses and program evaluations for more than 10 state Medicaid programs. He oversees all study planning, methodology development, statistical analyses and reporting, as well as all deliverables. Dr. Niemann directed a wide-ranging environmental scan of hospital-based pay-for-performance (P4P) plans for the State of Hawaii and advised on the development of a revised hospital-based P4P program. He has directed several assessments of statewide Medicaid access that include utilization and provider saturation analyses as well as spatial relationship analyses, including provider/beneficiary co-location and compliance with time and distance standards. Dr. Niemann also directed an analysis of the impact and extent of the opioid epidemic on specific state Medicaid programs and managed care organizations (MCOs). He provides research leadership, analytic expertise, and mentoring to junior level staff members. Dr. Niemann acts as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; as well as managing client relations and providing technical assistance. He specializes in developing methodologically sound evaluations and studies to determine the impact of policy and programs on payments and payment mechanisms, patient access to care, member utilization and outcomes, provider behavior, and savings and implementation cost estimates related to healthcare reform. He has also developed several pay-for-performance programs for Medicaid programs. Dr. Niemann is proficient in several statistical evaluation tools, including Stata and SAS, and has extensively used administrative claims data as part of designing and implementing impact evaluations.

Health Management Associates, Inc., Senior Consultant: Dr. Niemann created caseloads and cost estimates for MCOs to inform the decision to participate in a pilot program for Medicare

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

and Medicaid dual-eligible beneficiaries. He developed a statistical model of provider behavior under risk-adjusted home health rate structure and performed financial and utilization impact analyses and evaluations for a Medicaid home health model based on interrupted time series models using Medicaid claims data. Dr. Niemann developed estimates of impact to the Colorado calculated upper payment limit resulting from a Medicaid payment reform proposal. He researched and developed risk mitigation strategies for an MCO, performed data analysis based on technical economic and statistical models, and provided regular reports for a state hospital association for the distribution of payments and collection of assessments to taling over $100 million. Dr. Niemann performed data and statistical analysis for the implementation of a new rate structure for a statewide home- and community-based services (HCBS) waiver for persons with intellectual and developmental disabilities. He performed statistical evaluations of a case management pilot program based on claims, encounter, and medical record data. Dr. Niemann conducted evaluations of new programs to estimate impact on service utilization and costs on the basis of client characteristics such as chronic health conditions. Additionally, he developed statistical and financial models of the impacts of the introduction of managed care into a state Medicaid program.

Colorado Department of Health Care Policy and Financing, Supervisor, Budget Division: Dr. Niemann developed a model to recover approximately $3 million in misapplied federal funding and ensured compliance with all state and federal statutes. He researched and/or assigned Joint Budget Committee and Governor's Office of State Planning and Budgeting questions regarding the department's budget and programs. Dr. Niemann oversaw the development and production of reports that guided senior department leadership in its discretionary spending. He developed estimates and wrote narrative defense for several departmental budget requests.

Colorado Department of Health Care Policy and Financing, Rates Analyst, Rates Section: Dr. Niemann reviewed a variety of HCBS rates to ensure compliance with state and federal regulations. He provided technical oversight for the statistical analysis of nursing facility enrollment for Program of All-Inclusive Care for the Elderly (PACE) enrollees. Dr. Niemann reviewed new provider rates for the Children's Habilitation Residential Program Waiver (CHRP), based on unaudited provider cost data, ensuring reasonableness and inclusion of all allowable costs. He provided guidance for future development of CHRP rates and analyzed and developed recommendations regarding fiscal soundness monitoring of providers for PACE. Dr. Niemann led the implementation of telehealth rates for home health and HCBS programs. In addition, he developed economic analysis and complex models highlighting adverse-selection danger and resulting budgetary impacts of capitated telehealth rates.

Professional History

HSAG, Phoenix, Arizona: Director, DSAA (07/2019–present); Associate Director, DSAA (09/2016–06/2019); 09/2016–present

Health Management Associates, Inc., Denver, Colorado: Senior Consultant; 10/2012–08/2016

Colorado Department of Health Care Policy and Financing, Denver, Colorado: Supervisor, Budget Division (10/2007–10/2012); Rates Analyst, Rates Section (12/2006–10/2007); 12/2006–10/2012

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Center for Research on Economic and Social Policy at the University of Colorado at Denver, Denver, Colorado: Research Assistant; 1997–2000

Education

Doctorate, Economics, University of California, Santa Barbara, California, 2006

Master of Arts, Economics, University of California, Santa Barbara, California, 2001

Bachelor of Arts, with distinction, Economics, University of Colorado, Denver, Colorado, 2000

Bachelor of Science, with distinction, Mathematics, University of Colorado, Denver, Colorado, 2000

Select Publications

"Compensation for Taking When Both Equity and Efficiency Matter," with Perry Shapiro, in Property Rights: Eminent Domain and Regulatory Takings Re-Examined, (2010), edited by Bruce L. Benson, Palgrave Macmillan, New York.

"Efficiency and Fairness: Compensation for Takings," with Perry Shapiro, International Review of Law and Economics 28 (2008), pp. 157–165.

"Equity Effects of Alternative Assignments of Global Environmental Rights," with Stephen J. DeCanio, Ecological Economics 56 (2006), pp. 546–559.

Skills

Proficient with Stata; SAS; Regression Analysis of Time Series (RATS); Mathematica; MATLAB; LaTeX; Microsoft Word, Excel, Access, Outlook, and PowerPoint; and SQL. Basic knowledge of R and Visual Basic.

Medicaid Projects of Similar Scope and Size:

As a director on HSAG waiver team, Dr. Niemann provided oversight for the independent evaluation of the New Hampshire Premium Assistance Program 1115 wavier from 09/2016 through 02/2020. Currently, Dr. Niemann provides oversight for the independent evaluation of the New Mexico Centennial Care 2.0 1115 waiver.

Below are references who can attest to Mr. Niemann's competence and skill level for the cited projects.

Reference #1			
Contract:	**New Hampshire Premium Assistance Program 1115 wavier evaluation**		
Related EQR Task(s)	Wavier Evaluation Activities		
Name: **Title:**	Patrick McGowan Administrator Medicaid Quality Program		
Company*:	New Hampshire Department of Health and Human Services; Bureau of Program Quality		
Email:	patrick.mcgowan@dhhs.nh.gov	**Phone #:**	603.271.9534

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Reference #2			
Contract:	**New Mexico Centennial Care 2.0 1115 waiver evaluation**		
Related EQR Task(s)	Waiver Evaluation Activities		
Name: **Title:**	Maricela Vigil, MBA Contract Manager, Centennial Care 1115 Demonstration Waiver Evaluation		
Company:	Human Services Department; Medical Assistance Division PO Box 2348 Santa Fe, NM 87504-2348		
Email:	Maricela.Vigil@state.nm.us	**Phone #:**	505.709.5424

* See HSAG's State Profiles in Appendix 4 for specific mailing address information.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Appendix 6: NCQA Licensed Compliance Audit Organization Seal

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA



DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Appendix 7: NCQA HEDIS Compliance Audit License Agreement

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

NCQA HEDIS® COMPLIANCE AUDIT™
LICENSE AGREEMENT

This NCQA License Agreement (the "**Agreement**"), is effective October 30, 2021 (the "**Effective Date**"), by and between the National Committee for Quality Assurance ("**NCQA**") and Health Services Advisory Group, Inc. ("**Licensee**") (individually, a "**Party**," and collectively, the "**Parties**").

WHEREAS, NCQA is an independent non-profit organization widely recognized as the authority on quality for health care organizations, including health plans and provider organizations ("**Healthcare Organizations**"), and NCQA has established the Healthcare Effectiveness Data and Information Set ("**HEDIS®**") to measure performance of Healthcare Organizations;

WHEREAS, NCQA has established a standardized methodology to audit HEDIS or performance measure data collected by Healthcare Organizations; and

WHEREAS, NCQA desires to permit Licensee to perform NCQA HEDIS Compliance Audits™ ("**HEDIS Audits**") pursuant to this Agreement, and Licensee desires to become a NCQA-Licensed HEDIS Compliance Audit organization;

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

1. **Grant of Rights**. NCQA hereby grants to Licensee a non-exclusive right to perform HEDIS Audits in accordance with *Volume 5, HEDIS® Compliance Audit Standards Policies and Procedures* (the "**Audit Standards**"), using only the most recent editions of those documents in effect as of the date each HEDIS audit is performed. Additionally, Licensee may use *Volume 2, HEDIS® Technical Specifications for Health Plans* ("**Volume 2**") for the sole purpose of assisting the Licensee in conducting HEDIS Audits. Licensee may not distribute or copy Volume 2 or Volume 5. Use of Volume 2 or Volume 5 in any other print or electronic publication, service, software or product by the Licensee shall require a separate license with NCQA. Licensee shall not sublicense, assign or otherwise transfer any of its rights and obligations under this Agreement, including but not limited to Certified Auditors (defined in Section 7), without NCQA's prior written consent.

2. **Term**. This Agreement shall be effective upon the Effective Date and shall continue for one (1) year following the Effective Date (the "**Initial Term**"), unless terminated earlier under the terms of Section 14. This Agreement shall automatically renew for successive one-year terms (each a "**Renewal Term**") unless either Party provides notice of intent not to renew not less than sixty (60) days prior to the end of the Initial Term or then-current Renewal Term.

3. **License Fees**. Licensee agrees to pay the fees calculated according to NCQA's current Pricing Policy and Fee Schedule as published in the *NCQA HEDIS Compliance Audit Licensure Handbook* (the "**Handbook**"). Licensee agrees to not include any fee in its contracts with customers or clients that is designated as a fee from NCQA or to otherwise create the impression that Licensee is passing through to a customer or client any NCQA fees for related to this Agreement. All preprinted terms included on a purchase order, invoice, or other instrument issued by a Licensee as part of payment remittance shall neither be binding on NCQA nor deemed to modify this Agreement and are expressly rejected by NCQA.

4. **Audit Standards**. HEDIS Audits performed by Licensee must be done in compliance with the Audit Standards. NCQA may amend or generate a new edition of the Audit Standards at any time but will give Licensee at least thirty days' notice prior to the effective date of any such amendment or new edition.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Licensee shall not use, copy or distribute the Audit Standards in any way that violates NCQA's copyright. Licensee's failure to comply with the procedures and standards set forth in the Audit Standards may result in termination of this Agreement.

5. **Audit Opinions**. Licensee must issue a HEDIS Audit opinion to any Healthcare Organization for which it contracts to perform a HEDIS Audit within thirty days of completion of the HEDIS Audit. Licensee shall provide NCQA a copy of any HEDIS Audit opinion it issues within forty-eight hours of issuance.

6. **Insurance**. During the term of this Agreement, Licensee shall maintain professional liability insurance from a reputable carrier in an amount at least equal to Five Million Dollars ($5,000,000) and covering each NCQA-Certified HEDIS Compliance Auditor ("**Certified Auditor**") employed by or with whom Licensee contracts. Each year, Licensee shall provide NCQA with evidence of such insurance coverage and will notify NCQA of any change in such insurance coverage. Alternatively, if the Licensee wishes to self-insure, each year, Licensee must provide evidence to NCQA that they maintain adequate financial reserves to cover any potential liability exposure equal to Ten Million Dollars ($10,000,000). The Licensee agrees to notify NCQA of any changes to these reserves that would affect its ability to cover such losses.

7. **Certified Auditors**. Licensee will employ or contract with at least two Certified Auditors to perform HEDIS Audits pursuant to this Agreement. Licensee must verify with NCQA the certified status of any Certified Auditor before such Certified Auditor performs any HEDIS Audits for Licensee. A Certified Auditor must serve as the HEDIS Audit team leader and must be onsite during any HEDIS Audit performed by Licensee. Licensee shall notify NCQA in writing within seven days of Licensee's termination of employment or contract with any Certified Auditor.

8. **Licensure Handbook and Code of Professional Conduct**. Licensee acknowledges having reviewed the Handbook which includes the Code of Professional Conduct for NCQA-Licensed Organizations ("**Code of Conduct**") and agrees to abide by and be bound by all procedures and requirements contained therein. Licensee's failure to comply with the Handbook and Code of Conduct may result in immediate termination of this Agreement. Licensee also agrees to enforce the Code of Professional Conduct for Certified Auditors as set forth in the Handbook with respect to each Certified Auditor that Licensee employs or with whom Licensee contracts to conduct HEDIS Audits. NCQA retains the right to amend the Handbook and any other HEDIS audit program policies at its sole discretion and with thirty days' notice to Licensee. The Licensee and its employed or contracted Certified Auditors must review and comply with any modifications made to the Handbook and Code of Conduct, including any changes to the Pricing Policy and Fee Schedule as described in Section 3.

9. **Scheduling and Performance Monitoring**. Within 14 days' of NCQA's written request, Licensee must report to NCQA a complete and current list of all HEDIS Audits and/or performance measures for all Healthcare Organizations' product lines, including those for which the audited entity is not reporting HEDIS or performance measures to the NCQA data warehouse and which have a different annual submission date. NCQA may periodically monitor Licensee's performance and the performance of Certified Auditors under this Agreement retroactively and contemporaneously. NCQA's audit may include, but is not limited to, review of Licensee's audit procedures and audit results, review of Licensee's HEDIS audit work papers and/or assessment of Licensee's onsite HEDIS Audit performance. NCQA may also periodically conduct satisfaction surveys of Healthcare Organizations that have been audited by Licensee. Licensee agrees to cooperate with NCQA's audits and performance assessments and to notify any Healthcare Organization that Licensee contracts with to perform a HEDIS Audit that an NCQA representative may accompany Licensee's audit team and/or review Licensee's HEDIS audit work papers. Through the course of this performance monitoring activity, NCQA may identify areas of the Licensee's practice that are out of compliance with NCQA's Audit Standards. In these instances, Licensee agrees to take corrective actions as prescribed by

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

NCQA. Licensee also agrees to maintain all HEDIS audit records, reports and work papers for seven years after completion of a HEDIS audit and to make such records available free of charge to NCQA upon request.

10. **Grievance Procedure**. Licensee shall investigate and respond in a timely manner (not to exceed fourteen days from the filing of a complaint) to any complaint filed by a Healthcare Organization about the conduct or actions of a Certified Auditor employed by Licensee or with whom Licensee contracts to perform HEDIS Audits. Licensee must notify NCQA's Assistant Vice President of Measure Validation in writing of the substance of any complaint filed against a Certified Auditor within two business days and must also keep NCQA informed of the progress of a grievance investigation and notify NCQA of the results of Licensee's investigation and the nature of any corrective action. NCQA may investigate any complaints filed with NCQA regarding the actions of Licensee. Licensee agrees to cooperate fully in any such investigation by NCQA and to institute corrective actions deemed necessary by NCQA as a result of any such investigation. A valid, substantiated complaint may result in NCQA's immediate termination of this Agreement.

11. **Audit Appeals**. Licensee shall maintain an appeal process, acceptable to NCQA, which affords a Healthcare Organization the opportunity to appeal a HEDIS Audit determination issued by Licensee. Licensee must inform Healthcare Organizations that any changes in rates resulting from an appeal may not be eligible for resubmission to NCQA for inclusion in NCQA's reporting products or accreditation due to publication timelines and other submission deadlines set by third party stakeholders, including the Centers for Medicare and Medicaid Services. Appeals must be conducted within fourteen days of the filing of a request for appeal by a Healthcare Organization. Licensee must submit its written appeal process to NCQA's Assistant Vice President of Measure Validation for approval prior to execution of this Agreement. Licensee must conduct all appeals in compliance with the appeal process approved by NCQA. Any changes to such appeal process must also be approved in advance by NCQA. Licensee must keep NCQA informed of the progress of an appeal and notify NCQA of the outcome of any appeal and change in audit determination for a Healthcare Organization. Licensee's failure to follow the appeal process approved by NCQA shall be a material breach of this Agreement.

12. **Advertising Guidelines**. Licensee acknowledges that it may advertise or market its status a NCQA-Licensed HEDIS Compliance Audit organization only if it is current and valid. Licensee will not engage in advertising that features competitive comparisons with other NCQA-Licensed HEDIS Compliance Audit organizations. Licensee may not release all or any part of any monitoring reports to any third party. The Licensee further agrees that its failure to comply with such advertising guidelines, as revised by NCQA from time to time, may result in termination of this Agreement. All marketing materials must follow NCQA's General Marketing Guidelines as described on the NCQA Web page (www.ncqa.org/marketing.aspx) and/or Handbook.

13. **Confidentiality**. Except as otherwise provided in this Agreement, Licensee agrees to keep confidential and not disclose to any third party (including other clients) any information obtained by Licensee from a Healthcare Organization during a HEDIS Audit. Licensee further agrees to protect the privacy of any medical records or other patient identifiable information that Licensee may have access to during a HEDIS Audit in accordance with state and federal laws, rules and regulations, including the privacy and security requirements of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Licensee shall not release such confidential information, except (i) on prior written authorization from the Healthcare Organization; (ii) as otherwise required by law, rule or regulation; or (iii) in the event of fraud, falsification or manipulation of HEDIS or performance measure data by a Healthcare Organization, which fraud, falsification or manipulation shall be reported to NCQA by Licensee. Licensee further agrees to keep confidential any proprietary information about the business of NCQA obtained as a result of this Agreement. NCQA agrees to keep confidential any proprietary information about Licensee or Licensee's business that NCQA has access to as a result of this Agreement and any oversight activities NCQA performs of Licensee's audit practices, unless 1) a regulator or legal authority requests such

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

information as part of an investigation or review of Licensee's performance or a health plan's performance; 2) such information is relevant to the resolution of a legal dispute between the parties and the information is disclosed as part of the legal proceedings; or 3) NCQA is legally required to disclose such information in a court of law or other legal proceeding. In the event of requested disclosure under 1) and 3) above, NCQA shall give Licensee prior notice of any disclosure, and Licensee shall have an opportunity to take steps to protect the confidentiality of such proprietary information; but such actions shall not prevent NCQA from complying with the disclosure request.

14. **Termination of Agreement**. NCQA shall have the right to terminate this Agreement effective immediately in the event of a material breach of the terms of this Agreement by Licensee, provided NCQA has given Licensee written notice of the alleged breach and Licensee has failed to cure such breach within fourteen days after receipt of notice of breach. This includes failure to take corrective actions prescribed by NCQA as a result of monitoring activities. Licensee acknowledges that NCQA has relied upon the representations made by Licensee in the application materials submitted to NCQA, and the Licensee's compliance with the Code of Conduct. In the event such application materials contain false or misleading information, or the Code of Conduct is violated, NCQA shall have the right to immediately terminate this Agreement. NCQA may also terminate this Agreement for any reason upon 60 days' written notice. Upon termination of this Agreement, Licensee shall immediately cease holding itself out as an NCQA-Licensed HEDIS Compliance Audit organization and shall immediately return to NCQA any seal or other materials issued to Licensee by NCQA. Sections 13, 16, 17 and 20(B) shall survive termination of this Agreement.

15. **Warranties**. Licensee warrants that it will perform HEDIS Audits in a professional and workmanlike manner consistent with industry standards reasonably applicable to the performance of data audits and in accordance with the procedures and standards set forth in the Audit Standards. NCQA warrants that Licensee's use of the procedures and standards set forth in the Audit Standards will not infringe any copyright or other proprietary right of a third party.

16. **Indemnities**. Licensee shall indemnify, defend and hold NCQA harmless from any claim, suit, loss, damage, judgment, liability, or expense (including reasonable attorneys' fees) arising out of the performance of any HEDIS Audit by Licensee, its Certified Auditors, employees or contractors and the issuance of any HEDIS Audit opinion by Licensee, its employees or contractors.

17. **Limitation of Liability**. EXCEPT AS RELATED TO LICENSEE'S INDEMNIFICATON RESPONSIBIILTIES THE LIABILITY OF EITHER PARTY TO THE OTHER PARTY ARISING UNDER THIS AGREEMENT WHETHER IN CONTRACT, TORT, OR OTHERWISE SHALL BE LIMITED TO ACTUAL AND DIRECT DAMAGES. NEITHER PARTY SHALL HAVE ANY LIABILITY FOR ANY INCIDENTAL, SPECIAL, CONSEQUENTIAL OR OTHER INDIRECT DAMAGES ARISING UNDER OR RELATED TO THIS AGREEMENT, WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

18. **Licensee's Contract Provisions**. Licensee agrees to include the following provision in any contract with any organization to perform a HEDIS Audit:

    "[Organization] acknowledges that the National Committee for Quality Assurance ("NCQA") licenses independent organizations to audit HEDIS or performance measure data. Any audit opinion issued by an NCQA-licensed HEDIS audit organization is solely the opinion of the licensed organization and is not the opinion of NCQA. Organization agrees that it will not seek damages or otherwise seek to hold NCQA liable in any manner for any actions of a licensed HEDIS audit organization, the issuance of any audit opinion or the use of any audit opinion in connection with the Organization's business. Organization further agrees to comply with NCQA's *Advertising Guidelines* as described on the NCQA Web page http://www.ncqa.org/marketing.aspx as the same may be amended by NCQA from time to time."

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

19. **Prohibition on Pass-Through Fees**. Licensee agrees not to include in its contract to perform a HEDIS Audit for a Healthcare Organization any fee that is designated as a fee from NCQA, or to otherwise pass through or create the impression that it is passing through to the Healthcare Organization any NCQA fees.

20. **Miscellaneous**.

A. Entirety of Agreement. This Agreement contains a complete statement of all the arrangements between the Parties with respect to its subject matter and supersedes all prior agreements. This Agreement may not be amended, altered, modified or otherwise changed in any respect except in writing signed by both of the Parties. The Parties affirm that they are acting on behalf of, and that this Agreement shall bind and benefit, the Parties and their respective successors, subsidiaries and affiliates.

B. Governing Law and Jurisdiction. This Agreement will be governed by and construed in accordance with the laws of the District of Columbia, without reference to conflicts of law provisions, and any disputes related to this Agreement shall be resolved in a court of competent jurisdiction within the District of Columbia.

C. Severability. If any term of this Agreement is held to be inconsistent with any present or future law, ruling, or regulation of any court or authority having jurisdiction over the subject matter of this Agreement, such term shall be deemed to be rescinded or modified to the minimum extent necessary to comply with such law, ruling or regulation, and the remainder of this Agreement shall not be affected thereby.

D. No Waiver. The failure of a Party to insist upon strict adherence to any term of this Agreement on any occasion will not be considered a waiver or deprive or limit that Party of the right thereafter to insist upon strict adherence to that term in the particular instance or that term or any other term of this Agreement in any instance. Any waiver must be in writing.

E. Relationship of the Parties. The Parties have entered into this Agreement as independent contractors only, and nothing contained in this Agreement places or shall be construed to place the Parties in the relationship of legal representation, employer-employee, partners, joint venturers, or agency, and neither Party will have the power or authority to obligate or bind the other Party in any manner.

F. Notices. Any notice or other communications under this Agreement must be in writing and will be considered given when delivered personally or by certified mail, return receipt requested, or by reputable courier, to the Parties at the following addresses (or at such other address as a Party may specify by notice to the other):

NCQA:	1100 13th Street, NW Washington, DC 20005
Attention:	Assistant Vice President, Measure Collection and Audit
Copy:	Office of General Counsel
Licensee:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016
Attention:	Mary Ellen Dalton, PhD, MBA, RN Chief Executive Officer

5

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

G. HIPAA. NCQA and Licensee must sign and agree to the HIPAA Confidentiality Agreement addendum to this Agreement that provides applicable HIPAA privacy and security requirements.

H. Authorization to Execute. The undersigned represent that they are authorized to sign this Agreement on behalf of the Parties hereto, and that each part is authorized, empowered and able to enter into and fully perform all obligations under this Agreement.

I. Counterparts. This Agreement may be executed in two counterparts, and each counterpart shall constitute an original instrument, but both of which shall constitute one agreement.

IN WITNESS WHEREOF, the Parties' duly authorized representatives have signed duplicate originals of this Agreement effective on the date first set forth above.

National Committee for Quality Assurance

By: _____

Title: Chief Operating Officer

Date: September 7, 2021

Licensee

By: Mary Ellen Dalton

Title: Chief Executive Officer

Date: 9/7/2021

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

ADDENDUM TO NCQA HEDIS® COMPLIANCE AUDIT™
LICENSE AGREEMENT

HIPAA CONFIDENTIALITY AGREEMENT

In accordance with Section 20 (G) of the License Agreement (the "**Agreement**"), this Addendum incorporates the following HIPAA Confidentiality Agreement between NCQA and the Licensee:

WHEREAS, Licensee provides certain services to a "Covered Entity," as defined at 45 CFR §160.103, pursuant to which the Covered Entity may disclose to Licensee certain Protected Health Information (or "**PHI**" as defined in 45 C.F.R. §160.103) in the role of a "Business Associate" (as defined at 45 CFR §160.103) that is subject to protection under the Federal Privacy, Security, Breach Notification, and Enforcement Rules established at 45 C.F.R. Parts 160 and 164, as amended from time to time (collectively the "**HIPAA Rules**"), promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), and the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 ("**ARRA**");

WHEREAS, the HIPAA Rules dictate that Licensee, in its role as a Business Associate, shall enter into an agreement with any agent to whom it provides PHI who shall agree to the same restrictions and conditions that apply to the Business Associate as required by the HIPAA Rules; and

WHEREAS, NCQA will have access to PHI of the Covered Entity for purposes of the Agreement, and this Addendum shall apply to that PHI; and

WHEREAS, the purpose of this Addendum is to satisfy certain standards and requirements of the HIPAA Rules, as the same may be amended from time to time.

NOW THEREFORE, in consideration of the mutual promises below, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

I. GENERAL PROVISIONS

Section 1. **Definitions**. Unless otherwise specified in the Agreement or this Addendum, all capitalized terms used herein and not otherwise defined shall have the meanings established by 45 C.F.R. Parts 160 and 164, as amended from time to time. "PHI" shall mean Protected Health Information, as defined in 45 C.F.R. §160.103, limited to the information received from or on behalf of Licensee. "Electronic PHI" shall mean Electronic Protected Health Information, as defined in 45 C.F.R. §160.103, limited to the information received from or on behalf of Licensee. The terms "use" and "disclosure" and any and all other terms with defined meanings established by 45 C.F.R. Parts 160 and 164, as amended from time to time, shall have the same meaning for the purpose of this Agreement.

Section 2. **Effect**. This Addendum shall apply to any PHI subject to the Agreement and to any PHI viewed or provided by Licensee in the process of conducting a HEDIS Compliance Audit. Any provision of the Agreement, including all exhibits or other attachments thereto and all documents incorporated therein by reference, that is directly contradictory to one or more terms of this Addendum ("**Contradictory Term**"), shall be superseded by the terms of this Addendum to the extent and only to the extent of the contradiction and only to the extent that it is reasonably impossible to comply with both the Contradictory Term and the terms of this Addendum. Notwithstanding anything in this Addendum to the contrary, nothing in this Addendum shall alter the rights and obligations of the respective parties under the HIPAA Rules.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

II. RESPONSIBILITIES OF NCQA

Section 1. **Use and Disclosure of Protected Health Information.**

(a) NCQA may use and/or disclose PHI only as permitted or required by the Agreement, this Addendum, or as Required by Law, and in compliance with each applicable requirement of 45 CFR §164.504(e).

(b) NCQA may use the PHI in its possession for its proper management and administration or to fulfill any legal responsibilities of NCQA.

(c) NCQA may disclose PHI in its possession to a third party for the purpose of NCQA's proper management and administration or to fulfill any legal responsibilities of NCQA, if the disclosures are Required by Law and NCQA has received from the third party written assurances that (i) the information will be held confidentially and be used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the third party, and (ii) the third party will notify NCQA (and, in accordance with Article II, Section 3 of this Agreement, NCQA shall notify Licensee) of any instances of which it becomes aware in which the confidentiality of the information has been breached;

(d) NCQA may de-identify PHI obtained under this Addendum or under the Agreement, and use and/or disclose such de-identified data on NCQA's own behalf in accordance with the de-identification requirements of the HIPAA Rules;

(e) Within fifteen calendar days of receiving a written request from Licensee, NCQA will make available to Licensee information necessary for Licensee to make an Accounting of Disclosures of PHI about an Individual in accordance with 45 C.F.R. §164.528 and, in accordance with the requirements for Accounting for Disclosures made through an Electronic Health Record in 42 U.S.C. 17935(c), and if and when directed by Licensee, NCQA shall make that accounting directly to the Individual.

(f) NCQA with forward to Licensee within five business days of receiving any requests an Individual makes of NCQA pursuant to 45 C.F.R. §§ 164.524 or 164.526, so that Licensee or Covered Entity may respond to such requests. NCQA shall not respond directly to those Individual Requests.

(g) NCQA shall request, use and/or disclose the minimum amount of PHI necessary with regard to its use and/or disclosure of PHI under this Section 1. NCQA shall not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity. All other uses and disclosures of PHI not authorized by this Addendum or the Agreement are prohibited.

(h) NCQA will make available its internal practices, books, and records relating to the use and disclosure of PHI to the Secretary of the Department of Health and Human Services ("HHS") in accordance with the HIPAA Rules.

(i) NCQA acknowledges that it may be subject to the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the use and disclosure requirements and any guidance issued by the Secretary from time to time.

Section 2. **Appropriate Safeguards.** NCQA will use appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI, other than as provided for by the Agreement, this Addendum, or as Required by Law, in accordance with the requirements set forth in 45 C.F.R. Part 164, including implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

NCQA will also keep current and document such security measures in written policies, procedures or guidelines, and make its policies and procedures, and documentation relating to such safeguards, available to the Secretary in accordance with the HIPAA Rules.

Section 3. **Reporting of Improper Use or Disclosure of PHI.** NCQA will within ten business days of becoming aware of any use or disclosure of PHI not permitted or required by the Agreement or this Addendum, or of any Security Incident with respect to Electronic PHI of which it becomes aware, report such use, disclosure, Security Incident to Licensee. NCQA agrees to mitigate, to the extent practicable, any harmful effect that is known to NCQA of a use or disclosure of PHI by NCQA in violation of the requirements of this Agreement. NCQA further agrees to report without unreasonable delay, and in no case later than thirty calendar days after discovery, any Breach of any Unsecured PHI in accordance with the security breach notification requirements set forth in 45 C.F.R. §§ 164.400, 164.402, and 164.410 and any guidance issued by the Secretary from time to time.

Section 4. **Subcontractors and Agents.** NCQA agrees that any time PHI is provided or made available to its subcontractors or agents, NCQA will enter into an agreement with the subcontractor or agent that contains the same conditions and restrictions on the use and disclosure of PHI as contained in the Agreement and this Addendum, in accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, and will ensure that all of its subcontractors and agents to whom it provides Electronic PHI agree to implement reasonable and appropriate safeguards to protect such Electronic PHI.

Section 5. **Exchange of PHI and Communications.** NCQA agrees to the following:

(a) NCQA shall not directly or indirectly receive remuneration in exchange for any PHI in compliance with 45 C.F.R. §§ 164.502(a) (5), 164.504(e)(2)(i), and 164.508(a).

(b) NCQA shall not make or cause to be made any communication about a product or service that is prohibited by45. C.F.R. §§ 164.502(a)(5), 164.504(e)(2)(i), and 164.508(a).

(c) NCQA shall not make or cause to be made any written fundraising communication that is prohibited by 45 C.F.R. § 164.514(f).

III. OBLIGATIONS OF LICENSEE

Section 1. **Compliance with HIPAA and ARRA.** Licensee in performing its obligations and exercising its rights under this Addendum shall use and disclose PHI in compliance with the HIPAA Rules and ARRA, as applicable. Licensee agrees that it will not provide to NCQA PHI unless expressly requested by NCQA in the fulfillment of the Agreement.

IV. TERMINATION OF AGREEMENT

Section 1. **Termination of Agreement by Licensee.** Upon Licensee's knowledge of a breach of a material term of this Addendum by NCQA, Licensee shall provide NCQA with written notice of that breach in sufficient detail to enable NCQA to understand the specific nature of that breach and afford NCQA the opportunity to cure the breach; provided, however, that if NCQA fails to cure the breach within a reasonable time specified by Licensee, Licensee may terminate this Addendum. Upon termination of this Addendum under this Section, NCQA will comply with the return or destruction provisions of Article IV, Section 3 below, and Licensee may terminate the Agreement, unless the parties mutually agree that NCQA may review Licensee pursuant to the Agreement using only a Limited Data Set, or with information that has been de-identified, where such actions are permitted or authorized by Licensee's Covered Entity customer.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Section 2. **Termination of Agreement by NCQA.** Upon NCQA's knowledge of a breach of a material term of this Addendum by Licensee, NCQA shall provide Licensee with written notice of that breach in sufficient detail to enable Licensee to understand the specific nature of that breach and afford Licensee the opportunity to cure the breach; provided, however, that if Licensee fails to cure the breach within a reasonable time specified by NCQA, NCQA may terminate this Addendum as well as terminate the Agreement.

Section 3. **Return or Destruction of PHI.** Within thirty calendar days after termination or expiration of the Agreement or this Addendum, NCQA agrees to either return to Licensee or destroy all PHI received from the Licensee or created or received by NCQA on behalf of the Licensee and which NCQA still maintains in any form, including such information in possession of NCQA's subcontractors. NCQA agrees not to retain any copies of such PHI. If return or destruction of the PHI is not feasible, NCQA agrees to extend the protections, limitations and restrictions of this Addendum to NCQA's use and disclosure of PHI retained after termination and to limit any further uses or disclosures to the purposes that make return or destruction infeasible. Any de-identified information retained by NCQA shall not be re-identified except for a purpose permitted under this Addendum.

V. LIMITATION OF LIABILITY

Section 1. **Hold Harmless.** Each party agrees to hold harmless the other party to this Addendum from and against any and all claims, losses, liabilities, costs and other expenses (including reasonable attorney fees and costs associated with any suits, actions, proceedings, claims, or official investigations or inquiries) incurred as a result of: (i) any misrepresentation or non-fulfillment of any undertaking on the part of the party pursuant to this Addendum; and (ii) negligent or intentional acts or omissions in the party's performance under this Addendum. In no event will a party be responsible for any damages, caused by the failure of the other party to perform its responsibilities. If Covered Entity is an institution of a state government, this Article V shall apply only to the extent permitted under applicable state law, and nothing herein shall be deemed an express or implied waiver of sovereign immunity.

Section 2. **Damages.** NO PARTY SHALL BE LIABLE TO ANOTHER PARTY HERETO FOR ANY INCIDENTAL, CONSEQUENTIAL, SPECIAL, OR PUNITIVE DAMAGES OF ANY KIND OR NATURE RELATING TO OR ARISING FROM THE PERFORMANCE OR BREACH OF OBLIGATIONS SET FORTH IN THIS ADDENDUM, WHETHER SUCH LIABILITY IS ASSERTED ON THE BASIS OF CONTRACT, TORT (INCLUDING NEGLIGENCE OR STRICT LIABILITY), OR OTHERWISE, EVEN IF THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH LOSS OR DAMAGES.

VI. MISCELLANEOUS

Section 1. **Choice of Law and Jurisdiction.** The laws of the District of Columbia shall govern this Addendum. The parties agree that any suit or litigation arising under this Addendum shall only be resolved in a court of competent jurisdiction in the District of Columbia. Notwithstanding the foregoing, this choice of law and venue provision shall not apply if Licensee is an institution of a state government and afforded sovereign immunity under applicable state law.

Section 2. **Change in Law; Amendment to Agreement.** The parties agree to negotiate to amend this Addendum as necessary to comply with any amendment to any provision of HIPAA, ARRA, their implementing regulations or other applicable laws or regulations that materially alters either party or both parties' obligations under this Addendum. The parties agree to negotiate in good faith mutually acceptable and appropriate amendment(s) to this Addendum to give effect to such revised obligations. If the parties are unable to agree to mutually acceptable amendment(s) within sixty calendar days of the relevant change in law or regulations, either party may terminate this Addendum and the Agreement consistent with the terms of this Addendum and the Agreement.

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Section 3. **Third Party Beneficiaries.** Nothing in this Addendum shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

Section 4. **Survival.** Articles I and II; Article IV, Section 3; Articles V, and VI shall survive termination of this Addendum. The last sentence of Article IV, Section 1 shall survive termination of this Addendum with regard to any de-identified information that NCQA creates using Licensee's PHI.

Section 5. **Notice.** Any notice, consent, request or waiver, or other communications to be given hereunder by either party shall be given in writing and will be deemed to have been given when delivered personally or by registered mail, postage prepaid and return receipt requested or by facsimile with a confirming copy placed in the United States mail addressed as provided in Section 19 (F) of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum to be effective as of the date first above written.

For Licensee: Health Services Advisory Group, Inc.

By: Mary Ellen Dalton
Print Name: Mary Ellen Dalton, PhD, MBA, RN
Title: Chief Executive Officer
Date: 9/7/2021

For National Committee for Quality Assurance

By:
Print Name: Tom Fluegel
Title: Chief Operating Officer
Date: September 7, 2021

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

Appendix 8: NCQA HEDIS CAHPS Survey Vendor Certificate

DocuSign Envelope ID: A80C2634-0C49-4832-8985-D3C32C58D1FA

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

recognizes

Health Services Advisory Group, Inc. (HSAG)

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

CERTIFIED NCQA HEDIS® SURVEY VENDOR 2022

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2021
DATE GRANTED

October 31, 2022
EXPIRATION DATE

Docusign Envelope ID: D24F8ECB-7FDA-4667-A98B-94520A097B6B

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 1

LAGOV#: 2000773152

LDH #:

Agency Name... Bureau of Health Services Financing

(Regional/ Program/ Facility)

Original Contract Amount $6,782,194.00

AND

Original Contract Begin Date 03/01/2023

Health Services Advisory Group (HSAG)

Contractor Name

Original Contract End Date 02/28/2026

RFP Number: 3000017943

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $6,782,194.00 Current Contract Term: 02/28/2026

Statement of Work Approved

Change Contract To: To Maximum Amount: $6,782,194.00 Changed Contract Term: 02/28/2026

Statement of Work Submitted

Justifications for amendment:

Before the Centers for Medicare and Medicaid Services can approve the EQRO contract, in accordance with 42 CFR 438.370, specific points within the Statement of Work need to be in compliance with federal regulations and laws.

This Amendment Becomes Effective: 7/15/2024

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

Health Services Advisory Group, Inc.

Mary Ellen Dalton 10/23/2024

CONTRACTOR SIGNATURE DATE

PRINT NAME: Mary Ellen Dalton, **PHD MBA, RN**

CONTRACTOR TITLE: Chief Executive Officer

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

DocuSigned by: Kimberly Sullivan 6F18D2F07367420...

SIGNATURE DATE 10/24/2024

NAME: Kimberly Sullivan, JD

TITLE: Medicaid Executive Director

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

Bureau of Health Services Financing

Scope of Work

For

External Quality Review Organization (EQRO)

Health Services Advisory Group, Inc. (HSAG)

RFP #: 3000017943
PO# 2000773152

GLOSSARY AND ACRONYMS

Glossary

Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in payment for services that are not medically necessary, or that fail to meet professionally recognized standards for health care.
Addendum	A modification issued by LDH to modify the original solicitation document.
Agency	Any department, commission, council, board, office, bureau, committee, institution, agency, government, corporation, or other establishment of the executive branch of this State authorized to participate in any Contract resulting from this solicitation.
Agent	An entity or individual that Contracts with LDH or the EQRO to perform administrative functions, including but not limited to, fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.
Breach	The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule, which compromises the security, or privacy of the protected health information.
Bureau of Health Services Financing (BHSF)	The Agency within the Louisiana Department of Health, Office of Management and Finance, that has been designated as Louisiana's single State Medicaid agency to administer the Medicaid and CHIP programs.
Business Day	Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m., unless the context clearly indicates otherwise.
CAHPS	The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of enrollees' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).
Calendar Day	Each of the seven (7) days of the week. Unless otherwise specified, the term "days" in the Contract refers to calendar days/day.
Can	Denotes a preference but not a requirement.
Centers for Medicare and Medicaid Services (CMS)	The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the State Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA).
CFR	Code of Federal Regulations.
CHIP	Children's Health Insurance Program created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as LaCHIP.

Claim	A claim is either: (1) A bill for services, (2) a line item of service, or (3) all services for one enrollee within a bill.
Contract	Written and signed agreement between LDH and the Contractor, which will include, by reference, the RFP, any and all addenda, appendices, attachments, or amendments thereto, and the terms of the Contractor's Proposal.
Contract Execution	When all parties to the Contract have executed the Contract thereby putting its terms and conditions into effect.
Contract Term	The period during which the Contract is in effect.
Contractor	Any person having a contract with a governmental body; the selected Proposer.
Coordinated System of Care (CSoC)	A program designed to help children and youth, from ages 5 through 20, who have significant emotional and/or behavioral health challenges and are in, or at risk of out-of-home placement. It offers services and supports that help these youth return to or remain at home while they are being helped. This name also refers to Louisiana's Contracting Prepaid Inpatient Health Plan (PIHP).
Corrective Action Plan (CAP)	A plan developed by the Contractor that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframes necessary to address and resolve the deficiency. Use of the CAP will be at the discretion of LDH.
Covered Services	Those health care services to which an eligible Medicaid Beneficiary is entitled under the Louisiana Medicaid State Plan.
Deliverable	Anything submitted to LDH by the Contractor to fulfill requirements of the Contract, which include, but is not limited to the following, a document, manual, file, plan, or report.
Department	The Louisiana Department of Health also referred to as LDH throughout this RFP. The State Agency responsible for promoting and protecting health and ensuring access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana.
Disclosure	The release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.
Eligible	An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.
Encounter Data	Healthcare encounter data include: (i) all data captured during the course of a single healthcare encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the enrollee receiving services during the encounter; (ii) the identification of the enrollee receiving and the provider(s) delivering the healthcare services during the single encounter; and, (iii) a unique, i.e. unduplicated, identifier for the single encounter.

Enrollment Broker	The State's contracted or designated agent that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees and enrollees into an MCO.
Evidence-Based Practice	Clinical interventions that have demonstrated positive outcomes based on evidence produced from several research studies designed to assist consumers in achieving their desired goals of health and wellness.
External Quality Review (EQR)	The analysis and evaluation by a Contractor, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their providers furnish to Medicaid beneficiaries.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354, and performs external quality review and other EQR-related activities as set forth in 42 CFR § 438.358, or both.
Fiscal Intermediary (FI)	Designee or agent responsible in the current FI delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.
Fiscal Year (FY):	The budget year - Federal Fiscal Year: October 1 through September 30; State fiscal year: July 1 through June 30.
Fraud	As relates to Medicaid Program Integrity, fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain payment or certification; or claiming payment for services which were never delivered or received.
Full Time	Forty (40) hours per week.
Quality Measure Steward	The measure steward is responsible for making necessary updates to the measure, and for informing the validating entity about any changes made to the measure on an annual basis. In addition, the measure steward is responsible for providing the required measure information during the measure maintenance process.
Health Information	Any information, including genetic information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse, and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care.
Health Plan	An individual or group plan that provides, or pays the cost of, medical care.
HIPAA Privacy Rule	Health Insurance Portability and Accountability Act (HIPAA) federal standards for the privacy of individually identifiable health information, found at 45 CFR Part 164, Subpart E.

HIPAA Security Rule	Health Insurance Portability and Accountability Act (HIPAA) federal standards for the security of individually identifiable health information, found at 45 CFR Part 164, Subpart C.
Immediately	Without delay, but not more than twenty-four (24) hours.
Information Systems (IS)	A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.
Liquidated Damages	Damages that may be assessed whenever the Contractor or its Subcontractors fail to achieve certain performance standards and other required items as detailed in the terms and conditions of the Contract.
Louisiana Children's Health Insurance Program (LaCHIP)	Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides health care coverage for uninsured children up to age 19 through a Medicaid expansion program for children at or below 200% FPL and a separate State CHIP program for the unborn prenatal option and for children with income from 200% up to and including 250% FPL.
Louisiana Department of Health (LDH)	The State Agency responsible for promoting and protecting health and ensuring access to medical, preventive, and rehabilitative services for all citizens in the State of Louisiana.
Louisiana Medicaid State Plan	The binding written agreement between Louisiana's Department of Health and CMS that describes how the Medicaid program is administered and determines the services for which LDH will receive federal financial participation.
Managed Care Entity (MCE)	Denotes either a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, or primary care case management that has, or is seeking to qualify for, a comprehensive risk Contract that meets the requirements of 42 CFR § 438.2.
Managed Care Organization (MCO)	An entity that has, or is seeking to qualify for, a comprehensive risk Contract that meets the requirements of 42 CFR §438.2.
Managed Care Program	Louisiana Medicaid program providing Medicaid covered services to enrollees through select MCOs with the goal of effectively utilizing resources to promote the health and well-being of Louisianans in LDH's Medicaid Managed Care Program.
May / Can	The terms "may" and "can" denote an advisory or permissible action(s).
Measurable	Applies to a Contractor objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.
Measurement Year	The timeframe during which health care services are provided. For example, for most HEDIS® measures, the previous calendar year is the standard measurement year. The health care quality measure steward defines the measurement year (or period) in the technical specifications for each measure.

Medicaid	A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying healthcare providers for serving covered individuals.
Medicaid Beneficiary	An individual who has been determined eligible, pursuant to federal and State law, to receive medical care, goods, or services for which LDH may make payments under the Medicaid or LaCHIP programs.
Medicaid Managed Care Plan	Denotes either a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, or primary care case management as defined in this Glossary.
Medicaid Recipient	An individual who has been determined eligible, pursuant to federal and State law, to receive medical care, goods or services for which LDH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.
Medical Record	A single complete record kept at the site of the enrollee's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical health care services whether provided by the MCO, its Subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible, and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR § 456.111 and § 456.211.
Member	A Medicaid enrollee.
Monetary Penalty	Financial assessment that may be enforced whenever a Contractor and/or its Subcontractors fail to meet the requirements of this Contract.
Must	The term “must” denotes a requirement(s).
Network	As utilized in the RFP, “network” may be defined as a group of participating providers linked through provider agreements or Contracts with the MCEs to supply a range of medical services. Also called a provider network.
Network Adequacy	A network of providers for the managed care entities that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to enrollees without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.
Original Signature	Denotes that a document must be signed in ink.
Performance Improvement Projects (PIP)	Projects designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care, and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.

Performance Measures	Criteria that quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.
Plan	An individual or group that provides, or pays the cost of, medical care.
Policies	The general principles, which guide decisions and outcomes; high-level overall plans embracing general goals and acceptable procedure. As used herein in reference to LDH, policies are the general principles by which LDH is guided in its management of the Title XIX program.
Prepaid Ambulatory Health Plan (PAHP)	An entity Contracting with the State that meets the requirements contained in 42 CFR § 438.2.
Prepaid Inpatient Health Plan (PIHP)	An entity Contracting with the State that meets the requirements contained in 42 CFR § 438.2.
Proposer	A firm or individual who responds to this RFP.
Protected Health Information (PHI)	Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Provider	Any Medicaid service provider contracted with a Health Plan and/or enrolled in the Medicaid Program.
Provider Directory	A listing of health care service providers within the Contractor's provider network that is prepared by the MCO as a reference tool to assist enrollees in locating providers that are available to provide services.
Quality	The degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.
Quality Companion Guide	Written instructional document for performance improvement projects, performance measure specifications and validation processes.
Quality Strategy	Establishes a planned, systematic, organization wide approach to ongoing Quality Improvement processes to continually improve and monitor Medicaid/Children's Health Insurance Program (CHIP) care and services.
Readiness Review	Assessment prior to implementation of the MCE's ability to fulfill the RFP requirements. Such review may include, but is not be limited to, the review of proper licensure, operational protocols, review of MCE standards, and review of systems. The review may be done as a desk review, on-site review, or combination of both and may include interviews with pertinent personnel so that LDH can make an informed assessment of the MCE's ability and readiness to render services.
Redacted Proposal	The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes.
Relationship	Relationship is described as follows for the purposes of any business affiliations discussed in Section 5: A director, officer, or partner of the Contractor; a person with beneficial ownership of five percent or more of the Contractor's equity; or a person with an employment, consulting, or

	other arrangement (e.g., providers) with the Contractor's obligations under its Contract with the State.
Reliability	The internal consistency of a study instrument, and the reproducibility of study results when the survey or intervention is administered under different conditions (*e.g.*, by different people, or at different times).
Representative	Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative or AR.
Request for Proposals (RFP)	As it relates to the EQRO, the process by which LDH invites proposals from interested parties for the procurement of specified services.
Sample	A subset selected from a population.
Secure File Transfer Protocol (SFTP)	Software protocol for transferring data files from one computer to another with added encryption.
Shall / Will	The terms "shall" and "will" denote mandatory requirements.
Should	The term "should" denotes a desirable action.
Significant	As utilized in this RFP, except where specifically defined, shall mean important in effect or meaning.
Social Security Act	The current version of the Social Security Act of 1935 (42 U.S.C. §301 et seq.), which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).
Solvency	The minimum standard of financial health for a Contractor where assets exceed liabilities and timely payment requirements can be met.
Standard	A reference point, generally the ideal, against which other things can be evaluated; the model of authority or excellence.
State	The term "State" shall mean the State of Louisiana and its departments, agencies (including the Using Agency), boards, and commissions as well as their officers, agents, servants, employees, and volunteers.
State Plan	Refers to the Louisiana Medicaid State Plan.
Stratification	The process of partitioning data into distinct or non-overlapping groups.
Subcontractor	A person, agency, or organization with which the Contractor has subcontracted or delegated some of its management functions or other Contractual responsibilities to comply with the terms and provisions of the Contract.
Subsidiary	An affiliate controlled by such person or entity directly or indirectly through one or more intermediaries.
Timely	Existing or taking place within the designated period; within the time required by statue or rules and regulations, Contract terms, or policy requirements.
Title XIX	Title of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid Program.
Title XXI	Title of the Social Security Act of 1935, as amended, that encompasses and governs the Children's Health Insurance Program (CHIP).
Transition Phase	Includes all activities the EQRO is required to perform between the date the Contract is signed by all parties and the operational start date as defined in this RFP.
Transition Plan	Written plan developed by the Contractor, approved by LDH, to be employed during the Transition Phase, which includes all activities the

	Contractor is required to perform in conjunction with the end of the Contract.
Using Agency	The term "Using Agency" shall mean the governmental body of the State (including any authorized users) which is procuring any supplies, services, or major repairs, or any professional, personal, consulting, or social services under this Contract pursuant to the Louisiana Procurement Code, La. R.S. 39:1551-1755.
Utilization	The rate patterns of service usage or types of service occurring within a specified period.
Validation	The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias, and in accord with standards for data collection and analysis.
Variable	A characteristic or condition that changes or has different values for different individuals.
Week	The seven-day week, Monday through Sunday.
Will	Denotes a requirement.

Acronyms

BAFO	Best and Final Offers
BHSF	Bureau of Health Services Financing
CFR	Code of Federal Regulations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAHPS-A	Consumer Assessment of Healthcare Providers and Systems-Health Plan Survey 5.0H, Adult
CAHPS-C	Consumer Assessment of Healthcare Providers and Systems-Health Plan Survey 5.0H, Child
CAP	Corrective Action Plan
CAQH	Council for Affordable Quality Healthcare
CCC	Children with Chronic Conditions
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare and Medicaid Services
CSoC	Coordinated System of Care
CY	Calendar Year
DOA	Division of Administration
EFT	Electronic Funds Transfer
EQR	External Quality Review
EQRO	External Quality Review Organization
FPL	Federal Poverty Level
FTP	File Transfer Protocol
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health
IDSS	Interactive Data Submission System
IS	Information Systems

JLCB	Joint Legislative Committee on the Budget
LaCHIP	Louisiana Children's Health Insurance Program
LDH	Louisiana Department of Health
LDR	Louisiana Department of Revenue
MARS-E	Minimum Acceptable Risk Standards for Exchanges
MCE	Managed Care Entity
MCO	Managed Care Organization
MMIS	Medicaid Managed Information System
NCQA	National Committee for Quality Assurance
NON-CCC	Children with non-chronic conditions
NR	Not Reported
OAAS	Office of Aging and Adult Services
OBH	Office of Behavioral Health
OCDD	Office for Citizens with Developmental Disabilities
OMF	Office of Management and Finance
OPH	Office of Public Health
OS	Office of the Secretary
OSP	Office of State Procurement
OTS	Office of Technology Services
PAHP	Prepaid Ambulatory Health Plan
PDSA	Plan Do Study Act
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PII	Personally Identifiable Information
PIP	Performance Improvement Project
PM	Performance Measure
QRS	Quality Rating System
RFP	Request for Proposals
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
TA	Technical Assistance
USC	United States Code
VPN	Virtual Private Network

PART 6: SCOPE OF WORK

6.1 Scope of Work

The Contractor will be required to perform the EQR activities as outlined in 42 CFR § 438.358 and § 438.360 for the Louisiana Medicaid managed care delivery system. Specifically, the Contractor will be required to: 1) develop evaluation methodologies for the EQR activities; 2) perform data collection and analysis; 3) prepare reports presenting evaluation findings and recommendations; and 4) provide technical assistance to LDH and its contracted MCEs. Contractor will need to complete the deliverables in accordance with the frequencies and expectations specified in this RFP for the State to comply with federal requirements and to assure adequate oversight of Louisiana's Medicaid managed care delivery system.

The Contractor will be responsible for the deliverables as described in Section 6.2, including all preparatory and intervening steps, whether or not LDH has explicitly specified or delineated them within the RFP.

The services to be provided under the resulting Contract include multiple tasks and deliverables that are consistent with applicable federal EQR regulations and protocols for managed care entities such as MCOs, PIHPs and PAHPs. The specifications for deliverables required under the RFP may evolve from year to year in response to program changes. Such modifications would be implemented through an allowable Contract amendment which requires approval by the Office of State Procurement.

The Contractor shall have assigned staff who are, or have a subcontract with a qualified organization that is, designated as a National Committee for Quality Assurance (NCQA) certified Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Auditor.

The Contractor shall have the designation as, or subcontract with a qualified organization that is designated as, an NCQA-certified HEDIS Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Vendor.

6.1.1 The Contractor shall have the following at a minimum:

6.1.1.1 Staff with demonstrated experience, knowledge and/or skills of:

a. Serving Medicaid beneficiaries, handling Medicaid policies, data systems and processes;
b. Managed care delivery systems, organizations, and financing;
c. Quality assessment and improvement methods;
d. Research design and methodology, including statistical analysis; and
e. Practical or clinical health care experience.

6.1.1.2 Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.

6.1.1.3 Other clinical and non-clinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any Subcontractors.

6.1.1.4 The Contractor and its Subcontractors must be independent from the State Medicaid agency and from the MCOs, PIHPs, or PAHPs entities (described in 42 CFR § 438.310(c)(2)) that they review. To qualify as "independent":

6.1.1.4.1 If a State agency, department, university, or other State entity:

a. May not have Medicaid purchasing or managed care licensing authority; and

b. Must be governed by a Board or similar body whose majority of members are not government employees.

6.1.1.4.2 The Contractor **and its subcontractor(s) SHALL ~~MAY~~ NOT**:

6.1.1.4.2.1 Review any managed care entity, or a competitor operating in the State, over which **it** ~~the Contractor~~ exerts control or which exerts control over **it** ~~the Contractor~~ (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through:

a. Stock ownership;
b. Stock options and convertible debentures;
c. Voting trusts;
d. Common management, including interlocking management; and
e. Contractual relationships.

6.1.1.4.2.2 Deliver any health care services to Medicaid beneficiaries;

6.1.1.4.2.3 Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PIHP, or PAHP services, except for the related activities specified in 42 CFR § 438.358;

6.1.1.4.2.4 Review any MCO, PIHP, or PAHP entity for which it is conducting or has conducted an accreditation review within the previous three (3) years; or

6.1.1.4.2.5 Have a present, or known future, direct, or indirect financial relationship with an MCO, PIHP, or PAHP entity that it will review **under the terms of this Contract** ~~as a Contractor~~.

6.2 Deliverables and Performance Standards

The Contractor must perform the external quality review activities as outlined in 42 CFR § 438.358 and 438.360 for the Louisiana Medicaid managed care delivery system.

The federal Centers for Medicare and Medicaid Services (CMS) issued protocols for Contractors to use as guidance when undertaking the mandatory and optional tasks for external quality reviews. Included are protocols for validating performance measures, calculating performance measures, validating performance improvement projects, administering consumer or provider surveys of quality of care, validating consumer and provider surveys, and validating encounter data. The Contractor shall comply with federal rules and CMS protocols.

The Contractor shall produce a monthly activity/status report of all deliverables and services completed for the prior month as well as planned activities for the next month. The report shall include the deliverable, activity performed, status, date completed or timeline to completion and any anticipated project risks or issues. The report shall be submitted to LDH no later than the fifteenth (15^{th}) of each month.

The Contractor shall participate in monthly meetings to review the monthly activity report.

The Contractor shall participate in meetings as needed to address any issues with the deliverables of this Contract.

6.2.1 Performance Evaluation and Improvement

6.2.1.1 HEDIS Performance Measure (PM) Validation

LDH currently uses MCE self-reported, audited HEDIS performance measures as a component of the Quality Strategy to evaluate MCE performance, monitor MCE compliance with LDH's performance standards, meet federal requirements for the mandatory activity of validation of performance measures as specified in 42 CFR § 438.358, and complete a comparative review of quality process and outcome measures based on HEDIS. MCEs employ their own certified HEDIS auditor to complete the data collection and submission of the measures to NCQA and as required in the Medicaid Managed Care Program and Medicaid Managed Care Provider Agreements. The measures must have received a "report" designation from the HEDIS-certified auditor and must be specific to the Medicaid population under evaluation and as specified in the Provider Agreement.

The Contractor must complete the following tasks:

6.2.1.1.1 Review the health plans' final audit reports to identify any potential data collection or reporting issues that may impact the final audited rates;

6.2.1.1.2 Evaluate the reason any self-reported measures received an audit designation of "Not Reported" (NR);

6.2.1.1.3 Based on the review of the final audit reports and any NR designations for reported measures, provide a report summarizing the final audit reports to include documentation of any findings that impact LDH's evaluation of managed care delivery system performance, determination of the managed care delivery system's compliance with minimum performance standards, evaluation of performance related to the award of performance incentives, and recommendations to LDH related to potential corrective actions or quality improvement;

6.2.1.1.4 Develop, maintain, and update LDH's specifications documents for health plans' self-reported, audited results;

6.2.1.1.5 Validate that the HEDIS measures reported by the health plans are consistent with the protocols established by CMS for performance measure validation; and use the results for evaluation of the Louisiana Medicaid Program; and

6.2.1.1.6 Maintain a data repository for the health plans' National Committee for Quality Assurance (NCQA) Interactive Data Submission System (IDSS) self-reported, audited HEDIS results and final audit reports, facilitating access to the files for LDH and provide an industry-standard data exchange mechanism (e.g., secure file transfer protocol (FTP)).

Frequency: Annually **by July 31st or as otherwise specified by LDH**

Deliverable tied to payment: The Contractor must:

1. Produce one (1) final audit review summary report annually for the Louisiana Medicaid Managed Care Program. The report must contain MCE-specific findings.

2. Produce one (1) specifications document annually for the Louisiana Medicaid Managed Care Program delivery system that describes methods for the submission of the MCE self-reported, HEDIS audited data to LDH.

Payment: Each report and specification document shall be compensated at a fixed price.

6.2.1.2 HEDIS Performance Measure Calculation and Reporting

6.2.1.2.1 The Contractor must produce reports using the MCEs' self-reported, audited HEDIS data that include MCE-specific and Statewide results, and national benchmarks, per program, and MCE compliance with performance standards per LDH's specifications and timelines. Report formats will be developed in consultation with, and approved by, LDH.

Frequency: Annually **by July 31st or as otherwise specified by LDH**

Deliverable tied to payment: The Contractor will be responsible for producing one (1) report annually for the Louisiana Medicaid Managed Care Program that contains MCE-specific and Statewide results.

Payment: Each report shall be compensated at a fixed price.

6.2.1.3 Technical Assistance for Health Plan Performance Measures (HEDIS, CAHPS, non- HEDIS and LDH-specific measures)

6.2.1.3.1 The Contractor will assist LDH, as needed, in establishing performance measures and standards for the Louisiana Medicaid Managed Care Program and by making research-driven recommendations based on industry standards and best practices of other states, CMS, and national organizations. The following tasks pertain to the current Louisiana Medicaid Managed Care Program.

6.2.1.3.2 The Contractor shall assist LDH in the identification and selection of performance measures and/or measurement sets that are used to monitor the compliance of health plans with minimum performance standards and/or to award performance incentives to plans that meet LDH specified criteria. LDH has used criteria such as the following when selecting measures:

6.2.1.3.2.1 Are clinically appropriate for the specific population(s) being monitored;

6.2.1.3.2.2 Align with and support the goals of LDH's Quality Strategy;

6.2.1.3.2.3 Produce meaningful and robust results for Louisiana's key areas of focus;

6.2.1.3.2.4 Integrate new measures as industry measurement sets evolve (e.g., CHIPRA, Adult Medicaid Core Set, etc.);

6.2.1.3.2.5 Ensure reliability, availability, standardization, and accuracy of data sources (e.g. claims, vital statistics, etc.) required for calculation of measures; and

6.2.1.3.2.6 May be trended over time to measure changes in performance, comparisons to other Louisiana Medicaid plans, and comparisons with national benchmarks.

6.2.1.3.3 The Contractor shall recommend and/or evaluate methodologies for establishing minimum performance standards used to monitor plan compliance and set performance incentive levels used to award performance incentives to health plans using criteria specified by LDH. LDH has used criteria such as the following when selecting minimum performance standards:

6.2.1.3.3.1 Are based on research and knowledge of other states', organizations', and CMS' approaches to setting performance expectations for providers and MCEs;

6.2.1.3.3.2 Use national benchmarks and/or other industry-based standards when available and appropriate;

6.2.1.3.3.3 Drive performance improvement for Louisiana's Medicaid Managed Care Program;

6.2.1.3.3.4 May be adjusted if there are changes in methodologies after the performance expectations are set; and

6.2.1.3.3.5 Use statistical analyses, or other sound methodology for setting standards, when national benchmarks are not available.

6.2.1.3.4 The Contractor shall identify and inform LDH of updates in HEDIS, CAHPS, and nationally recognized non-HEDIS measure methodology within seven (7) calendar days of the release of published updates;

6.2.1.3.5 The Contractor shall quantify the potential impact on HEDIS results from methodology changes to specific HEDIS measures using sound analytical techniques, in accordance with LDH's timeline;

6.2.1.3.6 The Contractor shall recommend a methodology for adjusting performance standards if a measure's methodology changes after LDH performance standards are set;

6.2.1.3.7 The Contractor shall perform ad hoc analyses related to questions raised by LDH and/or health plans regarding performance measure result calculations;

6.2.1.3.8 The Contractor shall act as a liaison between LDH and NCQA and/or CMS with respect to specific questions on HEDIS or CAHPS measures and methodologies;

6.2.1.3.9 The Contractor shall ensure data collaboration, consistency, and coordination calculating HEDIS and CAHPS performance measure results with CMS for the duration of the Louisiana Medicaid Managed Care Program; and

6.2.1.3.10 For the CSoC PIHP, the Contractor will validate select performance measures in accordance with CMS EQR Protocol 2, Validation of Performance Measures, which may include non-HEDIS performance metrics.

6.2.1.3.11 The Contractor shall provide technical assistance to managed care entities and LDH, as needed, related to HEDIS and health plan self-reported data issues and their resolution.

Frequency: ~~As needed by LDH~~ **Annually by July 31st or as otherwise specified by LDH**

Deliverable tied to payment:

1. For every LDH technical assistance request, the Contractor will be responsible for providing a written summary for the Louisiana Medicaid managed care program that summarizes results and other information as requested by LDH.

2. Produce one (1) final audit review summary report annually for the CSoC Program. The report must contain MCE-specific findings.

Payment:

1. The Contractor shall be compensated at an hourly rate for activities related to technical assistance deliverable(s).

2. The Contractor shall be compensated at a fixed price for the CSoC report.

6.2.2 Consumer Surveys: Consumer Assessment of Healthcare Providers & Systems (CAHPS-A and CAHPS-C)

Louisiana Medicaid uses CAHPS surveys to monitor the performance of the Louisiana Medicaid Managed Care Program and to evaluate MCO compliance with program requirements. Louisiana Medicaid requires MCOs to administer annual adult and child CAHPS surveys to their Louisiana Medicaid membership and to submit their survey data to LDH, NCQA, and the Contractor.

The Contractor will be required to receive, validate, and analyze each MCO's CAHPS survey data and produce reports of survey findings for the State.

6.2.2.1 Data Receipt and Validation

Louisiana's managed care organizations are required to administer the NCQA HEDIS CAHPS Adult Medicaid Health Plan Survey and the NCQA HEDIS CAHPS Child Medicaid Health Plan Survey (with the chronic conditions measurement set) and to submit the items listed below to LDH on an annual basis. The plans are required to submit to the State member-level data according to CAHPS Submission Member-Level Data File Layout specifications. The documents submitted to the Contractor on behalf of LDH are:

6.2.2.1.1 NCQA Summary-Level Reports (three (3) pdf files)

6.2.2.1.2 NCQA CAHPS Member-Level Data File Layout

6.2.2.1.3 CAHPS Survey Instruments

6.2.2.1.4 Adult and Child raw data files from each managed care plan

6.2.2.1.5 Letter of validation from Contractor

6.2.2.1.6 Survey Supplier(s) Contact Information

The Contractor must perform the following requirements:

1. Establish and maintain a secure file transfer protocol (SFTP) site to allow for receipt of data;

2. Receive, maintain, and process the data;

3. Validate the data in accordance with the most current HEDIS Specifications for Survey Measures; NCQA's Quality Assurance Plan for HEDIS Survey Measures; NCQA data file layouts; and NCQA Summary Reports (for LDH's Contracting plans); and

4. Inform LDH that all required data files were received and confirmed with all data submission specifications.

6.2.2.2 Data Analysis

The Contractor must perform the following general requirements:

6.2.2.2.1 Analyze data using Medicaid CAHPS Health Plan Survey data files imported from LDH's contracted MCOs;

6.2.2.2.2 Analyze data in accordance with the most current HEDIS Specifications for Survey Measures, NCQA's Quality Assurance Plan for HEDIS Survey Measures, and the NCQA Summary-Level Reports (from LDH's contracted MCOs); and

6.2.2.2.3 Analyze adult and general child member (general population and chronic conditions) data at the Statewide level for each managed care plan.

The Contractor must perform the following specific analyses if not provided by the contracted managed care organizations:

6.2.2.2.3.1 Calculate response rates;

6.2.2.2.3.2 Prepare adult, general child, children with chronic conditions (CCC), and children without chronic conditions demographic (non-CCC) profiles;

6.2.2.2.3.3 Prepare general child, CCC, and non-CCC respondent profiles;

6.2.2.2.3.4 Prepare a profile of members classified as children with chronic conditions (i.e., responses to the CCC screener questions);

6.2.2.2.3.5 Conduct a respondent/non-respondent analysis and test for statistically significant differences between respondents and non-respondents at the MCO and Louisiana Medicaid Managed Care Program levels, with respect to member age, gender, race, and ethnicity;

6.2.2.2.3.6 Conduct a comparative analysis of MCO, Louisiana Medicaid Managed Care Program, and national Medicaid three point means, and test for statistically significant differences between MCO level and Louisiana Medicaid Managed Care Program level scores;

6.2.2.2.3.7 Conduct a trending analysis of MCO, Louisiana Medicaid Managed Care Program, and national Medicaid three point means, and test for statistically

significant differences between current and prior years' scores for each managed care plan and the Louisiana Medicaid Managed Care Program;

6.2.2.2.3.8 Produce star ratings tables for adult and general child members that compare MCO and Louisiana Medicaid Managed Care Program three point means for the core measures (i.e., global ratings and composite measures) to national Medicaid benchmarks provided in NCQA CAHPS Benchmarks and Thresholds for Accreditation;

6.2.2.2.3.9 Conduct a key drivers analysis for approximately three (3) of the CAHPS core measures (to be determined) which includes a review of MCOs and Louisiana Medicaid Managed Care Program performance on the key drivers to identify strengths and weaknesses and present findings using an analytic diagram or model (e.g., a priority matrix, opportunity);

6.2.2.2.3.10 Develop cross tabulations of specific survey data (e.g., responses to each survey question stratified by certain demographic variables), for the adult and general child populations, as specified by LDH;

6.2.2.2.3.11 Conduct a comparative analysis of CCC and non-CCC three point means, and test for statistically significant differences between CCC and non-CCC level scores;

6.2.2.2.3.12 Conduct a trending analysis of CCC and non-CCC three point means, and test for statistically significant differences between current and prior year's scores for each population; and

6.2.2.2.3.13 Develop cross tabulations of specific survey data (e.g., responses to each survey question stratified by certain demographic variables), for the CCC population only, as specified by LDH.

Frequency: Annually **by July 31st or as otherwise specified by LDH**

Deliverable tied to payment: The Contractor must produce the following reports each Contract year, for a total of four (4) reports.

1. One (1) Dashboard Report (this is a static report, approximately five (5) pages in length, that contains initial summary findings for the core measures, in graphical displays), submitted to LDH at the commencement of data analysis);

2. One (1) Executive Summary Report;

3. One (1) Full Report (to include an introduction, survey methodology, findings, conclusions and recommendations); and

4. One (1) Survey Methodology Report.

The Contractor will work with LDH to further define analytical and reporting expectations (e.g., report outlines, data analysis plans).

Payment: Each report shall be compensated at a fixed price.

6.2.3 MCE Quality Rating System (QRS)

Pending final guidance from CMS, the Contractor will assist LDH with adopting a Medicaid managed care Quality Rating System (QRS) developed by CMS to evaluate and apply a rating to measure the quality of care provided by Louisiana Medicaid MCEs. LDH will utilize the CMS framework, methodology and identified performance measures in accordance with 42 CFR § 438.334 that align with the summary indicators of the qualified health plan QRS developed per 45 CFR § 156.1120. LDH reserves the right to add additional performance measures to the QRS to ensure alignment with the Louisiana quality strategy.

Following the issuance of final CMS guidance, technical specifications and protocols, and at the request of LDH, the Contractor will:

6.2.3.1 Establish a work plan for producing the Louisiana Medicaid Quality Rating System, considering applicable national requirements from CMS including compliance with new CMS guidelines and innovative approaches used by other State Medicaid programs and/or the health care industry;

6.2.3.3 Support as necessary any data collection from MCEs and data submission to CMS as required for specified QRS performance measures;

6.2.3.4 Produce any associated reference materials (e.g., score calculation and data source documentation), as specified and approved by LDH, on an annual basis;

6.2.3.5 Develop and maintain the Louisiana Medicaid QRS methodology documents and revise annually in collaboration with LDH;

6.2.3.6 Integrate new measures as CMS and industry measurement sets evolve and as requested by LDH;

6.2.3.7 Modify/enhance the MCE Quality Rating System as specified by LDH in response to and in alignment with LDH's changing business requirements (e.g., LDH branding, changes in federal regulations, revisions to the Contracts between LDH and the Managed care entities) and/or changes to report card measure specifications (e.g., HEDIS, CAHPS);

6.2.3.8 Modify and/or enhance the QRS tools (analytics, reporting, and/or reference materials) as needed, to align with LDH's changing business requirements; and

6.2.3.9 Provide assistance to the plans on how to read, interpret, and use the system as part of a performance improvement strategy.

Frequency: Annually (subject to CMS finalization of QRS guidance and related technical specifications and protocols) **by July 31st or as otherwise specified by LDH**.

Deliverables tied to payment:

1. Following the issuance of final CMS technical specifications and protocols, the Contractor must establish a work plan for producing the Louisiana Medicaid QRS to assist LDH in evaluating the performance of the Louisiana Medicaid contracted MCEs. The work plan shall be updated annually as required.

2. Once the Louisiana Medicaid QRS becomes available, the Contractor must produce and evaluate the electronic scores and produce individual plan and summary results on an annual basis.

Payment: Each deliverable shall be compensated at a fixed price.

6.2.4 Provider Satisfaction Surveys

Louisiana Medicaid uses Provider Satisfaction Surveys to monitor the performance of its Medicaid Managed Care Program. The Contractor will be required to select and/or develop a survey instrument, administer the survey, validate and analyze the survey data, and prepare reports of survey findings for the State.

The Contractor must perform the following general requirements in collaboration with LDH:

6.2.4.1 Identify study populations and indicators;

6.2.4.2 Recommend, select, and/or develop survey methodology and instrument(s), with preference given to nationally-accepted, publicly-available survey measures and instruments;

6.2.4.3 Develop and follow a sampling plan that uses a representative sample, allows data to be analyzed per plan, and uses a ninety-five percent (95%) confidence level with a five percent (5%) margin of error;

6.2.4.4 Develop and follow a detailed work plan approved by LDH;

6.2.4.5 Develop and follow reporting expectations and report outlines in consultation with LDH;

6.2.4.6 Use survey administration protocols designed to achieve high response rates;

6.2.4.7 Use data collection procedures that ensure data are valid and reliable; and

6.2.4.8 Validate data by:

a. Validating that the number of records and completes match final disposition report;

b. Ensuring disposition codes and questions are coded according to project specifications;

c. Validating that all data elements have valid values; and

d. Calculating results in accordance with a data analysis plan approved by LDH.

Frequency: ~~Administer the survey annually for each Contract year. The timeframe for administering the survey (i.e., month/CY) during each Contract year will be determined in collaboration with LDH~~ **Annually by July 31st or as otherwise specified by LDH**.

Deliverable tied to payment: The Contractor must produce the following two (2) reports each Contract year:

1. One (1) Executive Summary (this is a static report, approximately two-five (2-5) pages in length, that contains narrative summary findings and graphical displays), submitted to LDH when data analyses are complete; and

2. One (1) Full Report (to include an introduction, methodology, findings, conclusions and recommendations).

Payment: Each report shall be compensated at a fixed price.

6.2.5 Performance Improvement Project Validation

LDH defines quality improvement as assessing and continually improving healthcare, operations, and services within a planned, systematic, collaborative, interdisciplinary process. This is accomplished through intra-departmental quality measurement, interdisciplinary committees, interdepartmental teams, and ongoing evaluation of performance. Quality, a standard of service excellence, is based upon the Institute for Healthcare Improvement's Triple Aim framework: 1) Improve the health of populations, 2) Enhance the patient experience of care (including quality and satisfaction, and 3) Reduce the per capita cost of health care. LDH Leadership has directed that continuous Quality Improvement be an ongoing, organization-wide activity aimed at achieving the goals of LDH's mission, values, and vision. Every member is entitled to quality health care and all providers, MCEs, vendors, and employees are individually accountable for contributing to improving patient care.

During each Contract year, each MCE will be required to conduct performance improvement projects (PIP) as outlined in their Contract. Each PIP will be validated by the Contractor. All PIPs must achieve, through periodic measurements and interventions, significant and sustained improvement in clinical and non-clinical areas which are expected to have a favorable effect on health outcomes and satisfaction. MCEs must adhere to LDH improvement project content and format specifications. All LDH-specified improvement projects span a minimum of twelve (12) months which includes planning and implementation activities, as well as putting processes in place for sustainability and further testing and refinement of interventions during the project period.

MCEs must submit the status and results of each improvement project to LDH on a schedule determined by LDH. The status and results of each phase of the PIP must be submitted to LDH and the Contractor on a schedule determined collaboratively by LDH and the MCE. LDH will work with the Contractor to identify which phases of the PIP shall be included in each year's validation process.

The Contractor must:

6.2.5.1 Provide technical assistance to MCEs in development, implementation, and administration of the LDH approved PIP(s), following CMS guidance on a Model for Improvement and focused on an LDH population stream;

6.2.5.2 Develop a standardized tool that incorporates CMS' PIP protocol with the Model for Improvement and rapid cycle improvement tools, such as process mapping, Pareto charts, run charts, key driver diagrams, the Plan Do Study Act (PDSA), and statistical process control methods. The standard tool should establish objective criteria that will be used to document the design, implementation, and outcomes of the PIP;

6.2.5.3 Using the standardized tool developed in 6.2.5.2, develop a scoring methodology that will be used to determine if the PIPs are valid and to rate the percentage of compliance with CMS' PIP protocols. Refer to the External Quality Review Protocols dated September 2012 located at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html;

6.2.5.4 Calculate percentage scores in accordance with the scoring methodology developed in 6.2.5.2 above;

6.2.5.5 Assign a validation status of 'Met', 'Partially Met', or 'Not Met' based on the calculation of an overall percentage score;

6.2.5.6 Provide a written assessment and/or technical report of what must be changed for the health plan to achieve a status of 'Met';

6.2.5.7 The technical report should include an assessment of the overall validity and reliability of study results and include any threats to accuracy and/or confidence in reporting; and

6.3.5.8 Ensure that the technical report includes a description of PIP interventions and outcomes information associated with each State-required PIP topic for the current EQR review cycle.

Frequency: Annually **by July 31st or as otherwise specified by LDH**

Deliverable tied to payment: The Contractor must produce one (1) report per MCE and PIP topic (i.e., individual reports should be produced for each PIP topic conducted by each plan). LDH anticipates up to five (5) PIP topics for each MCO and up to two (2) PIP topics for each PIHP and PAHP on an annual basis.

Payment: Each report shall be compensated at a fixed price.

6.2.6 Network Adequacy and Availability Validation

6.2.6.1 Validation of MCE Provider Network Adequacy and Availability

MCEs must ensure access to medically necessary Medicaid covered services and must meet network adequacy requirements as set forth by 42 CFR § 438.68, 42 CFR § 438.206, and 42 CFR § 438.207. The EQRO will validate these MCE requirements according to CMS protocols when applicable. Additional requirements may be added related to Network Adequacy Standards when CMS releases new protocols related to 42 CFR § 438.358(b)(1)(iv), as indicated in Section 6.2.11.

6.2.6.1.1 Evaluation of Provider Directory Accuracy

MCEs are required to submit provider directory information in a manner specified by LDH to ensure accuracy of provider information listed in directories that are used by Medicaid recipients. The Contractor will evaluate the accuracy of provider directory information submitted by MCEs:

1. Updated provider files will need to be provided to HSAG from each MCE on a weekly basis during Year 1 and quarterly thereafter. These files will be submitted in a standard format and error free.

2. HSAG will review a sample of providers from the MCE provider data files for validation using the MCE's online provider directory (i.e., the MCE provider data file will be compared to online provider directory). Changes to this protocol may require changes in the total sample size.

This evaluation must include, but may not be limited to, the following:

6.2.6.1.1.1 An audit of online provider directories to validate that the data elements are correct.

For the audits described above, the Contractor must do the following as approved by LDH:

a. Develop a study methodology that describes the evaluation approach;

b. Develop a standardized data collection tool;

c. Develop a sampling methodology; **Sampling will include up to 160 providers for each of the six MCEs, for a total of up to 960 reviews throughout the year**

d. Collect and analyze data; and

e. Prepare reports containing MCE-specific findings, and deliver all raw data to LDH.

Frequency: ~~The audit must be conducted quarterly.~~ **The audit must be conducted weekly through March 31st for Year 1 and quarterly thereafter.**

Deliverable tied to payment: For each audit conducted, the Contractor must submit a final report as described in item (e) above.

Payment: Each report shall be compensated at a fixed price.

6.2.6.1.2 Provider Access Surveys

To ensure MCEs' enrollees are able to appropriately access providers, the Contractor must conduct quarterly telephone surveys among a sample of providers to determine appointment availability information for new and existing enrollees.

6.2.6.1.2.1 Telephone Surveys

The Contractor must conduct the following:

6.2.6.1.2.1.1 Develop and/or update a study methodology describing the evaluation approach;

6.2.6.1.2.1.2 Develop a standardized data collection tool;

6.2.6.1.2.1.3 Develop a sampling methodology;

6.2.6.1.2.1.4 Collect and analyze data; and

6.2.6.1.2.1.5 Prepare a report containing MCE-specific findings, and deliver all raw data to LDH.

Frequency: Quarterly **or Semi-annual**

Deliverable tied to payment: After each survey, the Contractor will provide LDH with:

1. A final report that includes data tables with aggregate and MCE-specific results as described in 6.2.6.1.2.1.5.

2. One (1) excel file with MCE-specific worksheets containing provider-level survey data results.

Payment: Each report and results data shall be compensated at a fixed price.

6.2.6.1.3 Performance Measure Calculation and Reporting

The Contractor will be required to calculate, for each MCE, a performance measure that uses results from the telephone surveys. This must include:

6.2.6.1.3.1 Developing and updating a measure methodology document with LDH's input;

6.2.6.1.3.2 Recommending a strategy for setting and adjusting a performance standard;

6.2.6.1.3.3 Producing a report of MCE-specific rates in a format specified by LDH; and

6.2.6.1.3.4 Providing technical assistance to the each plan in each line of business and LDH related to the measure.

Frequency: Annually **by July 31st or as otherwise specified by LDH**.

Deliverable tied to payment: The Contractor must create one (1) Statewide report with results listed by each MCE.

Payment: Each report shall be compensated at a fixed price.

6.2.7 Readiness Reviews

The Contractor will conduct Readiness Reviews, as detailed below, as requested by LDH, to determine if there is the ability to enroll and provide the necessary level of access to and quality of Medicaid services. The Contractor shall evaluate each prospective MCE's compliance with LDH MCE Contract requirements. The number of reviews will depend on the number of MCEs contracted by LDH.

6.2.7.1 The Contractor shall:

6.2.7.1.1 Collaborate with LDH to determine the scope of and the dates for the Readiness Review;

6.2.7.1.2 Readiness Reviews shall be conducted before the plan begins to enroll potential enrollees. It will contain two (2) components, including:

6.2.7.1.2.1 Desk Reviews

A review of all prospective MCE's policies and procedures, program descriptions, committee meeting minutes, manuals, handbooks and quality data; and

6.2.7.1.2.2 On–Site Visits

A visit in the Medicaid MCE's office to review credentialing files, medical records, conduct staff interviews, review other areas not covered in the desk review, and provide feedback.

6.2.7.1.3 Collaborate with LDH on developing an electronic tool based on readiness review standards and requirements that shall be a means of gathering information and documentation.

6.2.7.1.3.1 The Contractor shall share approved criteria and/or tools in advance with each Medicaid MCE to ensure adequate preparation and discussion.

6.2.7.1.3.3 The Contractor shall schedule a conference call or discussion with each Medicaid MCE in conjunction with LDH to describe the process (both document review and on-site review) and detail the topics of the upcoming review, no later than (30) calendar days after receiving department's approval.

6.2.7.1.4 Have capabilities to review and assess MCE's information system.

6.2.7.1.4.1 Use criteria and tools approved by LDH to conduct on-site information systems reviews assessing each MCE's:

6.2.7.1.4.1.1 Data management processes;

6.2.7.1.4.1.2 Data integration and control procedures, including:

- Reviewing completed assessment tools and supporting documentation; and interviewing staff responsible for leading certain operational and/or functional aspects of the plans' information systems.
- Assessing the ability to link data from multiple sources.
- Examining processes for data transfers.
- Evaluating data warehouse structures and reporting capabilities.
- Reviewing processes, documentation and data files to ensure compliance with State specifications for encounter data submissions.
- Assessing the claims adjudication process and capabilities.

6.2.7.1.4.1.3 Evaluate the MCEs' information systems capabilities and identify any potential problem areas that may impact LDH's ability to monitor performance in key operational areas.

6.2.7.1.5 Provide LDH with a tracking report of progress on the readiness reviews. This tracking report shall include review progress of each Medicaid MCE and areas of concern in the form of a brief summary with dates and expectations for completing specified activities. This report shall be initiated at the time of the initial outreach to the Medicaid managed care entities and updated bi-weekly. This report shall be submitted electronically.

6.2.7.1.6 Submit a complete readiness review report within three (3) weeks after completion of the Medicaid MCE site visit. This report shall be submitted electronically.

Frequency: ~~As needed~~ **by July 31st or as otherwise specified by LDH**.

Deliverable tied to payment: The final written readiness report as described above.

Payment: Each report shall be compensated at a fixed price.

6.2.8 Compliance Reviews

MCEs are required to comply with federal and State program requirements specified in the Code of Federal Regulations, the Louisiana Revised Statutes, the Louisiana Administrative Code, LDH policies and procedures, as applicable, Provider Agreements, and 1915 (b) and (c) waivers. The Contractor must conduct an assessment of each plan's compliance with the requirements that are in effect during the time period under review. The assessment must include, but not be limited to, a review of the following areas: 1) availability of services; 2) assurance of adequate capacity and services; 3) coordination and continuity of care; 4) coverage and authorization of services; 5) credentialing and re-credentialing of services; 6) subcontracted relationships and delegation; 7) enrollee information and enrollee rights; 8) confidentiality of health information; 9) enrollment and disenrollment; 10) the grievance and complaint process; 11) practice guidelines; 12) quality assessment and performance improvement program; 13) health information systems; and 14) fraud and abuse.

6.2.8.1 The Contractor must conduct each of the following tasks:

6.2.8.1.1 In consultation with LDH, identify the topic areas and administrative standards that will be reviewed;

6.2.8.1.2 Develop an evaluation methodology and standardized data collection tool, in consultation with LDH that will be used for each MCE review. This will include, but is not limited to, a review of policies and procedures, staff interviews, and file reviews;

6.2.8.1.5 Conduct a desk review and/or on-site review;

6.2.8.1.6 Aggregate and analyze the data and information collected in order to communicate findings of compliance with the administrative standards;

6.2.8.1.7 Prepare MCE-specific reports of findings that include the completed data collection tool with cited references, as appropriate; and

6.2.8.1.8 Prepare program-specific reports if needed, as requested by LDH.

Frequency: The Contractor must conduct each of the following:

1. A comprehensive review of MCE's compliance with federal regulations described in 42 CFR § 438, conducted every three (3) years. The Proposer may be required to conduct partial reviews as determined by LDH; and

2. Targeted reviews must be conducted per as follows:

   a. Case Management desk reviews annually. All MCOs are included in this review; and

   b. Select additional operational topics (e.g., claims adjudication, non-emergency transportation, grievances and appeals) at intervals to be determined by LDH. The number of MCEs subject to a review will vary depending on the topic selected.

Deliverable tied to payment: For each review**:**

a. The Contractor must provide to LDH one (1) report per MCE that contains an executive summary, introduction, summary of findings, conclusion and recommendations for improvement. The completed data collection tool and the information sources used must be made available to LDH.

b. One (1) Executive Summary (this is a static report, approximately two-five (2-5) pages in length, that contains narrative summary findings and graphical displays), that summarizes how all MCEs performed in the compliance audit submitted to LDH.

Payment: Each report shall be compensated at a fixed price.

6.2.9 External Quality Review Annual Technical Report

The Contractor must produce a detailed technical report to ensure LDH's compliance with 42 CFR § 438.364, and ensure that a finalized annual technical report is submitted to LDH and CMS by April 30th of each year. The most recent report can be viewed on the following website: http://www.ldh.la.gov/inde.cfm/page/3176.

6.2.9.1 The Contractor must produce a detailed technical report that includes the following components:

6.2.9.1.1 A description of the manner in which the data from all EQR activities conducted in accordance with 42 CFR § 438.358 were aggregated and analyzed, and conclusions that were drawn with regard to the quality, timeliness and access to health care services furnished to health plans' members;

6.2.9.1.2 A description of the objectives; technical methods of data collection and analysis; description of data obtained, including validated performance data for each activity conducted in accordance with 42 CFR § 438.358(b) and (c); conclusions that were

drawn from the data for each activity included in the report; and problems encountered in performing the review;

6.2.9.1.3 An assessment of each MCE's strengths and weaknesses for the quality, timeliness and access to health care services furnished to Medicaid managed care members;

6.2.9.1.4 Recommendations for improving the quality of services furnished by each MCE including how the State can target goals and objects in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid managed care members;

6.2.9.1.5 Methodologically appropriate, comparative information about all Medicaid MCEs operating within Louisiana, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR § 438.352(e); and

6.2.9.1.6 An assessment of the degree to which a Medicaid MCE has effectively addressed recommendations for quality improvement made by the Contractor during the previous year's EQR.

6.2.9.2 LDH may not substantively revise the content of the final EQR technical report without evidence of error or omission.

6.2.9.3 The Contractor shall provide LDH with a tracking report of progress on annual reviews. This tracking report will include review of progress by Medicaid MCEs and areas of concern. The tracking report will consist of a brief summary with dates and expectations for completing specified activities. This report shall be transmitted electronically and updated bi-weekly.

6.2.9.4 The Contractor must electronically submit the Annual Technical Reports to LDH after the completion of the annual review of each Medicaid MCE and it must be submitted by March 1st of each calendar year prior to the CMS deadline of April 30th.

Frequency: Annually, by March 1st

Deliverable tied to payment: Produce a detailed report in compliance with 42 CFR § 438.364.

Payment: Each report shall be compensated at a fixed price.

6.2.10 Medicaid Managed Care Quality Strategy Evaluation

6.2.10.1 The Contractor must assist LDH in evaluating the effectiveness of the Louisiana Medicaid Quality Strategy.

The Contractor will, in consultation with LDH, develop an evaluation methodology and tools required to evaluate the effectiveness of the Medicaid Managed Care Quality Strategy as required by 42 CFR 438 Subpart E, that may be refined on an annual basis to reflect lessons learned from the prior year's evaluation.

The Contractor will conduct the evaluation and prepare a written report of review findings to be submitted to LDH within thirty (30) business days after completion of the evaluation.

Frequency: Annually **by July 31st or as otherwise specified by LDH**.

Deliverables tied to payment:

1. Evaluation methodology and tool(s).
2. The final evaluation written report.

Payment: Each report shall be compensated at a fixed price.

6.2.11 Additional Technical Assistance (TA) and Optional Activities

The Contractor may be required to provide technical assistance and/or optional activities described in 42 CFR § 438.358(c) or comparable activities that assess the quality or utilization of services in the participating MCOs, PAHP, and PIHP during the Contract period.

6.2.11.1 The specific nature of the technical assistance will be defined on a case-by-case basis, and shall include, but not be limited to, performance improvement project development and implementation, performance measure support, educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of healthcare initiatives.

6.2.11.3 The Contractor shall provide ad-hoc technical assistance to LDH and all Medicaid managed care entities upon request and approval of LDH.

6.2.11.4 Optional activities as described in 42 CFR § 438.358(c).

The Louisiana Medicaid managed care population optional activities include:

6.2.11.4.1 Conduct additional focus studies. Conduct a specific focus study to evaluate peer support services or other services/programs from a member and/or provider perspective.

6.2.11.4.2 Validation of encounter data

6.2.11.4.3 Administration or Validation of Consumer or Provider Surveys

6.2.11.4.4 Conduct and facilitate performance improvement projects

6.2.11.4.5 Calculation of performance measures

6.2.11.4.6 Developing and monitoring Corrective Action Plans

6.2.11.4.7 Produce additional reports at the request of LDH

6.2.11.4.8 Validation of Network Adequacy

6.2.11.4.9 Validation of MCO Quality Reports for Behavioral Health

6.2.11.4.10 Behavioral Health Provider Sample Selection for Quality Monitoring Audits

6.2.11.4.11 MCE Independent Assessments

Frequency: ~~As requested by LDH~~ **Annually by July 31st or as otherwise specified by LDH**.

Deliverable tied to payment: For every LDH request for technical assistance or optional activity, the Contractor will be responsible for adhering to both LDH and CMS specifications. The Contractor and LDH will agree on an appropriate format for reporting or delivering activities for the Louisiana Medicaid managed care program.

Payment: The Contractor shall be compensated at an hourly rate for activities related to technical assistance and optional activity deliverable(s).

6.2.12 Quality Companion Guide

6.2.12.1 The Contractor will develop a Quality Companion Guide in consultation with LDH that focuses on core quality improvement activities, assisting managed care entities with LDH Contract requirements, Contractor activities and processes outlined in 42 CFR 438 Subpart E, 438.358 and 438.364. The timeframes for each activity may be modified at the discretion of LDH.

6.2.12.2 The Quality Companion Guide shall be submitted to LDH for approval within sixty (60) days of Contract effective date and annually thereafter.

Frequency: Annually **by July 31st or as otherwise specified by LDH**.

Deliverable tied to payment: The Contractor must produce a comprehensive guide in consultation with LDH. The Quality Companion Guide shall include, but is not limited to, written instruction for performance improvement projects, performance measure specifications and validation processes.

Payment: The Quality Companion Guide shall be compensated at a fixed price.

6.2.13 Behavioral Health Member Satisfaction Survey

Louisiana uses behavioral health member satisfaction survey data to monitor access, quality of care, and member interaction with the Medicaid managed care organizations and the Coordinated System of Care (CSoC) Contractor. The Contractor will be required to select and/or develop a survey instrument, administer the survey, validate and analyze the survey data, and prepare reports of survey findings for each MCO and CSoC. The Contractor must perform the following general requirements in collaboration with LDH:

6.2.13.1 Identify study populations and indicators;

6.2.13.2 Recommend, select, and/or develop survey methodology and instrument(s), with preference given to nationally-accepted, publicly-available survey measures and instruments, and in consideration of applicable privacy laws;

6.2.13.3 Develop and follow a sampling plan that uses a representative sample, allows data to be analyzed per plan, and uses a ninety-five percent (95%) confidence level with a five percent (5%) margin of error for each program, Louisiana Medicaid managed care and CSoC;

6.2.13.4 Translate member surveys and accompanying material in prevalent non-English languages, including Spanish and Vietnamese.

6.2.13.5 Use survey administration protocols designed to achieve high response rates;

6.2.13.6 Use data collection procedures that ensure data are valid and reliable; and

6.2.13.7 Stratify data by age group, race, and region.

Frequency: Administer surveys annually, effective SFY 2020. The timeframe for administering the survey (i.e., month/CY) during each SFY will be determined in collaboration with LDH.

Deliverable tied to payment: The Contractor must produce the following two (2) reports each Contract year:

1. One (1) Executive Summary (this is a static report, approximately two-five (2-5) pages in length, that contains narrative summary findings and graphical displays), submitted to LDH when data analyses are complete; and

2. One (1) Full Report (to include an introduction, methodology, findings, conclusions and recommendations).

Payment: Each report shall be compensated at a fixed price.

6.2.14 Health Disparities Studies (Focused Studies)

6.2.14.1 Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report

6.2.14.1.1 Upon direction and approval by LDH, the Contractor must conduct health disparities analyses throughout the Contract term, including:

a. Developing methodologies;
b. Producing final health disparities data spreadsheets that evaluate health disparities among the LDH Medicaid contracted MCEs with recommendations for quality improvement. The data can include, but is not limited to, CMS Adult and Child Core Sets and MCO HEDIS data;
c. Summary report of data analyses; and
d. Pilot studies, if requested by LDH.

6.2.14.2 Health Disparities Study Supplemental Activity-Pilot Study

6.2.14.2.1 LDH may direct the Contractor to conduct pilot studies. The purpose of Conducting pilot studies may include, but are not limited to:

a. Testing completeness and accuracy of data elements and/or data calculation methods;
b. Testing whether the data and calculation methods produce the type of results needed;
c. Testing viability of proposed interventions;
d. Identifying unforeseen gaps, overlaps, or other complications in either the source data or calculation methods;
e. Identifying unknown causal factors for a healthcare issue; and/or

f. Conducting information-gathering activities to reveal root causes.

The Contractor must collaborate with LDH in determining the level of data analysis and LDH may elect to require the Contractor to expand a health disparity pilot study into an extensive study.

Frequency:

1. **Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report:** Annually **by July 31st or as otherwise specified by LDH.**
2. **Health Disparities Study Supplemental Activity-Pilot Study Final Report:** ~~As requested by LDH~~ **Annually by July 31st or as otherwise specified by LDH**

Deliverable tied to payment:

1. **Health Disparities Studies: Methodology, Data Spreadsheets and Summary Report**:
   a. Data spreadsheets must include all sources of data, denominators, numerators and methods of calculation for both the aggregate as well as subsections of each work product (i.e. charts, graphs, tables, etc.).
   b. One (1) Full Report (to include an introduction, methodology, findings, conclusions and recommendations).

2. **Health Disparities Study Supplemental Activity-Pilot Study Final Report:** The Contractor must produce a final report of the extensive study on a health disparity topic in any Contract year.

Payment: The Contractor shall be compensated at an hourly rate for activities related to health disparities studies deliverable(s).

~~**1.2.15 Assessment and Evaluation Activities for 1115 Demonstration Waivers**~~

~~LDH currently has an agreement with CMS to operate a Section 1115 demonstration waiver titled the Healthy Louisiana Substance Use Disorder (SUD) 1115 Demonstration. Section 1115 demonstration waivers require an independent party to conduct assessment and evaluation activities per 42 CFR § 431.424. Additionally, CMS may require other activities as outlined in each waiver's Special Terms and Conditions (*LA 1115 SUD Approval is incorporated herein and made part hereof by reference.* A copy of the current Terms and Conditions for the SUD 1115 Demonstration will be available at the following website:~~

~~https://ldh.la.gov/index.cfm/newsroom/detail/6369~~

~~The Contractor shall serve as the independent assessor/evaluator and complete all assessment and evaluation activities for each of LDH's 1115 demonstration waivers in accordance with their Special Terms and Conditions. The Contractor shall complete each of the following deliverables:~~

~~**1.2.15.1** Evaluation Design – the Contractor shall complete the Evaluation Design in accordance with the Special Terms and Conditions of each waiver and in consultation with LDH. The Evaluation Design will provide the basis for the evaluation of each Demonstration and shall include at a minimum general background information, evaluation questions and hypotheses, methodology, and methodological limitations.~~

~~**1.2.15.2** Mid-Point Assessment – the Contractor shall conduct a Mid-Point Assessment for each Demonstration that includes LDH's progress toward meeting demonstration milestones, performance measure targets, a determination of factors that affected achievement of or barriers to achieving milestones, and a status update on budget neutrality requirements.~~

~~**1.2.15.3** Interim and Summative Evaluation Report – the Contractor shall complete an Interim and Summative Evaluation Report as required in each Demonstration's Special Terms and Conditions and will discuss evaluation progress and present findings to date per the approved Evaluation Design for each waiver.~~

~~**Frequency:** Each deliverable listed above will be required once during each waiver's five-year life cycle~~

~~**Deliverable tied to payment:** The final document or report received and approved by LDH.~~

~~**Payment:** Each document or report shall be compensated at a fixed price.~~

6.2.16 Case Management Performance Evaluation

6.2.16.1 MCEs are required to offer Case Management services, for Medicaid Managed Care enrollees that have opted to accept case management services. LDH requires MCE reporting of data on Case Management services to determine the number of individuals, the types of conditions, and the impact that Case Management services have on members receiving those services.

6.2.16.2 Contractor shall facilitate the annual collection and validation of data submitted by MCEs regarding Case Management services.

6.2.16.3 Contractor shall evaluate the MCE's compliance with the Case Management provisions of its Contract with LDH.

6.2.16.4 Contractor shall evaluate the rates of engagement in Case Management, the specific services offered to enrollees receiving Case Management, and the effectiveness of Case Management in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

6.2.16.5 Contractor shall develop a draft and final report of its results and findings for each MCE. The Contractor shall collaborate with LDH to determine the strategy, approach, timing, and report format.

6.2.16.6 Contractor shall participate with LDH in an annual, formal webinar or in-person meeting with the MCEs to review results from the Case Management data, identify opportunities for improvement, and determine efficient application of Case Management services to positively impact outcomes.

Frequency: Annually by February 28th

Deliverable tied to payment: The Contractor must produce the following for each.

Deliverable tied to payment: The Contractor must produce the following for each MCE:

1. One (1) Full report (to include an introduction, methodology, findings, conclusions and recommendations) for each MCE.

Payment: Each report shall be compensated at a fixed price.

6.3 Technical Requirements

The Contractor will be required to transmit all non-proprietary data which is relevant for analytical purposes to LDH on a regular schedule in XML format or format compatible with LDH operations. Final determination of relevant data will be made by LDH based on collaboration between both parties. The schedule for transmission of the data will be established by LDH and dependent on the needs of the Department related to the data being transmitted. XML or compatible files for this purpose will be transmitted via SFTP to the Department. Both parties must approve any other data or method of transmission used for this purpose via written agreement.

6.3.1 General Provisions

6.3.1.1 The Contractor must maintain hardware and software compatible with LDH requirements that are secure and sufficient to successfully perform the services detailed in the Contract as the service level specified, which are as follows:

6.3.1.1.1 The Contractor shall adhere to State and federal regulations and guidelines, as well as industry standards and best practices for systems and/or functions required to support the requirements of the Contract.

6.3.1.1.2 The Contractor shall clearly identify any systems or portions of systems outlined in the proposal which are considered to be proprietary in nature.

6.3.1.1.3 The Contractor is responsible for all expenses required to obtain access to LDH systems and/or resources which are relevant to successful completion of the requirements of the Contract. The Contractor is also responsible for expenses required for LDH to obtain access to the Contractor's systems or resources which are relevant to the successful completion of the requirements of the Contract. Such expenses include, but are not limited to, hardware, software, network infrastructure and any licensing costs.

6.3.1.1.4 Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.

6.3.1.1.5 Contractor owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164).

6.3.1.1.6 Any Contractor use of flash drives or external hard drives for storage of LDH data must first receive written approval from LDH and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

6.3.1.1.7 All Contractor utilized computers and devices must:

6.3.1.1.7.1 Be protected by industry standard virus protection software that is automatically updated on a regular schedule;

6.3.1.1.7.2 Have installed all security patches that are relevant to the applicable operating system and any other system software; and

6.3.1.1.7.3 Have encryption protection enabled at the Operating System level.

6.3.1.2 The Contractor shall ensure appropriate protections of shared Personally Identifiable Information ("PII"), in accordance with 45 CFR §155.260.

6.3.1.2.1 The Contractor shall ensure that its system is operated in compliance with the Centers for Medicare and Medicaid Services' ("CMS") latest version of the Minimum Acceptable Risk Standards for Exchanges (MARS-E) Document Suite, currently MARS-E version 2.0.

6.3.1.2.2 Multi-factor authentication is a CMS requirement for all remote users, privileged accounts, and non-privileged accounts. In this context, "remote user" refers to staff accessing the network from offsite, normally with a client VPN ("Virtual Private Network") with the ability to access CM, specifically Medicaid, data.

6.3.1.2.3 A site-to-site tunnel is an extension of LDH's network. For Contractors that are utilizing a VPN site-to-site tunnel and also have remote users who access CMS data, the Contractor is responsible for providing and enforcing multi-factor authentication. Contractors that do not utilize a VPN site-to-site tunnel will be charged for dual authentication licensing and hardware tokens as necessary. Costs associated with the purchase and any replacement of lost hardware tokens will be charged to the Contractor.

6.3.2 Electronic Messaging

6.3.2.1 The Contractor shall provide a continuously available electronic mail communication link (email system) to facilitate communication with LDH. This email system shall be capable of attaching and sending documents created using software compatible with LDH's installed version of Microsoft Office 2016 and any subsequent upgrades as adopted.

6.3.2.2 The Contractor shall comply with national standards for submitting protected health information (PHI) electronically and shall set up a secure email system that is password protected for both sending and receiving any protected health information.

6.3.3 Information Security and Access Management

6.3.3.1 The Contractor's system shall:

6.3.3.1.1 Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

6.3.3.1.1.1 Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only will not be permitted to modify information;

6.3.3.1.1.2 Restrict access to specific SFTP or system functions and information based on an individual user profile, including inquiry only capabilities; access to all functions shall be restricted to specified staff jointly agreed to by LDH and the Contractor; and

6.3.3.1.1.3 Restrict unsuccessful attempts to access system functions to three (3) attempts with a system function that automatically prevents further access attempts and records these occurrences.

6.3.3.2 Records Retention:

6.3.3.2.1 Contractor shall retain all books, records and other documents relevant to the Contract and funds expended there under for at least ten (10) years after final payment. Contractor shall make available to LDH such records within thirty (30) days of LDH's written request and shall deliver such records to LDH's central office in Baton Rouge, Louisiana, all without expense to LDH. Contractor shall allow LDH to inspect, audit or copy records at the Contractor's site, without expense to LDH.

6.4 Contract Management Approach

6.4.1 The Contractor must describe how it will accomplish required tasks and deliverables, as deemed necessary to deliver the required scope of work including, but not limited to:

6.4.1.1 Project management approach and structure;

6.4.1.2 Communication protocols between LDH and Contractor;

6.4.1.3 Interaction with other LDH Proposers;

6.4.1.4 Schedule for key activities and milestones; and

6.4.1.5 Approach to managing project risks and issues.

6.4.2 An updated and detailed plan will be due to LDH within thirty (30) calendar days of Contract start date by the Contractor. The Contractor's Contract management work plan will be due annually thereafter.

6.5 Additional Reporting Requirements

6.5.1 The Contractor must be able to design, develop, and implement reports using the electronic formats, instructions, and timeframes specified by LDH. The Contractor shall maintain flexible reporting capabilities and must be able to respond to the reporting requests of LDH and its designees.

6.5.2 The Contractor shall certify all submitted data and reports, including, but not limited to, routine HEDIS performance reports, CAHPS, non-HEDIS, and PIPs. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The Contractor must submit the certification concurrently with the certified data and reports.

6.5.3 Louisiana Medicaid Transparency Report

6.5.3.1 The Contractor shall designate one (1) staff member to serve as the single point of contact for all requests related to the Transparency Report required by La. R.S. 40:1253.2. The Contractor shall comply with all LDH instructions and definitions related to this report.

6.5.3.2 The Contractor shall comply with all data requests and surveys from LDH or its designee.

6.5.4 Ad Hoc Reports:

The Contractor shall prepare and submit any other reports as required and requested by LDH, any LDH designee, and/or CMS, that is related to the Contractor's duties and obligations under the Contract. Ad Hoc reports shall be submitted within five (5) business days from request.

6.5.5 Submission Process and Timeframes

6.5.5.1 The Contractor shall ensure that all required reports or files are submitted to LDH in a timely manner for review and approval. The Contractor's failure to submit the reports or files as specified may result in the assessment of monetary penalties in the form of Liquidated Damages.

6.5.5.2 Unless otherwise specified, deadlines for submitting files and reports are as follows:

6.5.5.2.1 Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of the reporting month;

6.5.5.2.2 Quarterly reports and files shall be based on a calendar quarter and be submitted within thirty (30) calendar days of the end of the reporting quarter; and

6.5.5.2.3 Annual reports and files shall be based on a calendar year and shall be submitted within thirty (30) days of the end of the reporting year.

6.5.5.2.4 Annual reports and files based on State fiscal year shall be submitted within thirty (30) days of the end of the reporting year.

6.5.6 If the due date occurs on a weekend or Louisiana designated holiday, the report shall be due the following business day.

6.5.7 Regardless of the due date, all reports shall be submitted by close of business. For purposes of this section, close of business is defined as 5:00 p.m. Central Time.

6.5.8 The Contractor agrees to prepare complete and accurate reports for submission to LDH. If after preparation and submission, an error is discovered, the Contractor shall submit accurate reports in a timeframe directed by LDH. Failure of the Contractor to submit accurate reports may result in the assessment of monetary penalties in the form of Liquidated Damages.

6.5.9 The Contractor shall provide LDH with written reports that are clear, concise and useful for the audience for whom they are intended. The report shall be composed in a manner consistent with LDH specifications and with the Contractor's stated criteria. All reports shall be provided in electronic formats compatible with software applications in use by LDH (e.g., Microsoft Word, Excel) as well as in hard copy, as specified by LDH. The Contractor shall be responsible for assuring that it completely understands the specifications and requirements for all reporting and other activities under the Contract. Where required, the Proposer shall provide supporting documents such as report appendices.

6.5.10 By January 1st of each year, perform analysis and submit a report of existing and new Federal and State policies, procedures, and regulations to determine their impact on the EQRO components of the Louisiana Medicaid program and related State and Contractor-performed functions. The analysis shall include a review of portions of the Federal Register that would impact the Louisiana Medicaid Program.

6.6 Additional Staffing Requirements

6.6.1 Substitution of Personnel

6.6.1.1 The Contractor's Key Personnel assigned to the Contract shall not be replaced without the prior written consent of LDH. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any of the Contractor's personnel becomes unavailable due to resignation, illness, or other factors 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 shall make every reasonable attempt to assign the personnel listed in their proposal in the positions specified in the Proposal.

6.6.2 Written Policies, Procedures, and Position Descriptions

6.6.2.1 The Contractor shall develop and maintain written policies, procedures, and job descriptions for each functional area, consistent in format and style.

6.6.2.1.1 The Contractor shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions.

6.6.2.1.2 All policies and procedures shall be reviewed at least annually by the Contractor to ensure that the Contractor's written policies reflect current practices.

6.6.2.1.3 Job descriptions shall be reviewed at least annually by the Contractor to ensure that current duties performed by the employee reflect written requirements.

6.6.2.2 The Contractor must submit to LDH the following items annually:

6.6.2.2.1 An updated organization chart complete with the key personnel positions. The chart must include the person's name, title, email address, and telephone number.

6.6.2.2.2 A functional organization chart of the key program areas, responsibilities and the areas of the organization that report to that position.

6.6.3 Staff Training and Meeting Attendance

6.6.3.1 The Contractor shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill their requirements of their position prior to the beginning of work.

6.6.3.2 The Contractor must provide initial and ongoing staff training that includes an overview of Louisiana Medicaid Policy, Contract, and State and federal requirements specific to individual job functions.

6.6.3.3 The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by LDH. All meetings shall be considered mandatory for assigned Key Personnel unless otherwise indicated. Staff shall attend in person as directed by LDH. At a minimum, this includes an annual Contract review and quarterly performance improvement project meetings.

6.6.3.4 LDH reserves the right to attend any and all training programs and seminars conducted by the Contractor. The Contractor shall provide LDH a list of any training dates, time, and location, at least fourteen (14) calendar days prior to the actual date of training.

6.7 Transition Plan

6.7.1 In the event of written notification of termination of the Contract by either party, the Contractor shall submit a Transition Plan ("the Plan") within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the Contractor and LDH. The Plan shall address the turnover of records and information maintained by the Proposer. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the transition tasks. The Transition Plan must be approved by LDH.

6.7.2 If the Contract is not terminated by written notification as provided in above, the Contractor shall propose a Transition Plan three (3) months prior to the end of the Contract period, including any extensions to such period. The Plan shall address the possible turnover of the records and information maintained to either LDH or a third party designated by LDH. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Transition Plan must be approved by LDH.

6.8 Applicable Laws and Regulations

The Contractor agrees to comply with all applicable Federal and State laws, regulations, and rules, and shall ensure compliance by subcontractors, including, but not limited to:

6.8.1 All applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671g) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

6.8.2 The Byrd Anti-Lobbying Amendment (31 U.S.C. §1352) and regulations issued pursuant thereto, which provide that the Contractor and its Subcontractor(s) shall file the required certification. Each tier certifies to the tier above, that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier-to-tier up to the non-Federal award.

6.8.3 Right to Audit: The Louisiana Legislative Auditor, Office of the Governor, Division of Administration, and Department auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this Contract during the Contract and for a period of five (5) years following final payment.

Contractor grants to the State of Louisiana, through the Office of the Louisiana Legislative Auditor, Louisiana Department of Health, and State Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours. This right also includes timely and reasonable access to the Contractor's personnel for the purpose of interview and discussion related to such documents. The rights of access in this section are not limited to the required retention period but shall last as long as records are retained.

Contractor shall comply with federal and state laws and/or Department policy requiring an audit of Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the term of this contract, for any period, four (4) copies of the audit report shall be sent to the Louisiana Department of Health, Attention: Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797 and one (1) copy of the audit shall be sent to the originating office within the Department.

PART 7: PERFORMANCE MONITORING, NON-COMPLIANCE, AND MONETARY PENALTIES/LIQUIDATED DAMAGES

7.1 Performance Monitoring

7.1.1 All work performed by the Contractor will be monitored by the Medicaid Director or his/her designee.

7.1.2 LDH or its designee will monitor the operation of the Contractor for compliance with the provisions of the Contract, and applicable federal and State laws and regulations.

7.1.3 The Contractor shall provide access to documentation, records, premises, and staff as deemed necessary by LDH to monitor performance.

7.2 Non-Compliance

7.2.1 The Contractor shall be prepared to demonstrate compliance with any deliverable outlined in the Contract upon request by LDH.

7.2.2 Administrative Actions

7.2.2.1 Administrative actions exclude the assessment of monetary penalties, Liquidated Damages, and intermediate sanctions, but may include at a minimum the following:

7.2.2.1.1 A written Notice of Action when it is determined the Contractor is deficient or non-compliant with requirements or deliverables of the Contract;

7.2.2.1.2 Remedial education requirement regarding program policies and practices;

7.2.2.1.4 Referral for review by appropriate professional organizations; and/or

7.2.2.1.5 Referral to the Office of the Attorney General for fraud investigation.

7.3 Monetary Penalties/Liquidated Damages

7.3.1 In the event the Contractor fails to meet the performance standards specified within the Contract, the monetary penalties in the form of Liquidated damages defined below may be assessed. If assessed, the monetary penalties will be used to reduce the LDH's payments to the Proposer or if the monetary penalties exceed amounts due from LDH, the Proposer will be required to make cash payments for the amount in excess.

a. Late submission of any required report five hundred dollars ($800) per working day, per report.

b. For each day that any other Contract deliverable is late, incorrect or deficient, the Contractor shall be liable to LDH for monetary penalties in an amount not to exceed fifteen hundred dollars ($1500) per business day per deliverable.

7.3.2 LDH may also delay the assessment of monetary penalties if it is in the best interest of the Department to do so. LDH may give notice to the Contractor of a failure to meet performance standards but delay the assessment of monetary penalties in order to give the Contractor an opportunity to remedy the deficiency; if the Contractor subsequently fails to remedy the deficiency to the satisfaction of LDH, the Department may reassert the assessment of monetary penalties, even following Contract termination.

7.3.3 Attorney's Fees

7.3.3.1 In the event LDH should prevail in any legal action arising out of the performance or non-performance of the Contract, the Contractor shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

7.4 Fraud and Abuse

7.4.1 The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

7.4.2 Such policies and procedures must be in accordance with State and federal regulations. Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.



State Fiscal Year July 1, 2023–June 30, 2024

External Quality Review Technical Report

Aggregate Report for the Healthy Louisiana Managed Care Organizations

February 2025



Table of Contents

1. Executive Summary 1-1
Introduction 1-1
The Louisiana Medicaid Managed Care Program 1-1
Scope of External Quality Review 1-3
Report Purpose 1-5
Definitions 1-5
Methodologies 1-6
Louisiana's Medicaid Managed Care Quality Strategy 1-6
Overview of External Quality Review Findings 1-11

2. Validation of Performance Improvement Projects 2-1
Aggregate Results 2-1
Interventions 2-33
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 2-41
Methodology 2-42

3. Validation of Performance Measures 3-1
Aggregate Results 3-1
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 3-31
Methodology 3-39

4. Assessment of Compliance With Medicaid Managed Care Regulations 4-1
Aggregate Results 4-1
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 4-2
Methodology 4-3

5. Validation of Network Adequacy 5-1
Aggregate Results 5-1
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 5-33
Methodology 5-36

6. Consumer Surveys: CAHPS-A and CAHPS-C 6-1
Aggregate Results 6-1
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 6-2
Methodology 6-3

7. Behavioral Health Member Satisfaction Survey 7-1
Aggregate Results 7-1
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 7-2
Methodology 7-3

8. Health Disparities Focus Study 8-1
Methodology 8-4

9. Case Management Performance Evaluation 9-1
Introduction 9-1
Activities Conducted During SFY 2024 9-1
Aggregate Results 9-2
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 9-4
Methodology 9-6

10. Quality Rating System 10-1
Aggregate Results 10-1
Statewide MCO Strengths, Opportunities for Improvement, and Recommendations 10-2
Methodology 10-4

11. MCO Aggregate Strengths, Opportunities for Improvement, and Recommendations 11-1

12. Follow-Up on Prior Year's Recommendations 12-1

Appendix A. MCO Health Equity Plan Summaries A-1

Acknowledgments and Copyrights

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

HEDIS Compliance Audit™ is a trademark of NCQA.

Quality Compass® is a registered trademark of NCQA.

1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states that contract with managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) (collectively referred to as "managed care entities [MCEs]" in this report) for administering Medicaid and Children's Health Insurance Program (CHIP) programs to contract with a qualified external quality review organization (EQRO) to provide an independent external quality review (EQR) of the quality, timeliness, and accessibility of services provided by the contracted MCEs. Revisions to the regulations originally articulated in the BBA were released in the May 2016 Medicaid and CHIP Managed Care Regulations,[1-1] with further revisions released in November 2020.[1-2] The final rule is provided in Title 42 of the Code of Federal Regulations (42 CFR) Part 438 and cross-referenced in the CHIP regulations at 42 CFR Part 457. To comply with 42 CFR §438.358, the Louisiana Department of Health (LDH) has contracted with Health Services Advisory Group, Inc. (HSAG), a qualified EQRO.

The Louisiana Medicaid Managed Care Program

The day-to-day operations of the Louisiana Medicaid managed care program are the responsibility of the Bureau of Health Services Financing within LDH, with oversight of specialized behavioral health services, 1115 Substance Use Demonstration Waiver, and the Coordinated System of Care Waiver provided by the Office of Behavioral Health (OBH). In addition, the Bureau of Health Services Financing receives support from other LDH "program offices"—Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), and Office for Citizens with Developmental Disabilities (OCDD). Louisiana Medicaid managed care provides services to over 1.8 million Louisianans, which is approximately 39 percent of the State's population.

The current MCE contracts are full-risk capitated Louisiana Medicaid managed care contracts. Under the authority of a 1915(b) waiver from the Centers for Medicare & Medicaid Services (CMS), LDH contracts with six Healthy Louisiana MCOs to provide physical and behavioral health care and two dental PAHPs to provide dental services for Louisiana's Medicaid and CHIP members. Additionally, under the authority of a 1915(b)/1915(c) waiver from CMS, OBH contracts with a single behavioral

[1-1] Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, May 6, 2016. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Dec 16, 2024.

[1-2] Centers for Medicare & Medicaid Services. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care, November 13, 2020. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Dec 16, 2024.

health PIHP, Coordinated System of Care (CSoC), to help children with behavioral health challenges who are at risk for out-of-home placement. The MCEs contracted during state fiscal year (SFY) 2024 (July 1, 2023–June 30, 2024) are displayed in Table 1-1. Of note, no MCEs are exempt from EQR.

Table 1-1—Louisiana's Medicaid MCEs

MCE Name	Plan Type	Services Provided	Service Region	Acronym or Abbreviated Reference
Aetna Better Health	MCO	Behavioral and physical health	Statewide	ABH
AmeriHealth Caritas Louisiana	MCO	Behavioral and physical health	Statewide	ACLA
Healthy Blue	MCO	Behavioral and physical health	Statewide	HBL
Humana Healthy Horizons	MCO	Behavioral and physical health	Statewide	HUM
Louisiana Healthcare Connections	MCO	Behavioral and physical health	Statewide	LHCC
UnitedHealthcare Community	MCO	Behavioral and physical health	Statewide	UHC
DentaQuest USA Insurance Company (DentaQuest)	PAHP	Dental	Statewide	DQ
Managed Care North America	PAHP	Dental	Statewide	MCNA
Magellan of Louisiana	PIHP	Behavioral health services for children and youth with significant behavioral health challenges	Statewide	Magellan

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the CMS EQR Protocols released in February 2023.[1-3] For the SFY 2024 assessment, HSAG used findings from the mandatory and optional EQR activities to derive conclusions and make recommendations about the quality, timeliness, and accessibility of healthcare services provided by each MCE. Table 1-2 depicts the EQR activities conducted for each plan type.

Table 1-2—EQR Activities Conducted for Each Plan Type

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
Performance Improvement Project (PIP) Validation	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting, and whether the PIP demonstrated significant improvement in performance.	Protocol 1. Validation of Performance Improvement Projects	✓	✓	✓
Performance Evaluation and Improvement	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures	✓	✓	✓
Compliance Reviews (CRs)	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations	✓	✓	✓
Network Adequacy and Availability Validation (NAV)	The audit activity assesses the accuracy of the state-defined network adequacy indicators reported by the MCEs; evaluates the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used; and determines the overall phases of design, data collection, analysis,	Protocol 4. Validation of Network Adequacy	✓		

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

EQR Activities	Description	CMS EQR Protocol	MCO	PAHP	PIHP
	and interpretation of the network adequacy indicators, as set forth by the State. Additionally, this activity evaluates the accuracy of provider directory information submitted by the MCOs and determines appointment availability information by conducting telephone surveys among a sample of providers.				
Consumer Surveys: CAHPS-A and CAHPS-C	This activity reports the results of each MCO's CAHPS survey to HSAG for inclusion in this report.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Behavioral Health Member Satisfaction Survey	This activity assesses adult members with a behavioral or mental health diagnosis and child members with a mental health diagnosis who have received behavioral health services and are enrolled in an MCO.	Protocol 6. Administration or Validation of Quality of Care Surveys	✓		
Health Disparities Focus Study	This activity uses data collected from the five MCOs to identify health disparities based on race, ethnicity, and geography, where applicable, at the statewide and MCO levels.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
Case Management Performance Evaluation (CMPE)	This activity evaluates case management services to determine the number of individuals, the types of conditions, and the impact that case management services have on members receiving those services.	Protocol 9. Conducting Focus Studies of Health Care Quality	✓		
Quality Rating System (QRS)	This activity evaluates and applies a rating to measure the quality of care and performance of the MCOs to provide information to help eligible members choose an MCO.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP MCOs, PIHPs, and PAHPs	✓		

Report Purpose

To comply with federal healthcare regulations at 42 CFR Part 438, LDH contracts with HSAG to annually provide to CMS an assessment of the performance of the State's Medicaid and CHIP MCEs, as required at 42 CFR §438.364. This annual EQR technical report includes results of all EQR-related activities that the EQRO conducted with Louisiana Medicaid MCEs throughout SFY 2023. This EQR technical report is intended to help the Louisiana Medicaid managed care program:

- Identify areas for quality improvement (QI).
- Ensure alignment among an MCE's Quality Assessment and Performance Improvement (QAPI) requirements, the State's quality strategy, and the annual EQR activities.
- Purchase high-value care.
- Achieve a higher performance healthcare delivery system for Medicaid and CHIP beneficiaries.
- Improve the State's ability to oversee and manage the MCEs with which it contracts for services.
- Help the MCEs improve their performance with respect to the quality, timeliness, and accessibility of care.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of each Louisiana Medicaid MCE in each of the domains of quality, timeliness, and access.

		
Quality	**Timeliness**	**Access**
as it pertains to the EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]	as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

Methodologies

Requirement 42 CFR §438.364(a)(1) describes the manner in which (1) the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and (2) conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by each MCO.

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO, as well as the program overall. To produce Healthy Louisiana's MCO aggregate SFY 2024 EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each MCO to identify strengths and opportunities for improvement in each domain of quality, timeliness, and access to services furnished by the MCO for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and access to care and services furnished by the MCO.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of quality, timeliness, and access to care and services furnished by the MCO.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of care for the program.

Louisiana's Medicaid Managed Care Quality Strategy

In accordance with 42 CFR §438.340, LDH implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Louisiana Medicaid members under the Louisiana Medicaid managed care program. Louisiana's Medicaid Managed Care Quality Strategy (quality strategy) dated September 2023 is guided by the Triple Aim of the National Quality Strategy.

LDH's mission is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for citizens of the state of Louisiana. The Medicaid managed care program in Louisiana is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid members.

Goals and Objectives

The quality strategy identified goals and objectives that focus on process as well as achieving outcomes. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Louisiana Medicaid managed care program.

The quality strategy identifies the following three aims and eight associated goals:



Better Care: Make healthcare more person-centered, coordinated, and accessible so it occurs at the "Right care, right time, right place."

Goal 1: Ensure access to care to meet enrollee needs

Goal 2: Improve coordination and transitions of care

Goal 3: Facilitate patient-centered, whole-person care



Healthier People, Healthier Communities: Improve the health of Louisianans through better prevention and treatment and proven interventions that address physical, behavioral, and social needs.

Goal 4: Promote wellness and prevention

Goal 5: Improve chronic disease management and control

Goal 6: Partner with communities to improve population health and address health disparities



Smarter Spending: Demonstrate good stewardship of public resources by ensuring high-value, efficient care.

Goal 7: Pay for value and incentivize innovation

Goal 8: Minimize wasteful spending

Quality Strategy Evaluation[1-4]

Strengths

Overall, the quality strategy serves to effectively measure and improve the quality of Louisiana's Medicaid managed care services. LDH's initiatives tie to the quality strategy aims, goals, and objectives. The quality strategy also promotes identification and implementation of initiatives to monitor, assess, and improve access to care, quality of care, and timeliness of service delivery for Louisiana Medicaid

[1-4] Health Services Advisory Group, Inc. Louisiana Department of Health. Medicaid Managed Care Quality Strategy Evaluation, Review Period: March 20, 2022–March 19, 2023, July 2023. Louisiana Department of Health. Available at: https://ldh.la.gov/assets/docs/MQI/Strategy/MQIStrategyEvaluation.pdf. Accessed on: Dec 16, 2024.

members. LDH plans to incorporate goals from the National Quality Strategy in the quality strategy in the future. LDH oversees the MCEs in coordination with the quality strategy to promote accountability and transparency for improving health outcomes. LDH has an MCO contract requirement that the MCO should be committed to QI. Each MCO is required to be NCQA accredited and to conduct HEDIS performance measure reporting. LDH plans to also include the requirement for a commitment to QI in the PAHP contract.

Recommendations

- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH identify a measure to align with the following objectives:
  - Ensure appropriate hospice onboarding and transitioning from palliative care to hospice.
  - Promote early initiation of palliative care to improve quality of life.
  - Promote health development and wellness in children and adolescents.
  - Advance specific interventions to address social determinants of health.
  - Advance value-based payment arrangements and innovation.
  - Ensure members who are improving or stabilized in hospice are considered for discharge.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends LDH include performance measures for the PAHPs and PIHP in the quality strategy.
- To target improvement in Goal 3, "Facilitate patient-centered, whole-person care," HSAG recommends LDH continue to implement a PIP collaboration process for the PAHPs to collaborate on current and future PIPs.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH continue to work with the MCEs during PIP and Medicaid Advisory Committee (MAC) meetings to discuss best practices for performance measures. During these discussions, LDH could focus on specific performance measures in the quality strategy that have not met improvement objectives and target objectives.
- To improve MCO performance in Goal 6, "Partner with communities to improve population health and address health disparities," HSAG recommends that LDH dedicate time in established meetings with the MCOs to discuss their health equity plans and the progress being made through quality interventions to reduce health disparities.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends that LDH update performance measures in the quality strategy to align with the requirements in the Performance Measure Submission Guide for the MCOs.
- To target improvement in Goal 1, "Ensure access to care to meet enrollee needs," HSAG recommends LDH assess MCO failure to provide NEMT and have the MCOs implement interventions to improve provision of non-emergency medical transportation (NEMT) and ensure it is timely and accessible.
- To improve programwide performance in support of LDH's quality strategy goals, HSAG recommends LDH assess areas of noncompliance that resulted in an MCO receiving a notice of

monetary penalty. This assessment should identify root causes for noncompliance and then work to identify appropriate interventions to eliminate noncompliance and improve performance.

- HSAG recommends that LDH report rates for the following measures:
  - Enrollment by Product Line
  - Language Diversity of Membership
  - Race/Ethnicity Diversity of Membership

Actions on External Quality Review Recommendations

The EQRO identified the following recommendations for the quality strategy during SFY 2022–2023. These recommendations included how LDH could target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 includes the recommendations that the EQRO made to LDH to support program improvement and progress in meeting the goals of the quality strategy. The State's responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Table 1-3—SFY 2022–2023 EQRO Recommendations and LDH Actions

SFY 2022–2023 EQRO Recommendations	LDH Actions
HSAG recommended LDH consider a change in metric benchmarks so the MCEs can strive toward a consistent performance level. HSAG recommended LDH remove the target objectives and improvement objectives and establish benchmarks for all MCEs that align with nationally recognized quality measures (e.g., NCQA Quality Compass,[1-5] CMS Adult and Child Core Sets) or the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.	LDH declined to change the target objectives and improvement objectives.
HSAG recommended LDH consider using the measurement year (MY) 2023 reported rates in the 2024 quality strategy evaluation, which could include MY 2021 through MY 2023 results in order to include the most current data for evaluation.	LDH agreed to use the MY 2023 reported rates in the 2024 quality strategy evaluation.
HSAG recommended LDH remove the duplicate objective, promote healthy development and wellness in children and adolescents.	LDH updated the quality strategy to remove this duplicate objective.
HSAG recommended LDH consider adding the objectives, improve overall health and promote reproductive health objectives, to the quality strategy.	LDH updated the quality strategy to include these two objectives.
HSAG recommended LDH continue to collaborate with the MCOs to support adequate QI capacity, skills, and resources to support	LDH will continue to meet and collaborate with the MCOs related to

[1-5] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

SFY 2022–2023 EQRO Recommendations	LDH Actions
current and future PIPs. HSAG recommended LDH continue to meet regularly with the MCOs and share best practices for identifying QI goals, objectives, and interventions. Furthermore, LDH could consider incorporating a similar mechanism for the PAHPs to collaborate on current and future PIPs. HSAG also recommended LDH consider hosting a forum in which the MCEs could discuss programwide solutions to overcome barriers. These QI activities provide opportunities to improve population health by implementing best practices and addressing barriers and challenges.	PIPs. LDH agreed with the EQRO's recommendation to incorporate a similar PIP collaboration process for the PAHPs, and the process is currently being developed. Lastly, LDH considers the monthly PIP meetings to be an avenue for discussing programwide solutions to overcome barriers.
HSAG recommended LDH identify expectations for improvement targets over a three-year period. Current target improvements compare to the previous measurement year and do not consider the baseline measurement year.	LDH declined to change the improvement targets' time period.
HSAG recommended the MCEs consider whether there are disparities within their populations that contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommended the MCEs target QI interventions to reduce the identified disparities.	The MCOs document this process in their annual health equity plans.
HSAG recommended LDH consider working with the MCEs to share performance measure best practices and identify interdependencies across measures.	LDH currently works with the MCEs collaboratively during monthly and quarterly PIP meetings as well as quarterly MAC meetings. The MAC consists of MCE chief medical officers (CMOs). Best practices are discussed frequently. In addition, LDH meets with the MCO chief executive officers (CEOs) and other support staff during quarterly business reviews to discuss recommendations and best practices.
HSAG recommended LDH consider a contract statement for all MCEs that the MCEs' quality initiatives must be designed to help achieve the goals outlined in the quality strategy. Currently only the MCOs have this contract requirement.	LDH plans to add a similar statement to the dental contract. Quality is being revamped and expanded for dental. LA Medicaid will also work with OBH to incorporate in the CSoC contracts.
HSAG recommended LDH consider removing Aim statements from the quality strategy. CMS defines "quality strategy goals" as SMART (specific, measurable, attainable, relevant, and time-bound), high-level managed care performance aims that provide direction for the State. CMS defines "quality strategy (SMART) objectives" as measurable steps toward meeting the State's goals that typically include quality measures.	LDH plans to move to incorporate the CMS National Quality Strategy to encompass the four National Quality Strategy priority areas.

Overview of External Quality Review Findings

Validation of Performance Improvement Projects

With the start of HSAG's EQRO contract with LDH in March 2023, HSAG initiated PIP validation training and technical assistance activities to assist LDH and the MCOs in transitioning to HSAG's PIP validation process and methodology. The MCOs actively worked on PIPs throughout SFY 2024, and PIP validation activities were initiated. LDH required the MCOs to conduct PIPs on the following state-mandated topics during SFY 2024:

- *Behavioral Health Transitions of Care*
- *Ensuring Access to the COVID-19 [coronavirus disease 2019] Vaccine Among Healthy Louisiana Enrollees*
- *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years*
- *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees*
- *Screening for HIV [human immunodeficiency virus] Infection*
- *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*

At the time this report was drafted, HSAG's first validation cycle of the MCOs' *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees* PIP was in progress and is scheduled to be completed in SFY 2025; therefore, final validation findings, including assessment of indicator results, interventions, strengths and opportunities, and recommendations for this PIP will be reported in next year's annual EQR technical report.

Validation of Performance Measures

HSAG's validation of the MCOs' performance measures confirmed compliance with the standards of 42 CFR §438.330(a)(1). The results of the validation activity determined that each MCO was compliant with the standards of 42 CFR §438.330(c)(2).

Information Systems Capabilities Assessment

Based on a review of the final audit reports (FARs) issued by each MCO's independent certified HEDIS compliance auditor, HSAG found that all MCOs fully met the standard for all four of the applicable NCQA HEDIS information systems (IS) standards.

HEDIS—Quality, Timeliness, and Access

HSAG's analysis was based on comparison of HEDIS measures/measure indicators to the MY 2023 NCQA national 50th percentile, which served as the benchmark. A total of 47 measures, comprising 290 measure indicators, were selected for analysis. Of the 290 measure indicators, 12 were not reported in Quality Compass and were excluded from comparison to NCQA national 50th percentile benchmarks.

Of the 278 HEDIS measures/measure indicators with an associated benchmark, LHCC demonstrated the highest performance with 190 indicators performing greater than the NCQA national 50th percentile benchmark, and with ACLA also demonstrating higher performance with 173 indicators performing greater than the NCQA national 50th percentile benchmark. HUM had the most indicators that performed lower than the NCQA national 50th percentile benchmark (132 indicators); however, HUM's results should be reviewed with caution due to its limited period as an MCO in Louisiana. Detailed results are shown in Section 3—Validation of Performance Measures.

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG reviewed the corrective action plans (CAPs) that the MCOs prepared to remediate any deficiencies identified during the 2023 CR. HSAG and LDH evaluated the sufficiency of the CAPs. All MCOs demonstrated positive improvements in implementing the CAPs.

HSAG will conduct a comprehensive CR during 2025 to determine the extent to which the MCOs are in compliance with federal standards during the review period calendar year (CY) 2024.

Validation of Network Adequacy

Provider Directory Validation

HSAG's provider directory validation (PDV) indicated that, overall, the provider information maintained and provided by the plans showed a low level of agreement between the MCOs' online provider directories and the information obtained during the telephone calls to the providers' offices. Table 1-4 provides a summary of the findings from the study.

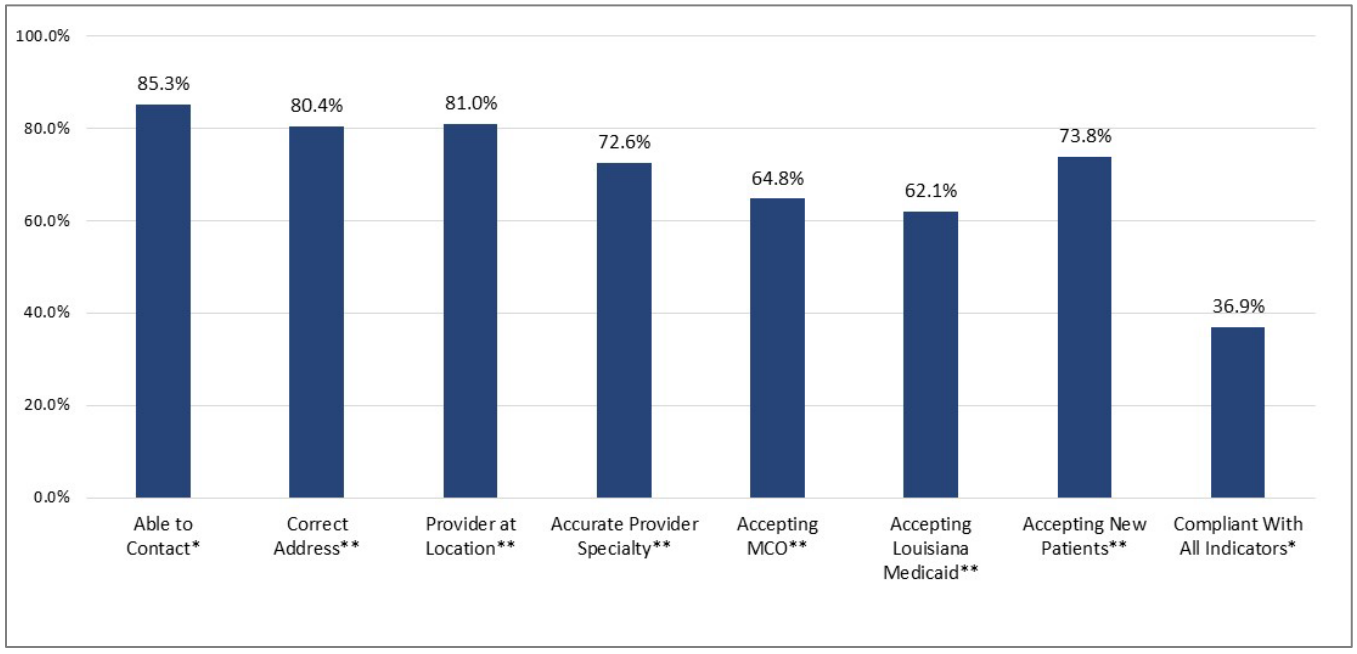
Table 1-4—Summary of PDV Findings

Concerns	Findings
Acceptance of Louisiana Medicaid was low.	Overall, 62.1 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 64.8 percent of providers accepted the requested MCO.
Provider's specialty in the provider data was inaccurate.	Overall, 72.6 percent of providers confirmed the specialty listed in the online directory was accurate.
Overall acceptance of new patients was low.	Overall, 73.8 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Address information was inaccurate.	Overall, 80.4 percent of locations confirmed the address listed in the online directory was accurate.
Affiliation with the sampled provider was low.	Overall, 81.0 percent of the locations confirmed affiliation with the sampled provider.

The overall response rate was 85.3 percent, and once contacted, the offices reported varying degrees of match rates for the online provider directory information. The accuracy of the MCO acceptance, Louisiana Medicaid acceptance, and accuracy of the provider's specialty exhibited the lowest match rates. Overall, only 36.9 percent of providers were compliant with all PDV indicators.

Figure 1-1 presents the summary results for all sampled providers and the percent compliant with all PDV indicators.

Figure 1-1—Summary Results for All Sampled Providers



*The denominator includes all sampled providers.
**The denominator includes cases reached.

Table 1-5 presents the PDV weighted compliance scores by MCO. Please see the NAV methodology for the weighted compliance score calculation criteria.

Table 1-5—PDV Weighted Compliance Scores

MCO	Total	Compliant[1]	Weighted Compliance Score
Total	**3,000**	**1,107**	**44.2%**
ABH	500	122	34.8%
ACLA	500	225	50.8%
HBL	500	175	43.5%
HUM	500	185	42.9%
LHCC	500	211	50.0%
UHC	500	189	43.0%

[1] Compliant providers include providers for which all indicators match between the MCO provider directory and the information obtained during the survey call to the sampled location.

Provider Access Survey

HSAG's provider access survey indicated that, overall, the provider information maintained and provided by the plans showed a low level of agreement between the MCOs' provider data and the information obtained during the telephone calls to the providers' offices. Table 1-6 provides a summary of the findings from the study.

Table 1-6—Summary of Provider Access Survey Findings

Concerns	Findings
Affiliation with the sampled provider was low.	Overall, 34.2 percent of the locations confirmed affiliation with the sampled provider.
Acceptance of new patients was low.	Overall, 41.1 percent of providers accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of Louisiana Medicaid was low.	Overall, 45.7 percent of providers accepted Louisiana Medicaid.
Acceptance of the MCO was low.	Overall, 50.0 percent of providers accepted the requested MCO.
Provider's specialty in the provider data was inaccurate.	Overall, 60.7 percent of providers confirmed the specialty listed in the provider data was accurate.
Address information was inaccurate.	Overall, 84.3 percent of locations confirmed the address listed in the provider data was accurate.

Table 1-7 presents the provider access survey call outcomes.

Table 1-7—Provider Access Survey Call Outcomes

Specialty	Able to Contact[1]	Correct Address[2]	Offering Services[2]	Accepting MCO[2]	Accepting Medicaid[2]	Accepting New Patients[2]	Confirmed Provider[2]	Offered Appointment[2]
Total	**71.9%**	**84.3%**	**60.7%**	**50.0%**	**45.7%**	**41.1%**	**34.2%**	**17.9%**
Primary Care	65.3%	86.8%	60.4%	46.4%	39.6%	32.8%	23.0%	24.7%
Pediatrics	78.8%	88.4%	68.3%	61.9%	59.8%	55.6%	50.3%	27.0%
Obstetricians/ Gynecologists (OB/GYNs)	74.2%	78.7%	58.4%	50.6%	49.4%	47.2%	37.1%	16.9%
Endocrinologists	77.7%	79.5%	58.9%	47.9%	43.8%	41.1%	38.4%	6.8%
Dermatologists	70.7%	85.7%	74.3%	55.7%	48.6%	41.4%	40.0%	15.7%
Neurologists	68.3%	81.7%	36.6%	24.4%	24.4%	23.2%	18.3%	2.4%
Orthopedic Surgeons	76.3%	80.0%	61.1%	54.4%	46.7%	42.2%	33.3%	6.7%

[1] The denominator includes all sampled providers.
[2] The denominator includes cases reached.

Table 1-8 and Table 1-9 present the provider access survey weighted compliance scores by specialty and MCO, respectively.

Table 1-8—Provider Access Survey Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**1,151**	**281**	**39.4%**
Primary Care	360	54	29.4%
Pediatrics	240	94	52.5%
OB/GYNs	120	33	42.8%
Endocrinologists	94	27	44.7%
Dermatologists	99	28	36.4%
Neurologists	120	15	37.2%
Orthopedic Surgeons	118	30	40.1%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

Table 1-9—Provider Access Survey Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**1,151**	**281**	**39.4%**
ABH	188	32	40.4%
ACLA	191	64	43.8%
HBL	194	47	37.6%
HUM	186	73	45.7%
LHCC	200	22	31.2%
UHC	192	43	38.0%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

Table 1-10 and Table 1-11 display the provider access survey after-hours weighted compliance scores by specialty and MCO, respectively.

Table 1-10—Provider Access Survey After-Hours Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**281**	**86**	**33.8%**
Primary Care	90	26	30.7%
Pediatrics	60	24	42.2%
OB/GYNs	30	11	41.1%
Endocrinologists	20	6	35.0%
Dermatologists	22	4	21.2%
Neurologists	30	9	34.4%
Orthopedic Surgeons	29	6	26.4%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

Table 1-11—Provider Access Survey After-Hours Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Total	**281**	**86**	**33.8%**
ABH	45	6	15.6%
ACLA	46	14	34.8%
HBL	48	15	34.7%
HUM	45	25	58.5%
LHCC	50	9	21.3%
UHC	47	17	39.0%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

NAV Audit

HSAG assessed the MCOs' provider-to-member ratios and determined that all MCOs met or exceeded LDH-established thresholds across all provider types.

HSAG assessed the MCOs' submitted distance results and found commonality among the MCOs that met the 100 percent threshold for distance requirements by provider type and urbanicity. Table 1-12 identifies the provider types/urbanicity for which all MCOs met the required LDH threshold for distance.

Table 1-12—Provider Types by Urbanicity, Compliant With Distance Standards Across All MCOs

Provider Type	Urbanicity
Adult Primary Care Provider (PCP) (Family/General Practice; Internal Medicine and Physician Extenders)	Rural
Pharmacy	Rural

HSAG assessed the appointment timeliness standards and determined that for the three behavioral health standards reported to LDH through the 359 template, all MCOs met the required compliance rate for non-urgent routine behavioral health care. ABH, ACLA, and LHCC met all three timeliness standards. Table 1-13 displays the behavioral health provider access and timeliness standard by visit type, for which performance goals were met by each MCO.

Table 1-13—MCOs That Met Behavioral Health Provider Access and Timeliness Goals, by Standard

Type of Visit	Access/Timeliness Standard	Plans That Met Performance Goal
Emergency Care	24 hours, 7 days/week within 1 hour of request	ABH, ACLA, HBL, LHCC, UHC
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	ABH, ACLA, LHCC
Non-Urgent Routine Behavioral Health Care	14 calendar days	ABH, ACLA, HBL, HUM, LHCC, UHC

Consumer Surveys: CAHPS-A and CAHPS-C

HSAG compared the Healthy Louisiana SWA's 2024 achievement scores to its corresponding 2023 achievement scores and the 2024 NCQA national averages to determine whether there were statistically significant differences. Overall, the Healthy Louisiana SWA's 2024 adult achievement scores were significantly higher than the 2024 NCQA adult Medicaid national averages for three measures: *Rating of All Health Care*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*. Furthermore, the Healthy Louisiana SWA's 2024 general child achievement scores were significantly higher than the 2024 NCQA general child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly*.

Behavioral Health Member Satisfaction Survey

HSAG compared the Healthy Louisiana SWA's 2024 achievement scores to the corresponding 2023 scores to determine whether there were statistically significant differences. Overall, the Healthy Louisiana SWA's 2024 adult and child scores were not statistically significantly higher or lower than the 2023 scores; therefore, no strengths or opportunities for improvement were identified.

Health Disparities Focus Study

For the 2023 Annual Health Disparities Focus Study, HSAG used MCO-provided CY 2022 stratified HEDIS and non-HEDIS indicator rates to identify disparities based on race, ethnicity, and geography, where applicable. HSAG also used the MCO-provided CAHPS data files to identify disparities based on race and ethnicity. A disparity was identified if the relative difference in an indicator rate between the group of interest (e.g., Black or African American group for the race demographic stratification) and the reference group (e.g., the White group for the race demographic stratification) was greater than 10 percent.

Table 1-14—Overall Statewide Disparities by Demographic Stratification

Demographic Stratification	Better Than the Reference Group	No Disparity Identified	Worse Than the Reference Group
Race (n=41)			
White	—	—	—
American Indian or Alaska Native	6 (37.5%)	7 (43.8%)	3 (18.8%)
Asian	4 (17.4%)	15 (65.2%)	4 (17.4%)
Black or African American	5 (12.2%)	29 (70.7%)	7 (17.1%)
Native Hawaiian or Other Pacific Islander	1 (100.0%)	0 (0.0%)	0 (0.0%)
Other	8 (25.0%)	22 (68.8%)	2 (6.3%)
Unknown	6 (15.8%)	21 (55.3%)	11 (28.9%)
Ethnicity (n=41)			
Non-Hispanic/Latino	—	—	—
Hispanic/Latino	17 (43.6%)	18 (46.2%)	4 (10.3%)
Unknown	6 (14.6%)	21 (51.2%)	14 (34.1%)
Geography (n=15)			
Urban	—	—	—
Rural	0 (0.0%)	10 (66.7%)	5 (33.3%)
Unknown	0 (0.0%)	3 (23.1%)	10 (76.9%)

— indicates the reference group for the select demographic stratification.

The following statewide disparities were found based on race, ethnicity, and geography:

- For the American Indian or Alaska Native group:
  - Rates were suppressed at the statewide level for 25 of 41 indicators, including all 20 indicators based on CAHPS data.
  - Three of the six indicators where the rate for the American Indian or Alaska Native group was better than the rate for the White group were in the Women's Health domain.
  - Two of the three indicators where the rate for the American Indian or Alaska Native group was worse than the rate for the White group were in the Children's Health domain.
- For the Asian group:
  - Rates were suppressed at the statewide level for 18 of 41 indicators, including 17 of the 20 indicators based on CAHPS data.
  - Two of the four indicators where the rate for the Asian group was better than the rate for the White group were in the Children's Health domain.
  - Two of the four indicators where the rate for the Asian group was worse than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization. The other two indicators were in the Behavioral Health domain.
- For the Black or African American group:
  - Three of the five indicators where the rate for the Black or African American group was better than the rate for the White group were in the Women's Health domain.
  - The rates for the Black or African American group were worse than the rates for the White group for most indicators in the Behavioral Health domain.
- For the Native Hawaiian or Other Pacific Islander group:
  - Rates were suppressed at the statewide level for 40 of 41 indicators.
  - The one reportable rate for the Native Hawaiian or Other Pacific Islander group was better than the rate for the White group (*Child and Adolescent Well-Care Visits* [WCV]).
- For the Other group:
  - Four of the eight indicators where the rate for the Other group was better than the rate for the White group were in the Children's Health domain.
  - The two indicators where the rate for the Other group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain.
- For the Unknown race group:
  - Two of the six indicators where the rate for the Unknown race group was better than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization.
  - Six of the 11 indicators where the rate for the Unknown race group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain. Additionally, the rates for the Unknown race group were below the rates for the White race group for all three indicators in the Behavioral Health domain.

- For the Hispanic/Latino group:
  - The rates for the Hispanic/Latino group were better than the rates for the Non-Hispanic/Latino group for 17 of 39 indicators with reportable rates, including all six indicators in the Children's Health domain and four of seven indicators in the Women's Health domain.
  - Two of the four indicators where the rate for the Hispanic/Latino group was worse than the Non-Hispanic/Latino group were in the Chronic Conditions domain, specifically related to hemoglobin A1c (HbA1c) control for diabetes.
- For the Unknown ethnicity group:
  - Four of the six indicators where the rate for the Unknown ethnicity group was worse than the rate for the Non-Hispanic/Latino group were in the Member Experience With Health Plan and Providers domain.
  - The rates for the Unknown ethnicity group were worse than the rates for the Non-Hispanic/Latino group for most measures in the Women's Health and Behavioral Health domains.
- For the Rural group:
  - No rates for the Rural group were better than the rates for the Urban group.
  - Four of the five indicators where the rate for the Rural group was worse than the rate for the Urban group were in the Women's Health domain, specifically related to postpartum contraception utilization.
- For the Unknown geography group:
  - No rates for the Unknown geography group were better than the rates for the Urban group.
  - The rates for the Unknown geography group were worse than the rates for the Urban geography group for all five indicators in the Children's Health domain and two of the three indicators in the Women's Health domain.

Case Management Performance Evaluation

During SFY 2024, HSAG conducted two CMPE reviews. HSAG evaluated the MCOs' compliance with the case management provisions of their contracts with LDH, including the rates of engagement in case management; the specific services offered to enrollees receiving case management; and the effectiveness of case management in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

The reviews identified successes and opportunities for improvement for all MCOs, which were used by LDH to inform guidance and develop CAPs to address performance. The following strengths were identified for the MCOs statewide:

- The results of both reviews demonstrated that no findings resulted in concerns regarding an enrollee's health, safety, or welfare.
- The results of both reviews demonstrated that five of the six MCOs were successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans, and multidisciplinary care team (MCT) development.

While the MCOs achieved successes with initial enrollee engagement case activities, all six MCOs demonstrated the following opportunities for improvement:

- Elements related to ongoing scheduled case management activities.
- Although the MCOs reported varying levels of success with enrollee engagement, they were generally unable to demonstrate use of alternative options for engagement. HSAG observed limited documentation of attempts to contact enrollees' formal or informal supports (i.e., physicians, BH professionals, pharmacists, personal assistants/homemakers) to assist with engagement attempts. In addition, while all six MCOs had unable to reach (UTR) processes to assist with enrollee engagement, the MCOs were unable to demonstrate consistent application of those processes.
- For the CY 2024 review, although the MCOs were generally successful in developing a plan of care (POC) with enrollees, there was opportunity for improvement related to person-centered planning.

Specific findings and recommended actions were provided to the MCOs through HSAG's CAP process. All MCOs successfully completed remediation actions to address the CAP findings, and the CAPs were closed in October 2024.

Quality Rating System

Figure 1-2 displays the 2024 Health Plan Report Card, which presents the 2024 rating results for each MCO. The 2024 Health Plan Report Card shows that, for the Overall Rating, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.5 stars. For the Consumer Satisfaction composite, one MCO (UHC) received 5.0 stars, two MCOs (HBL and LHCC) received 4.0 stars, and two MCOs (ABH an ACLA) received 3.5 stars. For the Prevention and Equity composite, ACLA, HBL, and UHC each received 3.0 stars, while ABH and LHCC received the lowest ratings at 2.5 stars. For the Treatment composite, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.0 stars.

Figure 1-2—2024 Health Plan Report Card

Issued 08/2024

Healthy Louisiana

2024 HEALTH PLAN REPORT CARD

The ratings below compare the performance of Louisiana's Medicaid health plans. This report card shows the results of care in the areas of Consumer Satisfaction, Prevention and Equity, and Treatment, and can aid you and your family when deciding on a health plan.

PERFORMANCE KEY	Lowest	Low	Average	High	Highest	Insufficient Data
	★	★★	★★★	★★★★	★★★★★	—

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Overall Rating*	★★★½	★★★½	★★★½	**New	★★★½	★★★½
CONSUMER SATISFACTION						
Overall Consumer Satisfaction	★★★½	★★★½	★★★★	**New	★★★★	★★★★★
Getting care: How easily and quickly did members get appointments, preventive care, tests, and treatments?	★★★★½	★★½	★★★½	**New	★★★½	—
Satisfaction with plan physicians: How happy are members with their primary care doctors?	★★★½	★★★½	★★★★½	**New	★★★★★	★★★★★
Satisfaction with plan services: How happy are members with their health plan and their overall care?	★★½	★★★½	★★★★½	**New	★★★★	★★★★★
PREVENTION AND EQUITY						
Overall Prevention and Equity	★★½	★★★	★★★	**New	★★½	★★★
Children/adolescent well-care: Do children and adolescents receive vaccines and weight assessments?	★★	★★½	★★½	**New	★★	★★½
Women's reproductive health: Do women receive care before and after their babies are born?	★★½	★★	★★★	**New	★★½	★★★½

Continued on next page...

Figure 1-2—2024 Health Plan Report Card (cont.)

	Aetna Better Health	AmeriHealth Caritas Louisiana	Healthy Blue	Humana Healthy Horizons	Louisiana Healthcare Connections	UnitedHealthcare Community Plan
Cancer screening: Do female members receive cervical cancer screenings?	★★	★★★	★★	**New	★★★	★★★
Equity: Do health plans collect race and ethnicity information from their members?	★★★★★	★★★★★	★★★★★	**New	NC	★★★★★
Other preventive services: Do members receive important preventive services?	★★★½	★★★★	★★★★	**New	★★★½	★★★
TREATMENT						
Overall Treatment	★★★	★★★	★★★	**New	★★★	★★★
Respiratory: Do people with respiratory issues get the services/treatments they need?	★★★½	★★★	★★★½	**New	★★★	★½
Diabetes: Do people with diabetes get the services/ treatments they need?	★★★½	★★★½	★★★★	**New	★★★★	★★★★½
Heart disease: Do people with heart disease get the services/ treatments they need?	★★★½	★★★	★★½	**New	★★★½	★★★
Behavioral health—care coordination: Do people with behavioral health issues get the follow-up care they need?	★½	★	★½	**New	★	★½
Behavioral health—medication adherence: Do people with behavioral health issues stay on prescribed medications?	★★★½	★★½	★★½	**New	★★★½	★★
Behavioral health—access, monitoring, and safety: Do people on behavioral health medications receive the services/ monitoring they need?	★★★★	★★★½	★★★★	**New	★★★	★★★★
Risk-adjusted utilization: Do members who are discharged from the hospital have unplanned readmissions within 30 days?	★★★	★★★	★★★	**New	★★★	★★★
Reduce low value care: Do members with low back pain receive unnecessary imaging tests?	★★	★★	★★	**New	★★	★★

*This rating includes all measures in the report card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.

**Due to Humana Healthy Horizons being a new plan in 2023, data are not available yet. Humana Healthy Horizons will be included in future health plan report cards.

Insufficient Data indicates that the plan was missing the majority of data for the composite.

NC indicates that the plan received a rating of 0 for the measure in this composite.

This report card is reflective of data collected between January 2023 and December 2023.

The categories and measures included in this report card are based on the 2024 National Committee for Quality Assurance (NCQA) Health Plan Ratings and LDH required measures lists. When feasible, categories and measures were kept consistent with the prior year's health plan report card, but some measures and categories were removed due to data availability. Any analysis, interpretation, and conclusions based on the data is solely that of the author. Anyone desiring to use or reproduce the materials must obtain approval from LDH.

2. Validation of Performance Improvement Projects

Aggregate Results

SFY 2024 (review period) was the second year that HSAG was contracted as the EQRO for LDH. LDH required the MCOs to carry out PIPs to address five state-mandated topics that were validated during SFY 2024. LDH also required the MCOs to initiate a new PIP topic, *Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees*, in January 2024 to be validated during SFY 2025. Table 2-1 summarizes the PIP topics carried out by each MCO.

Table 2-1—SFY 2024 MCO PIP Topics and Targeted Age Groups

PIP Topic	Targeted Age Group
Behavioral Health Transitions of Care	• 6 years and older • 13 years and older
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• 5–11 years • 12–15 years • 16 years and older
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• 6 months–18 months • 19 months–2 years • 3–5 years
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• 21–64 years
Screening for HIV Infection	• 13 years and older • 15–65 years
*Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees**	• *Not applicable*

*PIP to be validated during SFY 2025.

For each PIP topic, the MCOs collaborated on improvement strategies, meeting at least monthly collectively with LDH, throughout the year. The MCOs also submitted updates on improvement strategies and interim indicator results for each PIP topic quarterly that were reviewed by HSAG and LDH. HSAG provided feedback and technical assistance on PIPs to LDH and the MCOs at group and one-on-one meetings throughout the contract year.

Table 2-2 summarizes key PIP validation milestones that occurred from July 2023 through June 2024, the end of SFY 2024.

Table 2-2—SFY 2024 MCO PIP Activities

PIP Activities and Milestones	Dates
Monthly collaborative PIP meeting with LDH, the MCOs, and HSAG	July 2023–June 2024
The MCOs submitted Quarter 2 2023 PIP updates	July 2023
HSAG provided initial PIP proposal validation findings to the MCOs	September 2023
The MCOs submitted Quarter 3 2023 PIP updates	October 2023
The MCOs submitted draft PIP reports, to HSAG for validation	January 2024
The MCOs submitted Quarter 1 2024 PIP updates	April 2024
HSAG provided draft PIP report validation findings to the MCOs	February 2024
The MCOs submitted final PIP reports to HSAG for validation	March 2024
HSAG provided final PIP validation reports to the MCOs	April 2024

In SFY 2025, the MCOs will submit the draft PIP reports for initial validation in January 2025 and the final PIP reports for final validation in March 2025. HSAG will complete the second annual validation cycle in April 2025.

Validation Results and Confidence Ratings

Table 2-3 summarizes the MCOs' final PIP validation results and confidence ratings delivered by HSAG in April 2024.

Table 2-3—SFY 2024 PIP Validation Results for Each MCO

MCO	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
ABH	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
	Ensuring Access to the COVID-19 Vaccine	85%	89%	*Low Confidence*	33%	100%	*Moderate Confidence*

MCO	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
	Among Healthy Louisiana Enrollees						
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		
ACLA	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		
HBL	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Ensuring Access to the COVID-19 Vaccine	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

MCO	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
	Among Healthy Louisiana Enrollees						
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		
HUM	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	*Not Assessed*		
	Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	*Not Assessed*		
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		
LHCC	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Ensuring Access to the COVID-19 Vaccine	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*

MCO	PIP Topic	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
	Among Healthy Louisiana Enrollees						
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		
UHC	*Behavioral Health Transitions of Care*	100%	100%	*High Confidence*	33%	100%	*No Confidence*
	Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	100%	100%	*High Confidence*	33%	100%	*Low Confidence*
	Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	100%	100%	*High Confidence*	*Not Assessed*		
	Screening for HIV Infection	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Performance Indicator Results

Table 2-4 displays data for ABH's *Behavioral Health Transitions of Care* PIP.

Table 2-4—Performance Indicator Results for ABH's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 469 D: 2,845	16.49%	N: 567 D: 3,162	17.93%			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 968 D: 2,845	34.02%	N: 1,132 D: 3,162	35.80%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 85 D: 451	18.85%	N: 117 D: 585	20.00%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 141 D: 451	31.26%	N: 190 D: 585	32.48%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 115 D: 903	12.74%	N: 291 D: 1,312	22.18%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 166 D: 903	18.38%	N: 431 D: 1,312	32.85%▲			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-5 displays data for ACLA's *Behavioral Health Transitions of Care* PIP.

Table 2-5—Performance Indicator Results for ACLA's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 715 D: 4,053	17.64%	N: 741 D: 3,790	19.55%▲			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 1,389 D: 4,053	34.27%	N: 1,408 D: 3,790	37.15%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 159 D: 722	22.02%	N: 117 D: 565	20.71%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 243 D: 722	33.66%	N: 179 D: 565	31.68%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 252 D: 1,469	17.15%	N: 141 D: 1,158	12.18%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 424 D: 1,469	28.86%	N: 230 D: 1,158	19.86%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-6 displays data for HBL's *Behavioral Health Transitions of Care* PIP.

Table 2-6—Performance Indicator Results for HBL's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 1,183 D: 6,113	19.35%	N: 1,205 D: 6,047	19.93%			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 2,285 D: 6,113	37.38%*	N: 2,206 D: 6,047	36.48%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 197 D: 1,070	18.41%	N: 236 D: 1,136	20.77%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 325 D: 1,070	30.37%	N: 405 D: 1,136	35.65%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 149 D: 1,597	9.33%	N: 403 D: 2,129	18.93%▲			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 234 D: 1,597	14.65%	N: 600 D: 2,129	28.18%▲			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
* Baseline percentage for FUH—Total, 30 Days was calculated from the MCO's reported numerator and denominator. The MCO's reported baseline percentage could not be replicated using the reported numerator and denominator values.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-7 displays data for HUM's *Behavioral Health Transitions of Care* PIP. For HUM, CY 2023 was the baseline measurement period for this PIP topic because the MCO began operations for the Louisiana Medicaid Program on January 1, 2023.

Table 2-7—Performance Indicator Results for HUM's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 183 D: 1,417	12.91%					*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 406 D: 1,417	28.65%					*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 39 D: 274	14.23%					*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 57 D: 274	20.80%					*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 79 D: 613	12.89%					*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 122 D: 613	19.90%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-8 displays data for LHCC's *Behavioral Health Transitions of Care* PIP.

Table 2-8—Performance Indicator Results for LHCC's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 1,673 D: 9,156	18.27%	N: 1,717 D: 8,592	19.98% ▲			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 3,551 D: 9,156	38.78%	N: 3,444 D: 8,592	40.08%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 401 D: 1,804	22.23%	N: 349 D: 1,593	21.91%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 679 D: 1,804	37.64%	N: 598 D: 1,593	37.54%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 462 D: 2,912	15.87%	N: 309 D: 2,336	13.23%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 759 D: 2,912	26.06%	N: 509 D: 2,336	21.79%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-9 displays data for UHC's *Behavioral Health Transitions of Care* PIP.

Table 2-9—Performance Indicator Results for UHC's *Behavioral Health Transitions of Care* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 7 Days	N: 1,595 D: 7,632	20.90%	N: 1,432 D: 7,065	20.27%			*Not Assessed*
Follow-Up After Hospitalization for Mental Illness (FUH)—Total, 30 Days	N: 2,931 D: 7,632	38.40%	N: 2,619 D: 7,065	37.07%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 7 Days	N: 351 D: 1,469	23.89%	N: 268 D: 1,322	20.27%			*Not Assessed*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)—Total, 30 Days	N: 541 D: 1,469	36.83%	N: 429 D: 1,322	32.45%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 7 Days	N: 495 D: 3,021	16.39%	N: 308 D: 2,198	14.01%			*Not Assessed*
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)—Total, 30 Days	N: 785 D: 3,021	25.98%	N: 482 D: 2,198	21.93%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-10 displays data for ABH's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-10—Performance Indicator Results for ABH's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 61,361 D: 119,997	51.14%	N: 59,054 D: 115,387	51.18%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 53,937 D: 119,997	44.95%	N: 51,794 D: 115,387	44.89%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 19,056 D: 43,319	43.99%	N: 17,074 D: 39,406	43.33%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 25,516 D: 45,109	56.57%	N: 26,603 D: 46,500	57.21% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 4,292 D: 9,858	43.54%	N: 6,093 D: 13,510	45.10% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 12,497 D: 21,711	57.56%	N: 9,284 D: 15,971	58.13%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 16,691 D: 43,319	38.53%	N: 14,964 D: 39,406	37.97%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 22,353 D: 45,109	49.55%	N: 23,249 D: 46,500	50.00%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 3,580 D: 9,858	36.32%	N: 5,166 D: 13,510	38.24% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 11,313 D: 21,711	52.11%	N: 8,415 D: 15,971	52.69%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 2,381 D: 38,752	6.14%	N: 2,960 D: 10,318	28.69% ▲	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 1,975 D: 38,752	5.10%	N: 2,341 D: 10,318	22.69% ▲	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 2,246 D: 38,752	5.80%	N: 2,688 D: 19,834	13.55% ▲	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 1,679 D: 38,752	4.33%	N: 1,995 D: 19,834	10.06% ▲	*Not Assessed*

N–Numerator D–Denominator
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-11 displays data for ACLA's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-11—Performance Indicator Results for ACLA's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 76,027 D: 160,161	47.47%	N: 56,953 D: 119,679	47.59%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 65,993 D: 160,161	41.20%	N: 49,441 D: 119,679	41.31%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 21,267 D: 54,589	38.96%	N: 15,395 D: 39,733	38.75%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 37,155 D: 71,215	52.17%	N: 28,631 D: 54,276	52.75% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 4,451 D: 10,834	41.08%	N: 4,770 D: 11,411	41.80%	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 13,154 D: 23,523	55.92%	N: 8,157 D: 14,529	56.14%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 18,476 D: 54,589	33.85%	N: 13,341 D: 39,733	33.58%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 31,971 D: 71,215	44.89%	N: 24,758 D: 54,276	45.62% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 3,723 D: 10,834	34.36%	N: 3,979 D: 11,411	34.87%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 11,823 D: 23,523	50.26%	N: 7,363 D: 14,259	51.64% ▲	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 6,451 D: 21,037	30.67%	N: 4,751 D: 17,409	27.29%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 5,257 D: 21,037	24.99%	N: 3,784 D: 17,409	21.74%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 4,955 D: 34,900	14.20%	N: 3,758 D: 30,844	12.18%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 3,659 D: 34,900	10.48%	N: 2,763 D: 30,844	8.96%	*Not Assessed*

N–Numerator D–Denominator
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-12 displays data for HBL's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-12—Performance Indicator Results for HBL's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 30,214 D: 219,679	13.75%	N: 96,273 D: 209,541	45.94% ▲	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 15,214 D: 219,679	6.93%	N: 83,615 D: 209,541	39.90% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 5,802 D: 52,643	11.02%	N: 28,120 D: 75,297	37.35% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 9,020 D: 66,408	13.58%	N: 45,044 D: 86,175	52.27% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 1,589 D: 14,926	10.65%	N: 10,140 D: 23,983	42.28% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 13,803 D: 85,702	16.11%	N: 12,969 D: 24,086	53.84% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 2,811 D: 52,643	5.34%	N: 24,482 D: 75,297	32.51% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 4,633 D: 66,408	6.98%	N: 38,763 D: 86,175	44.98% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 699 D: 14,926	4.68%	N: 8,652 D: 23,983	36.08% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 7,071 D: 85,702	8.25%	N: 11,718 D: 24,086	48.65% ▲	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 8,870 D: 29,084	30.50%	N: 5,699 D: 22,057	25.84%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 7,252 D: 29,084	24.93%	N: 4,543 D: 22,057	20.60%	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 7,598 D: 53,137	14.30%	N: 4,744 D: 39,943	11.88%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 7,598 D: 53,137	14.30%	N: 3,580 D: 39,943	8.96%	*Not Assessed*

N–Numerator D–Denominator
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-13 displays data for HUM's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP. For HUM, CY 2023 was the baseline measurement period for this PIP topic because the MCO began operations for the Louisiana Medicaid Program on January 1, 2023.

Table 2-13—Performance Indicator Results for HUM's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 32,865 D: 89,181	36.85%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 32,107 D: 89,181	36.00%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 8,762 D: 27,125	32.30%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 14,191 D: 32,780	43.29%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 3,459 D: 9,737	35.52%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 6,453 D: 19,539	33.03%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 8,600 D: 27,125	31.71%	*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 13,858 D: 32,780	42.28%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 3,321 D: 9,737	34.11%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 6,328 D: 19,539	32.39%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 2,865 D: 13,200	21.70%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 2,751 D: 13,200	20.84%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 2,289 D: 24,390	9.38%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 2,103 D: 24,390	8.62%	*Not Assessed*

N–Numerator D–Denominator
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-14 displays data for LHCC's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-14—Performance Indicator Results for LHCC's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 150,623 D: 336,359	44.78%	N: 124,270 D: 270,672	45.91% ▲	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 129,645 D: 336,359	38.54%	N: 107,600 D: 270,672	39.75% ▲	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 41,242 D: 119,944	34.38%	N: 33,099 D: 93,939	35.23% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 79,610 D: 155,173	51.30%	N: 65,336 D: 122,176	53.48% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 10,501 D: 25,647	40.94%	N: 11,914 D: 28,898	41.23%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 19,270 D: 35,595	54.14%	N: 13,921 D: 25,659	54.25%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 35,546 D: 119,944	29.64%	N: 28,617 D: 93,939	30.46% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 67,955 D: 155,173	43.79%	N: 56,347 D: 122,176	46.12% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 8,796 D: 25,647	34.30%	N: 10,044 D: 28,898	34.76%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 17,348 D: 35,595	48.74%	N: 12,592 D: 25,659	49.07%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 17,507 D: 59,394	29.48%	N: 12,340 D: 48,927	25.22%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 14,427 D: 59,394	24.29%	N: 10,043 D: 48,927	20.53%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 12,916 D: 99,784	12.94%	N: 9,492 D: 85,725	11.07%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 9,712 D: 99,784	9.73%	N: 7,248 D: 85,725	8.45%	*Not Assessed*

N–Numerator D–Denominator
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-15 displays data for UHC's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP.

Table 2-15—Performance Indicator Results for UHC's *Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of COVID-19 vaccine, persons who received at least one vaccine dose	N: 158,887 D: 335,991	47.29%	N: 119,684 D: 252,981	47.31%	*Not Assessed*
Receipt of COVID-19 vaccine, persons who received a complete vaccine course	N: 137,938 D: 335,991	41.05%	N: 104,396 D: 252,981	41.27%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among White enrollees	N: 45,155 D: 122,415	36.89%	N: 33,425 D: 90,389	36.98%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Black enrollees	N: 79,360 D: 145,822	54.42%	N: 59,696 D: 108,441	55.05% ▲	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among Hispanic/Latino enrollees	N: 11,429 D: 26,498	43.13%	N: 11,963 D: 27,638	43.28%	*Not Assessed*
Receipt of at least one dose of COVID-19 vaccine among enrollees of other, missing, or unknown race/ethnicity	N: 22,943 D: 41,256	55.61%	N: 14,600 D: 26,512	55.07%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among White enrollees	N: 39,032 D: 122,415	31.88%	N: 29,122 D: 90,389	32.22%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Black enrollees	N: 68,438 D: 145,822	46.93%	N: 51,809 D: 108,441	47.78% ▲	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among Hispanic/Latino enrollees	N: 9,726 D: 26,498	36.70%	N: 10,211 D: 27,638	36.95%	*Not Assessed*
Receipt of a complete COVID-19 vaccine course among enrollees of other, missing, or unknown race/ethnicity	N: 20,742 D: 41,256	50.28%	N: 13,254 D: 26,513	49.99%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 12–15 years	N: 15,882 D: 50,655	31.35%	N: 11,152 D: 41,553	26.84%	*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Sustained Improvement
Receipt of complete COVID-19 vaccine series, ages 12–15 years	N: 13,230 D: 50,655	26.12%	N: 9,192 D: 41,553	22.12%	*Not Assessed*
Receipt of at least one COVID-19 vaccine, ages 5–11 years	N: 12,161 D: 85,529	14.22%	N: 8,401 D: 69,611	12.07%	*Not Assessed*
Receipt of complete COVID-19 vaccine series, ages 5–11 years	N: 9,290 D: 85,529	10.86%	N: 6,455 D: 69,611	9.27%	*Not Assessed*

N–Numerator D–Denominator
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-16 displays data for ABH's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-16—Performance Indicator Results for ABH's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 152 D: 3,300	4.60%	N: 135 D: 3,478	3.88%			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 291 D: 4,060	7.16%	N: 281 D: 4,450	6.31%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 280 D: 6,680	4.19%	N: 262 D: 7,080	3.70%			*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 723 D: 14,040	5.15%	N: 678 D: 15,008	4.52%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-17 displays data for ACLA's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-17—Performance Indicator Results for ACLA's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 295 D: 5,651	5.22%	N: 281 D: 3,315	8.48%▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 585 D: 5,670	10.32%	N: 683 D: 5,965	11.45%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 622 D: 11,073	5.62%	N: 520 D: 9,007	5.77%			*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 1,502 D: 22,358	6.72%	N: 1,484 D: 18,287	8.12%▲			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-18 displays data for HBL's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-18—Performance Indicator Results for HBL's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 497 D: 12,112	4.10%	N: 232 D: 33,509	0.69%			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,233 D: 19,645	6.28%	N: 225 D: 54,200	0.42%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 1,010 D: 40,446	2.50%	N: 245 D: 122,656	0.20%			*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 2,740 D: 72,203	3.79%	N: 702 D: 210,365	0.33%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-19 displays data for HUM's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP. For HUM, CY 2023 was the baseline measurement period for this PIP topic because the MCO began operations for the Louisiana Medicaid Program on January 1, 2023.

Table 2-19—Performance Indicator Results for HUM's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 137 D: 3,064	4.47%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 335 D: 4,611	7.27%					*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 403 D: 10,506	3.84%					*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 875 D: 18,181	4.81%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-20 displays data for LHCC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-20—Performance Indicator Results for LHCC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 1,612 D: 14,780	10.91%	N: 2,014 D: 15,383	13.09% ▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,205 D: 19,605	6.15%	N: 1,448 D: 19,548	7.41% ▲			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 858 D: 22,133	3.88%	N: 946 D: 22,215	4.26% ▲			*Not Assessed*

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 3,675 D: 56,518	6.50%	N: 4,408 D: 57,146	7.71%▲			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
▲ Designates a statistically significant improvement over baseline results ($p < 0.05$).
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-21 displays data for UHC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP.

Table 2-21—Performance Indicator Results for UHC's *Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years* PIP

Performance Indicator	Baseline (01/01/2022 to 12/31/2022)		Remeasurement 1 (01/01/2023 to 12/31/2023)		Remeasurement 2 (01/01/2024 to 12/31/2024)		Sustained Improvement
Fluoride varnish application by primary care provider (PCP) for children aged 6–18 months	N: 647 D: 16,029	4.04%	N: 517 D: 12,368	4.18%			*Not Assessed*
Fluoride varnish application by PCP for children aged 19 months–2 years	N: 1,306 D: 22,170	5.89%	N: 1,174 D: 21,191	5.54%			*Not Assessed*
Fluoride varnish application by PCP for children aged 3–5 years	N: 1,367 D: 52,878	2.59%	N: 1,338 D: 49,387	2.71%			*Not Assessed*
Fluoride varnish application by PCP for all children aged 6 months–5 years	N: 3,320 D: 91,077	3.65%	N: 3,029 D: 82,946	3.65%			*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 2.
Green shaded cells represent any improvement over baseline results.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-22 displays data for ABH's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-22—Performance Indicator Results for ABH's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 14,749 D: 30,785	47.91%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-23 displays data for ACLA's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-23—Performance Indicator Results for ACLA's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 18,158 D: 36,891	49.22%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-24 displays data for HBL's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-24—Performance Indicator Results for HBL's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 32,114 D: 75,714	42.41%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-25 displays data for HUM's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-25—Performance Indicator Results for HUM's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 3,647 D: 18,497	19.72%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-26 displays data for LHCC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-26—Performance Indicator Results for LHCC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 46,964 D: 89,499	52.47%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-27 displays data for UHC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP.

Table 2-27—Performance Indicator Results for UHC's *Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
The percentage of women aged 21–64 years who were screened for cervical cancer	N: 28,000 D: 137,209	20.40%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurement 1 and Remeasurement 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-28 displays data for ABH's *Screening for HIV Infection* PIP.

Table 2-28—Performance Indicator Results for ABH's *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement	N: 2,154	57.04%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
year among pregnant persons or persons with encounters for labor and delivery	D: 3,776						
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 3,225 D: 9,390	34.35%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,238 D: 10,890	48.10%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 25,261 D: 79,552	31.75%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-29 displays data for ACLA's *Screening for HIV Infection* PIP.

Table 2-29—Performance Indicator Results for ACLA's *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 3,496 D: 5,038	69.39%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 2,405 D: 6,628	36.29%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 3,568 D: 5,624	63.44%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 9,916 D: 110,751	8.95%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-30 displays data for HBL's *Screening for HIV Infection* PIP.

Table 2-30—Performance Indicator Results for HBL's *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 8,289 D: 12,391	66.89%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 5,469 D: 19,431	28.14%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 5,764 D: 8,893	64.82%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 21,728 D: 234,488	9.27%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-31 displays data for HUM's *Screening for HIV Infection* PIP.

Table 2-31—Performance Indicator Results for HUM's *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 2,700 D: 4,894	55.17%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 1,077 D: 2,810	38.33%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 2,408 D: 4,073	59.12%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 5,395 D: 76,165	7.08%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-32 displays data for LHCC's *Screening for HIV Infection* PIP.

Table 2-32—Performance Indicator Results for LHCC's *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 10,679 D: 14,450	73.90%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 7,803 D: 26,295	29.67%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 20,917 D: 51,895	40.31%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 42,423 D: 163,580	25.93%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Table 2-33 displays data for UHC's *Screening for HIV Infection* PIP.

Table 2-33—Performance Indicator Results for UHC's *Screening for HIV Infection* PIP

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among pregnant persons or persons with encounters for labor and delivery	N: 9,161 D: 14,124	64.86%					*Not Assessed*

Performance Indicator	Baseline (01/01/2023 to 12/31/2023)		Remeasurement 1 (01/01/2024 to 12/31/2024)		Remeasurement 2 (01/01/2025 to 12/31/2025)		Sustained Improvement
Persons screened for HIV during the measurement year among persons with past or present (injection) drug use	N: 6,463 D: 18,657	34.64%					*Not Assessed*
Persons screened for HIV during the measurement year among persons with risk factors related to sexual mode of transmission	N: 14,067 D: 23,190	60.66%					*Not Assessed*
Persons ever screened for HIV among all others aged 15 to 65 years without a diagnosis of HIV infection	N: 89,701 D: 90,472	99.15%					*Not Assessed*

N–Numerator D–Denominator
Gray shaded cells represent future data that will be updated for Remeasurements 1 and 2.
Note: Performance indicator results for each measurement period are based on data reported by the MCO for the PIP validation reporting deadline, which is January 31 of the following calendar year. Performance indicator rates reported for PIP validation may differ from final rates calculated by the MCO for other purposes.

Interventions

Table 2-34 through Table 2-39 summarize the MCOs' CY 2023 barriers and interventions.

Table 2-34—Barriers and Interventions Reported by ABH for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge • Providers do not receive details of enrollee's diagnosis and discharge plan • Enrollees not aware of the importance of follow-up care	• Enhanced admission, discharge, and transfer (ADT) data exchange for BH related emergency department (ED) visits and hospital stays. • Information technology (IT) system enhancements to connect follow-up providers with *Follow-Up After Hospitalization for Mental Illness* discharge plans. • Enrollee follow-up educational campaign to provide information on the importance of follow-up visits and assist with follow-up appointment scheduling.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Enrollees may not remember to obtain the second dose of a two dose vaccine series	• Distributed eligible enrollee lists and vaccination site lists to PCPs and facilitate referrals as needed.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application • Lack of enrollee parent/guardian understanding of benefits and importance of fluoride varnish treatment	• Enhanced MCO case management enrollee outreach and education with dental provider appointment scheduling. • Utilization of technology to ensure education on receiving fluoride varnish treatment in PCP offices for guardians of eligible enrollees. • Educate PCPs on the practice of applying fluoride varnish in the office setting and appropriate documentation of Current Procedural Terminology (CPT) code 99188. • Worked with providers to ensure that fluoride varnish treatments are occurring in the office.

PIP Topic	Barriers	Interventions
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Enrollees may not remember to schedule annual preventive appointments, which include cervical cancer screening	• Enrollee education regarding Centers for Disease Control and Prevention (CDC) cervical cancer screening guidelines related to recommended ages, types of screening methods, and populations who should receive screening. • Telephonic and text outreach campaigns to eligible enrollees to provide appointment scheduling and transportation assistance for cervical cancer screening. • Partnered with Crescent Care clinic to provide a community event that included enrollee education and the opportunity for enrollees to be screened during the event.
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Text message campaign and printed enrollee educational materials on HIV statistics and HIV screening guidelines. • Community events to provide enrollees with HIV education and screening opportunities.

Table 2-35—Barriers and Interventions Reported by ACLA for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Lack of hospital participation in health information exchange • Provider difficulty in identifying patients needing follow-up care • Lack of member access to care	• Utilization of ADT notification report of inpatient admits from *Follow-Up After Hospitalization for Mental Illness* population. • Utilization of ADT notification report of ED admits or discharges from *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* populations. • Utilization of ADT notification report to determine case management notification of ED admits or

PIP Topic	Barriers	Interventions
		discharges from *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* populations.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Challenges with reaching a large volume of eligible members via case management outreach alone	• Case managers telephonically outreach to enrollees enrolled in case management to assist with scheduling vaccine appointment. • Care coordinator and community navigator telephonically outreach enrollees not enrolled in case management to assist with scheduling vaccine appointment.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of access to a dental provider • Lack of provider knowledge that fluoride varnish applications can be done in a PCP office	• Enhanced enrollee outreach and education. • Enrollee outreach to facilitate dental appointment scheduling. • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) enrollee outreach and education to establish a dental home and facilitate dental provider appointment scheduling. • Outreach to enrollees in rural areas to provide education and care coordination.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee knowledge of multiple health conditions and importance of obtaining screening • Providers do not consistently recommend screening for enrollees	• Enhanced case management outreach to assist enrollees with scheduling cervical cancer screening. • Outreach and education to provider offices on the availability of gaps in care reports and enrollee and provider incentives, and to assist with any other barriers reported by the provider offices. • Quarter 4 provider push with Quarter 4 provider incentive offered outside of Quality Enhancement Program, incentive outreach and education.

PIP Topic	Barriers	Interventions
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Enhanced case management outreach for HIV screening for enrollees with current/past injection drug use. • Enhanced case management outreach for HIV screening for enrollees with risk factors related to sexual mode of transmission. • Enhanced case management outreach for HIV screening for enrollees 15–64 years of age without a diagnosis of HIV.

Table 2-36—Barriers and Interventions Reported by HBL for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Members forget to schedule appointments • Providers' lack of resources to schedule timely appointments	• Enhance hospital-to-MCO workflow for notification of hospital and ED ADTs. • Text message campaign to provide assistance with scheduling follow-up appointments.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of transportation and lack of access to nearby vaccine sites • Lack of understanding of vaccine safety and benefits	• Developed and implemented COVID-19 vaccination outreach to enrollees engaged in case management. • Outreach calls to those enrollees who have not completed the vaccination series (not received second dose).
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of member education and access to appointments • Lack of provider education	• Community outreach events for enrollees. • Provider outreach and education using care gap report, American Academy of Pediatrics (AAP) guidelines on fluoride use to prevent dental caries, LDH bulletin on fluoride varnish training reimbursement and course requirements, and Well-Ahead Louisiana resources.

PIP Topic	Barriers	Interventions
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of provider awareness of CDC screening guidelines and recommendations • Lack of enrollee knowledge of the screening procedure	• Education provided for enrollees in case management on what to expect during a cervical cancer screening and to address fear of the procedure. • Educational text campaign for enrollees not in case management to provide information on screening guidelines.
Screening for HIV Infection	• Enrollee fear of screening results • Lack of enrollee awareness on importance of HIV screening and CDC recommendations	• Developed an educational HIV screening outreach campaign for enrollees in case management. • Worked with a vendor to carry out an educational HIV screening text campaign for enrollees not in case management. • Collaborated with analytical staff to create an HIV screening gaps in care report for provider distribution.

Table 2-37—Barriers and Interventions Reported by HUM for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Case management team is only alerted on members that have a certain risk level • Lack of means to track scheduled visits	• Enhance hospital-to-MCO workflow for notification of hospital and ED ADTs.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to the COVID-19 vaccine • Challenges with reaching a large volume of eligible members via case management outreach alone	• COVID-19 vaccinations offered at all community events and referrals to pharmacies for vaccinations were offered to enrollees. • Incentivized enrollees for COVID-19 vaccination by promoting the Shots Per 100,000 program.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of enrollee knowledge on fluoride varnish education and access to screening	• Developed HUM branded oral health/fluoride varnish application educational collateral to be distributed at community events. • Partnered with a community health organization that focuses on oral

PIP Topic	Barriers	Interventions
		health to train HUM health workers to apply fluoride varnish. • Uploaded provider education links, including the Smiles for Life training, to the provider portal.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of provider awareness of CDC screening guidelines and recommendations	• *Cervical Cancer Screening* text message campaign to outreach all eligible enrollees 21–64 years of age who were identified on the *Cervical Cancer Screening* care gap report. • Quarterly provider visits by Quality and Provider Relations teams to offer provider education on using Compass, a centralized reporting platform, to view enrollee care gaps as well as the process for gap closure through attestation or upload of medical records.
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening	• Developed HUM branded educational material about the importance of HIV screening for distribution at relevant HUM sponsored events. • Quality/Provider Relations representatives met with provider groups to provide education on HIV screening recommendations for each group of eligible enrollees.

Table 2-38—Barriers and Interventions Reported by LHCC for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Limited behavioral health provider participation in ADT feeds/applications • Lack of engagement from members with substance use disorders (SUD) in follow-up care	• Enhanced hospital-to-MCO workflow for notification of hospital ADTs. • Linkage to aftercare with BH providers prior to discharge from hospital.
Ensuring Access to the COVID-19 Vaccine Among	• Lack of access to the COVID-19 vaccine	• Distributed eligible enrollee lists and vaccination site lists to PCPs and facilitated referrals as needed.

PIP Topic	Barriers	Interventions
Healthy Louisiana Enrollees	• Challenges with reaching a large volume of eligible members via case management outreach alone	• Distributed vaccination site lists to PCPs. • Eligible enrollees due for the second dose of COVID-19 vaccine outreached with reminder communications to facilitate completion of the vaccination series.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application • Lack of enrollee parent/guardian understanding of need to establish a dental provider	• Provider outreach and education using care gap report, AAP guidelines on fluoride use to prevent dental caries, LDH bulletin regarding reimbursement and course requirements/link, and Well-Ahead Louisiana resources. • Provided PCPs with customized list of enrollees for whom fluoride varnish application was indicated.
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of the importance of cervical cancer screening • Lack of provider knowledge of proper coding to capture screening	• Enhanced MCO case management enrollee outreach for enrollees with no cervical cancer screening (care gap) and assisted with appointment scheduling at OB/GYN. • Enhanced MCO case management enrollee outreach or education on cervical cancer screening. • Conducted provider outreach and education on cervical cancer screening guidelines and billing/coding guidelines.
Screening for HIV Infection	• Lack of enrollee knowledge on importance of HIV screening and on resources for obtaining screening • Enrollee's lack of transportation to screening appointments	• Enhanced MCO outreach for pregnant enrollees providing appointments scheduled for HIV screening. • Provider engagement and education regarding updated clinical practice guidelines for HIV screening, provider incentives, current enrollee incentives, billing/coding guidelines, and gaps in care report distribution.

Table 2-39—Barriers and Interventions Reported by UHC for Each PIP Topic

PIP Topic	Barriers	Interventions
Behavioral Health Transitions of Care	• Lack of timely notification for hospital discharge • Difficult to engage enrollees in follow-up treatment	• Enhanced hospital-to-MCO workflow for notification of hospital and ED ADTs through analyzing ADT feeds. • Linked enrollees to aftercare with BH providers prior to discharge from hospital or ED. • Contracted with provider, Eleanor Health, to provide proactive outreach and assistance in securing follow-up appointments and other case management needs for enrollees with SUD.
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	• Lack of access to COVID-19 vaccine • Challenges with reaching a large volume of eligible members via case management outreach alone • Enrollees may not remember to obtain second dose of two-dose vaccine series	• Developed and implemented COVID-19 vaccination outreach to enrollees not engaged in case management. • Live telephonic outreach with second vaccine dose reminder and scheduling assistance.
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	• Lack of PCP training in varnish application	• Provider education on the availability and use of care gap reports to identify enrollees due for fluoride varnish application. • Targeted outreach calls for enrollee groups with fluoride varnish application disparities (enrollees residing in Region 1, Native American/Indian enrollees, Alaskan Native enrollees, Native Hawaiian or Pacific Islander enrollees, and enrollees in foster care).
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	• Lack of enrollee awareness of guidelines for cervical cancer screening	• Educational outreach to enrollees in case management to provide education on cervical cancer screening and Medicaid transportation benefits. • Distribution of provider education materials and toolkit on cervical cancer screening.

PIP Topic	Barriers	Interventions
Screening for HIV Infection	• Lack of enrollee and provider knowledge on guidelines for HIV screening and on resources for obtaining screening	• Provided enhanced case management outreach for HIV screening education for all eligible pregnant enrollees in case management. • Provided enhanced case management outreach for HIV screening education to all eligible enrollees 15–65 years of age in case management.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs developed and carried out a methodologically sound design for all five PIPs that facilitated valid and reliable measurement of objective indicator performance over time. **[Quality]**
- The MCOs carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. **[Quality]**
- The MCOs collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all five PIPs. **[Quality]**

For the MCOs statewide, the following opportunities for improvement were identified:

- Although some improvement in performance indicator results has been achieved across the three PIP topics with reported remeasurement results, there continues to be room for improvement in achieving significant improvement in outcomes across all PIP topics for all MCOs. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following recommendations were identified:

- To facilitate significant outcomes improvement for all PIPs, the MCOs should review intervention evaluation results to determine if each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCOs should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed by new or revised interventions to drive outcomes improvement. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving MCO processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each MCO's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that LDH and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the QI strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluated whether the MCO executed a methodologically sound PIP.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[2-1]

HSAG's evaluation of each PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCO improves indicator results through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the MCOs with specific feedback and recommendations. The MCOs used a standardized PIP Submission Form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP Submission Form to conduct the annual validation.

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

In alignment with the CMS EQR Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflected HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. HSAG based this validation rating on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating was only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflected HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.

- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

HSAG analyzed the quantitative results obtained from the above PIP validation activities to identify strengths and opportunities for improvement in each domain of quality, timeliness, and accessibility of services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across the MCOs related to PIP validation or performance on the PIPs conducted.

How Conclusions Were Drawn

PIPs that accurately addressed the CMS EQR Protocol 1 requirements were determined to have high validity and reliability. Validity refers to the extent to which the data collected for a PIP measured its intent. Reliability refers to the extent to which an individual could reproduce the project results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was credible.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided by the MCOs, HSAG assigned each PIP topic to one or more of these three domains. While the focus of an MCO's PIP may have been to improve performance related to healthcare quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the MCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were assigned to other domains as appropriate. This assignment to domains is shown in Table 2-40.

Table 2-40—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Topic	Quality	Timeliness	Access
Behavioral Health Transitions of Care	✓	✓	✓
Fluoride Varnish Application to Primary Teeth of Enrollees Aged 6 Months to 5 Years	✓	✓	✓
Ensuring Access to the COVID-19 Vaccine Among Healthy Louisiana Enrollees	✓		✓
Improving Cervical Cancer Screening Rates Among Healthy Louisiana Enrollees	✓	✓	✓
Screening for HIV Infection	✓	✓	✓
Addressing Congenital Syphilis Through Improved Syphilis Screening for Healthy Louisiana Pregnant Enrollees	✓	✓	✓

3. Validation of Performance Measures

Aggregate Results

Information Systems Standards Review

HSAG reviewed the FARs produced for each MCO by the MCO's independent certified HEDIS compliance auditor to ensure that each MCO calculated its rates based on accurate data and according to NCQA's established standards.

The FARs include information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, medical record review validation (MRRV) results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. HSAG analyzed the MCOs' HEDIS MY 2023 results and evaluated each MCO's current performance levels in reference to NCQA's Quality Compass national Medicaid percentiles.

HSAG evaluated each MCO's IS to verify accurate HEDIS reporting. As part of the evaluation, each FAR, which contained the licensed organization's (LO's) assessment of IS capabilities, was reviewed. The IS evaluation focused on aspects of the MCOs' systems that could affect the HEDIS Medicaid reporting set.

In accordance with the MY 2023 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. The final audit results included final determinations of validity made by the independent certified HEDIS compliance auditor for each performance measure. The IDSS file detailed all rates that were submitted to NCQA and whether the LO deemed them to be reportable.

HSAG used the FAR and the MCO rates provided on the Interactive Data Submission System (IDSS) file as the primary data sources. Based on a review of the FARs issued by each MCO's independent certified HEDIS compliance auditor, HSAG found that the MCOs were determined to be fully compliant with all four of the applicable NCQA IS standards. HEDIS rates produced by the MCOs were reported to NCQA.

The MCOs' compliance with IS standards are highlighted in Table 3-1.

Table 3-1—MCO Compliance With IS Standards—MY 2022 and MY 2023 Comparison

IS Standard	MY 2022					MY 2023					
	ABH	ACLA	HBL	LHCC	UHC	ABH	ACLA	HBL	HUM	LHCC	UHC
IS R—Data Management and Reporting (formerly IS 6.0, IS 7.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
IS C—Clinical and Care Delivery Data (formerly IS 5.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
IS M—Medical Record Review Processes (formerly IS 4.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
IS A—Administrative Data (formerly IS 1.0, IS 2.0, IS 3.0)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Performance Measures

In SFY 2024 (review period), LDH required each contracted MCO to collect and report on 47 HEDIS measures, which includes 290 total measures indicators for HEDIS MY 2023 specified in the provider agreement. The measurement set includes 11 incentive measures.

Table 3-2 displays the 290 measure indicators required by LDH. Rates highlighted in **red** indicate the measure or SWA performance fell below the NCQA national 50th percentile, and rates highlighted in **green** indicate that the measure or SWA performance was at or above the NCQA national 50th percentile. Table 3-2 through Table 3-5 display a summary of the MCOs' HEDIS measure performance.

Table 3-2—MCO HEDIS Effectiveness of Care Performance Measures—MY 2022 and MY 2023 Comparison

	MY 2022						MY 2023						
HEDIS Measure	**ABH**	**ACLA**	**HBL**	**LHCC**	**UHC**	**SWA**	**ABH**	**ACLA**	**HBL**	**HUM**	**LHCC**	**UHC**	**SWA**
Follow-Up After Hospitalization for Mental Illness													
Within 7 Days of Discharge	17.29%	18.77%	20.35%	18.74%	20.90%	19.52%	18.61%	19.82%	23.27%	15.12%	20.70%	20.73%	**20.67%**
Within 30 Days of Discharge[I]	35.27%	36.26%	39.26%	39.48%	38.41%	38.33%	37.03%	38.49%	41.13%	32.48%	41.60%	39.16%	**39.62%**
Follow-Up After Emergency Department Visit for Mental Illness													
Within 7 Days of Discharge	20.18%	22.93%	21.35%	22.54%	23.89%	22.45%	20.76%	20.59%	24.63%	15.15%	22.39%	22.84%	**22.26%**
Within 30 Days of Discharge [I]	33.57%	35.30%	36.44%	37.76%	36.83%	36.52%	33.39%	31.59%	41.69%	22.35%	38.24%	37.68%	**36.83%**
Follow-Up After Emergency Department Visit for Substance Use[B]													
Within 7 Days of Discharge	22.24%	17.38%	16.87%	15.88%	16.39%	17.19%	15.38%	12.51%	13.28%	8.95%	13.42%	14.40%	**13.46%**
Within 30 Days of Discharge [I]	33.81%	28.94%	27.70%	26.05%	25.98%	27.70%	24.59%	20.50%	21.45%	14.86%	21.89%	22.92%	**21.75%**
Plan All-Cause Readmissions*													
Observed Readmissions (Numerator/Denominator)	10.37%	10.21%	9.76%	9.52%	11.14%	10.15%	11.18%	10.73%	9.32%	NA	10.06%	10.37%	**10.13%**
Expected Readmissions Rate	9.79%	9.65%	9.56%	9.40%	9.65%	9.57%	10.38%	10.04%	9.40%	NA	9.62%	10.00%	**9.77%**
Observed-to-Expected (O/E) Ratio (Observed Readmissions/Expected Readmissions)	1.0594	1.0574	1.0214	1.0122	1.1540	1.0603	1.0778	1.0691	0.9911	NA	1.0460	1.0376	**1.0368**
Depression Screening and Follow-Up for Adolescents and Adults													
Depression Screening (Total)	0.00%	2.59%	0.00%	0.00%	0.58%	1.00%	0.78%	2.37%	NR	0.08%	NR	0.85%	**1.06%**
Follow-Up on Positive Screen (Total)	0.00%	54.11%	0.00%	0.00%	72.73%	58.25%	83.33%	51.12%	NR	NA	NR	74.14%	**62.50%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.33%	84.13%	82.84%	82.52%	82.08%	82.78%	85.69%	84.73%	84.08%	92.86%	83.89%	83.96%	**84.36%**
Diabetes Monitoring for People With Diabetes and Schizophrenia	63.26%	69.07%	66.89%	67.44%	68.64%	67.47%	70.70%	71.29%	72.14%	70.69%	73.32%	72.74%	**72.29%**
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.65%	75.81%	73.42%	76.84%	81.71%	76.14%	83.33%	80.00%	79.75%	NA	81.91%	82.43%	**81.53%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics													
Blood Glucose Testing	56.23%	54.74%	57.32%	52.04%	55.99%	54.46%	60.00%	54.61%	57.96%	NA	52.36%	55.96%	**54.92%**
Cholesterol Testing	30.70%	29.05%	33.38%	25.42%	30.63%	28.80%	30.00%	25.00%	31.27%	NA	25.93%	30.19%	**28.09%**
Blood Glucose and Cholesterol Testing	30.70%	28.09%	32.61%	24.73%	29.76%	28.05%	29.38%	24.42%	30.48%	NA	24.86%	29.38%	**27.21%**
Lead Screening in Children	62.04%	66.91%	62.86%	61.64%	65.45%	63.59%	67.64%	69.83%	64.73%	43.59%	68.13%	64.24%	**66.40%**
Childhood Immunization Status													
Diphtheria, Tetanus, and Acellular Pertussis (DTaP)	61.56%	70.80%	69.34%	68.13%	67.88%	68.23%	70.32%	71.28%	72.51%	57.69%	70.45%	72.75%	**71.31%**
Polio Vaccine, Inactivated (IPV)	81.51%	88.81%	86.13%	89.05%	85.64%	87.00%	88.32%	87.53%	87.83%	79.17%	87.42%	86.37%	**87.17%**
Measles, Mumps, and Rubella (MMR)	80.29%	85.64%	83.45%	85.16%	84.43%	84.34%	84.43%	86.28%	88.08%	75.64%	86.33%	85.16%	**86.06%**
Haemophilus Influenzae Type B (HiB)	79.32%	85.16%	83.45%	84.67%	85.40%	84.33%	86.86%	85.44%	85.89%	77.24%	85.92%	85.40%	**85.66%**
Hepatitis B	83.45%	89.54%	87.83%	91.00%	87.59%	88.75%	90.02%	90.29%	89.78%	81.41%	90.35%	86.86%	**89.20%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Varicella-Zoster Virus (VZV)	80.29%	85.64%	83.70%	85.40%	83.94%	84.35%	84.67%	85.77%	89.05%	77.24%	86.44%	85.40%	**86.30%**
Pneumococcal Conjugate	64.48%	69.34%	70.32%	66.91%	69.83%	68.57%	67.40%	70.76%	73.97%	58.65%	69.52%	71.53%	**70.65%**
Hepatitis A	77.62%	81.75%	80.78%	80.78%	80.78%	80.70%	80.78%	84.15%	87.10%	77.56%	83.73%	82.73%	**83.82%**
Rotavirus	65.69%	65.45%	66.42%	67.15%	66.91%	66.63%	63.99%	66.61%	63.02%	62.18%	63.61%	63.99%	**63.96%**
Influenza	25.06%	28.22%	27.25%	27.98%	23.60%	26.49%	25.30%	20.30%	23.11%	14.74%	20.46%	21.17%	**21.26%**
Combination 3[I]	57.66%	63.50%	64.72%	61.80%	62.04%	62.44%	63.02%	64.95%	67.88%	51.60%	63.80%	65.94%	**64.96%**
Combination 7	50.36%	54.26%	55.23%	51.82%	54.01%	53.35%	50.85%	55.46%	54.74%	45.51%	52.45%	53.77%	**53.34%**
Combination 10	17.27%	22.87%	21.65%	20.92%	18.00%	20.30%	17.03%	16.04%	19.22%	8.65%	15.61%	15.33%	**16.16%**
Immunizations for Adolescents													
Meningococcal	76.89%	83.21%	82.73%	83.76%	84.67%	83.48%	79.32%	84.67%	83.21%	81.31%	86.60%	87.59%	**85.85%**
Tetanus, Diphtheria, and Pertussis/Tetanus and Diphtheria (Tdap/Td)	76.40%	83.70%	83.70%	84.46%	85.89%	84.30%	79.08%	85.40%	83.45%	81.31%	87.10%	88.08%	**86.29%**
Human Papillomavirus (HPV)	30.17%	40.39%	40.15%	37.60%	41.12%	39.08%	37.96%	45.01%	41.61%	34.42%	39.18%	45.26%	**41.77%**
Combination 1	75.91%	82.97%	82.24%	83.59%	84.67%	83.26%	78.59%	84.67%	83.21%	80.71%	86.36%	87.35%	**85.64%**
Combination 2[I]	29.68%	40.39%	39.90%	37.27%	40.39%	38.69%	37.47%	44.77%	41.61%	34.12%	38.87%	45.01%	**41.53%**
Colorectal Cancer Screening[I]	31.85%	35.17%	32.94%	34.06%	34.48%	33.81%	43.21%	44.95%	40.60%	67.18%	44.28%	43.82%	**43.44%**
Flu Vaccinations for Adults Ages 18 to 64	33.33%	40.86%	35.98%	35.14%	37.77%	36.62%	—	—	—	—	—	—	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents													
Body Mass Index (BMI) Percentile Documentation	77.62%	73.20%	77.13%	60.58%	83.21%	72.22%	80.05%	75.37%	76.89%	77.37%	81.51%	83.21%	**80.09%**
Counseling for Nutrition	66.67%	62.28%	62.53%	57.18%	68.86%	62.46%	65.69%	64.39%	64.23%	63.02%	70.56%	58.39%	**64.97%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Counseling for Physical Activity	62.29%	53.35%	55.96%	51.58%	60.10%	55.47%	63.50%	62.20%	59.61%	60.34%	59.12%	50.85%	**57.89%**
HIV Viral Load Suppression[I]	80.62%	75.50%	80.86%	79.78%	77.60%	79.04%	85.13%	80.81%	83.48%	73.46%	81.99%	82.05%	**82.26%**
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)[*,I]	26.67%	23.59%	26.97%	27.47%	26.47%	26.61%	27.93%	25.06%	26.32%	23.54%	27.18%	26.41%	**26.35%**
Chlamydia Screening in Women													
Total	59.22%	64.40%	60.72%	63.84%	64.02%	63.13%	64.55%	64.32%	64.50%	66.75%	67.37%	65.49%	**65.84%**
Breast Cancer Screening	54.72%	55.54%	55.07%	55.74%	57.11%	55.83%	—	—	—	—	—	—	—
Controlling High Blood Pressure[I]	59.85%	59.90%	53.77%	55.23%	61.31%	57.62%	63.26%	60.80%	56.93%	69.10%	60.34%	61.80%	**60.47%**
Statin Therapy for Patients With Cardiovascular Disease													
Received Statin Therapy—Total	81.37%	81.14%	80.54%	80.41%	80.50%	80.66%	82.75%	83.76%	83.00%	83.02%	81.94%	82.82%	**82.74%**
Statin Adherence 80%—Total	73.65%	67.81%	63.87%	73.30%	63.81%	67.86%	75.15%	68.02%	57.89%	67.42%	74.18%	61.52%	**66.40%**
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes													
Poor HbA1c Control (>9.0%)[,I]*	33.09%	39.66%	37.47%	45.99%	34.55%	38.96%	33.33%	33.09%	30.66%	27.25%	31.63%	23.60%	**29.55%**
HbA1c Control (<8.0%)	56.20%	53.04%	53.77%	44.77%	57.91%	52.48%	59.61%	59.61%	62.29%	66.91%	61.56%	70.07%	**63.65%**
Eye Exam for Patients With Diabetes	52.31%	50.36%	55.23%	53.04%	55.72%	53.85%	46.96%	51.09%	55.47%	54.74%	59.37%	54.74%	**55.06%**
Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)	61.31%	56.20%	64.48%	50.61%	67.15%	59.93%	62.29%	64.48%	63.50%	71.78%	63.02%	70.07%	**65.25%**
Pharmacotherapy for Opioid Use Disorder	34.26%	29.55%	22.62%	34.90%	21.84%	27.67%	38.41%	34.07%	24.55%	61.18%	34.11%	21.85%	**29.53%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Initiation and Engagement of Substance Use Disorder (SUD) Treatment													
Initiation of SUD Treatment	60.02%	64.68%	65.35%	55.86%	58.78%	60.37%	61.26%	65.10%	58.91%	59.40%	49.81%	60.16%	**57.95%**
Engagement of SUD Treatment	25.54%	28.33%	28.52%	21.55%	25.97%	25.62%	26.94%	30.10%	25.02%	26.91%	15.87%	28.17%	**24.37%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	67.24%	60.06%	65.71%	60.10%	67.86%	63.46%	68.80%	56.83%	64.93%	67.65%	61.74%	65.02%	**63.06%**
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.81%	55.42%	47.03%	59.14%	48.69%	53.17%	58.31%	57.23%	50.89%	64.55%	60.69%	51.27%	**55.72%**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication													
Initiation Phase	43.29%	40.70%	40.71%	42.92%	44.13%	42.65%	43.17%	49.75%	45.21%	NA	44.21%	46.24%	**45.52%**
Continuation Phase	60.00%	51.99%	53.59%	54.84%	58.40%	55.44%	63.39%	56.83%	53.66%	NA	51.43%	58.55%	**54.23%**
Antidepressant Medication Management													
Effective Acute Phase Treatment	60.92%	54.72%	55.41%	56.85%	53.91%	55.83%	61.92%	56.31%	55.53%	72.53%	59.73%	55.90%	**57.61%**
Effective Continuation Phase Treatment	45.35%	36.31%	37.51%	39.76%	35.51%	38.18%	46.12%	38.89%	37.60%	61.54%	42.60%	36.41%	**39.77%**
Appropriate Treatment for Children With Upper Respiratory Infection	79.17%	78.87%	79.93%	79.95%	79.48%	79.64%	79.68%	80.40%	80.11%	99.68%	80.12%	80.14%	**80.50%**
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	51.77%	53.82%	52.80%	52.58%	49.60%	51.85%	50.75%	54.77%	52.78%	98.14%	51.12%	48.99%	**51.81%**
Use of Imaging Studies for Low Back Pain	69.73%	72.61%	71.66%	71.47%	70.81%	71.31%	67.96%	69.88%	69.31%	70.31%	69.11%	69.60%	**69.31%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Non-Recommended Cervical Screening in Adolescent Females*	0.58%	2.08%	0.58%	2.07%	2.37%	1.81%	0.50%	2.45%	0.67%	1.33%	2.05%	2.51%	**1.85%**
Cervical Cancer Screening[I]	52.07%	55.36%	53.37%	56.69%	61.07%	56.53%	48.66%	56.27%	50.61%	30.17%	58.64%	56.45%	**53.47%**
Asthma Medication Ratio													
5–11 Years	—	—	—	—	—	—	84.14%	80.10%	80.20%	NA	79.44%	68.99%	**76.33%**
12–18 Years	—	—	—	—	—	—	85.71%	72.42%	78.00%	NA	74.41%	59.53%	**69.59%**
19–50 Years	—	—	—	—	—	—	74.73%	71.56%	76.56%	NA	72.27%	56.98%	**68.05%**
51–64 Years	—	—	—	—	—	—	81.82%	69.89%	75.98%	NA	69.43%	55.61%	**67.00%**
Total	—	—	—	—	—	—	79.36%	73.49%	77.55%	NA	74.21%	60.16%	**70.18%**
Topical Fluoride for Children													
1–2 Years	—	—	—	—	—	—	1.42%	6.32%	5.60%	2.27%	6.54%	2.24%	**4.76%**
3–4 Years	—	—	—	—	—	—	0.64%	9.66%	7.93%	0.88%	10.52%	0.93%	**6.32%**
Total	—	—	—	—	—	—	1.00%	7.97%	6.79%	1.50%	8.55%	1.56%	**5.56%**
Oral Evaluation, Dental Services													
0–2 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
3–5 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
6–14 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
15–20 Years	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
Total	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**

* Indicates a lower rate is desirable.
[I] Incentive Measure.
Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.
For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.
— is presented for measures that were not reported by the MCOs in MY 2022 and indicates that MY 2022 rates are not available for those measures.
Caution is recommended when comparing HUM's MY 2023 rates to other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

Table 3-3—MCO HEDIS Access to/Availability of Care Performance Measures—MY 2022 and MY 2023 Comparison

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Adults' Access to Preventive/Ambulatory Health Services													
20–44 Years	62.73%	68.28%	69.98%	72.25%	73.82%	70.84%	67.99%	68.12%	68.95%	53.57%	76.80%	75.53%	**71.25%**
45–64 Years	75.53%	78.39%	79.52%	81.11%	82.51%	80.13%	80.95%	79.39%	78.32%	57.41%	84.67%	84.90%	**80.87%**
65 Years and Older	71.82%	73.00%	75.56%	78.18%	75.65%	75.93%	68.44%	76.08%	69.42%	88.09%	82.46%	74.54%	**79.46%**
Total	67.43%	71.44%	72.84%	74.69%	76.47%	73.65%	72.59%	71.66%	71.81%	55.59%	79.11%	78.57%	**74.25%**
Prenatal and Postpartum Care													
Timeliness of Prenatal Care	76.40%	85.67%	85.07%	81.51%	82.97%	82.86%	81.02%	80.33%	82.97%	80.05%	78.83%	87.59%	**82.12%**
Postpartum Care	80.05%	76.83%	78.47%	75.18%	77.37%	77.00%	77.37%	73.77%	78.59%	76.64%	77.62%	77.37%	**77.27%**

Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.
Caution is recommended when comparing HUM's MY 2023 rates to the LDH target rates or other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

Table 3-4—MCO HEDIS Use of Services and Health Plan Descriptive Information Performance Measures—MY 2022 and MY 2023 Comparison

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Well-Child Visits in the First 30 Months of Life													
First 15 Months	58.55%	58.63%	58.59%	58.57%	62.07%	59.52%	68.42%	65.05%	62.83%	NA	63.17%	66.33%	**64.44%**
15 Months–30 Months	61.09%	63.54%	62.53%	63.41%	66.66%	63.95%	70.22%	69.78%	70.09%	NA	70.49%	69.64%	**70.10%**
Child and Adolescent Well-Care Visits													
3–11 Years	50.72%	54.64%	51.96%	55.24%	56.29%	54.57%	54.70%	57.12%	55.27%	50.03%	59.98%	58.94%	**57.47%**
12–17 Years	43.09%	52.08%	47.63%	52.49%	52.84%	51.26%	50.85%	53.65%	50.25%	46.88%	56.83%	56.04%	**54.10%**
18–21 Years	22.79%	26.97%	24.80%	27.83%	28.28%	27.04%	27.60%	28.92%	26.05%	22.23%	32.59%	30.21%	**29.30%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total	43.80%	48.50%	45.52%	49.12%	49.99%	48.34%	48.72%	51.04%	48.13%	44.11%	54.23%	52.93%	**51.39%**
Ambulatory Care													
Outpatient Visits/1,000 Member Years	4303.35	4670.87	4849.70	4932.72	5284.83	4930.50	4,490.94	4,494.01	5,103.55	3,422.64	5,253.10	5,420.48	**4,958.45**
*Emergency Department Visits/1,000 Member Years**	745.11	764.19	742.68	736.87	753.17	746.42	774.29	732.55	729.10	559.12	762.05	758.06	**735.72**
Inpatient Utilization—General Hospital/Acute Care													
Maternity—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	18.18	30.40	32.31	27.64	27.27	NQ	**28.03**
Maternity—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	119.74	147.31	143.70	133.39	171.84	NQ	**149.64**
Maternity—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	3.04	2.10	0.88	2.27	1.97	NQ	**1.85**
Maternity—Days/1,000 Member Years—Total	—	—	—	—	—	—	65.55	80.47	85.16	76.06	88.82	NQ	**82.50**
Maternity—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	6.53	10.17	11.12	9.37	9.65	NQ	**9.72**
Maternity—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	43.12	52.99	52.75	50.04	63.18	NQ	**54.81**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Maternity—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	0.64	0.66	0.36	0.71	0.63	NQ	**0.56**
Maternity—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	23.48	28.68	31.10	28.18	32.50	NQ	**30.03**
Maternity—Average Length of Stay—10–19 Years	—	—	—	—	—	—	2.78	2.99	2.91	2.95	2.82	NQ	**2.88**
Maternity—Average Length of Stay—20–44 Years	—	—	—	—	—	—	2.78	2.78	2.72	2.67	2.72	NQ	**2.73**
Maternity—Average Length of Stay—45–64 Years	—	—	—	—	—	—	4.78	3.16	2.45	3.18	3.13	NQ	**3.29**
Maternity—Average Length of Stay—Total	—	—	—	—	—	—	2.79	2.81	2.74	2.70	2.73	NQ	**2.75**
Surgery—Days/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	571.55	315.98	370.01	283.82	616.39	NQ	**463.70**
Surgery—Days/1,000 Member Years—1–9 Years	—	—	—	—	—	—	25.02	23.41	44.47	13.53	39.42	NQ	**33.47**
Surgery—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	34.62	31.24	31.35	18.52	36.85	NQ	**32.49**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Surgery—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	133.18	103.34	101.72	82.79	110.61	NQ	**106.78**
Surgery—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	370.27	359.41	328.32	344.01	379.07	NQ	**356.86**
Surgery—Days/1,000 Member Years—65–74 Years	—	—	—	—	—	—	259.16	266.28	371.28	622.78	288.59	NQ	**393.71**
Surgery—Days/1,000 Member Years—75–84 Years	—	—	—	—	—	—	616.49	695.44	1,170.53	1,050.05	651.36	NQ	**944.71**
Surgery—Days/1,000 Member Years—86 Years and Older	—	—	—	—	—	—	1,922.33	NA	0.00	548.66	508.73	NQ	**584.92**
Surgery—Days/1,000 Member Years—Total	—	—	—	—	—	—	154.00	112.99	127.42	95.80	124.12	NQ	**123.56**
Surgery—Discharges/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	22.30	17.48	18.25	13.58	23.45	NQ	**19.95**
Surgery—Discharges/1,000 Member Years—1–9 Years	—	—	—	—	—	—	3.42	3.39	3.76	2.16	3.91	NQ	**3.54**
Surgery—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	4.64	3.96	4.65	3.01	4.66	NQ	**4.35**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Surgery—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	14.90	13.28	14.13	10.82	15.65	NQ	**14.26**
Surgery—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	42.51	42.99	40.53	41.26	45.86	NQ	**42.97**
Surgery—Discharges/1,000 Member Years—65–74 Years	—	—	—	—	—	—	40.77	34.73	38.67	65.75	27.20	NQ	**42.16**
Surgery—Discharges/1,000 Member Years—75–84 Years	—	—	—	—	—	—	57.35	73.98	58.95	107.42	66.81	NQ	**87.74**
Surgery—Discharges/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	145.63	NA	0.00	50.34	59.85	NQ	**51.79**
Surgery—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	16.89	13.48	15.50	11.42	14.23	NQ	**14.43**
Surgery—Average Length of Stay—Less than 1 Year	—	—	—	—	—	—	25.63	18.08	20.28	20.89	26.29	NQ	**23.24**
Surgery—Average Length of Stay—1–9 Years	—	—	—	—	—	—	7.32	6.91	11.83	6.26	10.08	NQ	**9.44**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Surgery—Average Length of Stay—10–19 Years	—	—	—	—	—	—	7.47	7.89	6.74	6.16	7.90	NQ	**7.46**
Surgery—Average Length of Stay—20–44 Years	—	—	—	—	—	—	8.94	7.78	7.20	7.65	7.07	NQ	**7.49**
Surgery—Average Length of Stay—45–64 Years	—	—	—	—	—	—	8.71	8.36	8.10	8.34	8.27	NQ	**8.31**
Surgery—Average Length of Stay—65–74 Years	—	—	—	—	—	—	6.36	7.67	9.60	9.47	10.61	NQ	**9.34**
Surgery—Average Length of Stay—75–84 Years	—	—	—	—	—	—	10.75	9.40	19.86	9.78	9.75	NQ	**10.77**
Surgery—Average Length of Stay—85 Years and Older	—	—	—	—	—	—	13.20	NA	0.00	10.90	8.50	NQ	**11.29**
Surgery—Average Length of Stay—Total	—	—	—	—	—	—	9.12	8.38	8.22	8.39	8.72	NQ	**8.56**
Medicine—Days/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	464.15	447.26	401.07	405.50	399.89	NQ	**414.29**
Medicine—Days/1,000 Member Years—1–9 Years	—	—	—	—	—	—	39.66	38.43	42.21	21.95	46.78	NQ	**40.91**
Medicine—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	20.27	29.34	28.69	15.86	31.44	NQ	**27.72**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	117.49	117.80	100.58	73.77	119.05	NQ	**108.57**
Medicine—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	349.97	442.70	361.46	315.29	440.18	NQ	**393.48**
Medicine—Days/1,000 Member Years—65–74 Years	—	—	—	—	—	—	614.41	396.53	344.98	1,000.39	313.52	NQ	**550.81**
Medicine—Days/1,000 Member Years—75–84 Years	—	—	—	—	—	—	272.40	547.47	412.63	1,302.16	567.85	NQ	**921.88**
Medicine—Days/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	2,446.60	NA	455.36	2,008.39	389.03	NQ	**1,617.67**
Medicine—Days/1,000 Member Years—Total	—	—	—	—	—	—	142.36	137.61	132.55	99.99	129.83	NQ	**129.96**
Medicine—Discharges/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	65.78	78.27	74.93	60.70	82.28	NQ	**75.93**
Medicine—Discharges/1,000 Member Years—1–9 Years	—	—	—	—	—	—	9.27	11.42	12.08	7.37	13.50	NQ	**11.75**
Medicine—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	4.64	7.36	7.14	4.24	9.11	NQ	**7.45**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	22.06	26.16	20.98	15.51	26.84	NQ	**23.27**
Medicine—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	62.99	81.79	65.98	61.02	85.85	NQ	**73.88**
Medicine—Discharges/1,000 Member Years—65–74 Years	—	—	—	—	—	—	90.27	89.73	69.61	174.72	58.17	NQ	**99.37**
Medicine—Discharges/1,000 Member Years—75–84 Years	—	—	—	—	—	—	71.68	103.58	101.05	208.26	108.56	NQ	**158.65**
Medicine—Discharges/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	203.88	NA	107.14	186.24	89.78	NQ	**164.51**
Medicine—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	26.11	28.34	26.52	19.72	28.47	NQ	**26.76**
Medicine—Average Length of Stay—Less than 1 Year	—	—	—	—	—	—	7.06	5.71	5.35	6.68	4.86	NQ	**5.46**
Medicine—Average Length of Stay—1–9 Years	—	—	—	—	—	—	4.28	3.36	3.50	2.98	3.47	NQ	**3.48**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Medicine—Average Length of Stay—10–19 Years	—	—	—	—	—	—	4.37	3.99	4.02	3.74	3.45	NQ	**3.72**
Medicine—Average Length of Stay—20–44 Years	—	—	—	—	—	—	5.33	4.50	4.79	4.76	4.43	NQ	**4.67**
Medicine—Average Length of Stay—45–64 Years	—	—	—	—	—	—	5.56	5.41	5.48	5.17	5.13	NQ	**5.33**
Medicine—Average Length of Stay—65–74 Years	—	—	—	—	—	—	6.81	4.42	4.96	5.73	5.39	NQ	**5.54**
Medicine—Average Length of Stay—75–84 Years	—	—	—	—	—	—	3.80	5.29	4.08	6.25	5.23	NQ	**5.81**
Medicine—Average Length of Stay—85 Years and Older	—	—	—	—	—	—	12.00	NA	4.25	10.78	4.33	NQ	**9.83**
Medicine—Average Length of Stay—Total	—	—	—	—	—	—	5.45	4.86	5.00	5.07	4.56	NQ	**4.86**
Total Inpatient—Days/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	1,035.71	763.24	771.07	689.3 2	1,016.28	NQ	**877.99**
Total Inpatient—Days/1,000 Member Years—1–9 Years	—	—	—	—	—	—	64.68	61.84	86.69	35.49	86.20	NQ	**74.37**
Total Inpatient—Days/1,000 Member Years—10–19 Years	—	—	—	—	—	—	73.07	90.99	92.35	62.03	95.55	NQ	**88.24**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Days/1,000 Member Years—20–44 Years	—	—	—	—	—	—	370.41	368.44	346.00	289.95	401.50	NQ	**364.98**
Total Inpatient—Days/1,000 Member Years—45–64 Years	—	—	—	—	—	—	723.27	804.21	690.66	661.57	821.22	NQ	**752.20**
Total Inpatient—Days/1,000 Member Years—65–74 Years	—	—	—	—	—	—	873.57	662.81	716.26	1,623.17	602.12	NQ	**944.52**
Total Inpatient—Days/1,000 Member Years—75–84 Years	—	—	—	—	—	—	888.89	1,242.91	1,583.16	2,352.21	1,219.21	NQ	**1,866.59**
Total Inpatient—Days/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	4,368.93	NA	455.36	2,557.05	897.76	NQ	**2,202.59**
Total Inpatient—Days/1,000 Member Years—Total	—	—	—	—	—	—	348.13	309.98	327.43	250.83	318.35	NQ	**315.49**
Total Inpatient—Discharges/1,000 Member Years—Less than 1 Year	—	—	—	—	—	—	88.07	95.75	93.18	74.28	105.73	NQ	**95.88**
Total Inpatient—Discharges/1,000 Member Years—1–9 Years	—	—	—	—	—	—	12.68	14.81	15.84	9.53	17.41	NQ	**15.29**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Discharges/1,000 Member Years—10–19 Years	—	—	—	—	—	—	15.80	21.48	22.91	16.62	23.43	NQ	**21.53**
Total Inpatient—Discharges/1,000 Member Years—20–44 Years	—	—	—	—	—	—	80.08	92.43	87.86	76.38	105.67	NQ	**92.34**
Total Inpatient—Discharges/1,000 Member Years—45–64 Years	—	—	—	—	—	—	106.13	125.44	106.87	102.99	132.34	NQ	**117.41**
Total Inpatient—Discharges/1,000 Member Years—65–74 Years	—	—	—	—	—	—	131.04	124.46	108.29	240.47	85.37	NQ	**141.53**
Total Inpatient—Discharges/1,000 Member Years—75–84 Years	—	—	—	—	—	—	129.03	177.56	160.00	315.67	175.37	NQ	**246.39**
Total Inpatient—Discharges/1,000 Member Years—85 Years and Older	—	—	—	—	—	—	349.51	NA	107.14	236.58	149.63	NQ	**216.30**
Total Inpatient—Discharges/1,000 Member Years—Total	—	—	—	—	—	—	61.55	62.98	66.65	51.53	66.27	NQ	**63.75**
Total Inpatient—Average Length of Stay—Less than 1 Year	—	—	—	—	—	—	11.76	7.97	8.28	9.28	9.61	NQ	**9.16**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Total Inpatient—Average Length of Stay—1–9 Years	—	—	—	—	—	—	4.63	4.23	4.03	3.73	4.95	NQ	**4.10**
Total Inpatient—Average Length of Stay—10–19 Years	—	—	—	—	—	—	5.10	4.18	5.47	3.72	4.08	NQ	**4.86**
Total Inpatient—Average Length of Stay—20–44 Years	—	—	—	—	—	—	4.63	3.99	3.94	3.80	3.80	NQ	**3.95**
Total Inpatient—Average Length of Stay—45–64 Years	—	—	—	—	—	—	6.81	6.41	6.46	6.42	6.21	NQ	**6.41**
Total Inpatient—Average Length of Stay—65–74 Years	—	—	—	—	—	—	6.67	5.33	6.61	6.75	7.05	NQ	**6.67**
Total Inpatient—Average Length of Stay—75–84 Years	—	—	—	—	—	—	6.89	7.00	9.89	7.45	6.95	NQ	**7.58**
Total Inpatient—Average Length of Stay—85 Years and Older	—	—	—	—	—	—	12.50	NA	4.25	10.81	6.00	NQ	**10.18**
Total Inpatient—Average Length of Stay—Total	—	—	—	—	—	—	5.66	4.92	4.91	4.87	4.80	NQ	**4.95**
Enrollment by Product Line													
Less than 1 year	—	—	—	—	—	—	2,691	5,150	7,727	3,460	11,905	8,498	**39,430**
1–4 Years	—	—	—	—	—	—	11,152	20,015	25,724	13,205	48,863	35,729	**154,688**
5–9 Years	—	—	—	—	—	—	14,314	23,939	29,593	17,315	61,390	48,063	**194,614**
10–14 Years	—	—	—	—	—	—	12,278	22,337	27,981	16,022	60,025	48,805	**187,448**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
15–17 Years	—	—	—	—	—	—	7,821	13,656	17,499	9,640	35,848	29,427	**113,890**
18–19 Years	—	—	—	—	—	—	4,714	8,181	10,822	5,918	20,567	16,987	**67,190**
20–24 Years	—	—	—	—	—	—	11,250	17,206	29,150	12,564	41,722	32,834	**144,726**
25–29 Years	—	—	—	—	—	—	11,619	13,753	29,039	10,160	30,569	24,721	**119,861**
30–34 Years	—	—	—	—	—	—	11,975	13,567	28,245	9,487	29,615	25,021	**117,909**
35–39 Years	—	—	—	—	—	—	10,415	11,853	23,917	7,835	25,187	22,937	**102,144**
40–44 Years	—	—	—	—	—	—	9,114	10,296	20,891	6,440	22,294	21,081	**90,116**
45–49 Years	—	—	—	—	—	—	7,249	8,036	15,779	4,579	17,049	16,300	**68,991**
50–54 Years	—	—	—	—	—	—	6,982	6,878	14,108	3,824	14,789	14,740	**61,320**
55–59 Years	—	—	—	—	—	—	7,116	7,176	13,439	3,629	14,718	14,428	**60,505**
60–64 Years	—	—	—	—	—	—	7,057	6,623	12,677	3,392	13,907	13,567	**57,221**
65–69 Years	—	—	—	—	—	—	261	267	507	692	1,161	507	**3,396**
70–74 Years	—	—	—	—	—	—	86	82	142	392	170	174	**1,046**
75–79 Years	—	—	—	—	—	—	46	38	67	277	74	90	**592**
80–84 Years	—	—	—	—	—	—	NA	NA	53	212	48	55	**421**
85–89 Years	—	—	—	—	—	—	NA	NA	NA	120	NA	NA	**224**
90 Years and Older	—	—	—	—	—	—	NA	NA	NA	105	NA	NA	**173**
Unknown	—	—	—	—	—	—	NA	NA	NA	NA	NA	NA	**NA**
Total	—	—	—	—	—	—	136,199	189,108	307,397	129,267	449,932	374,001	**1,585,904**
Language Diversity of Membership													
Spoken Language Preferred for Health Care—Health Plan	—	—	—	—	—	—	0.00%	39.04%	100.00%	0.00%	0.00%	0.00%	**23.84%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Spoken Language Preferred for Health Care—CMS/State	—	—	—	—	—	—	100.00%	60.93%	0.00%	98.73%	99.91%	100.00%	**76.01%**
Spoken Language Preferred for Health Care—Other Third-Party	—	—	—	—	—	—	0.00%	0.04%	0.00%	1.27%	0.09%	0.00%	**0.15%**
Preferred Language for Written Materials—Health Plan	—	—	—	—	—	—	0.00%	38.51%	100.00%	0.00%	0.00%	0.00%	**23.78%**
Preferred Language for Written Materials—CMS/State	—	—	—	—	—	—	100.00%	61.45%	0.00%	98.73%	99.91%	0.00%	**52.79%**
Preferred Language for Written Materials—Other Third-Party	—	—	—	—	—	—	0.00%	0.04%	0.00%	1.27%	0.09%	100.00%	**23.43%**
Other Language Needs—Health Plan	—	—	—	—	—	—	0.00%	0.16%	100.00%	0.00%	0.00%	0.00%	**19.20%**
Other Language Needs—CMS/State	—	—	—	—	—	—	100.00%	99.79%	0.00%	0.00%	99.91%	0.00%	**47.96%**
Other Language Needs—Other Third-Party	—	—	—	—	—	—	0.00%	0.06%	0.00%	100.00%	0.09%	100.00%	**32.83%**
Spoken Language Preferred for Health Care—Percent English	—	—	—	—	—	—	0.00%	96.88%	98.00%	96.07%	98.36%	98.24%	**89.10%**
Spoken Language Preferred for Health Care—Percent Non-English	—	—	—	—	—	—	0.00%	3.05%	1.74%	2.66%	1.55%	1.76%	**1.78%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Spoken Language Preferred for Health Care—Percent Declined	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Spoken Language Preferred for Health Care—Percent Unknown	—	—	—	—	—	—	100.00%	0.07%	0.26%	1.27%	0.09%	0.00%	**9.12%**
Language Preferred for Written Materials—Percent English	—	—	—	—	—	—	0.00%	96.87%	98.00%	96.07%	98.36%	0.00%	**66.23%**
Language Preferred for Written Materials—Percent Non-English	—	—	—	—	—	—	0.00%	3.06%	1.74%	2.66%	1.55%	0.00%	**1.37%**
Language Preferred for Written Materials—Percent Declined	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Language Preferred for Written Materials—Percent Unknown	—	—	—	—	—	—	100.00%	0.07%	0.26%	1.27%	0.09%	100.00%	**32.40%**
Other Language Needs—Percent English	—	—	—	—	—	—	98.11%	98.17%	0.00%	0.00%	98.36%	0.00%	**47.18%**
Other Language Needs—Percent Non-English	—	—	—	—	—	—	1.84%	1.78%	0.00%	0.00%	1.55%	0.00%	**0.80%**
Other Language Needs—Percent Declined	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Other Language Needs—Percent Unknown	—	—	—	—	—	—	0.06%	0.06%	100.00%	100.00%	0.09 %	100.00%	**52.02%**
Race/Ethnicity Diversity of Membership													
Race—Health Plan	—	—	—	—	—	—	0.00%	35.80%	93.30%	0.00%	0.00%	0.00%	**22.17%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race—CMS/State	—	—	—	—	—	—	66.39%	53.72%	0.05%	35.56%	88.86%	72.12%	**56.65%**
Race—Other Direct	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.01%	1.59%	0.00%	**0.43%**
Race—Direct Total	—	—	—	—	—	—	66.39%	89.52%	93.35%	35.57%	90.44%	72.12%	**79.25%**
Race—Indirect Total	—	—	—	—	—	—	0.00%	0.00%	3.18%	0.00%	0.00%	0.00%	**0.61%**
Race—Unknown Total	—	—	—	—	—	—	33.61%	10.48%	3.47%	64.43%	9.56%	27.88%	**20.14%**
Ethnicity—Health Plan	—	—	—	—	—	—	0.00%	41.41%	92.20%	0.00%	0.00%	0.00%	**22.63%**
Ethnicity—CMS/State	—	—	—	—	—	—	72.75%	8.93%	0.00%	50.03%	2.16%	97.02%	**35.49%**
Ethnicity—Other Direct	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	8.10%	0.00%	**2.20%**
Ethnicity—Direct Total	—	—	—	—	—	—	72.75%	50.33%	92.20%	50.03%	10.26%	97.02%	**60.32%**
Ethnicity—Indirect Total	—	—	—	—	—	—	0.00%	0.00%	7.61%	0.00%	26.82%	0.00%	**8.74%**
Ethnicity—Unknown Total	—	—	—	—	—	—	27.25%	49.67%	0.19%	49.97%	62.92%	2.98%	**30.93%**
Race: White—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	4.05%	0.23%	0.00%	1.05%	0.00%	**0.81%**
Race: White—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	27.02%	14.51%	41.96%	32.62%	14.83%	37.91%	**28.15%**
Race: White—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.17%	0.02%	0.00%	0.00%	0.00%	**0.02%**
Race: White—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	16.51%	0.05%	0.45%	21.57%	0.00%	**7.88%**
Race: White—Ethnicity: Total	—	—	—	—	—	—	27.02%	35.24%	42.27%	33.07%	37.46%	37.91%	**36.87%**
Race: Black or African American—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	4.94%	0.07%	0.00%	0.26%	0.00%	**0.67%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Black or African American—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	31.94%	21.23%	44.01%	0.01%	17.42%	29.32%	**25.38%**
Race: Black or African American—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.22%	0.01%	0.00%	0.00%	0.00%	**0.03%**
Race: Black or African American—Ethnicity: Unknown	—	—	—	—	—	—	0.14%	22.96%	0.03%	0.71%	30.74%	0.00%	**11.17%**
Race: Black or African American—Ethnicity: Total	—	—	—	—	—	—	32.08%	49.35%	44.12%	0.72%	48.41%	29.32%	**37.26%**
Race: American Indian or Alaska Native—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.12%	0.01%	0.00%	0.04%	0.00%	**0.03%**
Race: American Indian or Alaska Native—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.55%	0.30%	0.75%	0.00%	0.24%	0.80%	**0.48%**
Race: American Indian or Alaska Native—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: American Indian or Alaska Native—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	0.35%	0.00%	0.63%	0.40%	0.00%	**0.21%**
Race: American Indian or Alaska Native—Ethnicity: Total	—	—	—	—	—	—	0.55%	0.78%	0.76%	0.63%	0.68%	0.80%	**0.72%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Asian—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.15%	0.07%	0.00%	0.02%	0.00%	**0.04%**
Race: Asian—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.46%	5.96%	0.00%	0.47%	1.10%	**1.58%**
Race: Asian—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asian—Ethnicity: Unknown	—	—	—	—	—	—	6.61%	0.77%	0.00%	1.14%	0.86%	0.00%	**1.02%**
Race: Asian—Ethnicity: Total	—	—	—	—	—	—	6.61%	1.38%	6.03%	1.14%	1.35%	1.10%	**2.64%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.02%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.03%	0.02%	0.00%	0.00%	0.01%	**0.01%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Unknown	—	—	—	—	—	—	0.03%	0.03%	0.00%	0.01%	0.01%	0.00%	**0.01%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Native Hawaiian or Other Pacific Islander—Ethnicity: Total	—	—	—	—	—	—	0.03%	0.08%	0.02%	0.01%	0.02%	0.01%	**0.02%**
Race: Some Other Race—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	0.22%	0.00%	0.38%	0.00%	**0.15%**
Race: Some Other Race—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	3.10%	0.00%	0.32%	0.00%	**0.68%**
Race: Some Other Race—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Some Other Race—Ethnicity: Unknown	—	—	—	—	—	—	0.11%	0.00%	0.01%	0.00%	1.80%	2.98%	**1.19%**
Race: Some Other Race—Ethnicity: Total	—	—	—	—	—	—	0.11%	0.00%	3.33%	0.00%	2.50%	2.98%	**2.02%**
Race: Two or More Races—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	1.21%	0.00%	0.00%	0.00%	0.00%	**0.14%**
Race: Two or More Races—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.14%	0.00%	0.00%	0.01%	0.00%	**0.02%**
Race: Two or More Races—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	**0.00%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Two or More Races—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	1.34%	0.00%	0.00%	0.02%	0.00%	**0.16%**
Race: Two or More Races—Ethnicity: Total	—	—	—	—	—	—	0.00%	2.70%	0.00%	0.00%	0.03%	0.00%	**0.33%**
Race: Unknown—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	1.63%	2.04%	0.35%	0.02%	0.62%	0.87%	**0.83%**
Race: Unknown—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.46%	0.68%	3.03%	0.00%	1.43%	27.01%	**7.38%**
Race: Unknown—Ethnicity: Asked but No Answer	—	—	—	—	—	—	11.14%	0.04%	0.00%	17.39%	0.00%	0.00%	**2.65%**
Race: Unknown—Ethnicity: Unknown	—	—	—	—	—	—	20.37%	7.72%	0.09%	47.02%	7.51%	0.00%	**9.27%**
Race: Unknown—Ethnicity: Total	—	—	—	—	—	—	33.61%	10.48%	3.47%	64.43%	9.56%	27.88%	**20.14%**
Race: Total—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	1.63%	12.53%	0.94%	0.02%	2.37%	0.87%	**2.67%**
Race: Total—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	59.97%	37.35%	98.83%	32.63%	34.71%	96.15%	**63.68%**
Race: Total—Ethnicity: Asked but No Answer	—	—	—	—	—	—	11.14%	0.45%	0.04%	17.39%	0.00%	0.00%	**2.71%**
Race: Total—Ethnicity: Unknown	—	—	—	—	—	—	27.25%	49.67%	0.19%	49.97%	62.92%	2.98%	**30.93%**
Race: Total—Ethnicity: Total	—	—	—	—	—	—	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**

HEDIS Measure	MY 2022						MY 2023						
	ABH	ACLA	HBL	LHCC	UHC	SWA	ABH	ACLA	HBL	HUM	LHCC	UHC	SWA
Race: Asked but No Answer—Ethnicity: Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Not Hispanic or Latino	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Asked but No Answer	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Unknown	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**
Race: Asked but No Answer—Ethnicity: Total	—	—	—	—	—	—	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**

* Indicates a lower rate is desirable.

Green: ≥ NCQA national 50th percentile benchmark, Red: < NCQA national 50th percentile benchmark.

For HEDIS measures: *NA* indicates that the denominator was too small (i.e., less than 30) to report a valid rate, *NR* indicates that the MCO did not report the measure, and *NQ* indicates that the MCO was not required to report the measure.

— is presented for measures that were not reported by the MCOs in MY 2022 and indicates that MY 2022 rates are not available for those measures.

Caution is recommended when comparing HUM's MY 2023 rates to the LDH target rates or other MCOs' rates due to HUM's limited period as an MCO in Louisiana.

Table 3-5—MCO HEDIS Performance Measure Summary—MY 2022 and MY 2023 Comparison

Measure Status	MY 2022					MY 2023*					
	ABH	ACLA	HBL	LHCC	UHC	ABH	ACLA	HBL	HUM	LHCC	UHC
≥ NCQA National 50th Percentile Benchmark	20	31	30	28	39	163	173	162	133	190	117
< NCQA National 50th Percentile Benchmark	58	47	48	50	39	113	94	112	132	85	67
NCQA National Benchmark Unavailable	11	11	11	11	11	12	12	12	12	12	12
Total	89	89	89	89	89	288	279	286	277	287	196

*The "Total" row presents the count of all HEDIS measure indicators that could be reported by the MCOs for MY 2023, excluding indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NB* (i.e., MCO did not provide the health benefit), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator). The "≥ NCQA National 50th Percentile Benchmark," "< NCQA National 50th Percentile Benchmark," and "NCQA National Benchmark Unavailable" rows present the count of indicators with reportable rates, for each MCO, that met the comparison criteria. For MY 2023, measure indicators with a rate of *NA* (i.e., denominator too small for a valid rate), *NR* (i.e., MCO did not report on the indicator), or *NQ* (i.e., MCO was not required to report the indicator) are excluded from the comparison rows because their results are not comparable to NCQA benchmarks.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs' SWA rate on the *Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening (Total)* measure indicator was above the NCQA national 50th percentile benchmark for MY 2023. This result suggests that the MCOs, collectively, were effective in coordinating with providers to ensure adolescent and adult Medicaid members were properly screened for depression, enabling timely follow-up care. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure were above the NCQA national 50th percentile benchmark for MY 2023. Additionally, the rates of four MCOs (ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were effective in ensuring that adult members on antipsychotics were screened for diabetes and had their diabetes monitored, resulting in positive health outcomes for this population. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were effective in ensuring that adult members with cardiovascular disease and schizophrenia had their cholesterol monitored to promote positive health outcomes. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Lead Screening in Children* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were effective in ensuring that children under 2 years of age were adequately receiving lead blood testing to ensure they maintained limited exposure to lead. **[Quality]**
- The rates of three or more MCOs, as well as the SWA rate on the following *Childhood Immunization Status* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *DTaP*, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Hepatitis A*, and *Combination 3*. These results suggest that the MCOs were effective in ensuring that children 2 years of age were receiving some immunizations to help protect them against a potential life-threatening disease. **[Quality and Access]**
- The rates of three or more MCOs, as well as the SWA rate on the following *Immunizations for Adolescents* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *Meningococcal*, *Tdap/Td*, *HPV*, *Combination 1*, and *Combination 2*. These results suggest that the MCOs were effective in ensuring that adolescent members were receiving immunizations to help protect them against meningococcal disease, tetanus, diphtheria, pertussis, and HPV. **[Quality]**

- The rates of all MCOs, as well as the SWA rate on the *Colorectal Cancer Screening* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs were effective in ensuring that members 45 to 75 years of age had appropriate screening for colorectal cancer. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Chlamydia Screening in Women—Total* measure indicator were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to facilitate annual follow-ups with and screening of sexually active members. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total* measure indicator were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to ensure that members with clinical atherosclerotic cardiovascular disease (ASCVD) received statin therapy to manage their condition, reducing the risk of adverse outcomes. **[Quality]**
- The rates of five or more MCOs, as well as the SWA rate on the *HbA1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to help members control their blood sugar levels, reducing the risk of complications. **[Quality]**
- The rates of four MCOs (HBL, HUM, LHCC, UHC), as well as the SWA rate on the *Eye Exam for Patients With Diabetes* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to ensure that adult members with diabetes received a retinal eye exam to screen for diabetic retinal disease. **[Quality]**
- The rates of four MCOs (ABH, ACLA, HUM, LHCC), as well as the SWA rate on the *Pharmacotherapy for Opioid Use Disorder* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to engage members with opioid use disorder in continuous treatment with pharmacotherapy, increasing the chance for positive outcomes. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* and *Engagement of SUD Treatment* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to initiate treatment for members with a new SUD episode and engaged these members in subsequent SUD services or medications within 34 days of their visit to initiate SUD treatment. **[Quality, Timeliness, and Access]**
- The rates of five MCOs (ABH, HBL, HUM, LHCC, UHC), as well as the SWA rate on the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to ensure the use of psychosocial care as first-line treatment for children and adolescents recently started on antipsychotic medications. **[Quality]**
- The rates of four MCOs (ABH, ACLA, HBL, UHC), as well as the SWA rate on the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure

indicator were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with providers to ensure that children prescribed ADHD medication participated in continuous follow-up visits with a practitioner with prescribing authority to properly manage their prescription. **[Quality, Timeliness, and Access]**

- The rates of four MCOs (ABH, ACLA, HBL, LHCC), as well as the SWA rate on the following *Asthma Medication Ratio* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023: *5–11 Years*, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*. These results suggest that the MCOs effectively coordinated with providers to help members with persistent asthma manage this treatable condition. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Well-Child Visits in the First 30 Months of Life—First 15 Months* and *15 Months–30 Months* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs effectively coordinated with PCPs to ensure that children were seen within the first 30 months of life to assess and influence members' early development. **[Quality and Access]**
- The rates of three MCOs (ACLA, LHCC, UHC), as well as the SWA rate on the *Child and Adolescent Well-Care Visits—12–17 Years* and *18–21 Years* measure indicators were above the NCQA national 50th percentile benchmark for MY 2023. These results suggest that these MCOs effectively coordinated with providers to ensure that adolescent members received appropriate well-care visits to provide screening and counseling. **[Quality and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- The rates of all MCOs, as well as the SWA rate on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in their coordination with providers to ensure that members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. **[Quality, Timeliness, and Access]**
- The rates of all MCOs, as well as the SWA rate on the *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. Additionally, the rates of all MCOs, as well as the SWA rate on the *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. **[Quality, Timeliness, and Access]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with facilitating appropriate post-discharge planning and care coordination. **[Quality]**

- The rates of three or more MCOs, as well as the SWA rate on the following *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *Blood Glucose Testing*, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*. These results suggest that the MCOs have room for improvement in their coordination with providers to effectively monitor blood glucose and cholesterol in child and adolescent members on antipsychotics. **[Quality]**
- The rates of three or more MCOs, as well as the SWA rate on the following *Childhood Immunization Status* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *Pneumococcal Conjugate*, *Rotavirus*, *Influenza*, *Combination 7*, and *Combination 10*. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure children under 2 years of age are receiving all appropriate vaccinations to protect them against potential life-threatening diseases. **[Quality and Access]**
- The rates of five or more MCOs, as well as the SWA rate on the following *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *BMI Percentile Documentation*, *Counseling for Nutrition*, and *Counseling for Physical Activity*. These results suggest that the MCOs have room for improvement in their coordination with providers to ensure that child and adolescent members are having their weight and BMI monitored, and are receiving appropriate counseling to reduce the risk for obesity and prevent adverse health outcomes. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Controlling High Blood Pressure* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to help members manage their blood pressure, reducing their risk for heart disease and stroke. **[Quality]**
- The rates of four MCOs (ACLA, HBL, HUM, UHC), as well as the SWA rate on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that MCOs have room for improvement in coordinating with providers to ensure that members with ASCVD adhere to statin therapy to effectively manage their condition. **[Quality]**
- The rates of four MCOs (ABH, ACLA, HBL, LHCC), as well as the SWA rate on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to help adult members with diabetes adequately control their blood pressure. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure that members with schizophrenia or schizoaffective disorder are dispensed and remain on an antipsychotic medication for at least 80 percent of their treatment period. **[Quality]**
- The rates of three MCOs (ABH, HBL, LHCC), as well as the SWA rate on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator were below the NCQA

national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to initiate appropriate follow-up visits for children prescribed ADHD medication. **[Quality, Timeliness, and Access]**

- The rates of four or more MCOs, as well as the SWA rate on the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to treat adult members diagnosed with major depression with antidepressant medication and help members remain on antidepressant medication for at least 84 days (Acute Phase) and through 180 days (Continuation Phase). **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that a diagnosis of upper respiratory infection (URI) does not result in an antibiotic dispensing event for members. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, LHCC, UHC), as well as the SWA rate on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that providers effectively prevent or minimize the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Use of Imaging Studies for Low Back Pain* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that MCOs have room for improvement with ensuring that providers properly order imaging studies. **[Quality]**
- The rates of all MCOs, as well as the SWA rate on the *Non-Recommended Cervical Screening in Adolescent Females* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that providers avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- The rates of five MCOs (ABH, ACLA, HBL, HUM, UHC), as well as the SWA rate on the *Cervical Cancer Screening* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in coordinating with providers to ensure that women ages 21 to 64 years receive appropriate, early detection cancer screening. **[Quality]**
- The rates of four MCOs, as well as the SWA rate on the following *Adults' Access to Preventive/Ambulatory Health Services* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023: *20–44 Years*, *45–64 Years*, *65 Years and Older*, and *Total*. These results suggest that the MCOs have room for improvement in coordinating with PCPs to ensure that adult members are engaging in preventive or ambulatory visits to manage their health and avoid adverse outcomes. **[Quality and Access]**
- The rates of five of more MCOs, as well as the SWA rate on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room

for improvement in coordinating with providers to ensure that members receive timely and adequate prenatal and postpartum care, in alignment with guidance provided by the AAP and the American College of Obstetricians and Gynecologists. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following recommendations were identified:

- To improve performance on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, and *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators, HSAG recommends that the MCOs work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and the MCOs. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as providing patient and provider education or improving upon coordination of care following discharge. **[Quality, Timeliness, and Access]**
- To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommends that the MCOs work with providers to improve post-discharge planning and care coordination. **[Quality]**
- To improve performance on the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators, HSAG recommends that the MCOs work with providers to identify root causes and trial interventions to ensure that children and adolescents with ongoing antipsychotic medication use have appropriate metabolic testing completed annually to appropriately manage their conditions. **[Quality]**
- To improve performance on the *Childhood Immunization Status* measure indicators, HSAG recommends that the MCOs focus their efforts on increasing immunizations for children. The MCOs should also consider conducting a root cause analysis and implementing appropriate interventions to improve performance that are evidence-based and address barriers such as parent dissatisfaction, provider capacity, or appointment accessibility. Additionally, the MCOs should consider inclusion of parent/guardian and provider participation when evaluating root causes of measure performance. **[Quality and Access]**
- To improve performance on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, HSAG recommends that the MCOs work with PCPs to identify and address barriers to primary care visits for children and adolescents in need of weight assessment and education on healthy habits. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality]**
- To improve performance on the *Controlling High Blood Pressure* measure, HSAG recommends that the MCOs work with providers to identify and address barriers to effective blood pressure management in members. The MCOs could also consider expanding on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such

as blood pressure monitoring devices, to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. Additionally, the MCOs could consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**

- To improve performance on the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure indicator, HSAG recommends the MCOs work with providers to identify and address barriers to statin therapy adherence among members with ASCVD. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as provider and member education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Blood Pressure Control for Patients With Diabetes (<140/90 mm Hg)* measure, HSAG recommends that the MCOs work with providers to identify and address barriers to effective blood pressure management for diabetic members. HSAG also recommends that the MCOs expand on existing strategies that focus on disease and chronic condition management, which may include providing at-home devices, such as blood pressure monitoring devices to hypertensive members; evaluating and expanding current and/or new member outreach and engagement initiatives; and offering provider education and engagement opportunities such as webinars and newsletters on hypertension management best practices. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality]**
- To improve performance on the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, HSAG recommends that the MCOs work with providers to identify and address barriers to the dispensing of antipsychotic medications to members with schizophrenia or schizoaffective disorder, and barriers to adherence to antipsychotic medications. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as provider education on the importance of medication adherence. **[Quality]**
- To improve performance on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator, HSAG recommends that the MCOs work with providers to identify and address barriers to initial follow-up visits with children prescribed ADHD medication. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions. **[Quality, Timeliness, and Access]**
- To improve performance on the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators, HSAG recommends that the MCOs work with providers to identify and address barriers to prescribing antidepressant medication to adult members with major depression and helping members remain on antidepressant medication for the appropriate amount of time. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient education and offering telehealth services. **[Quality]**

- To improve performance on the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce antibiotic dispensing to treat URIs. The MCOs could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce or prevent the prescribing of antibiotics for members with a diagnosis of bronchitis or bronchiolitis. The MCOs could also work with providers to review noncompliant claims to ensure there were no additional diagnoses during the appointment that justified the prescription of an antibiotic. **[Quality]**
- To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that the MCOs focus their efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that the MCOs work with providers to trial solutions to reduce the inappropriate ordering of imaging studies. Appropriate interventions to improve performance may include addressing provider behaviors, provider incentives, and addressing member expectation with education. **[Quality]**
- To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females. **[Quality]**
- To improve performance on the *Cervical Cancer Screening* measure, HSAG recommends that the MCOs work with providers to identify and address barriers to cervical cancer screening for women ages 21 to 64 years old. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as offering screenings at more locations or expanding clinic and screening hours. **[Quality]**
- To improve performance on the *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, HSAG recommends that the MCOs work with PCPs to identify and address barriers to preventive or ambulatory visits for adult members. The MCOs could also consider data analysis and stratification across key demographics such as race, ethnicity, age, and ZIP Code to identify disparities and implement targeted interventions, such as patient and provider education, outreach campaigns, and sending reminders. **[Quality and Access]**
- To improve performance on the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, HSAG recommends that the MCOs work with providers to identify and address barriers to timely and adequate prenatal and postpartum care. HSAG recommends the MCOs consider implementing interventions such as offering provider education and engagement opportunities, including educational webinars and newsletters on prenatal and postpartum health services, and piloting a member incentives program designed to encourage engagement in timely prenatal and postpartum care services. **[Quality, Timeliness, and Access]**

Methodology

Objectives

In accordance with 42 CFR §438.330(c), states must require MCOs to submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory EQR activities that the state Medicaid agencies are required to perform according to the Medicaid managed care regulations.

The primary objectives of the performance measure validation (PMV) process were to:

1. Evaluate the accuracy of performance measure data collected by the MCO.
2. Determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure.
3. Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

The CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023,[3-1] specifies that, in lieu of conducting a full on-site ISCA, the EQRO may review an assessment of the MCO's IS conducted by another party. If an MCO is accredited by NCQA, the MCO will have received a full IS assessment as part of its annual HEDIS Compliance Audit by an NCQA HEDIS Compliance Audit LO. In this case, HSAG would request and review the MCO's NCQA HEDIS Record of Administration, Data Management, and Processes (Roadmap), FAR, and the data submission tool in lieu of conducting an on-site assessment.

The validation process is described separately for the HEDIS and non-HEDIS measures that the MCOs report.

HEDIS Measure Validation

The MCOs that report HEDIS measures to NCQA must undergo an audit of their data conducted by an NCQA HEDIS Compliance Audit LO. For these HEDIS measures, HSAG reviews the rates submitted on the NCQA reporting tool (Interactive Data Submission System [IDSS]), which is audited prior to submission, and the FAR, which is completed by the LO and describes the process used to produce the measure rates and any problems that the MCOs experienced in the HEDIS process. Included in the FAR are the measures deemed *Not Reportable* due to biases in the calculation process.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

HSAG used the results of the audit to report the results of each measure reported to LDH. Using information provided in the FAR and, if necessary, additional documentation (i.e., NCQA HEDIS Roadmap), HSAG prepared a report indicating the measure results for each of the MCOs that are required to report to LDH. Measures deemed *Not Reportable* were flagged. SWAs were computed, and NCQA Quality Compass benchmarks were provided as well. Results for the prior two years were provided for trending, when appropriate. Any issues in reporting any measure (e.g., medical record abstraction issues) were noted and, if LDH requested any other statistical analyses, the results were included in the report.

Non-HEDIS Measure Validation

For state-specific measures and standardized non-HEDIS measures (e.g., the Prevention Quality Indicators), University of Louisiana Monroe (ULM), contracted by LDH, conducted the audit. Measures that did not pass validation were deemed *Not Reportable*, and the reasons for this designation (e.g., unresolved source code issues) were noted. If LDH requested any other statistical analyses, the results were included in the report. ULM conducted the validation for non-HEDIS measures, and HSAG provided assistance when needed.

Description of Data Obtained

HSAG used the FAR and the MCO rates provided on the IDSS file as the primary data sources. The FAR included information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, MRRV results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. The FAR included final determinations of validity made by the auditor for each performance measure. The IDSS file detailed all rates that were submitted to NCQA and whether the auditor deemed them to be reportable. The IDSS file is "locked" by the auditor so that no changes can be made to the results.

How Data Were Aggregated and Analyzed

In accordance with the MY 2023 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5, the LOs evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCO's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. For each HEDIS measure, the MCO was evaluated on how its rate compared to the NCQA Quality Compass MY 2023 national 50th percentile Medicaid Health Maintenance Organization (HMO) benchmark.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG evaluated the results for each performance measure and the 2023 performance levels based on comparison to the NCQA national 50th percentile benchmark to identify

strengths and opportunities for improvement and determine whether each strength and opportunity for improvement impacted one or more of the domains of quality, timeliness, or access. Additionally, for each opportunity for improvement, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCO's Medicaid members.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-6. The measures marked *NA* are related to utilization of services.

Table 3-6—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Childhood Immunization Status—DTaP, *IPV*, *MMR*, *HiB*, *Hepatitis B*, *VZV*, *Pneumococcal Conjugate, Hepatitis A*, *Rotavirus*, *Influenza*, *Combination 3*, *Combination 7*, and *Combination 10*	✓		✓
Immunizations for Adolescents—Meningococcal, *Tdap/Td*, *HPV*, *Combination 1*, and *Combination 2*	✓		
Colorectal Cancer Screening	✓		
Cervical Cancer Screening	✓		
Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge and *Within 30 Days of Discharge*	✓	✓	✓
HbA1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%) and *HbA1c Control (<8.0%)*	✓		
Controlling High Blood Pressure	✓		
HIV Viral Load Suppression	✓		
Low-Risk Cesarean Delivery (Cesarean Rate for Low-Risk First Birth Women)	✓		
Child and Adolescent Well-Care Visits—3–11 Years, *12–17 Years*, *18–21 Years*, and *Total*	✓		✓
Well-Child Visits in the First 30 Months of Life—First 15 Months and *15 Months–30 Months*	✓		✓
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, *45–64 Years*, *65 Years and Older*, and *Total*	✓		✓
Ambulatory Care—Outpatient Visits/1,000 Member Years and *Emergency Department Visits/1,000 Member Years*	NA	NA	NA

Performance Measure	Quality	Timeliness	Access
Plan All-Cause Readmissions—Observed Readmissions, *Expected Readmissions*, and *O/E Ratio*	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing, *Cholesterol Testing*, and *Blood Glucose and Cholesterol Testing*	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Lead Screening in Children	✓		
Flu Vaccinations for Adults Ages 18 to 64	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation, *Counseling for Nutrition*, and *Counseling for Physical Activity*	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total and *Statin Adherence 80%—Total*	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Eye Exam for Patients With Diabetes	✓		
Pharmacotherapy for Opioid Use Disorder	✓		
Initiation and Engagement of SUD Treatment—Initiation of SUD and *Engagement of SUD*	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Non-Recommended Cervical Screening in Adolescent Females	✓		
Depression Screening and Follow-Up for Adolescents and Adults	✓		

Performance Measure	Quality	Timeliness	Access
Use of Imaging Studies for Low Back Pain	✓		
Asthma Medication Ratio—5–11 Years, *12–18 Years*, *19–50 Years*, *51–64 Years*, and *Total*	✓		
Topical Fluoride for Children—1–2 Years, *3–4 Years*, and *Total*	✓		
Oral Evaluation, Dental Services—0–2 Years, *3–5 Years*, *6–14 Years*, *15–20 Years*, and *Total*	✓		
Inpatient Utilization—General Hospital/Acute Care—Maternity, *Surgery*, *Medicine*, and *Total Inpatient*	NA	NA	NA
Enrollment by Product Line	NA	NA	NA
Language Diversity of Membership	NA	NA	NA
Race/Ethnicity Diversity of Membership	NA	NA	NA

4. Assessment of Compliance With Medicaid Managed Care Regulations

Aggregate Results

Federal regulations require the MCOs to undergo a CR at least once every three years to determine compliance with federal standards.

Table 4-1 delineates the CR standards that were reviewed during the current three-year CR cycle, along with scores for each MCO.

Table 4-1—Summary of CR Scores for the Three-Year Review Period: CY 2021–CY 2023[1,2,3]

Standard Name	ABH			ACLA			HBL			LHCC			UHC		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Enrollment and Disenrollment[2]		**42.9%**			**100%**			**71.4%**			**85.7%**			**85.7%**	
Member Rights and Confidentiality	93.0%			99.1%			99.1%			99.1%			99.5%		
Member Information															
Coverage and Authorization of Services	98.5%			99.2%			100%			99.2%			100%		
Emergency and Post-Stabilization Services															
Availability of Services	99.2%			95.0%			99.6%			100%			98.8%		
Assurances of Adequate Capacity and Services	100%			100%			100%			100%			100%		
Coordination and Continuity of Care	91.6%			95.2%			100%			91.0%			90.7%		
Provider Selection	97.8%			100%			97.8%			100%			97.8%		
Subcontractual Relationships and Delegation	100%			100%			100%			100%			100%		
Practice Guidelines	100%			100%			100%			100%			100%		
Health Information Systems	100%			100%			100%			100%			100%		
Quality Assessment and Performance Improvement Program	98.6%			98.6%			100%			100%			100%		

Standard Name	ABH			ACLA			HBL			LHCC			UHC		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Grievance and Appeal Systems	100%			100%			99.3%			100%			100%		
Program Integrity	95.8%			100%			100%			94.6%			100%		

[1] Gray shading indicates the standard was not reviewed in the calendar year.

[2] Bold text indicates scores that were determined by HSAG. All other scores were determined by LDH's former EQRO. HSAG's scoring methodology included three levels: *Met*, *Not Met*, and *Not Applicable*.

[3] HUM was excluded from this results summary as it was a new MCO to the Louisiana market as of January 2023; therefore, HUM was not subject to the CR.

Follow-Up on Previous Compliance Review Findings

Following the year two CR, HSAG worked with LDH to issue CAPs for elements in Standard I—Enrollment and Disenrollment that were not compliant. The MCOs were required to submit the CAP for approval. Upon approval from LDH and HSAG, the MCOs were required to implement the CAP and submit evidence of implementation. HSAG worked with LDH to review, approve, and monitor CAPs during SFY 2023.

The MCOs achieved compliance in 14 of 14 elements from the 2023 CAPs, demonstrating positive improvements in implementing CAPs from 2023.

HSAG will conduct a comprehensive CR during 2025 to determine the extent to which the MCOs are in compliance with federal standards.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs successfully remediated all 14 elements, indicating that initiatives were implemented and demonstrated compliance with the requirements under review. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- HSAG did not identify any opportunities for improvement.

For the MCOs statewide, the following recommendations were identified:

- HSAG did not identify any required actions or recommendations.

Methodology

Standards

Table 4-2 delineates the CR activities as well as the standards that were reviewed during the first two years of the three-year CR cycle. In year three (CY 2023), HSAG conducted a follow-up review of each MCO's CAPs from the previous CR. HSAG will conduct a comprehensive CR during CY 2025 to determine the extent to which the MCOs are in compliance with federal standards during the review period CY 2024.

Table 4-2—Summary of CR Standards

Standard	Year One (CY 2021)			Year Two (CY 2022)			Year Three (CY 2023)		
	MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment				✓	✓	✓			
Standard II—Member Rights and Confidentiality	✓	✓	✓						
Standard III—Member Information	✓	✓	✓						
Standard IV—Emergency and Poststabilization Services	✓	NA				✓			
Standard V—Adequate Capacity and Availability of Services	✓	✓	✓						
Standard VI—Coordination and Continuity of Care	✓	✓	✓						
Standard VII—Coverage and Authorization of Services	✓	✓	✓						
Standard VIII—Provider Selection	✓	✓	✓						
Standard IX—Subcontractual Relationships and Delegation	✓		✓		✓				
Standard X—Practice Guidelines	✓	✓	✓						
Standard XI—Health Information Systems	✓	✓	✓						
Standard XII—Quality Assessment and Performance Improvement	✓	✓	✓						
Standard XIII—Grievance and Appeal Systems	✓	✓	✓						
Standard XIV—Program Integrity	✓	✓	✓						
CAP Review							✓	✓	✓

NA=not applicable for the PAHPs

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table 4-3 describes the standards and associated regulations and requirements reviewed for each standard.

Table 4-3—Summary of CR Standards and Associated Regulations[1,2]

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56 42 CFR §438.608	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214 42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.608

[1] The CR standards comprise a review of all requirements, known as "elements," under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] Note that in year one, the previous EQRO utilized a different numbering system for the standards.

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that

the standards are followed is the second step. The objective of each virtual review was to provide meaningful information to LDH and the MCOs regarding:

- The MCOs' compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the MCOs into compliance with federal managed care regulations and contract requirements with the standard areas reviewed.
- The quality, timeliness, and access to care furnished by the MCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the MCOs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess the MCOs' compliance with regulations, HSAG conducted the five activities described in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* February 2023.[4-1] Table 4-4 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 4-4—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and LDH contract requirements: • HSAG and LDH collaborated to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG developed and submitted CR tools, report templates, and agendas, and sent review dates to LDH for review and approval. • HSAG forwarded the CR tools and agendas to the MCOs. • HSAG scheduled the virtual reviews to facilitate preparation for the reviews.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCO pre-virtual review preparation session to describe HSAG's processes and allow the MCOs the opportunity to ask questions about the review process and MCO expectations.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 16, 2024.

For this protocol activity,	HSAG completed the following activities:
	• HSAG confirmed a primary MCO contact person for the review and assigned HSAG reviewers to participate. • During the MCO pre-virtual review preparation session, HSAG notified the MCOs of the request for desk review documents. HSAG delivered a desk review form, the CR tool, CAP implementation review tool, and a webinar review agenda via HSAG's Secure Access File Exchange (SAFE) site. The desk review request included instructions for organizing and preparing the documents to be submitted. The MCO provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and CR consisted of the completed desk review form, the CR tool with the MCO's section completed, policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled webinar and prepared a request for further documentation and an interview guide to use during the webinar.
Activity 3:	**Conduct MCO Virtual Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual review activities. • During the review, HSAG met with groups of the MCO's key staff members to obtain a complete picture of the MCO's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • HSAG conducted a closing conference during which HSAG reviewers summarized preliminary findings, as appropriate.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the 2023 LDH-approved CR Report Template to compile the findings and incorporate information from the CR activities. • HSAG analyzed the findings and calculated final scores based on LDH-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to LDH**
	• HSAG populated and submitted the draft reports to LDH and the MCOs for review and comments. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final reports to the MCOs and LDH.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Written policies and procedures
- Management/monitoring reports and audits
- Narrative and/or data reports across a broad range of performance and content areas
- Records for delegation
- Member and provider materials

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from the desk review, virtual interviews conducted with key MCO personnel, and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCO's performance in complying with each standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to LDH and to each MCO's staff members for their review and comment prior to issuing final reports.

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and opportunities for improvement in each domain of quality, timeliness, and access to care furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across MCOs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw

conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or access to care and services provided by the MCOs. Table 4-5 depicts assignment of the standards to the domains of care.

Table 4-5—Assignment of CR Standards to the Quality, Timeliness, and Access Domains

CR Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		
Standard XIII—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Program Integrity	✓	✓	✓

5. Validation of Network Adequacy

Aggregate Results

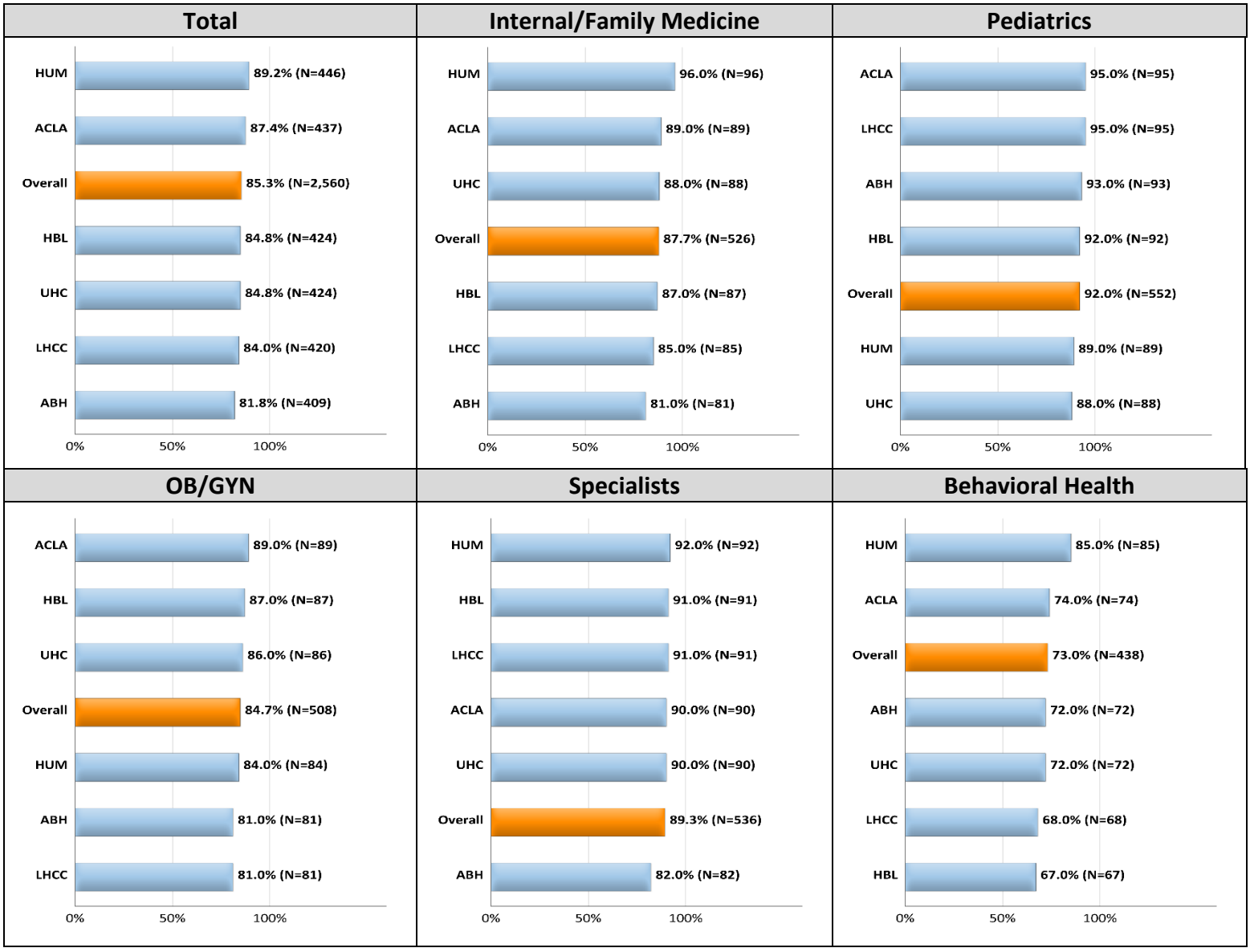
Provider Directory Accuracy

HSAG conducted PDV reviews from July 2023 through November 2023 (review period). This section presents the results from the CY 2023 PDV for all sampled providers by MCO and specialty type across all four quarters.

Response Rate

Figure 5-1 illustrates the survey disposition and response rates by MCO and specialty type.

Figure 5-1—PDV Response Rates by MCO and Specialty Type



Correct Address

Figure 5-2 displays the percentage of cases in which the survey respondent reported that the MCOs' provider directory reflected the correct address.

Figure 5-2—Respondents With the Correct Address



Provider at Correct Location

Figure 5-3 displays the percentage of cases in which the survey respondent confirmed that the sampled provider was at the location.

Figure 5-3—Respondents That Confirmed Sampled Provider at Correct Location



Specialty

Figure 5-4 displays the percentage of cases in which the survey respondent confirmed that the sampled provider was the specialty indicated in the MCO's provider directory.

Figure 5-4—Respondents That Confirmed Provider Specialty



Acceptance Rates

Figure 5-5 through Figure 5-7 display the percentage of cases in which the survey respondent confirmed the provider accepted the requested MCO, Louisiana Medicaid, and new patients, respectively.

Figure 5-5—Respondents That Confirmed the Provider Accepted the MCO



Figure 5-6—Respondents That Confirmed the Provider Accepted Louisiana Medicaid

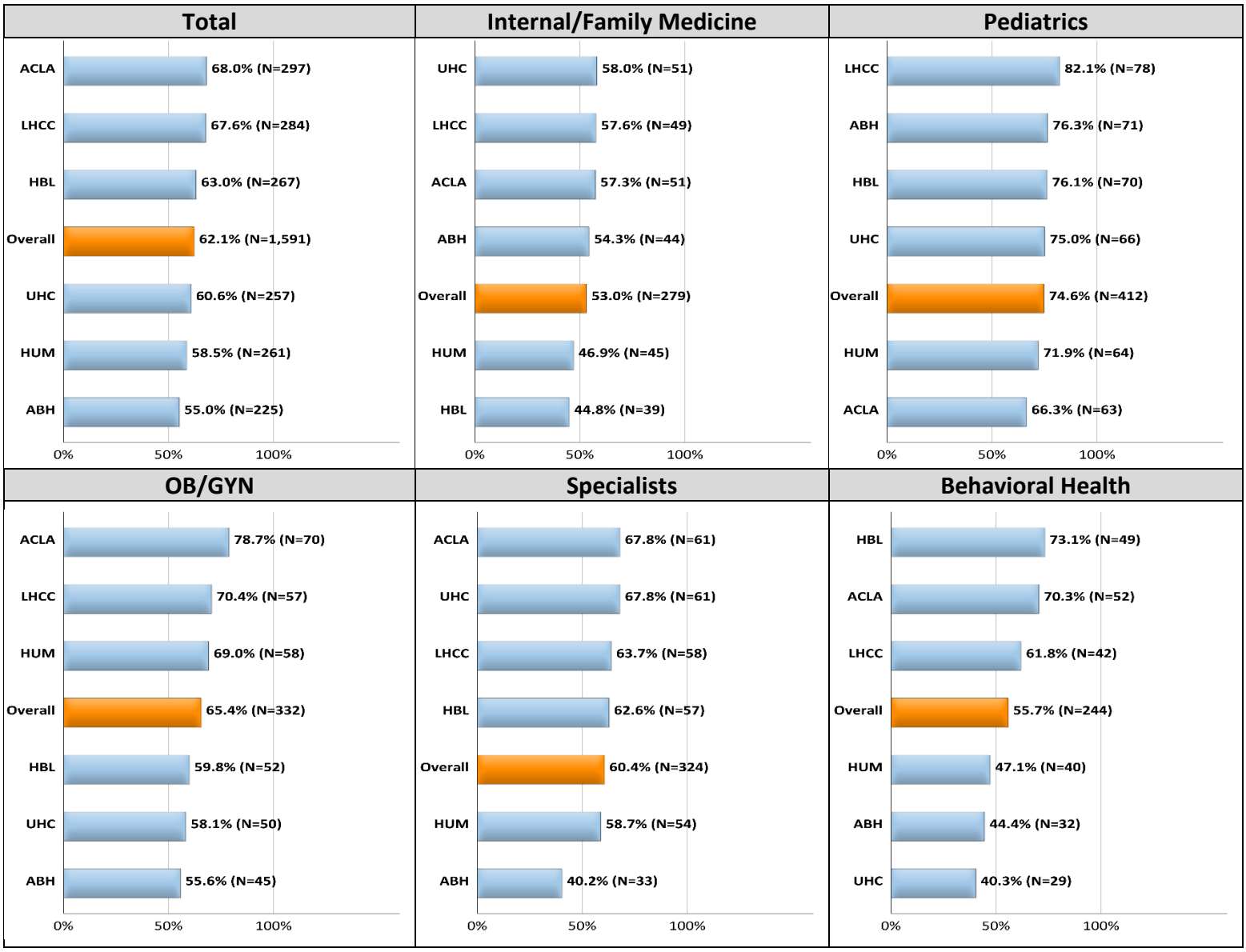


Figure 5-7—Respondents That Confirmed the Provider Accepted New Patients



Compliance Scores

Table 5-1 and Table 5-2 present the PDV weighted compliance scores by specialty type and MCO, respectively.

Table 5-1—PDV Weighted Compliance Scores by Specialty Type

Specialty	Total	Compliant[1]	Weighted Compliance Score
Overall	**3,000**	**1,107**	**44.2%**
Internal Medicine/Family Medicine	600	188	39.0%
Pediatrics	600	313	59.1%
OB/GYN	600	216	46.4%
Specialists (any)	600	233	45.0%
Behavioral Health (any)	600	157	31.2%

[1] Compliant providers include providers for which all indicators match between the online directory and the information obtained during the survey call to the sampled location.

Table 5-2—PDV Weighted Compliance Scores by MCO and Specialty Type

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Overall	**3,000**	**1,107**	**44.2%**
ABH	**500**	**122**	**34.8%**
Internal Medicine/Family Medicine	100	21	35.0%
Pediatrics	100	40	54.3%
OB/GYN	100	22	35.0%
Specialists (any)	100	19	24.3%
Behavioral Health (any)	100	20	25.3%
ACLA	**500**	**225**	**50.8%**
Internal Medicine/Family Medicine	100	34	40.7%
Pediatrics	100	46	53.3%
OB/GYN	100	57	64.0%
Specialists (any)	100	47	52.0%
Behavioral Health (any)	100	41	44.0%
HBL	**500**	**175**	**43.5%**
Internal Medicine/Family Medicine	100	27	34.3%
Pediatrics	100	53	60.3%
OB/GYN	100	32	44.0%

Specialty Type	Total	Compliant[1]	Weighted Compliance Score
Specialists (any)	100	37	46.3%
Behavioral Health (any)	100	26	32.3%
HUM	**500**	**185**	**42.9%**
Internal Medicine/Family Medicine	100	33	37.7%
Pediatrics	100	49	53.7%
OB/GYN	100	42	51.0%
Specialists (any)	100	35	41.0%
Behavioral Health (any)	100	26	31.0%
LHCC	**500**	**211**	**50.0%**
Internal Medicine/Family Medicine	100	35	42.7%
Pediatrics	100	69	73.0%
OB/GYN	100	37	50.0%
Specialists (any)	100	45	52.0%
Behavioral Health (any)	100	25	32.3%
UHC	**500**	**189**	**43.0%**
Internal Medicine/Family Medicine	100	38	43.7%
Pediatrics	100	56	60.0%
OB/GYN	100	26	34.7%
Specialists (any)	100	50	54.3%
Behavioral Health (any)	100	19	22.3%

[1]Compliant providers include providers for which all indicators match between the online directory and the information obtained during the survey call to the sampled location.

Table 5-3 presents the reasons for noncompliance.

Table 5-3—Reasons for Noncompliance

Reason	ABH	ACLA	HBL	HUM	LHCC	UHC	Total
Noncompliant providers	**75.6% (378)**	**55.0% (275)**	**65.0% (325)**	**63.0% (315)**	**57.8% (289)**	**62.2% (311)**	**63.1% (1,893)**
Total reasons for noncompliance[1]	**441**	**325**	**397**	**378**	**332**	**372**	**2,245**
Provider does not participate with MCO or Louisiana Medicaid	9.6% (48)	12.2% (61)	17.2% (86)	24.2% (121)	16.0% (80)	22.4% (112)	16.9% (508)
Provider is not at site	21.4% (107)	15.4% (77)	12.4% (62)	13.4% (67)	8.0% (40)	10.0% (50)	13.4% (403)

Reason	ABH	ACLA	HBL	HUM	LHCC	UHC	Total
Provider not accepting new patients	4.4% (22)	4.8% (24)	6.8% (34)	8.2% (41)	5.2% (26)	7.6% (38)	6.2% (185)
Wrong telephone number	0.8% (4)	0.2% (1)	1.0% (5)	0.4% (2)	0.4% (2)	0.4% (2)	0.5% (16)
No response/busy signal/disconnected telephone number (after three calls)	17.0% (85)	11.6% (58)	14.2% (71)	9.8% (49)	15.6% (78)	14.6% (73)	13.8% (414)
Representative does not know	0.2% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (1)
Incorrect address reported	23.2% (116)	13.8% (69)	14.0% (70)	11.6% (58)	8.6% (43)	12.0% (60)	13.9% (416)
Address (suite number) needs to be updated	3.8% (19)	2.8% (14)	3.8% (19)	2.2% (11)	3.2% (16)	1.6% (8)	2.9% (87)
Wrong specialty reported	7.8% (39)	4.2% (21)	10.0% (50)	5.8% (29)	9.4% (47)	5.8% (29)	7.2% (215)

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.

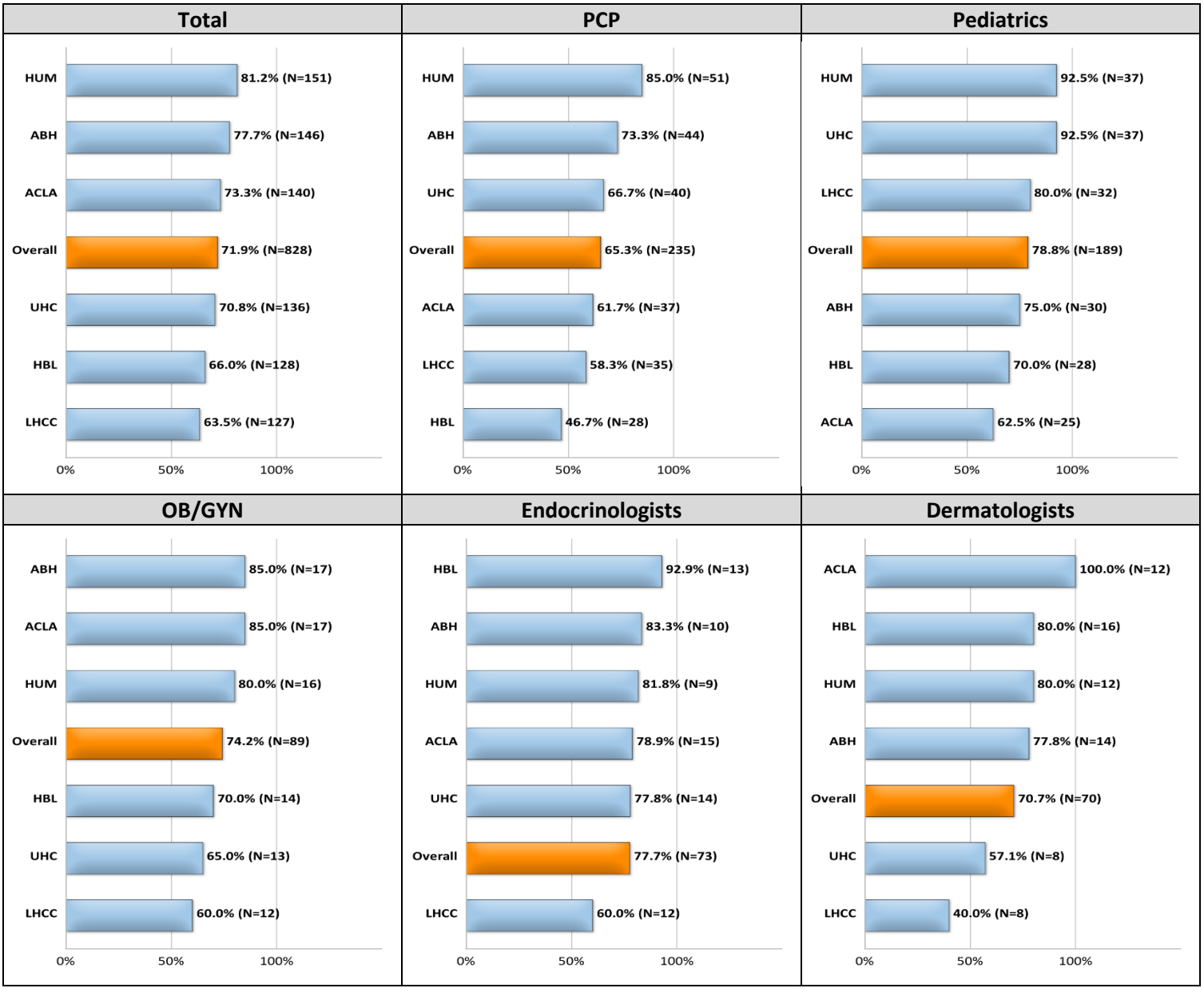
Provider Access Surveys

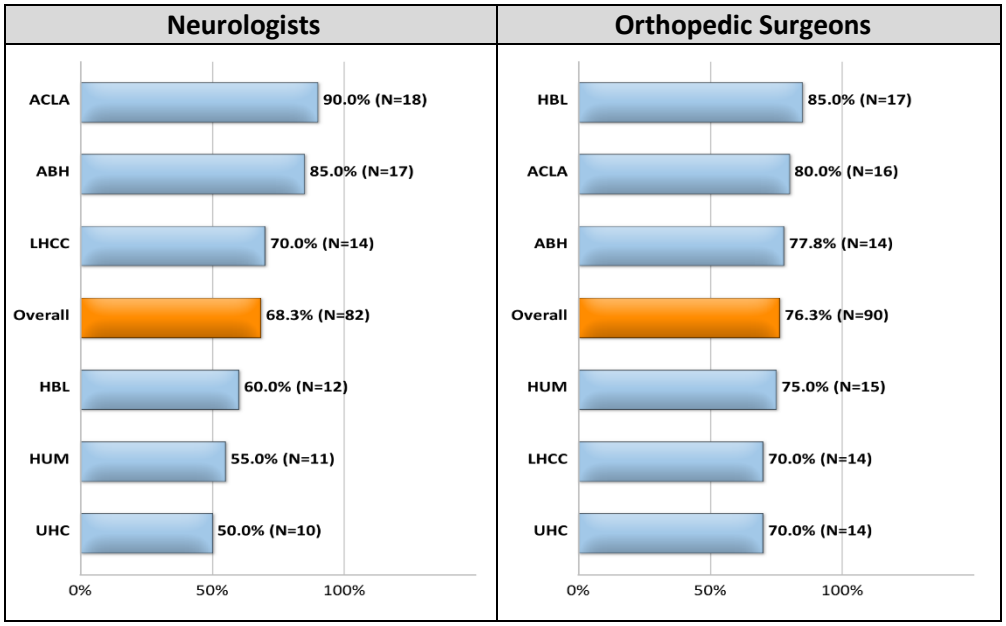
HSAG conducted provider access surveys in September 2023 and November to December 2023 (review period). This section presents the results from the CY 2023 provider access surveys for all sampled providers by MCO and specialty type.

Response Rate

Figure 5-8 illustrates the provider access survey response rates by MCO and specialty type.

Figure 5-8—Provider Access Survey Response Rates by MCO and Specialty Type

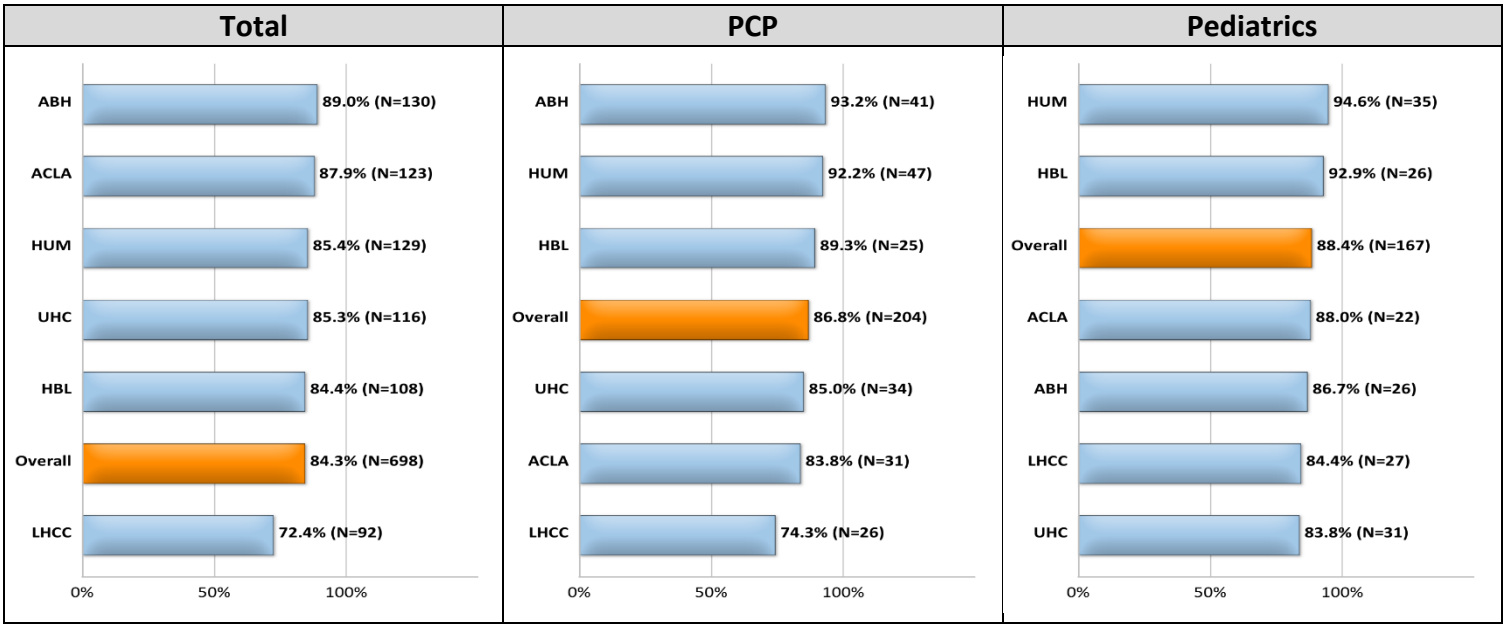


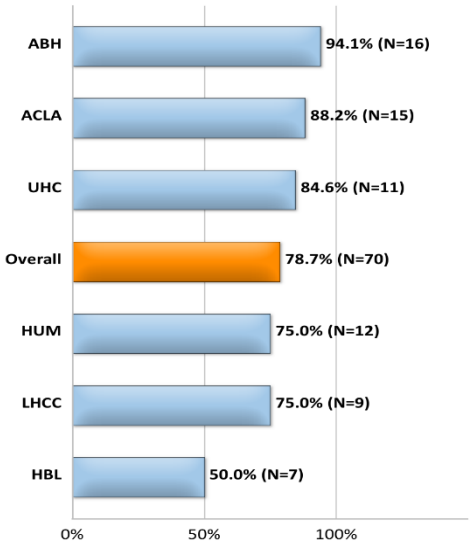
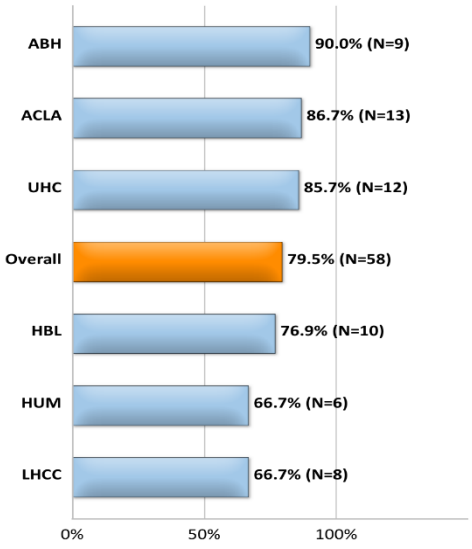
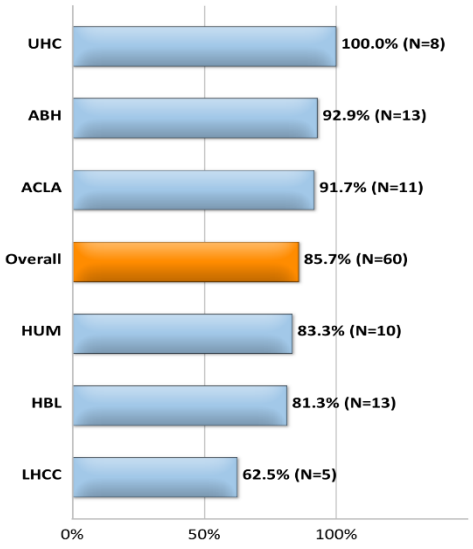


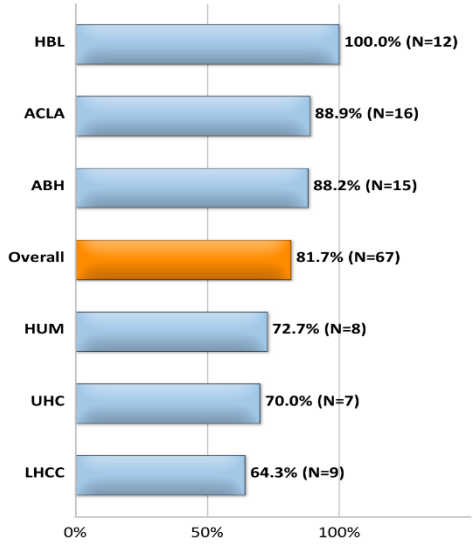
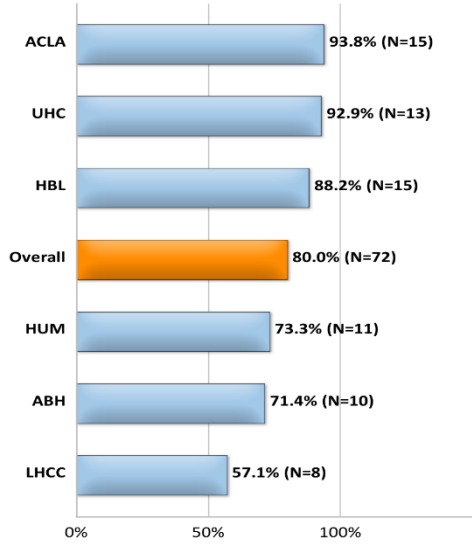
Correct Address

Figure 5-9 displays the percentage of cases in which the provider access survey respondent reported that the MCOs' provider data reflected the correct address.

Figure 5-9—Provider Access Survey Respondents With the Correct Address



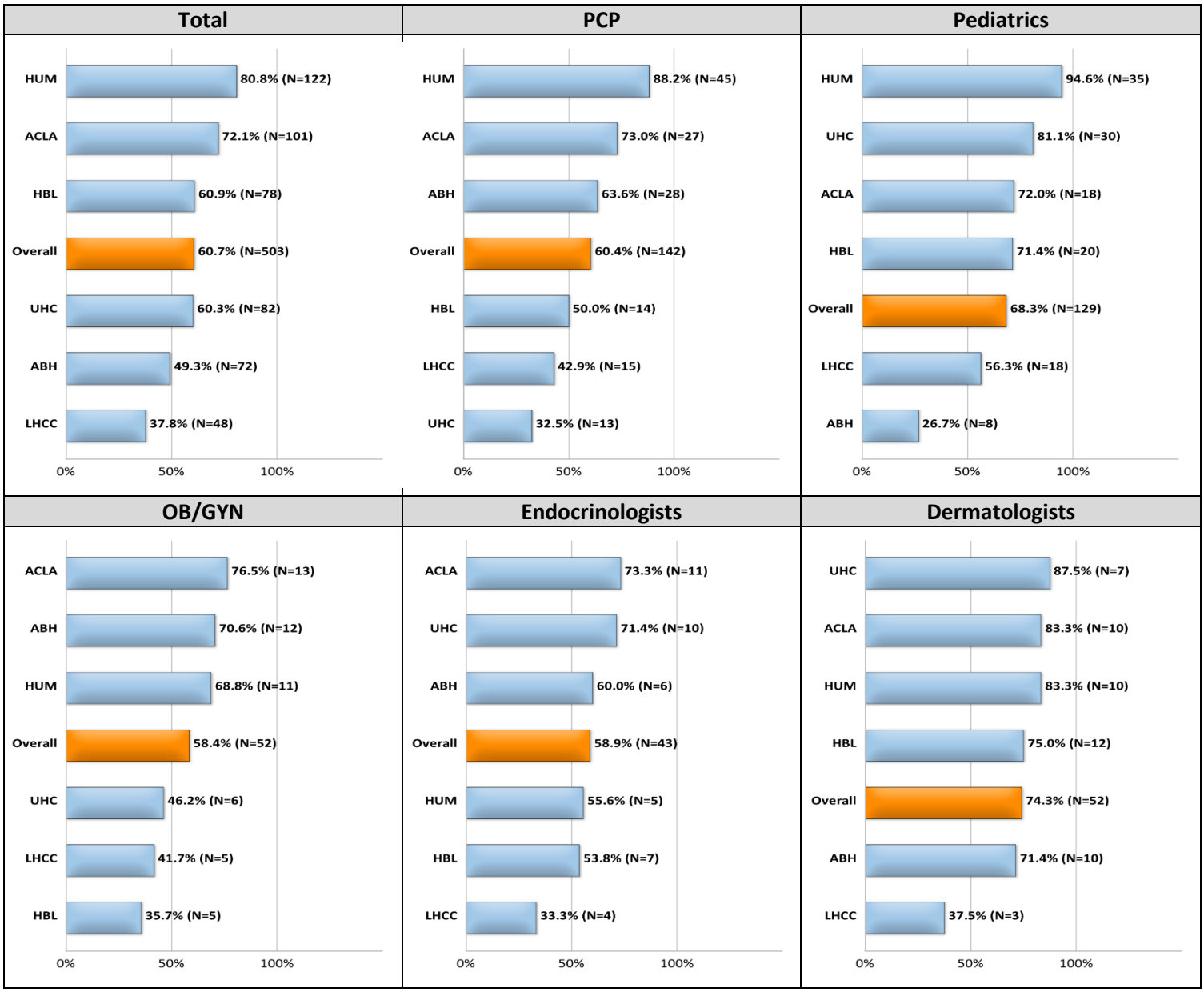
OB/GYN	Endocrinologists	Dermatologists
		

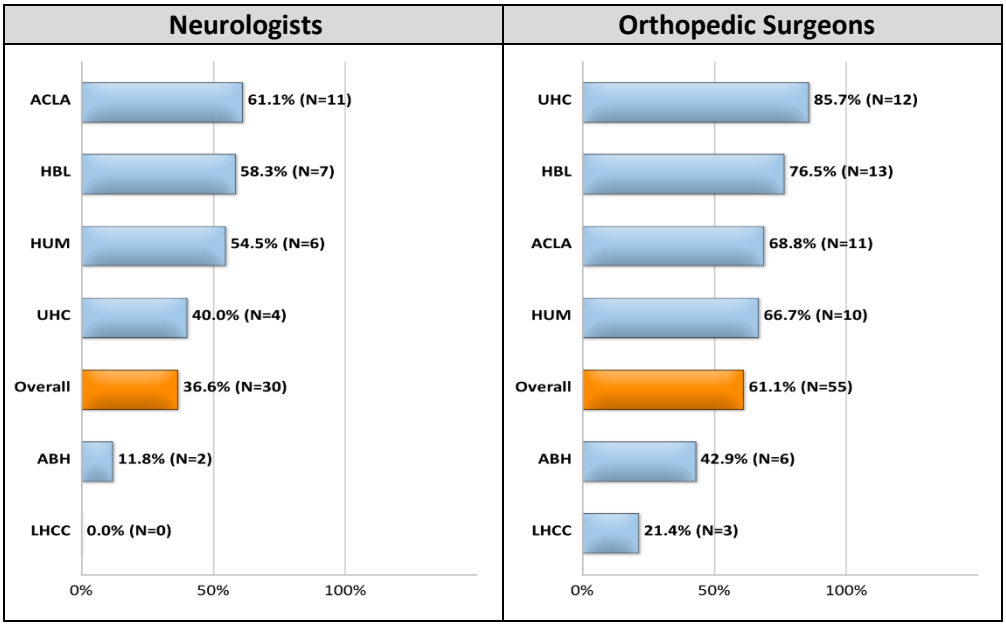
Neurologists	Orthopedic Surgeons
	

Offered Requested Services

Figure 5-10 displays the percentage of cases in which the provider access survey respondent confirmed that the sampled location offered the requested services.

Figure 5-10—Provider Access Survey Locations That Offered the Requested Services

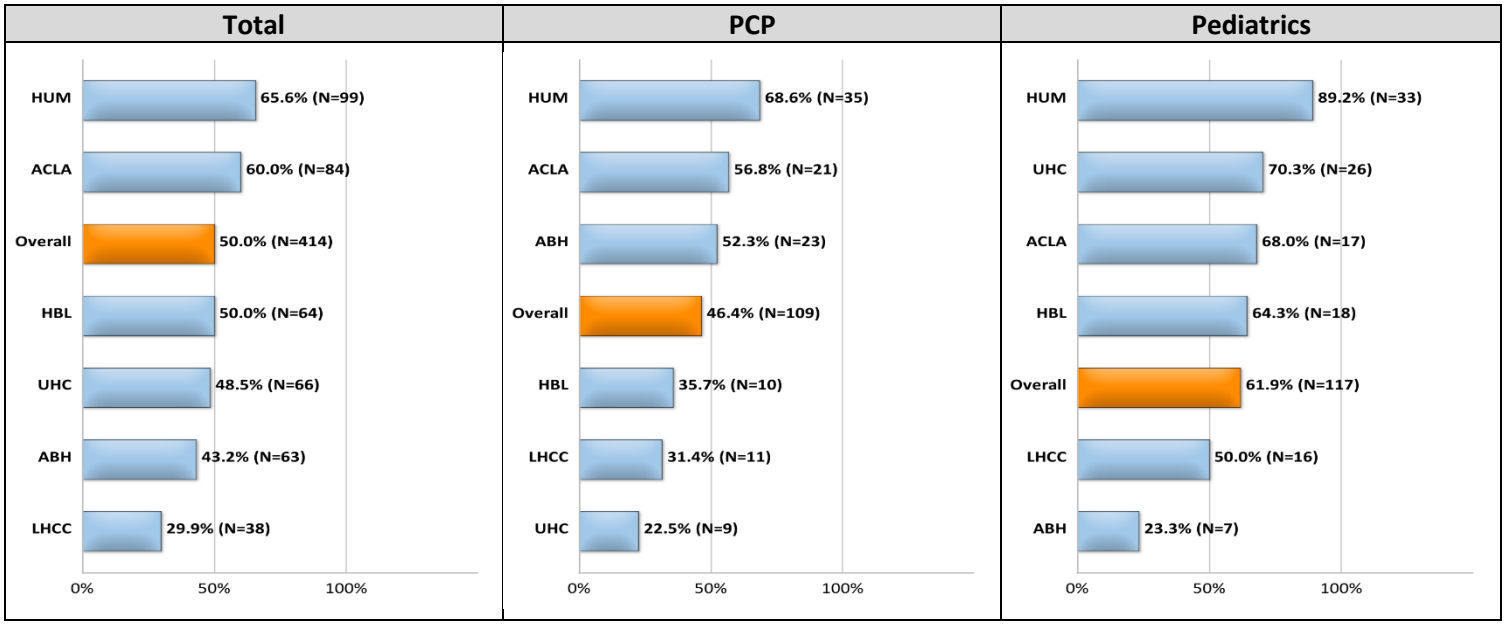


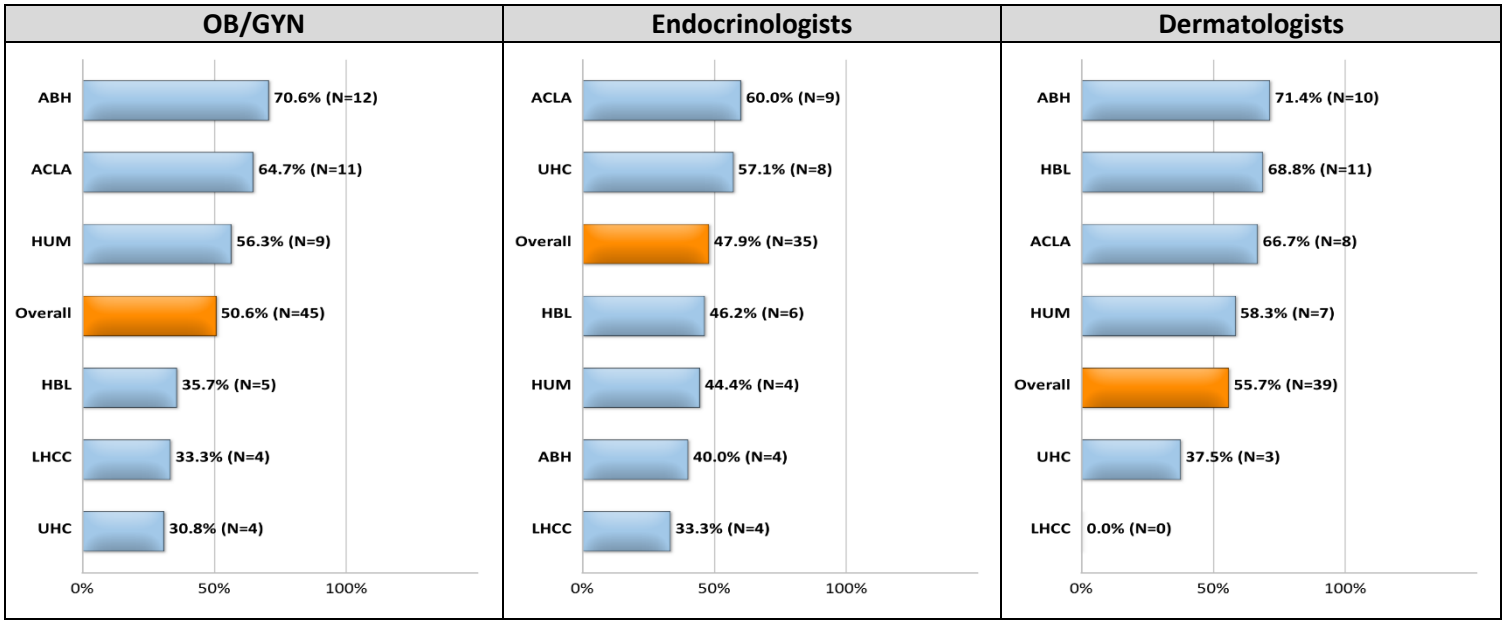


Acceptance Rates

Figure 5-11 through Figure 5-13 display the percentage of cases in which the provider access survey respondent confirmed the location accepted the requested MCO, Louisiana Medicaid, and new patients, respectively.

Figure 5-11—Provider Access Survey Respondents That Confirmed the Location Accepted the MCO




OB/GYN
ABH 70.6% (N=12)
ACLA 64.7% (N=11)
HUM 56.3% (N=9)
Overall 50.6% (N=45)
HBL 35.7% (N=5)
LHCC 33.3% (N=4)
UHC 30.8% (N=4)
0% 50% 100%
Endocrinologists
ACLA 60.0% (N=9)
UHC 57.1% (N=8)
Overall 47.9% (N=35)
HBL 46.2% (N=6)
HUM 44.4% (N=4)
ABH 40.0% (N=4)
LHCC 33.3% (N=4)
0% 50% 100%
Dermatologists
ABH 71.4% (N=10)
HBL 68.8% (N=11)
ACLA 66.7% (N=8)
HUM 58.3% (N=7)
Overall 55.7% (N=39)
UHC 37.5% (N=3)
LHCC 0.0% (N=0)
0% 50% 100%

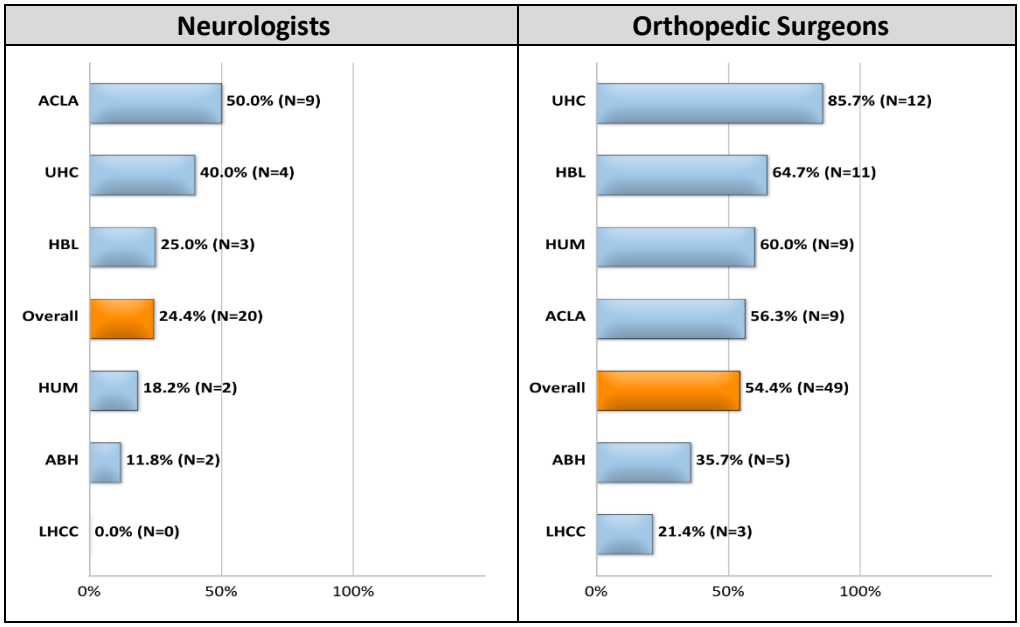
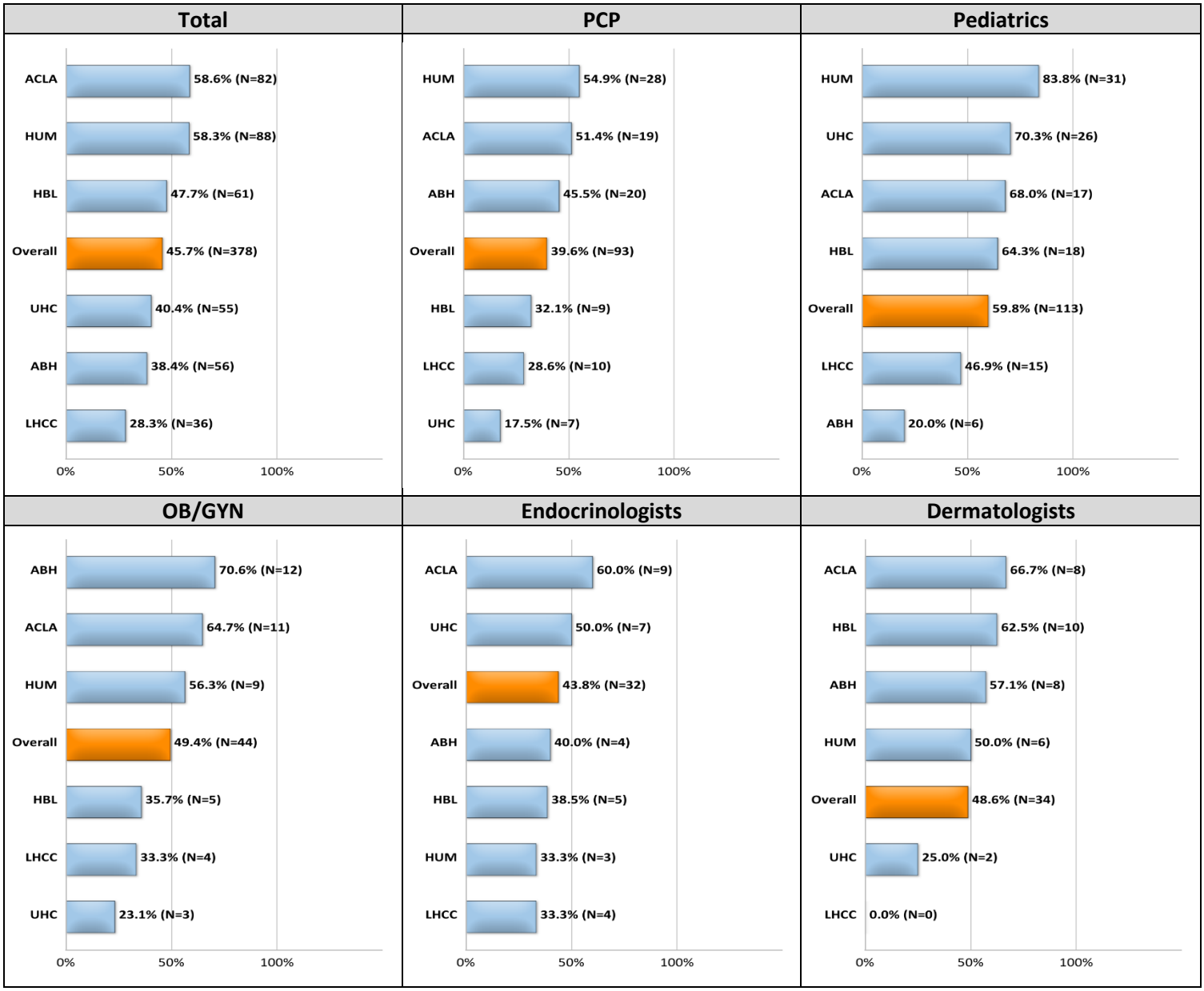

Neurologists
ACLA 50.0% (N=9)
UHC 40.0% (N=4)
HBL 25.0% (N=3)
Overall 24.4% (N=20)
HUM 18.2% (N=2)
ABH 11.8% (N=2)
LHCC 0.0% (N=0)
0% 50% 100%
Orthopedic Surgeons
UHC 85.7% (N=12)
HBL 64.7% (N=11)
HUM 60.0% (N=9)
ACLA 56.3% (N=9)
Overall 54.4% (N=49)
ABH 35.7% (N=5)
LHCC 21.4% (N=3)
0% 50% 100%

Figure 5-12—Provider Access Survey Respondents That Confirmed the Location Accepted Louisiana Medicaid



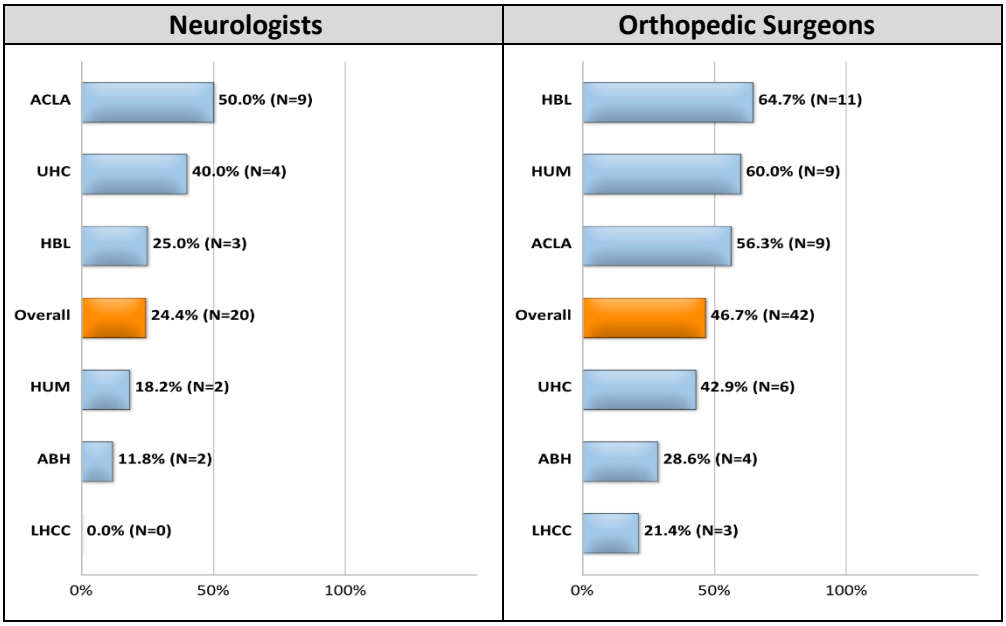
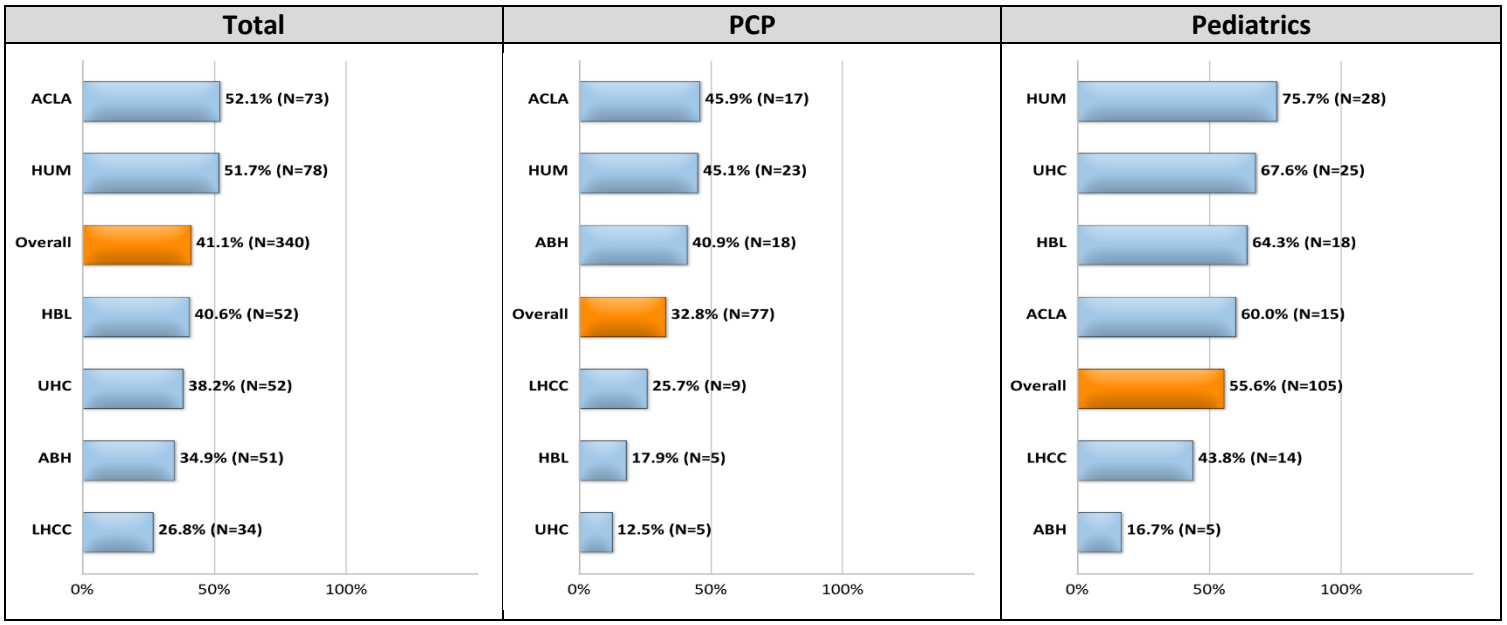
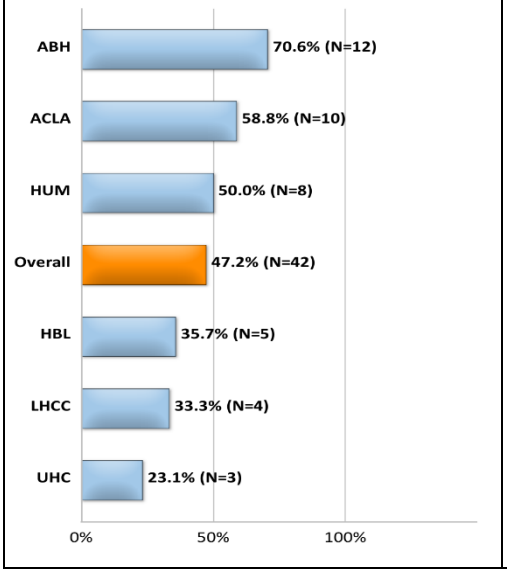


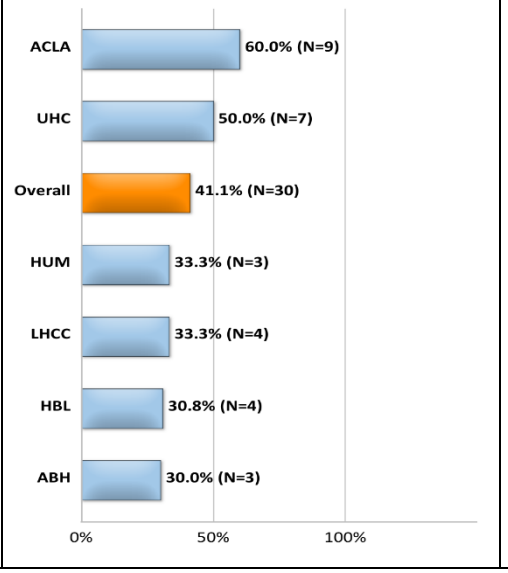
Figure 5-13—Provider Access Survey Respondents That Confirmed the Location Accepted New Patients



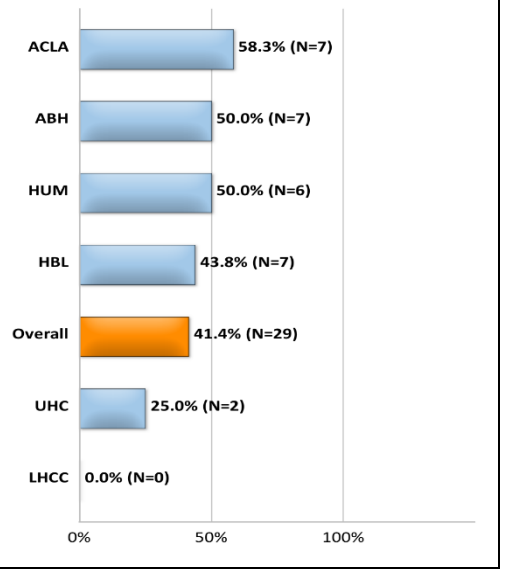
OB/GYN



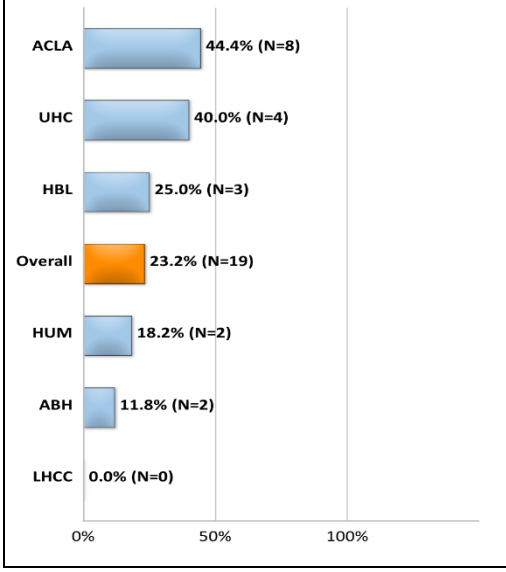
Endocrinologists



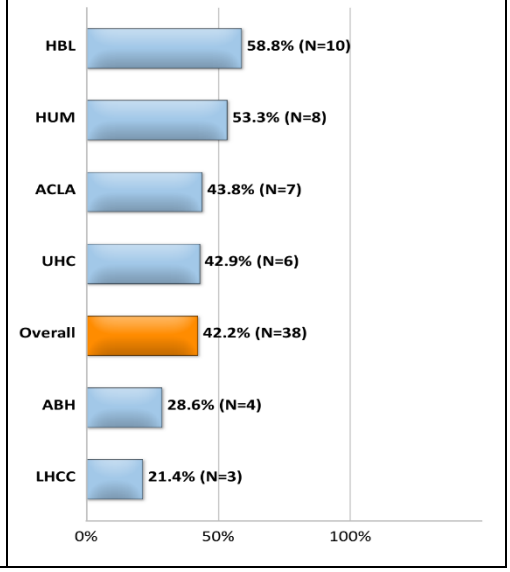
Dermatologists



Neurologists



Orthopedic Surgeons

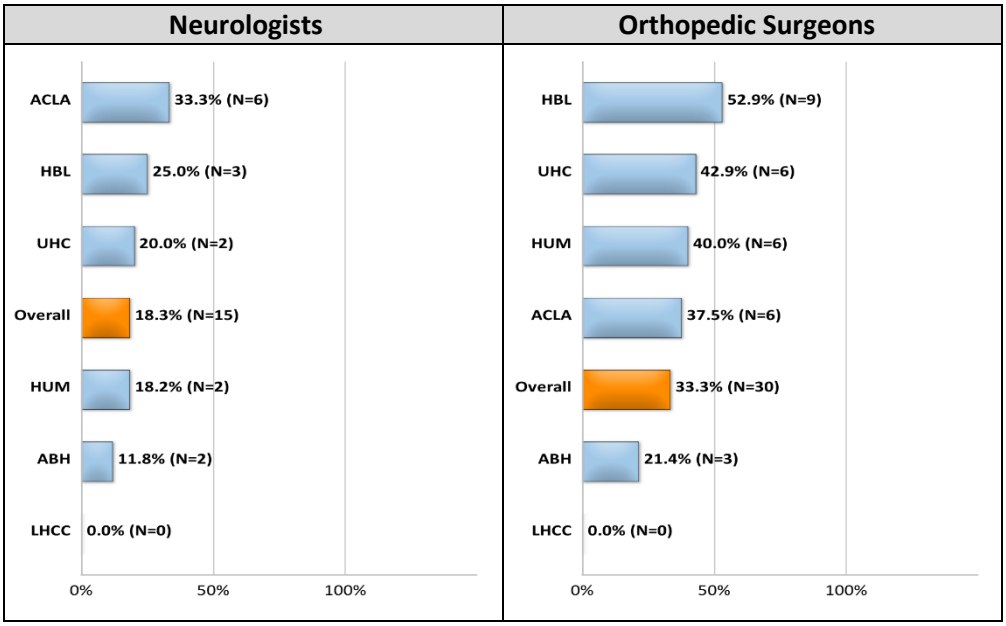


Provider at Correct Location

Figure 5-14 displays the percentage of cases in which the provider access survey respondent confirmed that the sampled provider was at the location.

Figure 5-14—Provider Access Survey Respondents That Confirmed Sampled Provider at Location

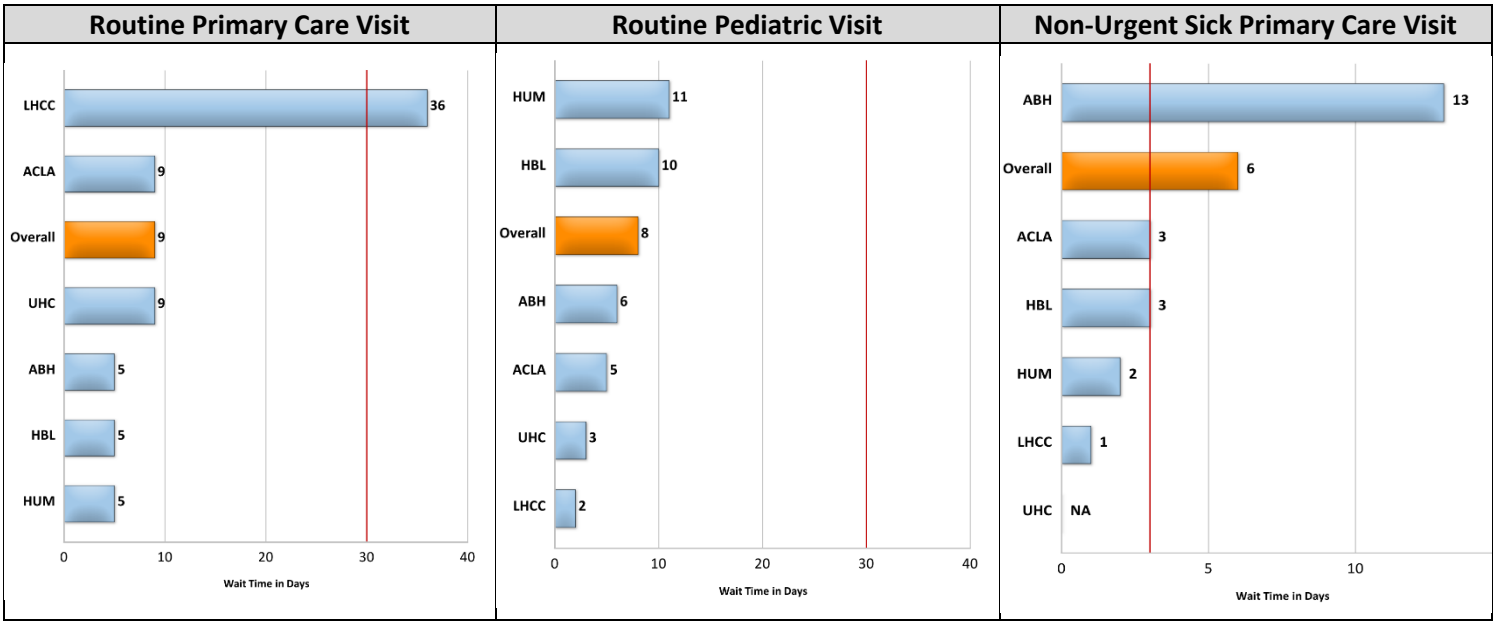


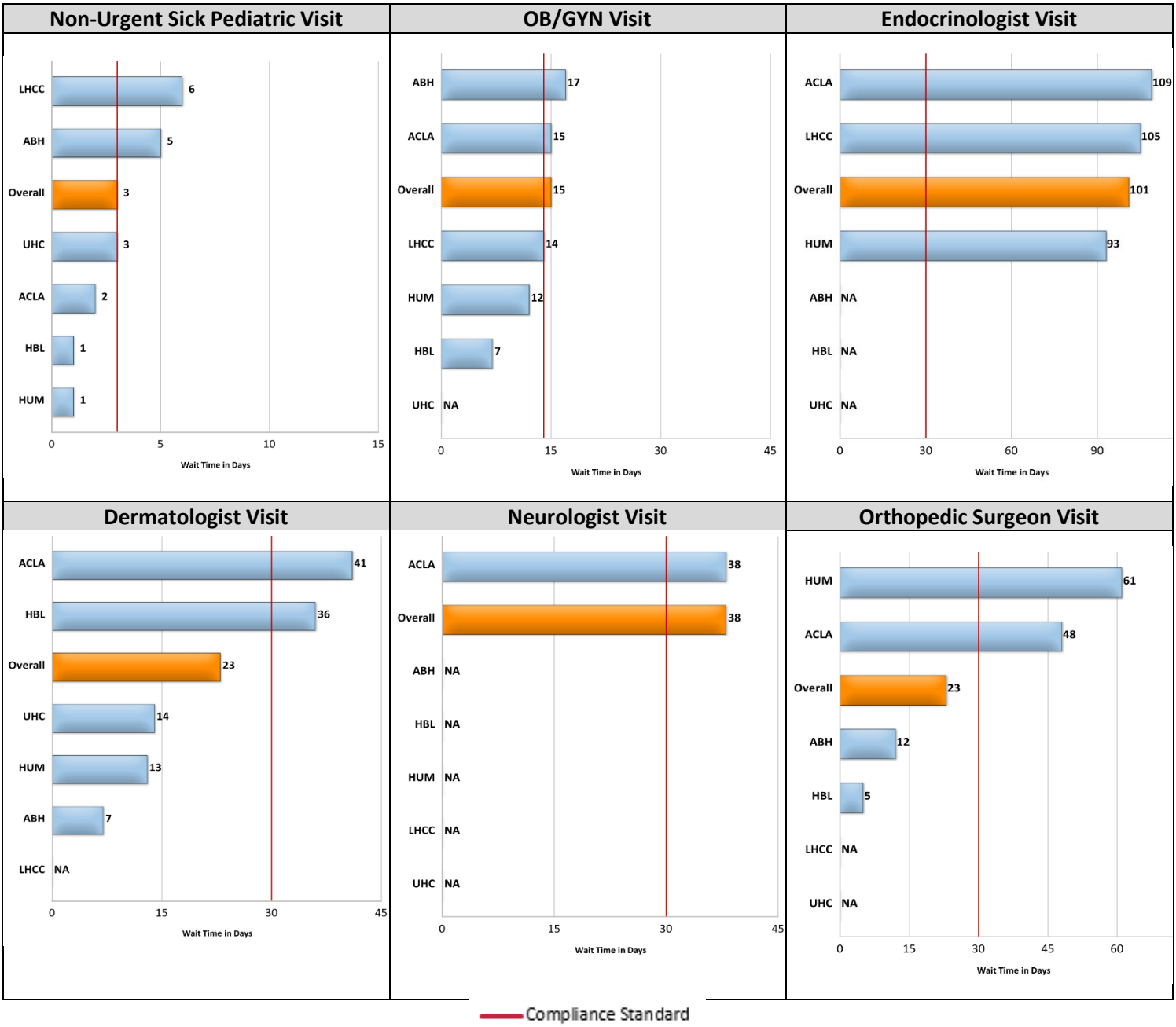


Wait Times

Figure 5-15 displays the average wait times for new patient appointments.

Figure 5-15—Provider Access Survey Average New Patient Wait Times



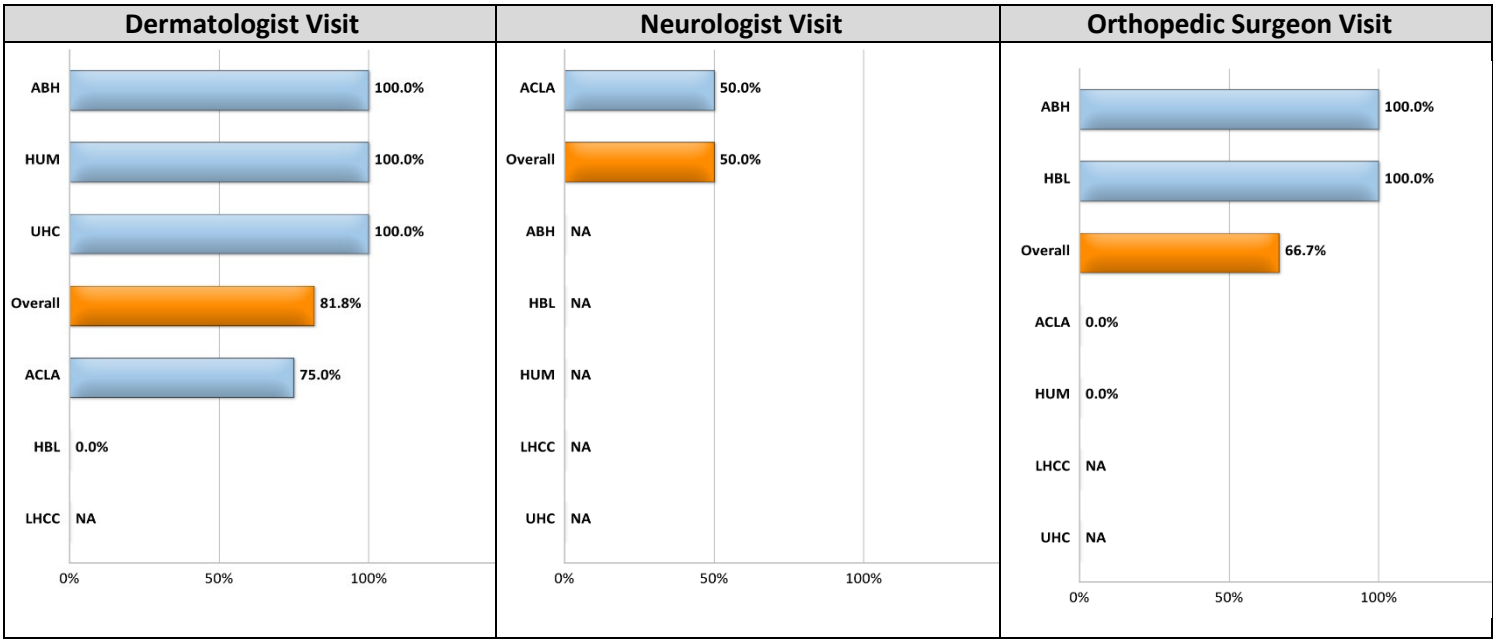


NA indicates that cases responding to the survey did not offer a new patient appointment date.

Figure 5-16 displays the percentage of cases within the appointment availability compliance standards for new patient appointments of six weeks (i.e., 30 business days) for routine primary care appointments, 72 hours (i.e., three business days) for non-urgent sick primary care appointments, one month (i.e., 30 calendar days) for specialist appointments, and 14 calendar days for initial prenatal care appointments (i.e., OB/GYN).

Figure 5-16—Appointments Meeting Compliance Standards





The denominator includes cases reached, accepting new patients, and offering an appointment for the given scenario.
NA indicates that cases responding to the survey did not offer a new patient appointment date.

Compliance Scores

Table 5-4 and Table 5-5 present the provider access survey weighted compliance scores by specialty and MCO, respectively.

Table 5-4—Provider Access Survey Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**1,151**	**281**	**39.4%**
Primary Care	360	54	29.4%
Pediatrics	240	94	52.5%
OB/GYNs	120	33	42.8%
Endocrinologists	94	27	44.7%
Dermatologists	99	28	36.4%
Neurologists	120	15	37.2%
Orthopedic Surgeons	118	30	40.1%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

Table 5-5—Provider Access Survey Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**1,151**	**281**	**39.4%**
ABH	**188**	**32**	**40.4%**
Primary Care	60	8	29.4%
Pediatrics	40	3	40.8%
OB/GYNs	20	8	55.0%
Endocrinologists	12	2	36.1%
Dermatologists	18	6	46.3%
Neurologists	20	2	56.7%
Orthopedic Surgeons	18	3	38.9%
ACLA	**191**	**64**	**43.8%**
Primary Care	60	13	29.4%
Pediatrics	40	14	44.2%
OB/GYNs	20	9	55.0%
Endocrinologists	19	9	57.9%
Dermatologists	12	7	61.1%
Neurologists	20	6	50.0%
Orthopedic Surgeons	20	6	45.0%
HBL	**194**	**47**	**37.6%**
Primary Care	60	4	20.6%
Pediatrics	40	16	51.7%
OB/GYNs	20	4	38.3%
Endocrinologists	14	4	45.2%
Dermatologists	20	7	43.3%
Neurologists	20	3	31.7%
Orthopedic Surgeons	20	9	55.0%
HUM	**186**	**73**	**45.7%**
Primary Care	60	21	39.4%
Pediatrics	40	28	71.7%

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
OB/GYNs	20	7	45.0%
Endocrinologists	11	3	42.4%
Dermatologists	15	6	44.4%
Neurologists	20	2	21.7%
Orthopedic Surgeons	20	6	40.0%
LHCC	**200**	**22**	**31.2%**
Primary Care	60	4	23.9%
Pediatrics	40	11	45.0%
OB/GYNs	20	3	33.3%
Endocrinologists	20	4	40.0%
Dermatologists	20	0	11.7%
Neurologists	20	0	38.3%
Orthopedic Surgeons	20	0	26.7%
UHC	**192**	**43**	**38.0%**
Primary Care	60	4	33.3%
Pediatrics	40	22	61.7%
OB/GYNs	20	2	30.0%
Endocrinologists	18	5	42.6%
Dermatologists	14	2	19.0%
Neurologists	20	2	25.0%
Orthopedic Surgeons	20	6	35.0%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

Table 5-6 presents the reasons for noncompliance.

Table 5-6—Provider Access Survey Reasons for Noncompliance

Reasons	ABH	ACLA	HBL	HUM	LHCC	UHC	Total
Noncompliant providers	**83.0% (156)**	**66.5% (127)**	**75.8% (147)**	**60.8% (113)**	**89.0% (178)**	**77.6% (149)**	**75.6% (870)**
Total reasons for noncompliance[1]	**158**	**129**	**147**	**114**	**178**	**149**	**875**
Provider does not participate with MCO or Louisiana Medicaid	8.5% (16)	9.9% (19)	8.8% (17)	18.3% (34)	6.0% (12)	14.1% (27)	10.9% (125)
Provider is not at site	10.1% (19)	4.7% (9)	2.6% (5)	2.7% (5)	5.5% (11)	4.2% (8)	5.0% (57)
Provider not accepting new patients	2.7% (5)	4.7% (9)	4.6% (9)	5.4% (10)	1.0% (2)	1.6% (3)	3.3% (38)
Wrong telephone number	1.1% (2)	3.1% (6)	6.2% (12)	0.5% (1)	5.0% (10)	4.7% (9)	3.5% (40)
No response/busy signal/ disconnected telephone number (after 2 calls)	21.3% (40)	24.1% (46)	28.4% (55)	18.3% (34)	32.5% (65)	24.5% (47)	24.9% (287)
Incorrect address reported	8.5% (16)	8.9% (17)	10.3% (20)	11.8% (22)	17.5% (35)	10.4% (20)	11.3% (130)
Address (suite number) needs to be updated	1.1% (2)	1.0% (2)	0.0% (0)	0.5% (1)	0.5% (1)	0.5% (1)	0.6% (7)
Wrong specialty reported	30.9% (58)	11.0% (21)	14.9% (29)	3.8% (7)	21.0% (42)	17.7% (34)	16.6% (191)

[1] The total reasons for noncompliance may not equal the number of noncompliant providers because providers may have multiple reasons for noncompliance.

After-Hours Telephone Survey Findings

Table 5-7 and Table 5-8 present the provider access survey after-hours weighted compliance scores by specialty and MCO, respectively.

Table 5-7—Provider Access Survey After-Hours Weighted Compliance Scores by Specialty

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**281**	**86**	**33.8%**
Primary Care	90	26	30.7%
Pediatrics	60	24	42.2%
OB/GYNs	30	11	41.1%

Specialty	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Endocrinologists	20	6	35.0%
Dermatologists	22	4	21.2%
Neurologists	30	9	34.4%
Orthopedic Surgeons	29	6	26.4%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

Table 5-8—Provider Access Survey After-Hours Weighted Compliance Scores by MCO

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Overall	**281**	**86**	**33.8%**
ABH	**45**	**6**	**15.6%**
Primary Care	15	3	22.2%
Pediatrics	10	1	10.0%
OB/GYNs	5	2	46.7%
Endocrinologists	2	0	16.7%
Dermatologists	4	0	0.0%
Neurologists	5	0	0.0%
Orthopedic Surgeons	4	0	0.0%
ACLA	**46**	**14**	**34.8%**
Primary Care	15	1	6.7%
Pediatrics	10	5	53.3%
OB/GYNs	5	2	46.7%
Endocrinologists	4	1	25.0%
Dermatologists	2	0	16.7%
Neurologists	5	4	80.0%
Orthopedic Surgeons	5	1	40.0%
HBL	**48**	**15**	**34.7%**
Primary Care	15	5	37.8%
Pediatrics	10	2	23.3%
OB/GYNs	5	4	80.0%

MCO	Total Number of Providers Surveyed	Compliant[1]	Weighted Compliance Score
Endocrinologists	3	1	44.4%
Dermatologists	5	1	20.0%
Neurologists	5	1	26.7%
Orthopedic Surgeons	5	1	20.0%
HUM	**45**	**25**	**58.5%**
Primary Care	15	12	80.0%
Pediatrics	10	8	83.3%
OB/GYNs	5	1	26.7%
Endocrinologists	2	1	50.0%
Dermatologists	3	0	11.1%
Neurologists	5	0	6.7%
Orthopedic Surgeons	5	3	60.0%
LHCC	**50**	**9**	**21.3%**
Primary Care	15	3	20.0%
Pediatrics	10	3	30.0%
OB/GYNs	5	1	20.0%
Endocrinologists	5	0	6.7%
Dermatologists	5	1	20.0%
Neurologists	5	0	13.3%
Orthopedic Surgeons	5	1	33.3%
UHC	**47**	**17**	**39.0%**
Primary Care	15	2	17.8%
Pediatrics	10	5	53.3%
OB/GYNs	5	1	26.7%
Endocrinologists	4	3	75.0%
Dermatologists	3	2	66.7%
Neurologists	5	4	80.0%
Orthopedic Surgeons	5	0	0.0%

[1] Compliant providers include providers for which all indicators match between the MCO provider data and the information obtained during the survey call to the sampled location.

Table 5-9 presents the after-hours noncompliance reasons.

Table 5-9—Provider Access Survey After-Hours Noncompliance Reasons

Reason for Noncompliance	Count	Rate[1] (%)
Voicemail or answering service	87	31.0%
Disconnected number	28	10.0%
Provider is not at site	28	10.0%
Incorrect address	27	9.6%
Continuous ringing	17	6.0%
Extended hold time	4	1.4%
Fax machine	2	0.7%
Busy signal	1	0.4%
Not a medical practice	1	0.4%
Total	**195**	**69.4%**

[1] The denominator includes all sampled providers.

NAV Audit

This section presents the results from the CY 2023 (review period) NAV audit.

HSAG conducted the SFY 2024 validation of network adequacy indicators in accordance with the CMS EQR Protocol 4 activities, confirming the MCOs' ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the MCOs and LDH's network adequacy monitoring efforts.

Based on the results of a completed Information Systems Capabilities Assessment (ISCA) combined with a virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCOs' interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each MCO according to Table 5-10.

Table 5-10—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No identified indicators in scope of review obtained a *No Confidence* or *Low Confidence* rating determination for any MCO.

HSAG assessed the MCOs' provider-to-member ratios and determined that all MCOs met or exceeded LDH-established thresholds across all provider types.

HSAG assessed the MCOs' submitted distance results and found commonality among the MCOs that met the 100 percent threshold for distance requirements by provider type and urbanicity. Table 5-11 identifies the provider types/urbanicity for which all MCOs met the required LDH threshold for distance.

Table 5-11—Provider Types by Urbanicity, Compliant With Distance Standards Across All MCOs

Provider Type	Urbanicity
Adult PCP (Family/General Practice; Internal Medicine and Physician Extenders*)	Rural
Pharmacy	Rural

* Physician Extenders: Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services to adults.

HSAG assessed the appointment timeliness standards and determined that for the three behavioral health standards reported to LDH through the 359 template, all MCOs met the required compliance rate for non-urgent routine behavioral health care. ABH, ACLA, and LHCC met all three timeliness standards. Table 5-12 displays the behavioral health access and timeliness standard by visit type, which were met by each MCO.

Table 5-12—MCOs That Met Behavioral Health Provider Access and Timeliness Goals, by Standard

Type of Visit	Access/Timeliness Standard	Plans That Met Compliance Goal
Emergency Care	24 hours, 7 days/week within 1 hour of request	ABH, ACLA, HBL, LHCC, UHC
Urgent Non-Emergency Behavioral Health Care	48 hours (2 calendar days)	ABH, ACLA, LHCC
Non-Urgent Routine Behavioral Health Care	14 calendar days	ABH, ACLA, HBL, HUM, LHCC, UHC

During the NAV review period, HSAG determined the access/timeliness standards in Table 5-13 were not included in the LDH-required reporting templates, resulting in an *Unable to Validate* validation rating for each associated indicator.

Table 5-13—MCO Access and Timeliness Standards Unable to Validate

Type of Visit/Admission/Appointment	Access/Timeliness Standard
Urgent Non-Emergency Care	24 hours, 7 days/week within 24 hours of request
Non-Urgent Sick Primary Care	72 hours
Non-Urgent Routine Primary Care	6 weeks
After Hours, by Phone	Answer by live person or call back from a designated medical practitioner within 30 minutes
OB/GYN Care for Pregnant Women	
1st Trimester	14 days
2nd Trimester	7 days
3rd Trimester	3 days
High-Risk Pregnancy, Any Trimester	3 days
Family Planning Appointments	1 week
Specialist Appointments	1 month
Scheduled Appointments	Less than a 45-minute wait in office
Psychiatric Inpatient Hospital (Emergency Involuntary)	4 hours
Psychiatric Inpatient Hospital (Involuntary)	24 hours
Psychiatric Inpatient Hospital (Voluntary)	24 hours
American Society of Addiction Medicine (ASAM) Levels 3.3, 3.5, and 3.7	10 business days
Residential Withdrawal Management (WM)	24 hours when medically necessary
Psychiatric Residential Treatment Facilities (PRTF)	20 calendar days

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The MCOs demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identify ways to improve the accessibility and timeliness of care for members. **[Quality, Timeliness, and Access]**
- No strengths were identified in the PDV activity, as all indicators had match rates below 90 percent.
- Of the cases that offered an appointment date in the provider access survey, 93.5 percent of routine primary care cases and 92.9 percent of routine pediatric cases offered an appointment within the compliance standard. **[Timeliness and Access]**

- Overall, the MCOs had well-defined processes and procedures in place to ensure the efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- Acceptance of the MCO was inaccurate with 64.8 percent of providers in the PDV and 50.0 percent of locations in the provider access survey accepting the requested MCO. **[Quality and Access]**
- Overall, only 72.6 percent of providers in the PDV and 60.7 percent of locations in the provider access survey confirmed the specialty was accurate. **[Quality and Access]**
- Overall, acceptance of new patients was relatively low with 73.8 percent of providers in the PDV and 41.1 percent of locations in the provider access survey accepting new patients. **[Quality and Access]**
- Provider affiliation varied by survey type with 81.0 percent of PDV locations and 34.2 percent of provider access survey locations confirming the sampled provider was at the location. **[Quality and Access]**
- Overall, only 17.9 percent of the provider access survey locations offered an appointment. Of the cases that offered an appointment, 81.8 percent of dermatology cases, 69.6 percent of non-urgent sick pediatric cases, 66.7 percent of non-urgent sick primary care cases, 66.7 percent of orthopedic surgeon cases, 53.3 percent of OB/GYN cases, 50.0 percent of neurology cases, and none of the endocrinology cases were within the wait time compliance standards. **[Timeliness and Access]**
- Compliance scores varied by MCO and survey type with an overall compliance score of 44.2 percent for the PDV, 39.4 percent for the provider access survey, and 33.8 percent for the after-hours provider access survey. **[Quality and Access]**
- Compliance scores also varied by provider type with behavioral health having the lowest compliance score at 31.2 percent and pediatrics having the highest compliance score at 59.1 percent for the PDV. For the provider access survey, primary care exhibited the lowest compliance score at 29.4 percent and pediatrics exhibited the highest compliance score at 52.5 percent. While dermatologists exhibited the lowest compliance score at 21.2 percent, pediatrics exhibited the highest compliance score at 42.2 percent for the after-hours provider access survey. **[Quality and Access]**
- LDH provides multiple reporting templates for plan reporting on LDH-defined network adequacy standards including distance, provider-to-member ratios, and access and availability. HSAG has noted that there is a misalignment among these reporting templates and the contractual language for the standards. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following recommendations were identified:

- Acceptance of Louisiana Medicaid was inaccurate with 62.1 percent of providers in the PDV and 45.7 percent of locations in the provider access survey accepting Louisiana Medicaid. **[Quality and Access]**
- LDH should provide each MCO with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which each MCO will address provider data deficiencies

identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance). **[Quality and Access]**

- In addition to updating provider information, each MCO should conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent. **[Quality and Access]**
- The MCOs should consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care. **[Timeliness and Access]**
- HSAG recommends LDH review its reporting templates against the contractual language to align with and more accurately reflect the LDH-desired population stratifications by urbanicity and adult and pediatric populations to ensure consistent reporting by the MCEs. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The purpose of NAV activities is to evaluate the sufficiency of the provider network as reported by the MCO, ensure the sufficiency of the network to provide adequate access to all services covered under the contract for all members, and provide recommendations to address network deficiencies.

In accordance with 42 CFR §438.350(a), states that contract with MCOs, PIHPs, and PAHPs, collectively referred to as "MCEs," are required to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the LDH-defined network adequacy indicators reported by the MCOs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by LDH.

Technical Methods of Data Collection

In February 2023, CMS released updates to the CMS EQR protocols, including the newly developed NAV protocol. As established in the 2016 final rule, states must begin conducting the NAV activity at 42 CFR §438.358(b)(1)(iv) no later than one year from the issuance of the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[5-1] Therefore, in February 2024, HSAG began conducting NAV activities in accordance with the CMS EQR Protocol 4 and will report results in the EQR technical report due April 30, 2025.

Provider Directory Validation

HSAG conducted PDV reviews from July 2023 through November 2023. To conduct the NAV analysis, HSAG utilized the MCOs' online provider directories to locate and extract provider data elements. Trained interviewers collected survey responses using a standardized script to validate survey indicators pertaining to provider data accuracy, such as telephone number, address, provider specialty, provider

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 17, 2024.

affiliation with the requested MCO, provider's acceptance of Medicaid, and accuracy of new patient acceptance.

Provider Access Survey

HSAG conducted provider access surveys in September 2023 and November to December 2023. To conduct the NAV analysis, each MCO used the data request document prepared by HSAG to identify providers potentially eligible for survey inclusion, and to submit provider data files used to populate its online provider directory to HSAG. At a minimum, the data elements requested for each provider included: provider name, Medicaid identification (ID), National Provider Identification (NPI) number, provider specialty, physical (practice) address, telephone number, provider taxonomy code, and whether the provider accepted new patients.

Upon receipt of the data files, HSAG assessed the data to ensure alignment with the requested data file format, data field contents, and logical consistency between data elements. HSAG also assessed the distribution of provider specialty data values present in each MCO's data to determine which data values attributed to each provider domain.

NAV Audit

HSAG collected network adequacy data from the MCOs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR Protocol 4.

HSAG conducted a virtual review with the MCOs that included team members from the EQRO, MCO staff, and staff from vendors, if applicable. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each MCO included the following:

- Opening meeting
- Review of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key MCO staff members who were involved with the calculation and reporting of network adequacy indicators.

Description of Data Obtained

HSAG, with approval from LDH, conducted the following network adequacy monitoring tasks during CY 2023:

1. PDV, to validate the MCOs' online provider directories to ensure members have appropriate access to provider information. HSAG utilized the MCOs' online provider directories to locate and extract provider data elements required to conduct the survey component of the PDV activity.
2. Provider access survey, to determine the accuracy of the managed care network information supplied to Healthy Louisiana members using the MCOs' provider data files and to ensure that Louisiana provider networks are following the established LDH standard for office-hour appointments. HSAG utilized the MCOs' provider data files used to populate their online provider directories to conduct the survey component of the provider access survey activity.
3. HSAG prepared a document request packet that was submitted to each MCO outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCO's IS and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the MCOs to conduct the NAV audits:

- IS data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Data Were Aggregated and Analyzed

Provider Directory Validation

For each sampled case, HSAG compared the MCOs' provider directory values to the information obtained via the survey call for the following list of indicators. All items must match exactly, except for common United States Postal Service (USPS) standard abbreviations and naming conventions (e.g., E and East or 1st and First).

- Telephone number
- Address
- Office affiliation with the sampled provider
- Accuracy of provider specialty

- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance

HSAG used the following validation responses to assess each indicator:

- Yes, the information matched between the online provider directory and the survey call.
- No, the information did not match between the online provider directory and the survey call.

Using the results of the PDV, HSAG calculated a compliance score for each MCO. The criteria in Table 5-14 were used to calculate the weight of each noncompliance survey outcome.

Table 5-14—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-15—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-14. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent.

Provider Access Survey

Using a survey script approved by LDH, HSAG validated the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Accuracy of provider specialty
- Provider affiliation with the requested MCO
- Provider's acceptance of Louisiana Medicaid
- Accuracy of new patient acceptance
- Sampled provider at location
- Appointment availability

Using the results of the survey, HSAG calculated a compliance score for each MCO. The criteria in Table 5-16 were used to calculate the weight of each noncompliance survey outcome.

Table 5-16—Noncompliance Reasons and Weighting

Noncompliance Reason	Weight
Provider does not participate with MCO or Louisiana Medicaid	3
Provider is not at site	3
Provider not accepting new patients	3
Wrong telephone number	3
No response/busy signal/disconnected telephone number (after three calls)	3
Representative does not know	3
Incorrect address reported	2
Address (suite number) needs to be updated	1
Wrong specialty reported	1
Refused to participate in survey	0

Table 5-17—Weighted Noncompliance Criteria

Weighted Noncompliance Scores	
Numerator	The numerator is the sum of all provider noncompliance scores for the MCO. Each provider record received a noncompliance score based upon the reasons for noncompliance in Table 5-16. If multiple noncompliance criteria are met, the noncompliance criterion with the largest weight was used.
Denominator	The denominator is the number of provider records multiplied by 3.

Weighted compliance score equation:

MCO's weighted compliance score = 1 – the weighted noncompliance score

Compliance: The MCOs were compliant if their weighted compliance score was ≥ 75 percent.

NAV Audit

HSAG assessed each MCO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the MCO's and State's network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCO used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

How Conclusions Were Drawn

Provider Directory Validation/Provider Access Survey

HSAG determined that results of network adequacy activities could provide information about MCO performance related to the quality, timeliness, and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Healthy Louisiana member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the MCOs' ability to track and monitor their respective provider networks.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-18.

Table 5-18—Assignment of NAV Activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
PDV	✓		✓
Provider Access Survey	✓	✓	✓

NAV Audit

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table 5-19.

Table 5-19—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100
Number of *Not Met* elements determined to have significant bias on the results.

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table 5-20 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table 5-20—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCO provide a root cause analysis of the finding.
- Working with the MCE to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:

– The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

By assessing each MCO's performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG also provided a recommendation to help target improvement.

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 5-21.

Table 5-21—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Provider: Enrollee Ratio	✓	✓	✓
Distance	✓	✓	✓
Access and Timeliness Standards	✓	✓	✓

6. Consumer Surveys: CAHPS-A and CAHPS-C

Aggregate Results

Table 6-1 presents the 2022, 2023, and 2024 (review period) adult achievement scores for the Healthy Louisiana SWA.[6-1]

Table 6-1—Adult Achievement Scores for the Healthy Louisiana SWA

Measure	2022	2023	2024
Rating of Health Plan	80.18%	80.38%	77.66%
Rating of All Health Care	77.01%	76.24%	79.68% ↑
Rating of Personal Doctor	84.54%	85.60%	86.61% ↑
Rating of Specialist Seen Most Often	81.33%	82.46%	85.65%
Getting Needed Care	79.82%	80.47%	83.35%
Getting Care Quickly	83.25%	82.54%	82.56%
How Well Doctors Communicate	91.54%	93.11%	94.59% ↑
Customer Service	91.92%	92.14%	90.22%

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 NCQA national average.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 NCQA national average.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Table 6-2 presents the 2022, 2023, and 2024 (review period) general child achievement scores for the Healthy Louisiana SWA.

Table 6-2—General Child Achievement Scores for the Healthy Louisiana SWA

Measure	2022	2023	2024
Rating of Health Plan	88.13%	86.74%	88.48% ↑
Rating of All Health Care	87.67%	89.15%	89.95% ↑
Rating of Personal Doctor	90.35%	90.72%	91.73%
Rating of Specialist Seen Most Often	84.31%	85.95%	87.54%
Getting Needed Care	85.25%	89.06%	84.66%
Getting Care Quickly	87.85%	89.34%	89.88% ↑
How Well Doctors Communicate	93.70%	95.46%	94.06%

[6-1] HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, caution should be exercised when comparing the 2022 and 2023 rates to 2024, as the 2022 and 2023 rates include five MCOs and the 2024 rate includes six MCOs.

Measure	2022	2023	2024
Customer Service	87.92%	88.47%	88.09%

↑ *Indicates the 2024 score is statistically significantly higher than the 2024 NCQA national average.*
↓ *Indicates the 2024 score is statistically significantly lower than the 2024 NCQA national average.*
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the adult population, the 2024 Healthy Louisiana SWA's scores were statistically significantly higher than the 2024 NCQA national averages for *Rating of All Health Care*, *Rating of Personal Doctor,* and *How Well Doctors Communicate*. **[Quality]**
- For the general child population, the 2024 Healthy Louisiana SWA's scores were statistically significantly higher than the 2024 NCQA national averages for *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly*. **[Quality and Timeliness]**

For the MCOs statewide, the following opportunities for improvement were identified:

- For the adult and general child populations, the 2024 Healthy Louisiana SWA's scores were not statistically significantly lower in 2024 than 2023 nor statistically significantly lower than the 2024 NCQA national averages on any of the measures; therefore, no opportunities for improvement were identified.

For the MCOs statewide, the following recommendations were identified:

- HSAG recommends that the MCOs monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The CAHPS activity assesses adult members' and parents'/caretakers' of child members experiences with an MCO and the quality of care that they/their children receive. The goal of the CAHPS surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

The MCOs accomplished the technical method of data collection by administering the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. The MCOs employed various methods of data collection used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents) and mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents). In addition, some MCOs had an option for members to complete the survey in Spanish and Chinese. Adult members and parents/caretakers of child members completed the surveys from February through May 2024, following NCQA's data collection protocol.

The CAHPS 5.1H Medicaid Health Plan Surveys included a set of standardized items (39 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed members' experiences with care. The survey categorized questions into eight measures of experience. These measures included four global ratings and four composite measures.[6-2] The global ratings reflected patients' overall experiences with their personal doctor, specialist, MCO, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, HSAG calculated the percentage of respondents who chose a positive experience rating (a response value of 8, 9, or 10 on a scale of 0 to 10). For each of the four composite measures, HSAG calculated the percentage of respondents who chose a positive response. CAHPS composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measures was a response of "Usually" or "Always."

[6-2] For this report, the 2024 Child Medicaid CAHPS results presented are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

For this report, HSAG did not include results for a CAHPS measure if the NCQA minimum reporting threshold of 100 respondents was not met. Additionally, for this report, HSAG compared the adult and general child Medicaid populations' survey findings to the 2024 NCQA CAHPS adult and general child Medicaid national averages.[6-3]

Description of Data Obtained

The CAHPS survey asks adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The MCOs contracted with a CAHPS vendor to administer the survey to adult members and parents/caretakers of child members. The CAHPS survey asks about members' experiences with their MCO during the last six months of the measurement period (i.e., July through December 2023).

The MCOs' CAHPS vendors administered the surveys from February to May 2024. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey received a disposition code of "completed" if at least three of the designated five questions were completed.[6-4] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, did not meet the eligible population criteria, had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). The survey also identified ineligible members during the process. The survey vendor recorded this information and provided it to HSAG in the data received.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2024 achievement scores were compared to their corresponding 2023 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2024 achievement scores and the 2023 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2024 than 2023 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2024 than 2023 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was not denoted with a triangle.

Additionally, HSAG compared MCO scores to the NCQA national averages to determine if there were any statistically significant differences. An MCO that performed statistically significantly higher than the 2024 NCQA national average was denoted with a green upward arrow (↑).[6-5] Conversely, an MCO

6-3 National data were obtained from NCQA's 2024 Quality Compass.

6-4 A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 10, 19, 23, and 28. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for child Medicaid: questions 3, 25, 40, 44, and 49.

6-5 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

that performed statistically significantly lower than the 2024 NCQA national average was denoted with a red downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2024 NCQA national average was not denoted with an arrow.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2023 survey results to the 2024 NCQA national averages to determine if there were any statistically significant differences. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the global ratings and composite measures presented in this report and relating the questions to the definitions of the three domains. This assignment to the domains is depicted in Table 6-3.

Table 6-3—Assignment of CAHPS Survey Measure Activities to the Quality, Timeliness, and Access Domains

CAHPS Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

7. Behavioral Health Member Satisfaction Survey

Aggregate Results

Table 7-1 presents the 2023 and 2024 (review period) adult achievement scores for the Healthy Louisiana SWA.[7-1]

Table 7-1—Adult Statewide Results for the Healthy Louisiana SWA

Measure	2023	2024
Rating of Health Plan	58.96%	56.43%
How Well People Communicate	90.06%	92.65%
Cultural Competency	73.77%+	82.85%+
Helped by Counseling or Treatment	67.65%	69.38%
Treatment or Counseling Convenience	86.70%	88.46%
Getting Needed Treatment	77.08%	81.83%
Help Finding Counseling or Treatment	47.04%	52.90%
Customer Service	67.14%+	71.32%
Helped by Crisis Response Services	76.09%	75.17%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.

▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*

▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Table 7-2 presents the 2023 and 2024 (review period) child achievement scores for the Healthy Louisiana SWA.

Table 7-2—Child Statewide Results for the Healthy Louisiana SWA

Measure	2023	2024
Rating of Health Plan	62.67%	65.18%
How Well People Communicate	92.54%	90.74%
Cultural Competency	97.85%+	90.17%+
Helped by Counseling or Treatment	58.20%	56.92%
Treatment or Counseling Convenience	89.52%	86.12%
Getting Needed Treatment	77.36%	77.13%

[7-1] HUM started providing coverage to child and adult Medicaid beneficiaries throughout Louisiana starting January 1, 2023. Therefore, caution should be exercised when comparing the 2022 and 2023 rates to 2024, as the 2022 and 2023 rates include five MCOs and the 2024 rate includes six MCOs.

Measure	2023	2024
Help Finding Counseling or Treatment	41.85%+	46.93%+
Customer Service	61.54%+	59.54%+
Getting Professional Help	88.83%	85.72%
Help to Manage Condition	85.94%	83.70%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.

▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*

▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the adult and child populations, the 2024 Healthy Louisiana SWA scores were not statistically significantly higher in 2024 than 2023 on any of the measures; therefore, no strengths were identified.

For the MCOs statewide, the following opportunities for improvement were identified:

- For the adult and child populations, the 2024 Healthy Louisiana SWA scores were not statistically significantly lower in 2024 than 2023 on any of the measures; therefore, no opportunities for improvement were identified.

For the MCOs statewide, the following recommendations were identified:

- HSAG recommends that the MCOs monitor the measures to ensure significant decreases in scores over time do not occur. **[Quality, Timeliness, and Access]**

Methodology

Objectives

The primary objective of this activity is to gather direct feedback from Healthy Louisiana adult members and parents/caretakers of child members who received behavioral health services regarding their experiences and the quality of the services they received. The survey covers topics that are important to members, such as the communication skills of people they saw for counseling or treatment and the accessibility of behavioral health services. This feedback will aid in improving overall experiences of adults and parents/caretakers of child members who receive behavioral health services.

Technical Methods of Data Collection and Analysis

To conduct the activity, HSAG, with support from LDH, developed and administered a custom behavioral health member satisfaction survey to the Healthy Louisiana MCO members. The survey was administered to adult members and parents/caretakers of child members identified as having three or more specified outpatient behavioral health encounters during the measurement period. All adult members and parents/caretakers of sampled child members completed the survey from June to August 2024.

The adult and child behavioral health member satisfaction survey included one global measure question, one composite measure, and 11 individual item measures. The global measure (also referred to as global rating) reflects overall member experience with the MCO. The composite measure is a set of questions grouped together to address a specific aspect of care (i.e., *How Well People Communicate*). The individual item measures are individual questions that look at different areas of care (e.g., *Cultural Competency* or *Helped by Counseling or Treatment*).

For the global rating, HSAG calculated the percentage of respondents who chose a positive experience rating (i.e., a response of 9 or 10 on a scale of 0 to 10). For the composite measure, HSAG calculated the percentage of respondents who chose a positive response. The composite measure response choices were "Never," "Sometimes," "Usually," or "Always." A positive response for the composite measure was a response of "Usually" or "Always." For the individual item measures, HSAG calculated the percentage of respondents who chose a positive response (i.e., "Usually/Always," "Yes," "A lot," or "Not a problem").

For this report, HSAG included results for a measure even when there were less than 100 respondents. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. HSAG used a cross (+) to denote scores with fewer than 100 respondents.

Description of Data Obtained

The behavioral health member satisfaction survey asked adult members or parents/caretakers of child members to report on and to evaluate their/their child's experiences with behavioral health services. HSAG requested sample frame data files from each MCO that included the following information related to each member of the eligible population: name, gender, date of birth, mailing address, telephone number, primary language, race, and ethnicity. HSAG utilized information received in the sample frame data files to conduct the behavioral health member satisfaction survey.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the 2024 achievement scores were compared to their corresponding 2023 achievement scores to determine whether there were statistically significant differences. Statistically significant differences between the 2024 achievement scores and the 2023 achievement scores are noted with directional triangles. An MCO's score that performed statistically significantly higher in 2024 than 2023 is noted with a black upward triangle (▲). An MCO's score that performed statistically significantly lower in 2024 than 2023 is noted with a black downward triangle (▼). An MCO that did not perform statistically significantly higher or lower between years was not denoted with a triangle.

Additionally, HSAG compared the MCO-specific results to the total MCO program average (i.e., Health Louisiana SWA) to determine if the results were significantly different. The total MCO program results were weighted based on the eligible population included in each MCO. An MCO that performed statistically significantly higher than the program average was denoted with an upward black arrow (↑). Conversely, an MCO that performed statistically significantly lower than the program average was denoted with a downward black arrow (↓) arrow. An MCO that did not perform statistically significantly different than the program average was not denoted with an arrow. Comparisons to national data could not be performed given the custom nature of the survey instruments administered.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care and services provided by the MCOs, HSAG assigned the measures evaluated in the behavioral health member satisfaction survey to one or more of these three domains. This assignment to domains is shown in Table 7-3.

Table 7-3—Assignment of Behavioral Health Member Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Rating of Health Plan	✓		
How Well People Communicate	✓		
Cultural Competency	✓		

Behavioral Health Member Satisfaction Survey Measure	Quality	Timeliness	Access
Helped by Counseling or Treatment	✓		
Treatment or Counseling Convenience			✓
Getting Counseling or Treatment Quickly	✓	✓	
Getting Needed Treatment	✓		✓
Barriers to Counseling or Treatment	✓		✓
Help Finding Counseling or Treatment	✓		✓
Customer Service	✓		
Crisis Response Services Used			✓
Receipt of Crisis Response Services			✓
Helped by Crisis Response Services	✓		
Getting Professional Help	✓		✓
Help to Manage Condition	✓		

8. Health Disparities Focus Study

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Health equity is achieved when everyone has the opportunity to attain their full health potential, and no one is disadvantaged because of socially determined circumstances. Achieving it requires focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.[8-1] In an effort to measure and address health disparities, LDH and HSAG partnered to perform the 2023 Annual Health Disparities Focus Study.

In order to understand health disparities identified for the Louisiana Medicaid population, it is important to consider the demographic breakdowns of this population. In 2022, Louisiana's Medicaid population consisted of the following groups: Black or African American (48.6 percent), White (38.2 percent), Hispanic/Latino (6.1 percent), More than One Race (5.5 percent), Asian/Native Hawaiian and Pacific Islander (1.3 percent), and American Indian or Alaska Native (0.4 percent).[8-2] About 64 percent of children living in small towns or rural areas belong to Louisiana's Medicaid population compared to 54 percent of children living in urban areas. Similarly, non-elderly adults constitute a larger percentage of Louisiana's Medicaid rural population (32 percent) compared to non-elderly adults living in urban areas (24 percent).[8-3]

For the 2023 Annual Health Disparities Focus Study, HSAG used MCO-provided CY 2022 stratified HEDIS and non-HEDIS indicator rates to identify disparities based on race, ethnicity, and geography, where applicable. HSAG also used the MCO-provided CAHPS data files to identify disparities based on race and ethnicity. A disparity was identified if the relative difference in an indicator rate between the group of interest (e.g., Black or African American group for the race demographic stratification) and the reference group (e.g., the White group for the race demographic stratification) was greater than 10 percent. Please refer to the Methodology section below for more information.

High-Level Findings

Table 8-1 displays the percentage and count of indicators (out of 41 possible indicators) for which disparities were identified or were not identified at the statewide level for each demographic

[8-1] Healthy People 2030. Health Equity in Healthy People 2030. Available at: https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030. Accessed on: Jan 6, 2025.

[8-2] Kaiser Family Foundation. Distribution of People Ages 0-64 with Medicaid by Race/Ethnicity. 2023. Available at: https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on: Jan 6, 2025.

[8-3] Osorio A, Alker J, Park E. Medicaid's Coverage Role in Small Towns and Rural Areas: Aug 17, 2023. Available at: https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/. Accessed on: Jan 6, 2025.

stratification. Please note, for the geography stratification, only 15 indicators were assessed for disparities. Additionally, for each demographic stratification, the sum of the count of indicators that are better than, worse than, or similar to (i.e., no disparity identified) the reference group may not equal the total number of possible indicators due to suppressed rates (i.e., small numerators or denominators).

Table 8-1—Overall Statewide Disparities by Demographic Stratification

Demographic Stratification	Better Than the Reference Group	No Disparity Identified	Worse Than the Reference Group
Race (n=41)			
White	—	—	—
American Indian or Alaska Native	6 (37.5%)	7 (43.8%)	3 (18.8%)
Asian	4 (17.4%)	15 (65.2%)	4 (17.4%)
Black or African American	5 (12.2%)	29 (70.7%)	7 (17.1%)
Native Hawaiian or Other Pacific Islander	1 (100.0%)	0 (0.0%)	0 (0.0%)
Other	8 (25.0%)	22 (68.8%)	2 (6.3%)
Unknown	6 (15.8%)	21 (55.3%)	11 (28.9%)
Ethnicity (n=41)			
Non-Hispanic/Latino	—	—	—
Hispanic/Latino	17 (43.6%)	18 (46.2%)	4 (10.3%)
Unknown	6 (14.6%)	21 (51.2%)	14 (34.1%)
Geography (n=15)			
Urban	—	—	—
Rural	0 (0.0%)	10 (66.7%)	5 (33.3%)
Unknown	0 (0.0%)	3 (23.1%)	10 (76.9%)

—indicates the reference group for the select demographic stratification.

The following statewide disparities were found based on race, ethnicity, and geography:

- For the American Indian or Alaska Native group:
  - Rates were suppressed at the statewide level for 25 of 41 indicators, including all 20 indicators based on CAHPS data.
  - Three of the six indicators where the rate for American Indian or Alaska Native group was better than the rate for the White group were in the Women's Health domain.
  - Two of the three indicators where the rate for the American Indian or Alaska Native group was worse than the rate for the White group were in the Children's Health domain.
- For the Asian group:
  - Rates were suppressed at the statewide level for 18 of 41 indicators, including 17 of the 20 indicators based on CAHPS data.

  - Two of the four indicators where the rate for the Asian group was better than the rate for the White group were in the Children's Health domain.
  - Two of the four indicators where the rate for the Asian group was worse than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization. The other two indicators were in the Behavioral Health domain.
- For the Black or African American group:
  - Three of the five indicators where the rate for the Black or African American group was better than the rate for the White group were in the Women's Health domain.
  - The rates for the Black or African American group were worse than the rates for the White group for a majority of indicators in the Behavioral Health domain.
- For the Native Hawaiian or Other Pacific Islander group:
  - Rates were suppressed at the statewide level for 40 of 41 indicators.
  - The one reportable rate for the Native Hawaiian or Other Pacific Islander group was better than the rate for the White group (*Child and Adolescent Well-Care Visits* [WCV]).
- For the Other group:
  - Four of the eight indicators where the rate for the Other group was better than the rate for the White group were in the Children's Health domain.
  - The two indicators where the rate for the Other group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain.
- For the Unknown race group:
  - Two of the six indicators where the rate for the Unknown race group was better than the rate for the White group were in the Women's Health domain, specifically related to postpartum contraception utilization.
  - Six of the 11 indicators where the rate for the Unknown race group was worse than the rate for the White group were in the Member Experience With Health Plan and Providers domain. Additionally, the rates for the Unknown race group were below the rates for the White race group for all three indicators in the Behavioral Health domain.
- For the Hispanic/Latino group:
  - The rates for the Hispanic/Latino group were better than the rates for the Non-Hispanic/Latino group for 17 of 39 indicators with reportable rates, including all six indicators in the Children's Health domain and four of seven indicators in the Women's Health domain.
  - Two of the four indicators where the rate for the Hispanic/Latino group was worse than the Non-Hispanic/Latino group were in the Chronic Conditions domain, specifically related to HbA1c control for diabetes.
- For the Unknown ethnicity group:
  - Four of the six indicators where the rate for the Unknown ethnicity group was worse than the rate for the Non-Hispanic/Latino group were in the Member Experience With Health Plan and Providers domain.

  - The rates for the Unknown ethnicity group were worse than the rates for the Non-Hispanic/Latino group for a majority of measures in the Women's Health and Behavioral Health domains.
- For the Rural group:
  - No rates for the Rural group were better than the rates for the Urban group.
  - Four of the five indicators where the rate for the Rural group was worse than the rate for the Urban group were in the Women's Health domain, specifically related to postpartum contraception utilization.
- For the Unknown geography group:
  - No rates for the Unknown geography group were better than the rates for the Urban group.
  - The rates for the Unknown geography group were worse than the rates for the Urban geography group for all five indicators in the Children's Health domain and two of the three indicators in the Women's Health domain.

For race, ethnicity, and geography, the Unknown group had the largest number of disparities identified where the rate was worse than the rate for the reference group. HSAG recommends LDH and the MCOs work to improve data collection for race, ethnicity, and geography of their members to improve the ability to identify disparities and ultimately address these disparities. For the Hispanic/Latino group, rates were better than the rates for the Non-Hispanic/Latino group for a majority of indicators within the Children's Health domain and Women's Health domain, and for almost one-third of the indicators within the Member Experience With Health Plan and Providers domain. However, given the volume of members with Unknown ethnicity information, more information is necessary to assess if these disparities still persist once ethnicity information is better classified. Additionally, HSAG recommends LDH consider collecting race, ethnicity, and geography information at a member-level so relationships across demographic categories can be better understood. The Black or African American group had low performance related to low birthweight births, well-child visits for children under 15 months of age, and a follow-up care after ED visits or hospitalizations related to behavioral health. These disparities align with disparities seen nationally, so HSAG recommends LDH and the MCOs focus improvement efforts in alignment with national initiatives to close these gaps in care.

Methodology

Objectives

The Louisiana Medicaid Managed Care Quality Strategy outlines that one of LDH's objectives is to advance health equity and address social determinants of health. In an effort to measure and address health disparities, LDH and HSAG partnered to perform the 2023 Annual Health Disparities Focus Study. For the 2023 Annual Health Disparities Focus Study, HSAG identified statewide and MCO-specific disparities based on race, ethnicity, and geography using CY 2022 data.

Technical Methods of Data Collection

HSAG used the MCO-provided *Race Ethnicity and Rural Urban Stratification* Microsoft Excel (Excel) spreadsheets to identify disparities based on race, ethnicity, and geography for select HEDIS and non-HEDIS indicators. HSAG used the MY 2022 HEDIS IDSS data files and MY 2022 CAHPS data files to identify disparities for select HEDIS and CAHPS indicators based on race and ethnicity.

Description of Data Obtained

Table 8-2 displays all measure indicators, data sources, and the applicable stratifications that were assessed for health disparities. HSAG assigned each indicator to one of the following domains based on the type of care or health status being measured: Member Experience With Health Plan and Providers, Getting Care, Chronic Conditions, Children's Health, Women's Health, and Behavioral Health.

Table 8-2—Measure Indicators, Data Sources, and Stratifications Organized by Domains

Measure Indicator	Data Source	Stratification
Member Experience With Health Plan and Providers		
Rating of Health Plan—Adult (RHP–Adult) and *Child* (RHP–Child)	CAHPS Data	Race and Ethnicity
Rating of All Health Care—Adult (RHC–Adult) and *Child* (RHC–Child)		
Customer Service—Adult (CS–Adult) and *Child* (CS–Child)		
How Well Doctors Communicate—Adult (HWD–Adult) and *Child* (HWD–Child)		
Rating of Personal Doctor—Adult (RPD–Adult) and *Child* (RPD–Child)		
Rating of Specialist Seen Most Often—Adult (RSP–Adult) and *Child* (RSP–Child)		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit (MSC–Quit), *Discussing Cessation Medications* (MSC–Meds), and *Discussing Cessation Strategies* (MSC–Strategies)		
Getting Care		
Getting Needed Care—Adult (GNC–Adult) and *Child* (GNC–Child)	CAHPS Data	Race and Ethnicity
Getting Care Quickly—Adult (GCQ–Adult) and *Child* (GCQ–Child)		
Flu Vaccinations for Adults (FVA)		
Colorectal Cancer Screening (COL)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography

Measure Indicator	Data Source	Stratification
Chronic Conditions		
Controlling High Blood Pressure (CBP)^	HEDIS IDSS	Race and Ethnicity
HbA1c Control for Patients With Diabetes^—HbA1c Control (<8.0 Percent) (HBD–8) and *HbA1c Poor Control (>9.0 Percent)* (HBD–9)*	HEDIS IDSS	Race and Ethnicity
Human Immunodeficiency Virus (HIV) Viral Load Suppression (HVL)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Children's Health		
Child and Adolescent Well-Care Visits (WCV)	HEDIS IDSS	Race and Ethnicity
Childhood Immunization Status—Combination 3 (CIS–3)^	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Immunizations for Adolescents—Combination 2 (IMA–2)^		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)		
Low Birthweight Births (LBW)*		
Women's Health		
Cervical Cancer Screening (CCS)^	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Contraceptive Care—Postpartum Care—Long-Acting Reversible Contraception (LARC)—3 Days—Ages 21–44 (CCP–LARC3–2144) and *90 Days—Ages 21–44* (CCP–LARC90–2144)		
Contraceptive Care—Postpartum Care—Most or Moderately Effective Contraception (MMEC)—3 Days—Ages 21–44 (CCP–MMEC3–2144) and *90 Days—Ages 21–44* (CCP–MMEC90–2144)		
Prenatal and Postpartum Care^—Timeliness of Prenatal Care (PPC–Prenatal) and *Postpartum Care* (PPC–Postpartum)	HEDIS IDSS	Race and Ethnicity
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up (FUH–30)	*Race Ethnicity and Rural Urban Stratification* Excel	Race, Ethnicity, and Geography
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM–30)		
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up (FUA–30)		

^ indicates a measure indictor that can be calculated using the hybrid methodology.
** indicates that a lower rate is better for this measure indicator.*

How Data Were Aggregated and Analyzed

Statewide Rate Calculations

HSAG calculated stratified rates for all HEDIS, non-HEDIS, and CAHPS measure indicators listed in Table 8-2. For the HEDIS and non-HEDIS measure indicators reported through IDSS files (HEDIS only) and the *Race Ethnicity and Rural Urban Stratification* Excel spreadsheets (HEDIS and non-HEDIS), HSAG extracted the stratified MCO-reported numerators, denominators, and rates provided in the reporting templates.

Additionally, HSAG used the survey responses provided in the CAHPS data files to calculate the stratified MCO-specific CAHPS rates. Each member was assigned a race and ethnicity based on their survey responses. To calculate a rate for a CAHPS measure indicator, HSAG converted each individual question by assigning the positive responses (i.e., "9/10," "Usually/Always," and "Yes" where applicable) to a "1" for each individual question, as described in *HEDIS MY 2022 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of "0." HSAG then calculated the percentage of respondents with a positive response (i.e., a "1"). For composite measures (i.e., CS, GNC, GCQ, and HWD), HSAG calculated the positive rating by taking the average percentage of positive ratings for each question within the composite. An MCO-specific stratified rate was calculated by determining the percentage of respondents who gave a positive response for each race and ethnicity. For the Effectiveness of Care CAHPS measure indicators (i.e., MSC and FVA), HSAG identified the denominator and numerator in alignment with the *HEDIS MY 2022 Volume 2: Technical Specifications for Health Plans*.

HSAG then calculated a statewide aggregate for each HEDIS, non-HEDIS, and CAHPS measure indicator by summing the numerators and denominators reported by each MCO. For measure indicator rates that were reported using the hybrid methodology (please see Table 8-2 for measure indicators with a hybrid option), rates were based on a sample selected from the measure indicator's eligible population. For the *Immunizations for Adolescents—Combination 2* (IMA–2) indicator one MCO reported the hybrid measure using the administrative option (i.e., the rate is not based on a sample of cases). Given that one MCO's eligible population was larger than 411, HSAG transformed the administrative denominator and numerator to replicate a sample of 411 members in order to limit the overrepresentation of the MCO's members toward the SWA. To do this, HSAG first calculated a transformed weight by taking 411 divided by the eligible population of the total rate. HSAG then multiplied each stratified numerator and denominator by the transformed weight to calculate the transformed numerator and denominator. This method allowed for each stratification in the transformed rate to maintain the same proportion of the total population as the original rate, while also having the same performance (i.e., the transformed rate is equal to the original rate). Table 8-3 provides an example of how the transformed rates were calculated.

Table 8-3—Transformed Rate Calculation

Race Category	Eligible Population (A)	Numerator (B)	Rate (C)	Transformed Weight (D) 411/A	Transformed Denominator (E) A*D	Transformed Numerator (F) B*D	Transformed Rate (G) F/E
Total	5,000	2,500	50.00%	0.0822	411.0000	205.5000	50.00%
White	1,700	800	47.06%		139.7400	65.7600	47.06%
Black or African American	2,100	1,200	57.14%		172.6200	98.6400	57.14%
American Indian or Alaska Native	25	13	52.00%		2.0550	1.0686	52.00%
Asian	30	16	53.33%		2.4660	1.3152	53.33%
Native Hawaiian or Other Pacific Islander	10	6	60.00%		0.8220	0.4932	60.00%
Other	800	401	50.13%		65.7600	32.9622	50.13%
Unknown	335	170	50.75%		27.5370	13.9740	50.75%

Identifying Health Disparities

For the measure indicators listed in Table 8-2, HSAG identified statewide and MCO-specific disparities based on race, ethnicity, and geography, where applicable (see Table 8-2 for which stratifications apply to each measure indicator). Table 8-4 and Table 8-5 display the race and ethnicity categories that were included in each of the MCO-provided *Race Ethnicity and Rural Urban Stratification* Excel spreadsheets, HEDIS IDSS, and CAHPS data files, along with individual racial and ethnic groups that comprise each category. Given the variation in race and ethnicity categories across data files, HSAG included the individual racial and ethnic groups from each data source in the "Groups Included" columns in Table 8-4 and Table 8-5; however, the race and ethnicity categories listed were used in the analysis, where applicable.

Table 8-4—Race Categories

Race Category	Groups Included
White*	White
Black or African American	Black or African American, Black or African-American

Race Category	Groups Included
American Indian or Alaska Native	American Indian or Alaska Native, American Indian and Alaska Native
Asian	Asian
Native Hawaiian or Other Pacific Islander	Native Hawaiian and Other Pacific Islander, Native Hawaiian or Other Pacific Islander
Other	Other, Some Other Race, Two or More Races
Unknown^	Unknown, Asked but No Answer

** indicates reference group for the identification of racial disparities.*
^ indicates for the CAHPS measure indicators, "Unknown" includes members who did not provide a response.

Table 8-5—Ethnicity Categories

Ethnicity Category	Groups Included
Hispanic/Latino	Hispanic/Latino, Hispanic or Latino
Non-Hispanic/Latino*	Non-Hispanic/Latino, Not Hispanic/Latino, Not Hispanic or Latino
Unknown^	Unknown Ethnicity, Declined Ethnicity, Asked but No Answer

** indicates reference group for the identification of ethnic disparities.*
^ indicates for the CAHPS measure indicators, "Unknown" includes members who did not provide a response.

Table 8-6 displays the geography categories and the parishes included in each.

Table 8-6—Geography Categories and Parishes

Geography	Parishes
Urban*	Acadia, Ascension, Bossier, Caddo, Calcasieu, East Baton Rouge, Jefferson, Lafayette, Lafourche, Livingston, Orleans, Ouachita, Plaquemines, Rapides, St. Bernard, St. Charles, St. James, St. John, St. Landry, St. Martin, St. Tammany, Terrebonne, Webster, West Baton Rouge
Rural	Allen, Assumption, Avoyelles, Beauregard, Bienville, Caldwell, Cameron, Catahoula, Claiborne, Concordia, DeSoto, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson Davis, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Pointe Coupee, Red River, Richland, Sabine, St. Helena, St. Mary, Tangipahoa, Tensas, Union, Vermilion, Vernon, Washington, West Carroll, West Feliciana, Winn
Unknown	Unknown

** indicates reference group for the identification of disparities.*

A disparity was identified if the relative difference between the demographic group (the group of interest) and the reference group was more than 10 percent. For rates for which a higher rate indicates better performance, the relative difference was calculated using the following equation:

$$Relative\ Difference = \frac{(Group\ of\ Interest\ Performance Rate - Reference\ Group\ Performance Rate)}{Reference Group\ Performance Rate}$$

For example, for identifying racial disparities, if the rate of eligible members receiving well-child visits for the White group was 65.0 percent and the rate for the Black or African American group was 45.0 percent, the rate for the Black or African American group (the group of interest) was below the rate for the White group (the reference group) by more than a 30 percent relative difference, indicating a disparity. This is shown in the equation below:

$$-30.8\% = \frac{(45.0\% - 65.0\%)}{65.0\%}$$

For measure indicators for which a lower rate indicates better performance,[8-4] the relative difference was calculated using the following equation:

$$Relative\ Difference = \frac{(Reference\ Group\ Performance Rate - Group\ of\ Interest\ Performance Rate)}{Reference Group\ Performance Rate}$$

For example, for identifying racial disparities, if the low birthweight rate for the Black or African American group was 13.0 percent and the rate for the White group was 9.0 percent, the rate for the Black or African American group (the group of interest) was above the rate for the White group (the reference group) by more than a 40 percent relative difference, indicating a disparity. This is shown in the equation below:

$$-44.4\% = \frac{(9.0\% - 13.0\%)}{9.0\%}$$

Disparities were categorized by the following color system:

1. indicates the rate for the group of interest was better than the reference group (i.e., the relative difference was more than 10 percent).
2. indicates the rate for the group of interest was worse than the reference group (i.e., the relative difference was less than −10 percent).
3. White cells indicate that a disparity was not identified.

[8-4] Please refer to those measure indicators in Table 8-2 marked with an asterisk (*) for measure indicators for which a lower rate indicates better performance.

How Conclusions Were Drawn

To draw conclusions about identified statewide health disparities, HSAG assessed whether specific measure indicators, domains, or demographic groups had disparities consistently identified.

9. Case Management Performance Evaluation

Introduction

States may direct their EQROs to conduct focus studies for QI, administrative, legislative, or other purposes. Focus studies may examine clinical or nonclinical aspects of care provided by MCOs and assess quality of care at a specific point in time. LDH contracted with HSAG to conduct a focused CMPE to evaluate each MCO's compliance with the case management provisions of its contract with LDH and determine the effectiveness of case management activities.

Activities Conducted During SFY 2024

During SFY 2024, HSAG and LDH collaborated to determine the scope, methodology, data sources, and timing of the CMPE. HSAG conducted the focus study in accordance with the CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023.[9-1]

During SFY 2024, HSAG completed two CMPE reviews. Each review focused on specific populations of enrollees with special health care needs (SHCN):

- CY 2023 review (conducted from October through December 2023 [review period]): Enrollees with a classification of SHCN-Medical ("SHCN-MED"), SHCN-Behavioral Health ("SHCN-BH"), or "SHCN-BOTH" (composed of both MED and BH cases).
- CY 2024 review (conducted from March through April 2024 [review period]): Enrollees with a classification of SHCN-Department of Justice at-risk ("SHCN-DOJ-AR").

The MCOs included in the CMPE reviews are displayed in Table 9-1.

Table 9-1—Plan Names

MCO Name	Acronym or Abbreviated Reference
Aetna Better Health	ABH
AmeriHealth Caritas Louisiana	ACLA
Healthy Blue	HBL
Humana Healthy Horizons	HUM
Louisiana Healthcare Connections	LHCC
UnitedHealthcare Community	UHC

[9-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 7, 2025.

The results of both reviews, including conclusions, strengths, and opportunities for improvement, are included in this EQR technical report.

Aggregate Results

During the CY 2023 (review period) review, a total of 588 case files were reviewed. Table 9-2 summarizes the aggregate and stratified scores for each performance domain.

Table 9-2—Performance Scores by Domain*

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
Assessment (Aggregate)	**842**	**122**	**198**	**602**	**83%**
ABH	159	50	28	63	88%
ACLA	108	2	14	176	89%
HBL	130	20	34	116	82%
HUM	219	16	33	32	88%
LHCC	128	29	39	104	80%
UHC	98	5	50	111	67%
Care Planning (Aggregate)	**2,063**	**131**	**496**	**1,426**	**82%**
ABH	384	51	72	193	86%
ACLA	206	1	111	382	65%
HBL	443	29	32	196	94%
HUM	423	8	43	226	91%
LHCC	367	35	96	202	81%
UHC	240	7	142	227	63%
Enrollee Interaction and Coordination of Services (Aggregate)	**843**	**91**	**242**	**0**	**79%**
ABH	118	18	64	0	68%
ACLA	182	8	10	0	95%
HBL	143	31	26	0	87%
HUM	177	10	13	0	94%
LHCC	118	11	71	0	65%

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
UHC	105	13	58	0	67%

* The results reflected in this table are not statistically significant or representative of performance as related to the MCO's membership as a whole.
** "Percentage Met" is the percentage of *Met* and *Met Based on Due Diligence* elements excluding any *NA* cases.

During the CY 2024 review, a total of 129 case files were reviewed. Table 9-3 summarizes the aggregate and stratified scores for each performance domain.

Table 9-3—Performance Scores by Domain*

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
Assessment (Aggregate)	**105**	**69**	**58**	**155**	**75%**
ABH	5	6	9	28	55%
ACLA	20	15	18	37	66%
HBL	13	8	14	19	60%
HUM	6	8	0	1	100%
LHCC	35	17	2	36	96%
UHC	26	15	15	34	73%
Care Planning (Aggregate)	**702**	**58**	**360**	**299**	**68%**
ABH	82	1	47	46	64%
ACLA	141	9	109	71	58%
HBL	98	4	61	35	63%
HUM	27	3	14	11	68%
LHCC	199	30	29	72	89%
UHC	155	11	100	64	62%
Enrollee Interaction and Coordination of Services (Aggregate)	**131**	**37**	**90**	**0**	**65%**
ABH	15	3	14	0	56%
ACLA	32	10	18	0	70%
HBL	16	7	13	0	64%
HUM	6	3	1	0	90%

Domain	Number of *Met* Elements	Number of *Met Based on Due Diligence* Elements	Number of *Not Met* Elements	Number of *Not Applicable (NA)* Elements	Percentage Met**
LHCC	32	5	23	0	62%
UHC	30	9	21	0	65%

* The results reflected in this table are not statistically significant or representative of performance as related to the MCO's membership as a whole.
** "Percentage Met" is the percentage of *Met* and *Met Based on Due Diligence* elements excluding any *NA* cases.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- The results of both reviews demonstrated that no findings resulted in concerns regarding an enrollee's health, safety, or welfare. **[Quality]**
- For the CY 2023 review, two of the six MCOs demonstrated overall performance of greater than 80 percent for all three domains. **[Quality]**
- The results of both reviews demonstrated that five of the six MCOs were successful in completing activities during initial engagement with the enrollee, including initial assessments and care plans, and MCT development. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- While the MCOs achieved successes with initial enrollee engagement case activities, all six MCOs demonstrated opportunity for improvement with elements related to ongoing scheduled case management activities. **[Timeliness]**
- The MCOs reported varying levels of success with enrollee engagement; however, the MCOs were generally unable to demonstrate use of alternative options for engagement. HSAG observed limited documentation of attempts to contact enrollees' formal or informal supports (i.e., physicians, BH professionals, pharmacists, personal assistants/homemakers) to assist with engagement attempts. In addition, while all six MCOs had UTR processes to assist with enrollee engagement, the MCOs were unable to demonstrate consistent application of those processes. **[Quality and Timeliness]**
- For the CY 2024 review, although the MCOs were generally successful in developing a POC with enrollees, there was opportunity for improvement related to person-centered planning. **[Quality]**

For the MCOs statewide, the following recommendations were identified:

- The MCOs should evaluate their oversight processes to ensure that case managers and supervisory staff have tools to effectively manage activities that occur regularly. Case management system flags, queues, or reports that remind staff members of upcoming contact requirements (i.e., reassessments,

POC updates, enrollee contacts) should be considered; leadership audits may need to focus on these time-sensitive elements. **[Quality and Timeliness]**

- The MCOs should consider efforts to strengthen documentation of an enrollee's refusal of in-person contact for completion of reassessments, plan of care updates, and scheduled contacts. The MCOs may consider reeducation of case managers on documentation expectations. **[Quality and Timeliness]**
- The MCOs must evaluate their processes to ensure enrollee engagement if the enrollee refuses face-to-face contact. The MCOs should consider revisions to processes to, at a minimum, offer telephonic contact for those enrollees refusing face-to-face contact, and should consider virtual face-to-face options and in-person visits with enrollees at the location of their choice. All case management staff members should be trained on the expectation to complete case management activities in alternate formats if an enrollee refuses face-to-face contact. **[Quality and Timeliness]**
- The MCOs should evaluate MCT processes to ensure MCT meetings are conducted at regular intervals, or that an enrollee's refusal of MCT meetings is documented. The MCOs should consider efforts to educate enrollees on the importance of the MCT. The MCOs could consider evaluating documentation templates to identify opportunities to reduce duplication of case manager efforts. **[Timeliness]**
- The MCOs should reeducate case managers on expectations for person-centered planning and inclusion of all required POC elements. **[Quality]**

Methodology

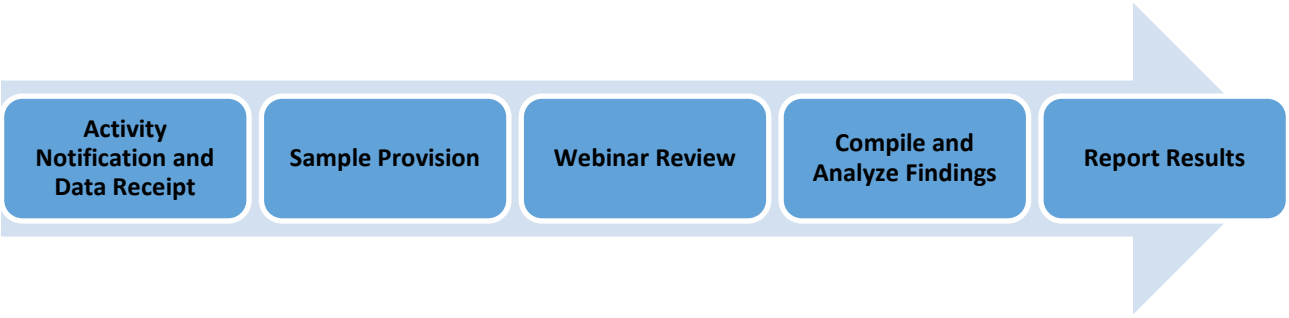
Objectives

LDH requires the Healthy Louisiana MCO reporting of data on case management services to determine the number of individuals, the types of conditions, and the impact that case management services have on enrollees receiving those services. LDH established case management requirements to ensure that the services provided to enrollees with SHCN are consistent with professionally recognized standards of care. To assess MCO compliance with case management elements, LDH requested that HSAG evaluate the MCOs' compliance with the case management provisions of their contracts with LDH, including the rates of engagement in case management; the specific services offered to enrollees receiving case management; and the effectiveness of case management in terms of increasing the quality of care, increasing the receipt of necessary services, and reducing the receipt of potentially unnecessary services such as acute care.

HSAG's CMPE review tool comprehensively addressed the services and supports that are necessary to meet enrollees' needs. The tool included elements for review of case management documentation and enrollee care plans to ensure that they are consistent with a person-centered approach to care planning and service delivery and that outcomes are being achieved or progress is being made toward their achievement. The CMPE review tool included MCO contract requirements, evaluation criteria of those requirements, and reviewer determinations of performance.

Review Process

HSAG's case management review process included five activities:



Activity 1: Activity Notification and Data Receipt

To initiate the case management review, HSAG conducted an activity notification webinar for the MCOs. During the webinar, HSAG provided information about the activity and expectations for MCO participation, including provision of data. HSAG requested the *LA PQ039 Case Management* report from each MCO.

Table 9-4—Activity 1: Activity Notification and Data Receipt

For this step,	HSAG will…
Step 1:	**Notify the MCOs of the review.**
	HSAG hosted a webinar to introduce the activity to the MCOs. The MCOs were provided a timeline, review tools, and a question and answer (Q&A) document post-webinar. HSAG provided assistance to all MCOs prior to the review, including clear instructions regarding the scope of the review, timeline and logistics of the webinar review, identification of expected review participants, and any other expectations or responsibilities.
Step 2:	**Receive data universes from the MCOs.**
	HSAG reviewed the data received from the MCOs for completeness.

Activity 2: Sample Provision

Upon receipt of each MCO's *LA PQ039 Case Management* report, HSAG reviewed the data to ensure completeness for sample selection. To be included in the sample, the enrollee must have met the following criteria:

For the CY 2023 review:

- Have a classification of "SHCN-MED," "SHCN-BH," or "SHCN-BOTH." HSAG identified these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or before June 1, 2023. HSAG identified these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of at least three months. HSAG identified these enrollees by utilizing data from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.

For the CY 2024 review:

- Have a classification of "SHCN-DOJ-AR." HSAG identified these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Identified by the MCOs as "accepted" in the "enrollment offer result" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or after October 1, 2023. HSAG identified these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of at least three months. HSAG identified these enrollees by utilizing data from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.

  If the criteria above did not allow for the sample size to be achieved, HSAG conducted a second stage approach to include enrollees meeting the following criteria:

- Have a classification of "SHCN-DOJ-AR." HSAG will identify these enrollees by the "reason identified for case management" field provided in the *LA PQ039 Case Management* report.
- Identified by the MCOs as "enrolled in case management" in the "assessment result" field provided in the *LA PQ039 Case Management* report.
- Current case management span began on or after October 1, 2023. HSAG will identify these enrollees by the "date entered case management" field provided in the *LA PQ039 Case Management* report.
- Enrollees with a case management span of less than 90 days as identified from the "date entered case management" and "date exited case management" fields provided in the *LA PQ039 Case Management* report.
- Have a completed assessment and plan of care. HSAG will identify these enrollees by the "date of assessment" and "date plan of care completed" fields provided in the *LA PQ039 Case Management* report.

Enrollees who were identified by the MCOs for case management but not enrolled were excluded from the sample.

In future review years, HSAG will collaborate with LDH to determine any changes to the sampling criteria, including exclusions such as enrollees who were selected for the review the year prior.

Based on the inclusion criteria, HSAG generated a random sample of enrollees for each MCO, which included a 10 percent oversample to account for exclusions or substitutions. HSAG provided each MCO with its sample 10 business days prior to the webinar review. The MCO was given five business days to provide HSAG with any requests for exclusions or substitutions. If the oversample was not large enough to obtain the necessary sample size, HSAG selected additional random samples to fulfill the sample size. The final sample of cases were confirmed with the MCO no later than three business days prior to the webinar review.

Table 9-5—Activity 2: Sample Provision

For this step,	HSAG will…
Step 1:	**Identify enrollees for inclusion in the sample.**
	HSAG utilized the data provided in each MCO's *LA PQ039 Case Management* report.
Step 2:	**Provide the sample to the MCOs.**
	HSAG provided the sample and oversample to each MCO 10 business days prior to the webinar review. The sample was provided via HSAG's SAFE site.
Step 3:	**Finalize the sample.**
	The MCOs provided HSAG with any requests for exclusions or substitutions to the sample within five business days of receipt of the sample file from HSAG. HSAG provided the final sample to each MCO no later than three business days prior to the webinar.

Activity 3: Webinar Review

HSAG collaborated with the MCOs to schedule and conduct webinar reviews with key MCO staff members to:

- Ensure understanding of terminology and documents used by the MCO to record case management activities.
- Review sampled cases to determine compliance with contractual requirements.

The webinar review consisted of several key activities:

- Entrance Conference: HSAG dedicated the first 15 minutes of each webinar to introduce the activity and the HSAG review team, and to provide key logistics of the review. HSAG reviewed documentation naming conventions with the MCO to ensure understanding of the information that will be displayed by the MCO and reviewed during the activity.
- Case Review: HSAG conducted a review of each sample file. The MCO's case management representative(s) navigated the MCO's case management system and responded to HSAG reviewers' questions. The review team determined evidence of compliance with each of the scored elements on the CMPE review tool. Concurrent interrater reliability was conducted by the HSAG team lead to respond to questions from the review team in real time so that feedback could be provided to the MCO, and any discrepancies addressed, prior to the end of the review.
- Leadership Meeting (optional): HSAG scheduled a meeting with the MCO and LDH to discuss the progress of the review and provide preliminary findings. The meeting also allowed HSAG to confirm information that may be needed to complete the review of cases, and for the MCO to ensure understanding of LDH's expectations.
- Exit Conference: HSAG scheduled a 30-minute exit conference with the MCO and LDH. During the exit conference, HSAG provided a high-level summary of the cases reviewed, preliminary findings, and recommendations to address opportunities for improvement.

Table 9-6—Activity 3: Webinar Review

For this step,	HSAG will…
Step 1:	**Provide the MCOs with webinar dates.**
	HSAG provided the MCOs with their scheduled webinar dates. HSAG considered MCO requests for alternative dates or accommodations.
Step 2:	**Identify the number and types of reviewers needed.**
	HSAG assigned review team members who were content area experts with in-depth knowledge of case management requirements who also had extensive experience and proven competency conducting case reviews. To ensure interrater reliability, HSAG reviewers were trained on the review methodology to ensure that the determinations for each element of the review were made in the same manner.

For this step,	HSAG will…
Step 3:	**Conduct the webinar review.**
	During the webinar, HSAG set the tone, expectations, and objectives for the review. MCO staff members who participated in the webinar reviews navigated their documentation systems, answered questions, and assisted the HSAG review team in locating specific documentation. As a final step, HSAG met with MCO staff members and LDH to provide a high-level summary and next steps for receipt of findings.

Scoring Methodology

HSAG used the CMPE review tool to record the results of the case reviews. HSAG used a two-point scoring methodology. Each requirement was scored as *Met* or *Not Met* according to the criteria identified below. HSAG used a designation of *NA* if the requirement was not applicable to a record; *NA* findings were not included in the two-point scoring methodology.

Met indicated full compliance defined as the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.
- Cases reviewed had documentation that met "due diligence" criteria.

Not Met indicated noncompliance defined as either of the following:

- Cases reviewed did not meet the scoring criteria assigned to each requirement.
- Not all documentation was present.

Not Applicable (NA) indicated a requirement that was not scored for compliance based on the criteria listed for the specific element in the Review Tool and Evaluation Criteria document.

HSAG calculated the overall percentage-of-compliance score for each of the requirements. HSAG calculated the score for each requirement by adding the score from each case, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable cases. Data analysis also included aggregate performance by domain.

Reporting of Abuse, Neglect, or Exploitation (ANE)

If, during the review process, a reviewer identified potential ANE of an enrollee, HSAG reported the concern to the MCO immediately upon identification and to LDH within 24 hours of identification. If the reviewer identified a potential health, safety, or welfare concern that did not rise to the level of an ANE, HSAG reported the concern to the MCO and LDH at the identification of the concern and no later than the end of the webinar review.

Activity 4: Compile and Analyze Findings

Following the webinar review, HSAG compiled and analyzed findings for each MCO. Findings included performance by domain and each scored element. Additional data gathering information may be compiled to inform analysis and results (e.g., program information such as the total number of enrollees in case management during the lookback period).

Domain and Element Performance

Findings were compiled into domains, which represent a set of elements related to a specific case management activity (e.g., assessment, care planning). Domain performance was calculated by aggregating the scores for each element in the domain and dividing by the total number of applicable cases. Domain performance scores provided a high-level result to inform analysis of opportunities for improvement.

Analysis of scored element performance allowed for targeted review of individual elements that may impact overall domain performance. Individual element performance scores were used to inform analysis of specific opportunities for improvement, especially when an element performed at a lower rate than other elements in the domain.

Analysis of findings included identification of opportunities for improvement.

Activity 5: Report Results

HSAG developed a draft and final report of results and findings for each MCO. The report described the scores assigned for each requirement, assessment of the MCO's compliance by domain, and recommendations for improvement. Following LDH's approval of the draft report, HSAG issued the final report to LDH and each MCO. HSAG also developed an aggregate report of all findings, stratified by MCO, which was delivered to LDH.

How Conclusions Were Drawn

Upon completion of the activity, HSAG provided results for each MCO in three performance domains: Assessment, Care Planning, and Enrollee Interaction and Coordination of Services. Each domain included scored elements, displayed in Table 9-7, which demonstrated each MCO's compliance with contractual requirements.

Table 9-7—Assignment of CMPE Measures to the Quality, Timeliness, and Access Domains

CMPE Measure	Quality	Timeliness	Access
The enrollee's initial health needs assessment was completed within 90 calendar days of enrollment.		✓	
The enrollee's initial comprehensive assessment was completed within 90 calendar days of identification of SHCN.		✓	

CMPE Measure	Quality	Timeliness	Access
A reassessment was completed in person quarterly with the enrollee.		✓	
A POC was developed within 30 calendar days of identification of risk stratification.		✓	
A POC was developed within 90 calendar days of identification of risk stratification.		✓	
The MCO developed and implemented a person-centered care plan reflective of the most recent assessment and included all enrollee goals, needs, and risks as well as the formal and informal supports responsible for assisting the enrollee with the POC. (2023 review only)	✓		
The MCO implemented a POC that was developed with the enrollee. (2024 review only)	✓		
The POC includes goals, choices, preferences, strengths, and cultural considerations identified in the assessment. (2024 review only)	✓		
The POC includes interventions to reduce all risks/barriers identified in the assessment. (2024 review only)	✓		
The POC incorporates the BH treatment plan, as applicable. (2024 review only)	✓		
The POC identifies the formal and informal supports responsible for assisting the enrollee. (2024 review only)	✓		
The POC was updated per the enrollee's tier schedule.		✓	
The POC was updated when the enrollee's circumstances or needs changed significantly, or at the request of the enrollee, their parent or legal guardian, or a member of the MCT.	✓		
The MCO developed an MCT, including the case manager, enrollee and/or authorized representative, and members based on the enrollee's specific care needs and goals.	✓		✓
The MCT was convened at regular intervals required for the enrollee's tier level.		✓	
The case manager made valid timely contact, or due diligence is documented in the enrollee's record.		✓	
For enrollees demonstrating needs requiring coordination of services, the case manager coordinated needed care/services, actively linking the enrollee to providers; medical services; and residential, social, community, and other support services.	✓		✓

Aggregate Results

The 2024 (CY 2023 [review period]) QRS results for each MCO are displayed in Table 10-1.

Table 10-1—2024 (CY 2023) QRS Results

Composites and Subcomposites	ABH	ACLA	HBL	LHCC	UHC
Overall Rating*	**3.5**	**3.5**	**3.5**	**3.5**	**3.5**
Consumer Satisfaction	**3.5**	**3.5**	**4.0**	**4.0**	**5.0**
Getting Care	4.5	2.5	3.5	3.5	Insufficient Data
Satisfaction with Plan Physicians	3.5	3.5	4.5	5.0	5.0
Satisfaction with Plan Services	2.5	3.5	4.5	4.0	5.0
Prevention and Equity	**2.5**	**3.0**	**3.0**	**2.5**	**3.0**
Children and Adolescent Well-Care	2.0	2.5	2.5	2.0	2.5
Women's Reproductive Health	2.5	2.0	3.0	2.5	3.5
Cancer Screening	2.0	3.0	2.0	3.0	3.0
Equity	5.0	5.0	5.0	NC	5.0
Other Preventive Services	3.5	4.0	4.0	3.5	3.0
Treatment	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
Respiratory	3.5	3.0	3.5	3.0	1.5
Diabetes	3.5	3.5	4.0	4.0	4.5
Heart Disease	3.5	3.0	2.5	3.5	3.0
Behavioral Health—Care Coordination	1.5	1.0	1.5	1.0	1.5
Behavioral Health—Medication Adherence	3.5	2.5	2.5	3.5	2.0
Behavioral Health—Access, Monitoring, and Safety	4.0	3.5	4.0	3.0	4.0
Risk-Adjusted Utilization	3.0	3.0	3.0	3.0	3.0
Reduce Low Value Care	2.0	2.0	2.0	2.0	2.0

**This rating includes all measures in the 2024 Health Plan Report Card as well as an Accreditation bonus for those MCOs that are NCQA Accredited.*
Insufficient Data indicates that the plan was missing most data for the composite or subcomposite.
NC indicates that the plan received a rating of 0 for the measure in this composite.
Note: A sixth MCO, HUM, was not included in the analysis as the MCO did not start providing coverage until MY 2023.

For the Overall Rating, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.5 stars. For the Consumer Satisfaction composite, one MCO (UHC) received 5.0 stars, two MCOs (HBL and LHCC) received 4.0 stars, and two MCOs (ABH and ACLA) received 3.5 stars. For the Prevention and Equity composite, ACLA, HBL, and UHC each received 3.0 stars, while the remaining two MCOs (ABH and LHCC) both received 2.5 stars. For the Treatment composite, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.0 stars.

Statewide MCO Strengths, Opportunities for Improvement, and Recommendations

For the MCOs statewide, the following strengths were identified:

- For the Consumer Satisfaction composite, one of five MCOs (UHC) received 5.0 points and two of five MCOs (HBL and LHCC) received 4.0 points, demonstrating that most MCO members are satisfied with their health plan, providers, and the care they receive. Of note, despite UHC not having sufficient data for the Getting Care subcomposite, UHC received 5.0 points for the two remaining subcomposites (Satisfaction with Plan Physicians and Satisfaction with Plan Services), demonstrating strength for this MCO. **[Quality and Timeliness]**
- For the Prevention and Equity composite, four MCOs (ABH, ACLA, HBL, and UHC) received 5.0 points for the Equity subcomposite, demonstrating strength for health plans collecting race and ethnicity information from their members. Additionally, four MCOs (ABH, ACLA, HBL, and LHCC) received at least 3.5 points for the Other Preventive Services subcomposite, demonstrating strength for these MCOs related to providing chlamydia screenings in women and tobacco cessation counseling. **[Quality and Access]**
- For the Treatment composite, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received at least 3.5 points for the Diabetes subcomposite, demonstrating strength for these MCOs related to diabetic care. Additionally, four MCOs (ABH, ACLA, HBL, and UHC) received at least 3.5 points for the Behavioral Health—Access, Monitoring, and Safety subcomposite, demonstrating strengths for these MCOs in providing care for adults and children using antipsychotics, adults and children with SUD, and children using ADHD medication. **[Quality, Timeliness, and Access]**

For the MCOs statewide, the following opportunities for improvement were identified:

- For the Consumer Satisfaction composite, ABH and ACLA were the lowest performing MCOs. ABH received 2.5 points for the Satisfaction with Plan Services subcomposite, demonstrating opportunities for this MCO to ensure members are satisfied with their health plan. ACLA received 2.5 points for the Getting Care subcomposite, demonstrating opportunities for this MCO to ensure members get the care they need. **[Quality and Timeliness]**
- For the Prevention and Equity composite, ABH and LHCC were the lowest performing MCOs with both MCOs receiving 2.5 points. None of the five MCOs received more than 2.5 points for the Children and Adolescent Well-Care subcomposite, demonstrating opportunities for improvement for

the MCOs related to ensuring children and adolescents receive important immunizations as well as ensuring BMI percentiles are documented for children and adolescents. **[Quality and Access]**

- For the Treatment composite, five MCOs scored the lowest on the Behavioral Health—Care Coordination subcomposite, with ACLA and LHCC receiving 1.0 point each and the remaining MCOs receiving 1.5 points each, demonstrating opportunities for improvement for the MCOs to ensure timely follow-up care after hospitalizations and ED visits for mental illness.
- Additionally, five MCOs demonstrated opportunities for improvement for the Reduce Low Value Care subcomposite, with each MCO receiving 2.0 points; these MCOs should ensure members with low back pain do not receive unnecessary imaging tests. **[Quality, Timeliness, and Access]**

The MCOs should reference the recommendations made in Section 3—Validation of Performance Measures and Section 6—Consumer Surveys: CAHPS-A and CAHPS-C as the 2024 Health Plan Report Card reflects HEDIS and CAHPS results.

Methodology

Objectives

HSAG was tasked with developing a QRS to evaluate the performance of the five Healthy Louisiana Medicaid MCOs (i.e., ABH, ACLA, HBL, LHCC, and UHC) relative to national benchmarks and assign ratings to each MCO in key areas.[10-1] The 2024 Health Plan Report Card is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection

HSAG received MY 2023 CAHPS member-level data files and HEDIS IDSS data files from LDH and the six MCOs. The *HEDIS MY 2023 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2023 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Description of Data Obtained

HSAG received the final, auditor-locked HEDIS IDSS data files from each of the MCOs, as well as the CAHPS member-level data files and summary reports. HSAG also downloaded the 2023 (MY 2022) Quality Compass national Medicaid all lines of business (ALOB) benchmarks for this analysis.[10-2]

How Data Were Aggregated and Analyzed

Using the HEDIS and CAHPS measure results for each MCO, HSAG calculated MCO ratings in alignment with NCQA's 2024 Health Plan Ratings Methodology, where possible, for the following composites and subcomposites:[10-3]

- Overall
- Consumer Satisfaction
  - Getting Care
  - Satisfaction with Plan Physicians
  - Satisfaction with Plan Services

[10-1] Due to HUM being a new MCO in 2023, there were no data available for this year's QRS activity. HUM will be included in future Health Plan Report Cards.

[10-2] 2023 (MY 2022) Quality Compass national Medicaid ALOB benchmarks were used since LDH requested a finalized report card by August 5, 2024, and 2024 (MY 2023) Quality Compass national Medicaid ALOB benchmarks were not available until September 27, 2024.

[10-3] National Committee for Quality Assurance. 2024 Health Plan Ratings Methodology. Available at: https://www.ncqa.org/wp-content/uploads/2024-HPR-Methodology_Updated-December-2023.pdf. Accessed on: Jan 7, 2025.

- Prevention and Equity
  - Children and Adolescent Well-Care
  - Women's Reproductive Health
  - Cancer Screening
  - Equity
  - Other Preventive Services
- Treatment
  - Respiratory
  - Diabetes
  - Heart Disease
  - Behavioral Health—Care Coordination
  - Behavioral Health—Medication Adherence
  - Behavioral Health—Access, Monitoring, and Safety
  - Risk-Adjusted Utilization
  - Reduce Low Value Care

For each measure included in the 2024 Health Plan Report Card, HSAG compared the raw, unweighted measure rates to the 2023 (MY 2022) Quality Compass national Medicaid ALOB percentiles and scored each measure as outlined in Table 10-2. For the *Plan All-Cause Readmissions* measure, HSAG followed NCQA's methodology for scoring risk-adjusted utilization measures.

Table 10-2—Measure Rate Scoring Descriptions

Score	MCO Measure Rate Performance Compared to National Benchmarks
5	The MCO's measure rate was at or above the national Medicaid ALOB 90th percentile.
4	The MCO's measure rate was at or between the national Medicaid ALOB 66.67th and 89.99th percentiles.
3	The MCO's measure rate was at or between the national Medicaid ALOB 33.33rd and 66.66th percentiles.
2	The MCO's measure rate was at or between the national Medicaid ALOB 10th and 33.32nd percentiles.
1	The MCO's measure rate was below the national Medicaid ALOB 10th percentile.

HSAG then multiplied the scores for each measure by the weights that align with NCQA's 2024 Health Plan Ratings. For each composite and subcomposite, HSAG calculated scores using the following equation:

$$Composite\ or\ Subcomposite\ Rating = \frac{\sum(Measure\ Rating * Measure\ Weight)}{\sum(Measure\ Weights)}$$

To calculate the Overall Rating, HSAG calculated a weighted average using the weighted measure-level scores previously calculated. HSAG also added 0.5 bonus points to scores for MCOs that were Accredited or had Provisional status, and 0.15 bonus points for MCOs that had Interim status. These bonus points were added to the Overall Rating before rounding to the nearest half-point.

For the Overall Rating and each composite/subcomposite rating, HSAG aligned with NCQA's rounding rules and awarded scores as outlined in Table 10-3.

Table 10-3—Scoring Rounding Rules

Rounded Score	5	4.5	4.0	3.5	3.0	2.5	2.0	1.5	1.0	0.5	0.0
Score Range	≥4.750	4.250–4.749	3.750–4.249	3.250–3.749	2.750–3.249	2.250–2.749	1.750–2.249	1.250–1.749	0.750–1.249	0.250–0.749	0.000–0.249

How Conclusions Were Drawn

For the 2024 Health Plan Report Card, HSAG displayed star ratings based on the final scores for each rating. Stars were partially shaded if the MCO received a half rating (e.g., a score of 3.5 was displayed as 3.5 stars).

11. MCO Aggregate Strengths, Opportunities for Improvement, and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2024 to comprehensively assess the MCOs' performance in providing quality, timely, and accessible healthcare services to Louisiana's Medicaid and CHIP members. HSAG provides the MCOs' aggregate strengths, opportunities for improvement, and recommendations in Table 11-1 through Table 11-3.

Table 11-1—Strengths Related to Quality, Timeliness, and Access

Overall MCO Strengths	
Quality, Timeliness, and Access	• For the NAV audit, for provider-to-member ratios, all MCOs met or exceeded LDH-established thresholds across all provider types. • The MCOs demonstrated strength in compliance by successfully remediating all 14 elements, indicating that initiatives were implemented and demonstrated compliance with the requirements under review. • The MCOs demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identify ways to improve the accessibility and timeliness of care for members. • The MCOs demonstrated strength in three measures from the adult CAHPS survey. Overall, the Healthy Louisiana SWA's 2024 adult achievement scores were significantly higher than the 2024 NCQA adult Medicaid national averages for three measures: *Rating of All Health Care*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*.
Quality and Timeliness	• The MCOs demonstrated strength in three measures from the child CAHPS survey. The Healthy Louisiana SWA's 2024 general child achievement scores were significantly higher than the 2024 NCQA general child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Care Quickly*.
Quality	• The MCOs developed and carried out a methodologically sound design for all five PIPs that facilitated valid and reliable measurement of objective indicator performance over time. • The MCOs carried out interventions for all five PIPs that had the potential to address identified barriers and improve performance indicator results. • The MCOs collected, analyzed, and reported intervention-specific effectiveness data to monitor the progress and impact of interventions throughout the most recent measurement period for all five PIPs.

Table 11-2—Opportunities for Improvement Related to Quality, Timeliness, and Access

Overall MCO Opportunities for Improvement	
Quality and Access	• The PDV indicated that, overall, the provider information maintained and provided by the plans showed a low level of agreement between the MCOs' online provider directories and the information obtained during the telephone calls to the providers' offices.
Quality, Timeliness, and Access	• HSAG's provider access survey indicated that, overall, the provider information maintained and provided by the plans showed a low level of agreement between the MCOs' provider data and the information obtained during the telephone calls to the providers' offices. • The rates of all MCOs, as well as the SWA rate on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement in their coordination with providers to ensure that members hospitalized for mental health issues receive adequate follow-up care after hospital discharge to reduce the risk of re-hospitalization. • The rates of all MCOs, as well as the SWA rate on the *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. Additionally, the rates of all MCOs, as well as the SWA rate on the *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with properly managing the care of patients discharged after an ED visit for mental illness and for substance use, as they are vulnerable after release. • LDH provides multiple reporting templates for plan reporting on LDH-defined network adequacy standards including distance, provider-to-member ratios, and access and availability. HSAG has noted that there is a misalignment among these reporting templates and the contractual language for the standards. • The 2024 Health Plan Report Card showed that, for the Overall Rating, five MCOs (ABH, ACLA, HBL, LHCC, and UHC) received 3.5 stars.
Quality	• The rates of all MCOs, as well as the SWA rate on the *Plan All-Cause Readmissions—O/E Ratio* measure indicator were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with facilitating appropriate post-discharge planning and care coordination. • The rates of all MCOs, as well as the SWA rate on the *Use of Imaging Studies for Low Back Pain* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that providers properly order imaging studies. • The rates of all MCOs, as well as the SWA rate on the *Non-Recommended Cervical Screening in Adolescent Females* measure were below the NCQA national 50th percentile benchmark for MY 2023. These results suggest that the MCOs have room for improvement with ensuring that providers avoid unnecessary cervical cancer screenings for adolescent females.

Table 11-3—Recommendations

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
• To facilitate significant outcomes improvement for all PIPs, HSAG recommends that the MCOs review intervention evaluation results to determine whether each intervention is having the desired impact and how interventions can be revised to increase effectiveness. The MCOs should also revisit MCO-specific barrier analyses for each PIP to evaluate whether additional barriers need to be addressed through new or revised interventions to drive outcomes improvement.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention Goal 6: Partner with communities to improve population health and address health disparities Goal 8: Minimize wasteful spending
• To improve performance on the *Follow-Up After Hospitalization for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, *Follow-Up After Emergency Department Visit for Mental Illness—Within 7 Days of Discharge* and *Within 30 Days of Discharge*, and *Follow-Up After Emergency Department Visit for Substance Use—Within 7 Days of Discharge* and *Within 30 Days of Discharge* measure indicators, HSAG recommends that the MCOs work with providers to identify barriers to timely follow-up care and trial solutions to improve coordination of care following discharge among providers and between providers and the MCOs.	Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention
• To improve performance on the *Plan All-Cause Readmissions—O/E Ratio* measure, HSAG recommends that the MCOs work with providers to improve post-discharge planning and care coordination.	Goal 2: Improve coordination and transitions of care
• To improve performance on the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that the MCOs focus their efforts on decreasing unnecessary imaging for low back pain. HSAG also recommends that the MCOs work with providers to trial solutions to reduce the inappropriate ordering of imaging studies.	Goal 3: Facilitate patient-centered, whole-person care Goal 4: Promote wellness and prevention
• To improve performance on the *Non-Recommended Cervical Screening in Adolescent Females* measure, HSAG recommends that the MCOs work with providers to trial solutions to reduce or avoid unnecessary cervical cancer screenings for adolescent females.	Goal 2: Improve coordination and transitions of care Goal 3: Facilitate patient-centered, whole-person care

Overall MCO Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
• HSAG recommends that LDH provide each MCO with the case-level PDV and provider access survey data files (i.e., flat files) and a defined timeline by which each MCO will address provider data deficiencies identified during the PDV reviews and/or provider access survey (e.g., provider specialty, MCO acceptance, and Louisiana Medicaid acceptance).	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
• In addition to updating provider information, HSAG recommends that each MCO conduct a root cause analysis to identify the nature of the data mismatches for PDV and provider access survey study indicators that scored below 90 percent.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
• HSAG recommends that the MCOs consider conducting a review of the offices' eligibility verification requirements to ensure these barriers do not unduly burden members' ability to access care.	Goal 1: Ensure access to care to meet enrollee needs Goal 2: Improve coordination and transitions of care
• HSAG recommends that LDH review its reporting templates against the contractual language to align with and more accurately reflect the LDH-desired population stratifications by urbanicity and adult and pediatric populations to ensure consistent reporting by the MCEs.	Goal 3: Facilitate patient-centered, whole-person care

12. Follow-Up on Prior Year's Recommendations

Regulations at 42 CFR §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. LDH required each MCO to document the follow-up actions per activity that the MCO completed in response to SFY 2022–2023 recommendations. Each MCO's response is included in the SFY 2024 EQR technical report produced for each MCO. Please reference the MCO-specific reports to review MCO responses to prior EQR recommendations and HSAG's assessment of their responses.

Appendix A. MCO Health Equity Plan Summaries

For the annual EQR technical report, LDH asked HSAG to summarize information from each MCO's health equity plan submissions from July 2024. Each MCO's response is included in the SFY 2024 EQR technical report produced for each MCO. Please reference the MCO-specific reports to review MCO responses.

Medicaid Managed Care Organization Contract Extension Request
JLCB – November 2025
LDH LEGISLATIVE FACT SHEET

Overview

- LDH is requesting to extend its existing contracts with the six Healthy Louisiana Managed Care Organizations (MCOs) for an additional 12 months (1/1/26 through 12/31/26).
    1. Aetna Better Health of Louisiana
    2. AmeriHealth Caritas Louisiana
    3. Healthy Blue
    4. Humana Healthy Horizons in Louisiana
    5. Louisiana Healthcare Connections
    6. UnitedHealthcare Community Plan

- This will utilize part of the two-year extension period built into the existing MCO contracts; the Department is currently in year three of the original contract term.
- Ensures continued coverage for approximately 1.5 million Medicaid enrollees statewide.

Background

- Managed care has allowed LDH to expand access to primary and preventive care, behavioral health integration, and care coordination.
- It has also supported initiatives such as reducing early elective deliveries and increasing prenatal visit adherence, opioid response, and chronic disease management.
- 2019–2022: LDH rebid the managed care contracts through a competitive procurement process. Contracts were awarded to six MCOs beginning January 1, 2023, marking the current procurement cycle.
- 2025: LDH is preparing for the next generation of managed care contracts, focusing on value, transparency, and improved health outcomes.

Impact

- LDH is not operating under a “business as usual” approach.
- The Department’s goal is to deliver a better, more responsive and a more accountable managed care program that better serves Louisiana’s citizen and providers.
- The extension period allows LDH to strengthen contract design and increase transparency/accountability, which ultimately helps improve health outcomes.
- Changes to the MCO contracts, effective January 1, 2026 aim to:
    - Enhance care coordination and member engagement
    - Strengthen behavioral health parity and oversight
    - Expand population health and chronic disease focus
    - Improve administrative clarity and provider relations
    - Modernize clinical and case management standards
    - Reinforce transparency, accountability, and quality improvement

Medicaid Managed Care Organization Contract Extension Request
JLCB – November 2025
LDH LEGISLATIVE FACT SHEET

Detail of Contract Extension Changes (Amendment 12)

1. Improved Clarity and Definitions
   - Expanded and clarified definitions of Care Coordination, Care Management, Case Management, and Case Manager — adds specific outreach methods (e.g., text, email, telephonic contact) and integrates social determinants of health (SDOH).
   - Updated definition of Enrollees with Special Health Care Needs (SHCN) to include broader, person-centered language that reflects functional, behavioral, and social needs.

2. Enhanced Mental Health Parity Oversight
   - Strengthened requirements for Mental Health Parity compliance (42 CFR Part 438, Subpart K).

3. Modernized Population Health Priorities
   - Expanded list of population health focus areas to include obesity, asthma, COPD, sickle cell disease, and cancer.

4. Strengthened Case Management and Care Integration
   - Major restructuring of Section 2.7 (Care Management) to:
     - Clarify timelines for health needs assessments and case management assessments.
     - Use standardized tools approved by LDH.
     - Require in-person plan-of-care development and regular updates.
   - Added clearer expectations for transitional case management (e.g., post-discharge follow-up within 7 days, housing coordination).

5. Expanded Flexibility and Member Support
   - New flexibility for MCOs to contact recently disenrolled members (within 60 days) to assist with re-enrollment or coverage transitions.

6. Administrative and Oversight Improvements
   - Adjusted timelines (e.g., performance review submissions extended from 2 to 5 business days) for feasibility and quality.
   - Clarified newborn enrollment and disenrollment procedures to prevent retroactive adjustments and provider payment confusion.
     Refined Value-Added Benefits (VAB) submission timelines.
   - Requires the establishment of a Gold Card Program to recognize and incentivize high-performing providers who demonstrate consistent quality of care, compliance with clinical guidelines, and efficiency in service delivery.

7. Focus on Quality and Outcomes

- Updated withhold portion of the Contractor's monthly Capitation Payments to incentivize quality and health outcomes from 2% to 3%.

8. Program Integrity and Compliance

- Updated fraud definition to reference Louisiana's Medical Assistance Programs Integrity Law and the federal False Claims Act.
- Updates the length of time allowed for MCOs to complete an audit from 10 months to one year
- Removes the 5-year lookback limitation on LDH provider audits.
- Provides clarification regarding:
  - The False Claims Act and MAPIL law including applicable monetary penalties;
  - 42 CFR 438.608 updated reporting frequency,
  - Expectations on compliance with existing language to withhold payments when providers fail to respond to record requests; and
  - Expectations on seeking approval to extrapolate provider overpayments.

9. Behavioral Health

- Compliance with the ASAM 4th Edition standards,
- Removes the Specialty Care provider type to improve tracking and GeoAccess mapping.
- Licensed Mental Health Specialists and other provider types added due to behavioral health workforce expansion efforts consistent with the Behavioral Health Services Provider Manual.
- Distance standards consolidated.
- Behavioral Health Rehab Provider Agency type being eliminated, as it is outdated; all MHRs now fall under the Mental Health Rehabilitation Agency category.
- Adjustments made to the claim submission requirements and the distance threshold from enrollees' residences to network providers to a more realistic standard.

Partnering for Progress in Medicaid Managed Care

- LDH truly appreciates the feedback and engagement of legislators in helping to shape the future direction of the Medicaid managed care program.
- The Department continues to reach out to legislative members, providers, and stakeholders to schedule meetings and gather additional feedback and suggestions on how to improve the program and shape the next procurement.
- This ongoing collaboration reflects LDH's commitment to transparency and partnership throughout both the current extension and the upcoming procurement process.

Medicaid Managed Care Organization Contract Extension Request
JLCB – November 2025

LDH LEGISLATIVE FACT SHEET

SFY 25 Statewide Average PMPM payment:

- MCO Capitation Rate = $ 513.76
- Directed Payments = $ 227.57
- Total Expected Payment PMPM = $ 741.33

SFY 26 Statewide Average PMPM payment:

- MCO Capitation Rate = $ 562.98
- Directed Payments = $ 320.94
- Total Expected Payment PMPM = $ 883.92

SFY 26 Key Capitation Rate Updates:

- 3.7% - Increased Medical and Pharmacy Trend related to higher claim costs
- 2.2% - Senate Bill 190 – Increasing rates to 85% of Medicare
- 0.9% - Increased acuity resulting from Medicaid disenrollments related to the expiration of the continuous eligibility provision

Medicaid Managed Care Organization Contract Extension Request
JLCB – November 2025

LDH LEGISLATIVE FACT SHEET

LOUISIANA DEPARTMENT OF HEALTH

Fiscal Responsibility

- The extension supports efficient use of Medicaid funds while ensuring program stability and continuity of services.

Managed Care Organization	12 month extension (projections)	PMPMs	Directed Payments	MCIP	Current Membership	Percentage of Membership
Aetna Better Health of Louisiana	$1,898,869,809	$1,154,410,156	$654,037,281	$90,422,372	165,163	12%
AmeriHealth Caritas Louisiana	$1,889,246,301	$1,148,559,584	$650,722,608	$89,964,109	155,884	11%
Healthy Blue	$3,335,252,821	$2,027,653,350	$1,148,777,908	$158,821,563	260,167	18%
Humana Health Horizons in Louisiana	$1,077,923,310	$655,319,080	$371,274,549	$51,329,681	119,690	8%
Louisiana Healthcare Connections	$4,626,670,059	$2,812,765,193	$1,593,587,244	$220,317,622	376,817	26%
United Healthcare Community Plan	$4,205,634,244	$2,556,798,187	$1,448,567,760	$200,268,297	344,614	24%
Total	$17,033,596,544	$10,355,505,550	$5,866,967,350	$811,123,644	1,422,335	100%

Link to LDH's website for the original contracts and previously adopted amendments to the contracts:

https://ldh.la.gov/resources?cat=0&d=0&y=0&s=0&q=Executed%20Contracts&pn=1

Link to all supporting documents relating to Agenda Item 12 (2025 Meetings > Nov 20):

https://jlcb.legis.la.gov/default_Archives2025

Jeff Landry
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

MEMORANDUM

To: Joint Legislative Committee on Budget members

From: Drew Maranto
Undersecretary

Date: October 15, 2025

Subject: October Medicaid Report

In accordance with the preamble language to Schedule 09 in HB1 of the 2025 Regular Session, attached please find the October Medicaid report. As required, this report represents the actual Means of Financing and Expenditures for Fiscal Year 2025 and the initial budget allocation by appropriation for Fiscal Year 2026.

Beginning in November 2025 and monthly thereafter, each monthly report will provide updated projected expenditures and anticipated revenue collections in the Medicaid program for Fiscal Year 2026.

Should you have any questions about this or subsequent reports, please contact my office at 225-342-9504 or via email at Drew.Maranto@la.gov

LOUISIANA DEPARTMENT OF HEALTH

LOUISIANA MEDICAID PROGRAM
BUREAU OF HEALTH SERVICES FINANCING

YEAR END FINANCIAL REPORT

FOR STATE FISCAL YEAR 2024/25

&

INITIAL PROGRAMMATIC ALLOCATIONS

FOR STATE FISCAL YEAR 2025/26

LOUISIANA DEPARTMENT OF HEALTH

LOUISIANA MEDICAID PROGRAM
Table of Contents

Contents	Table	Page
HB1 Requirement		i
SECTION-A: SFY2024/25 ACTUALS INFORMATION		
Medical Vendor Program-Actual Means of Finance - SFY2024/25	1	A1
Appropriated Budget and Actual Expenditures - SFY2024/25	2	A1
Actual Expenditures by Sub-programs - SFY2024/25	3	A2&A3
Actual Public Private Partnership Allocations- SFY2024/25	4	A4
SECTION-B: SFY2025/26 INFORMATION		
Medical Vendor Program - Means of Finance - SFY2025/26	5	B1
Existing Appropriation - SFY2025/26	6	B1
Initial Sub-program Allocations - SFY2025/26	7	B2&B3
Public Private Partnership Projected Allocation - SFY2025/26	8	B4

Louisiana Medical Vendor Agency Financial Reporting Requirements

Act 1 of the 2025 Regular Legislative Session appropriates revenues and expenditures for the State's Medical Vendor Payments agency at a program level as follows:

Program	Type of Payment
100	Payments to Private Providers
200	Payments to Public Providers
300	Medicare Buy-Ins and Supplements
400	Uncompensated Care Costs

LDH allocates appropriated revenues and expenditures within each of the four programs. Revenues and expenditures at a program level are bound by the limits in HB 1. Sub-program allocations are at the discretion of LDH. Initial allocations and final actuals may vary.

LOUISIANA MEDICAID PROGRAM

Table-1: Medical Vendor Program - Actual Means of Finance - SFY 2024/25

Financing Category	Appropriated Budget*	Actual Revenue	Over/(Under)	Difference in Percent
	A	B	C=B-A	D=(C/A)*100
State General Fund	2,178,584,751	2,178,584,751	0	0.0%
Interagency Transfer	189,406,975	183,308,182	(6,098,793)	(3.2%)
Self Generated Revenue	445,969,621	394,555,454	(51,414,167)	(11.5%)
Statutory Dedications	1,443,456,217	1,384,789,286	(58,666,931)	(4.1%)
Sub-Total State	4,257,417,564	4,141,237,673	(116,179,891)	(2.7%)
Federal	12,558,249,308	12,425,269,024	(132,980,283)	(1.1%)
Total Means of Finance	$16,815,666,872	$16,566,506,697	($249,160,175)	(1.5%)

Table-2: Appropriated Budget and Actual Expenditures - SFY 2024/25

Program	Appropriated Budget*	Actual Expenditures	Over/(Under)	Difference in Percent
	A	B	C= B - A	D=(C/A)*100
Private Providers	15,426,730,453	15,287,202,320	(139,528,133)	(0.9%)
Public Providers	261,994,884	261,277,041	(717,843)	(0.3%)
Buy-Ins & Supplements	833,239,966	822,293,809	(10,946,157)	(1.3%)
Uncompensated Care	293,701,569	195,733,526	(97,968,043)	(33.4%)
Total Program	$16,815,666,872	$16,566,506,697	($249,160,175)	(1.5%)

*Excluding the carryforward to FY 2026.

LOUISIANA MEDICAID PROGRAM

Table-3: Actual Expenditures by Sub-programs - SFY 2024/25

A: Private Providers Sub-programs		FY 25 Actuals
Ambulatory Surgical Clinics	A_01	2,356,766
Case Management Services	A_02	10,311,463
Durable Medical Equipment	A_03	8,782,154
EPSDT (Screening and Early Diagnosis)	A_04	10,338,450
Early Steps	A_05	23,391,703
Family Planning	A_06	396,790
Federally Qualified Health Centers	A_07	4,049,239
Hemodialysis Services	A_08	20,152,119
Home Health Services	A_09	9,168,059
Hospice Services	A_10	121,206,108
Hospital - Inpatient Services	A_11	116,323,909
Hospital - Outpatient Services	A_12	49,060,236
ICF-DD Community Homes	A_13	256,389,436
Laboratory and X - Ray Services	A_14	4,801,497
LT - PCS	A_15	197,244,768
Mental Health - Inpatient Services	A_16	6,776,425
Nursing Homes	A_17	1,487,469,198
PACE	A_18	21,797,862
PDHC	A_19	2,303,302
Pharmaceutical Products and Services	A_20	83,367,229
Physician Services	A_21	30,263,219
Rural Health Clinics	A_22	9,817,948
Transportation:Emergency-Ambulance	A_23	19,548,687
Transportation:Non-Emergency-Ambulance	A_24	1,048,417
Waiver: Adult Day Health	A_25	5,732,221
Waiver: Community Choices	A_26	236,747,122
Waiver: Most Appropriate	A_27	699,487,214
Other Private Providers	A_28	(7,000,743)
Sub-Total Fee for Service (FFS)		**3,431,330,797**
FFS Supplemental Payments	A_29 a	149,451,377
Managed Care - Directed Payments	A_29 b	3,153,486,425
Managed Care Incentive Program (MCIP)	A_29 c	608,204,992
Sub-Total Supplemental Payments	A_29	**3,911,142,794**
Managed Care - Non-Expansion	A_30	4,880,833,031
Managed Care - Expansion	A_31	4,360,351,801
Dental Benefit Program - Non-Expansion	A_32	218,255,052
Dental Benefit Program - Expansion	A_33	16,896,651
Behavioral Health Partnership	A_34	75,607,359
Sub-Total MCOs		**9,551,943,894**
Pharmacy Rebates - Regular	A_35	(845,313,701)
Pharmacy Rebates - Expansion	A_36	(761,901,464)
Sub- Total Pharmacy Rebates		**(1,607,215,165)**
Private Providers Total		**15,287,202,320**

LOUISIANA MEDICAID PROGRAM

Actual Expenditures by Sub-programs - 2024/25… Continued

B: Public Providers Sub-Programs		FY 25 Actuals
LSU - Facilities	B_01	803,043
LSU - Physicians	B_02	6,410,340
LDH - State Developmental Facilities	B_03	170,128,885
LDH - Villa Feliciana Nursing Home	B_04	13,192,835
LDH - Office of Public Health	B_05	22,166
LDH - Office of Behavioral Health	B_06	3,076,271
LDH - Human Services Districts	B_07	286,779
State - Education	B_08	104,622
Local Education Agencies	B_09	67,252,101
Total Public Providers		**261,277,041**
C: Buy-Ins & Supplements Sub-Programs		
Medicare Premiums & Supplements	C_01	601,296,814
Part-D Clawback	C_02	220,996,995
Total Buy-Ins		**822,293,809**
D: Uncompensated Care Sub-Programs		
LSU - Facilities (Lallie Kemp)	D_01	8,833,704
IMD DSH (LDH-OBH)	D_02	140,218,922
Private Hospitals	D_03	46,680,900
Total Uncompensated Care		**195,733,526**
Grand Total Medical Vendor Program		**16,566,506,697**

LOUISIANA MEDICAID PROGRAM

Table-4: Public Private Partnership - Allocation - SFY 2024/25

Hospital	Directed Payments	UPL/FMP	UCC/DSH	Total Payments
Bogalusa (Wash/St. Tamm)	$10,928,125	$0	$0	$10,928,125
Houma (LJ Chabert)	$60,283,327	$0	$0	$60,283,327
Baton Rouge - OLOL	$191,497,921	$0	$0	$191,497,921
Baton Rouge - Woman's	$62,604,258	$0	$0	$62,604,258
New Orleans (ILH)	$455,051,969	$0	$0	$455,051,969
Lafayette (Univ Med Cntr)	$137,164,778	$0	$19,254,124	$156,418,902
Independence (Lallie Kemp)	$0	$0	$8,833,704	$8,833,704
Lake Charles (WO Moss)	$89,899,162	$0	$0	$89,899,162
Monroe (EA Conway)	$32,482,834	$0	$0	$32,482,834
Alexandria (Huey P. Long)	$94,338,113	$0	$0	$94,338,113
Shreveport (LSU-HSC)	$208,388,427	$5,000,000	$0	$213,388,427
Total	**$1,342,638,914**	**$5,000,000**	**$28,087,828**	**$1,375,726,742**

LOUISIANA MEDICAID PROGRAM

Table-5: Medical Vendor Program - Means of Finance - SFY 2025/26

Financing Category	Existing Appropriation*
State General Fund	2,494,809,223
Interagency Transfer	230,513,518
Self Generated Revenue	870,061,609
Statutory Dedications	1,854,654,780
Sub-Total State	5,450,039,130
Federal	16,607,196,594
Total Means of Finance	$22,057,235,724

Table-6: Expenditure Appropriation - SFY 2025/26

Program	Existing Appropriation*
Private Providers	20,587,598,082
Public Providers	264,356,671
Buy-Ins & Supplements	901,704,500
Uncompensated Care	303,576,471
Total Medical Vendor Program	$22,057,235,724

*Including the carryforward from FY 2025.

LOUISIANA MEDICAID PROGRAM

Table-7: Initial Sub-program Allocations - SFY 2025/26		
A: Private Providers Sub-programs		**Initial Sub-program Allocations**
Ambulatory Surgical Clinics	A_01	2,739,855
Case Management Services	A_02	12,284,769
Durable Medical Equipment	A_03	16,965,414
EPSDT (Screening and Early Diagnosis)	A_04	14,246,993
Early Steps	A_05	26,684,358
Family Planning	A_06	491,838
Federally Qualified Health Centers	A_07	11,276,700
Hemodialysis Services	A_08	27,329,136
Home Health Services	A_09	10,545,641
Hospice Services	A_10	126,206,108
Hospital - Inpatient Services	A_11	123,816,154
Hospital - Outpatient Services	A_12	52,807,947
ICF-DD Community Homes	A_13	386,035,105
Laboratory and X - Ray Services	A_14	6,107,706
LT - PCS	A_15	198,104,885
Mental Health - Inpatient Services	A_16	8,702,784
Nursing Homes	A_17	1,519,618,201
Program for All Inclusive Care for the Elderly (PACE)	A_18	24,872,168
Pediatric Day Health Care (PDHC)	A_19	3,247,603
Pharmaceutical Products and Services	A_20	86,169,294
Physician Services	A_21	60,889,165
Rural Health Clinics	A_22	11,449,160
Transportation:Emergency-Ambulance	A_23	23,246,526
Transportation:Non-Emergency-Ambulance	A_24	2,369,470
Waiver: Adult Day Health	A_25	8,474,497
Waiver: Community Choices	A_26	267,305,984
Waiver: Most Appropriate (MAW)	A_27	706,115,921
Other Private Providers	A_28	567,596
Sub-Total Fee for Service (FFS)		**$3,738,670,978**
FFS Supplemental Payments	A_29 a	154,401,774
Managed Care - Directed Payments	A_29 b	6,402,866,691
Managed Care Incentive Program (MCIP)	A_29 c	863,003,469
Sub-Traditional Private Providers	A_29	**$7,420,271,934**
Managed Care Organizations		
Managed Care - Non-Expansion	A_30	5,491,452,000
Managed Care - Expansion	A_31	4,907,405,665
Dental Benefit Program - Regular	A_32	243,130,033
Dental Benefit Program - Expansion	A_33	22,779,423
Coordinated System of Care (CSoC)	A_34	72,591,974
Sub-Total MCOs		**$10,737,359,096**
Pharmacy Rebates - Regular	A_35	(590,425,174)
Pharmacy Rebates - Expansion	A_36	(718,278,752)
Sub- Total Pharmacy Rebates		**($1,308,703,926)**
Grand Total Private Providers		**$20,587,598,082**

LOUISIANA MEDICAID PROGRAM

Table-7: Initial Sub-program Allocations - SFY 2025/26… Continued

B: Public Providers Sub-Programs		Initial Sub-program Allocations
LSU - Facilities	B_01	944,587
LSU - Physicians	B_02	6,639,037
LDH - State Developmental Facilities	B_03	170,259,365
LDH - Villa Feliciana Nursing Home	B_04	22,184,407
LDH - Office of Public Health	B_05	58,114
LDH - Office of Behavioral Health	B_06	3,307,987
LDH - Human Services Districts	B_07	355,000
State - Education	B_08	164,663
Local Education Agencies	B_09	60,443,511
Total Public Providers		**$264,356,671**
C: Buy-Ins & Supplements Sub-Programs		
Medicare Premiums & Supplements	C_01	659,451,477
Part-D Clawback	C_02	242,253,023
Total Buy-Ins		**$901,704,500**
D: Uncompensated Care Sub-Programs		
LSU - Facilities (Lallie Kemp)	D_01	12,423,397
IMD DSH (LDH-OBH)	D_02	132,917,149
Private Hospitals	D_03	158,235,925
Total Uncompensated Care		**$303,576,471**
Grand Total Medical Vendor Program		**$22,057,235,724**

LOUISIANA MEDICAID PROGRAM

Table-8: Public Private Partnership - Allocation - SFY 2025/26

Hospital	Directed Payments	UPL	UCC/DSH	Total Payments
Bogalusa (Wash/St. Tamm)	$15,858,233	$0	$0	$15,858,233
Houma (LJ Chabert)	$84,611,867	$0	$0	$84,611,867
Baton Rouge - OLOL	$250,869,472	$0	$0	$250,869,472
Baton Rouge - Woman's	$99,378,125	$0	$0	$99,378,125
New Orleans (ILH)	$608,000,491	$0	$0	$608,000,491
Lafayette (Univ Med Cntr)	$176,800,760	$0	$0	$176,800,760
Independence (Lallie Kemp)	$0	$0	$12,423,397	$12,423,397
Lake Charles (WO Moss)	$101,841,891	$0	$0	$101,841,891
Monroe (EA Conway)	$93,248,331	$0	$0	$93,248,331
Alexandria (Huey P. Long)	$123,216,208	$0	$0	$123,216,208
Shreveport (LSU-HSC)	$286,372,043	$5,000,000	$0	$291,372,043
Total	**$1,840,197,421**	**$5,000,000**	**$12,423,397**	**$1,857,620,818**

Jeff Landry
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

MEMORANDUM

To: Joint Legislative Committee on Budget members

From: Drew Maranto
Undersecretary

Date: November 14, 2025

Subject: November Medicaid Report

Attached, please find the Medicaid forecast report for November 2025. The report utilizes actual revenue and expenditures through October 31, 2025 and trends them forward through June 30, 2026.

As you will note, the forecast currently projects expenditures under the budget by approximately $138.6M. This is mainly due to a lower Medicaid Expansion enrollment forecast than what was contemplated in the FY26 budget.

Should you have any questions about this or subsequent reports, please contact my office at 225-342-9504 or via email at Drew.Maranto@la.gov

DEPARTMENT OF HEALTH

LOUISIANA MEDICAID PROGRAM

BUREAU OF HEALTH SERVICES FINANCING

FORECAST REPORT

STATE FISCAL YEAR 2025/26

November 2025

LOUISIANA DEPARTMENT OF HEALTH

LOUISIANA MEDICAID PROGRAM
Table of Contents

Contents	Table	Page
Table-1: Means of Finance	1	1
Table-2: Budget and Forecast by Program	2	1
Table-3: Current Forecast by Sub-Program	3	2 & 3
Table-4: Public Private Partnership Allocations	4	4
Table-5 Enrollment for State Fiscal Year 2025/26	5	5
Table-6 Schedule of Program Changes	6	6
Notes		7

LOUISIANA MEDICAID PROGRAM

Table-1: Revenue Forecast - Means of Finance - SFY 2025/26

See "Notes" Page 7

Financing Category	Budget Appropriation (1.1)	Forecast Revenue Collections	Over / (Under)	Percent Difference
	A	B	C = B - A	D = (C/A)*100
State General Fund	2,494,809,223	2,492,709,909	(2,099,314)	(0.1)
Interagency Transfers	230,513,518	230,513,518	0	0.0
Self Generated Revenue	870,061,609	870,061,609	0	0.0
Statutory Dedications	1,854,654,780	1,846,697,655	(7,957,125)	(0.4)
Federal	16,607,196,594	16,478,639,891	(128,556,703)	(0.8)
Total Means of Finance	$22,057,235,724	$21,918,622,583	($138,613,141)	(0.6)

Table-2: Expenditure Forecast by Budget Program - SFY 2025/26

Program	Budget Appropriation (1.1)	Current Forecast (2)	(Over) / Under	Percent Difference
	A	B	C = A - B	D = (C/A)*100
Private Providers	20,587,598,082	20,448,126,989	139,471,093	0.7
Public Providers	264,356,671	265,214,623	(857,952)	(0.3)
Buy-Ins & Supplements	901,704,500	901,704,500	0	0.0
Uncompensated Care	303,576,471	303,576,471	0	0.0
Total Program	$22,057,235,724	$21,918,622,583	$138,613,141	0.6

LOUISIANA MEDICAID PROGRAM

Table-3: Expenditure Forecast by Budget Category of Service - SFY 2025/26

A: Private Providers Sub-Programs		Initials (1.2) A	Actuals to Date thru Oct 2025 B	Current Forecast (2) C	Difference D = A - C
Ambulatory Surgical Clinics	A_01	2,739,855	1,136,146	2,849,057	(109,202)
Case Management Services	A_02	12,284,769	3,555,581	11,115,666	1,169,103
Durable Medical Equipment	A_03	16,965,414	2,838,272	15,295,276	1,670,138
EPSDT (Screening and Early Diagnosis)	A_04	14,246,993	3,484,875	14,019,053	227,940
Early Steps	A_05	26,684,358	8,687,511	24,958,584	1,725,774
Family Planning	A_06	491,838	150,438	474,780	17,058
Federally Qualified Health Centers	A_07	11,276,700	1,783,403	10,820,412	456,288
Hemodialysis Services	A_08	27,329,136	5,870,833	25,014,308	2,314,828
Home Health Services	A_09	10,545,641	3,188,847	10,641,985	(96,344)
Hospice Services	A_10	126,206,108	41,043,234	124,418,113	1,787,995
Hospital - Inpatient Services	A_11	123,816,154	45,944,812	127,181,616	(3,365,462)
Hospital - Outpatient Services	A_12	52,807,947	19,707,542	56,875,023	(4,067,076)
ICF-DD Community Homes	A_13	386,035,105	121,392,172	359,641,280	26,393,825
Laboratory and X - Ray Services	A_14	6,107,706	1,858,126	5,143,732	963,974
Long Term Personal Care Services (LT - PCS)	A_15	198,104,885	72,388,143	212,006,367	(13,901,482)
Mental Health - Inpatient Services	A_16	8,702,784	3,035,535	8,601,750	101,034
Nursing Homes	A_17	1,519,618,201	505,464,697	1,518,514,732	1,103,469
Program for All Inclusive Care for the Elderly (PACE)	A_18	24,872,168	7,653,259	24,285,421	586,747
Pediatric Day Health Care (PDHC)	A_19	3,247,603	732,579	2,057,325	1,190,278
Pharmacy Payments	A_20	86,169,294	29,583,216	89,328,270	(3,158,976)
Physician Services	A_21	60,889,165	13,713,546	65,122,099	(4,232,934)
Rural Health Clinics	A_22	11,449,160	3,818,508	12,283,609	(834,449)
Transportation: Emergency-Ambulance	A_23	23,246,526	8,172,462	22,392,695	853,831
Transportation: Non-Emergency-Ambulance	A_24	2,369,470	450,879	1,382,685	986,785
Waiver: Adult Day Health	A_25	8,474,497	2,007,494	5,816,928	2,657,569
Waiver: Community Choices	A_26	267,305,984	90,747,416	264,976,501	2,329,483
Waiver: Most Appropriate (MAW)	A_27	706,115,921	249,687,454	716,349,162	(10,233,241)
Other Private Providers	A_28	567,596	(2,700,939)	567,596	0
Sub-Total Traditional Private Providers		**3,738,670,978**	**1,245,396,041**	**3,732,134,025**	**6,536,953**
FFS Supplemental Payments	A_29a	154,401,774	31,356,492	154,401,774	0
Managed Care - Directed Payments	A_29b	6,402,866,691	340,612,158	6,402,866,691	0
Managed Care Incentive Program (MCIP)	A_29c	863,003,469	117,980,793	863,003,469	0
Sub-Total Supplemental Payments		**7,420,271,934**	**489,949,443**	**7,420,271,934**	**0**
Managed Care Organizations					
Managed Care - Regular	A_30	5,491,452,000	1,553,733,616	5,503,500,626	(12,048,626)
Managed Care - Expansion	A_31	4,907,405,665	1,329,291,971	4,750,682,047	156,723,618
Dental Benefit Program - Regular	A_32	243,130,033	70,512,497	246,111,845	(2,981,812)
Dental Benefit Program - Expansion	A_33	22,779,423	5,130,076	22,704,244	75,179
Behavioral Health Partnership/CSOC	A_34	72,591,974	27,154,675	81,426,194	(8,834,220)
Sub-Total MCOs		**10,737,359,096**	**2,986,822,835**	**10,604,424,956**	**132,934,140**
Pharmacy Rebates - Regular	A_35	(590,425,174)	(323,886,068)	(590,425,174)	0
Pharmacy Rebates - Expansion	A_36	(718,278,752)	(209,809,361)	(718,278,752)	0
Sub-Total Rebates		**(1,308,703,926)**	**(533,695,429)**	**(1,308,703,926)**	**0**
Total Private Providers		**$20,587,598,082**	**$4,187,472,890**	**20,448,126,989**	**$139,471,093**

LOUISIANA MEDICAID PROGRAM

Table-3: Expenditure Forecast by Budget Category of Service - SFY 2024/25... Continued

B: Public Providers Sub-Programs		Initials (1,2) A	Actuals to Date thru Oct 2025 B	Current Forecast (2) C	Difference D = A - C
LSU - Facilities	B_01	944,587	437,243	971,685	(27,098)
LSU - Physicians	B_02	6,639,037	2,313,178	6,504,354	134,683
LDH - State Developmental Facilities	B_03	170,259,365	56,476,797	170,259,365	0
LDH - Villa Feliciana Nursing Home	B_04	22,184,407	7,764,409	22,973,689	(789,282)
LDH - Office of Public Health	B_05	58,114	19,303	54,304	3,810
LDH - Office of Behavioral Health	B_06	3,307,987	1,296,980	3,579,997	(272,010)
LDH - Human Services Districts	B_07	355,000	109,680	332,057	22,943
State - Education	B_08	164,663	28,772	95,661	69,002
Local Education Agencies	B_09	60,443,511	36,364,549	60,443,511	0
Total Public Providers		**$264,356,671**	**$104,810,911**	**$265,214,623**	**(857,952)**
C: Buy-Ins & Supplements Sub-Programs					
Medicare Premiums & Supplements	C_01	659,451,477	92,778,154	659,451,477	0
Part-D Claw back (3)	C_02	242,253,023	34,868,513	242,253,023	0
Total Buy-Ins		**$901,704,500**	**$127,646,667**	**$901,704,500**	**0**
D: Uncompensated Care Sub-Programs					
LSU - Facilities (Lallie Kemp)	D_01	12,423,397	0	12,423,397	0
IMD DSH (LDH-OBH)	D_02	132,917,149	0	132,917,149	0
Private Hospitals	D_03	158,235,925	126,511,343	158,235,925	0
Total Uncompensated Care		**$303,576,471**	**$126,511,343**	**$303,576,471**	**0**
Grand Total Medical Vendor Program		**$22,057,235,724**	**$4,546,441,812**	**$21,918,622,583**	**138,613,141**

LOUISIANA MEDICAID PROGRAM

Table-4: Public Private Partnership - Allocated - SFY 2025/26

Hospital	Directed Payments	UPL/FMP	UCC/DSH	Total Payments
Bogalusa (Wash/St. Tamm)	$15,858,233	$0	$0	$15,858,233
Houma (LJ Chabert)	$84,611,867	$0	$0	$84,611,867
Baton Rouge - OLOL	$250,869,472	$0	$0	$250,869,472
Baton Rouge - Woman's	$99,378,125	$0	$0	$99,378,125
New Orleans (ILH)	$608,000,491	$0	$0	$608,000,491
Lafayette (Univ Med Cntr)	$176,800,760	$0	$0	$176,800,760
Independence (Lallie Kemp)	$0	$0	$12,423,397	$12,423,397
Lake Charles (WO Moss)	$101,841,891	$0	$0	$101,841,891
Monroe (EA Conway)	$93,248,331	$0	$0	$93,248,331
Alexandria (Huey P. Long)	$123,216,208	$0	$0	$123,216,208
Shreveport (LSU-HSC)	$286,372,043	$5,000,000	$0	$291,372,043
Total	**$1,840,197,421**	**$5,000,000**	**$12,423,397**	**$1,857,620,818**

SFY 26 directed payments are from the HDPP model submitted to CMS.

LOUISIANA MEDICAID PROGRAM

Table-5: Enrollment for State Fiscal Year 2025/26

Month	Expansion	Non-Expansion	Total
Jul '25	493,685	1,082,414	1,576,099
Aug	487,336	1,079,282	1,566,618
Sep	484,898	1,077,279	1,562,177
Oct	469,645	1,071,410	1,541,055
Nov			0
Dec			0
Jan'26			0
Feb			0
Mar			0
Apr			0
May			0
Jun'26 (Projected)	458,200	1,073,216	1,531,416

LOUISIANA MEDICAID PROGRAM

Table-6: Program Changes Since Last Report

1	Nothing to report this period.
2	
3	
4	
5	
6	

LOUISIANA MEDICAID PROGRAM
(Numbered Notes to the Monthly Financial Report)

1.1 This column represents the Appropriation provided in Act 1 of the 2025 Regular Legislative Session. Revenues and expenditures for the State's Medical Vendor Payments agency at a program level and approved BA-7s for Means of Finance and for the Medicaid Program's four (4) budget expenditure categories: (A) Payments to Private Providers, (B) Payments to Public Providers, (C) Medicare Buy-Ins & Supplements, and (D) Uncompensated Care Costs.

1.2 This column represents the spread of Appropriation (Act 1 of the 2025 Regular Legislative Session) and approved BA-7s for the Medical Vendor Payments for private provider sub-programs, public providers, Medicare Buy-Ins & Supplements, and Uncompensated care payments.

2 This column represents the SFY 2025/26 expenditures forecast. It is based on the latest available data/information and reflects projected payments through the end of the State Fiscal Year.

3 Claw back Expenditures are financed with 100% state funds to pay Part-D premiums.

4 Medicaid enrollment information can be found at
https://ldh.la.gov/resources?cat=&d=0&y=0&s=0&q=medicaid%20enrollment%20trends
Numbers reported for July 25 through the current period represent actual enrollment while the June 26 numbers are projected. Enrollment is calculated by counting anyone enrolled at any point in the month.

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 12

LAGOV#: 2000683487

LDH #:

Original Contract Amount: $3,569,491,194.00

Original Contract Begin Date: 01-01-2023

Original Contract End Date: 12-31-2025

RFP Number: 3000017417

MVA

(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

AND

Aetna Better Health of Louisiana, Inc.

Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $3,874,496,959.00 Current Contract Term: 01/01/23-12/31/25

CF-1
11) Termination Date: 12/31/2025
12) Maximum Contract Amount: $3,874,496,959.00
13) Estimated Amounts by Fiscal Year: FY23: $588,884,043; FY24: $1,273,098,619; FY25: $1,324,022,564; FY26: $688,491,733.00
15) Attachments and Exhibits:
Attachment A11 - Model Contract; Attachment C10, In Lieu of Services (ILOS)
Attachment F10 - Provider Network Standards; Attachment G11, Table of Monetary Penalties

Change Contract To: If Changed, Maximum Amount: $5,773,366,768.00 If Changed, Contract Term: 01/01/23-12/31/2026

CF-1
11) Termination Date: 12/31/2026
12) Maximum Contract Amount: $5,773,366,768.00
13) Estimated Amounts by Fiscal Year: FY23: $588,884,043; FY24: $1,273,098,619; FY25: $1,324,022,564;
FY 26: $1,615,068,572; FY27: $972,292,970
15) Attachments and Exhibits:
Attachment A12 - Model Contract; Attachment C12, In Lieu of Services (ILOS), Attachment F12 - Provider Network Standards;
Attachment G12, Table of Monetary Penalties

Justifications For Amendment:

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

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

LDH is extending the contract for twelve (12) additional months at the same rates, terms, and conditions of the initial contract term. This amendment extends the contract through December 31, 2026.

This Amendment Becomes Effective: 01-01-2026

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
Aetna Better Health of Louisiana, Inc.	**Secretary, Louisiana Department of Health or Designee**
CONTRACTOR SIGNATURE — DATE	SIGNATURE — DATE
PRINT NAME: Bridget Galatas	NAME: Bruce D. Greenstein
CONTRACTOR TITLE: Chief Executive Officer	TITLE: Secretary
	OFFICE: Louisiana Department of Health
	PROGRAM SIGNATURE — DATE
	NAME: Drew Maranto

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

MVA

(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

AND

AmeriHealth Caritas Louisiana, Inc.

Contractor Name

Amendment #: 12

LAGOV#: 2000683488

LDH #:

Original Contract Amount: $5,448,726,034.00

Original Contract Begin Date: 01-01-2023

Original Contract End Date: 12-31-2025

RFP Number: 3000017417

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $5,914,308,595.00 Current Contract Term: 01/01/23-12/31/25

CF-1
11) Termination Date: 12/31/2025
12) Maximum Contract Amount: $5,914,308,595.00
13) Estimated Amounts by Fiscal Year: FY23: $898,914,618; FY24: $1,943,348,565; FY25: $2,021,082,508; FY26: $1,050,962,904
15) Attachments and Exhibits:
Attachment A11 - Model Contract; Attachment C10, In Lieu of Services (ILOS)
Attachment F10 - Provider Network Standards; Attachment G11, Table of Monetary Penalties

Change Contract To: If Changed, Maximum Amount: $7,803,554,896.00 If Changed, Contract Term: 01/01/23-12/31/2026

CF-1
11) Termination Date: 12/31/2026
12) Maximum Contract Amount: $7,803,554,896.00
13) Estimated Amounts by Fiscal Year: FY23: $898,914,618; FY24: $1,943,348,565; FY25: $2,021,082,508;
FY26: $1,447,362,382; FY27: $967,365,371
15) Attachments and Exhibits:
Attachment A12 - Model Contract; Attachment C12, In Lieu of Services (ILOS), Attachment F12 - Provider Network Standards;
Attachment G12, Table of Monetary Penalties

Justifications For Amendment:

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

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

LDH is extending the contract for twelve (12) additional months at the same rates, terms, and conditions of the initial contract term. This amendment extends the contract through December 31, 2026.

This Amendment Becomes Effective: 01-01-2026

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
AmeriHealth Caritas Louisiana, Inc.	**Secretary, Louisiana Department of Health or Designee**
CONTRACTOR SIGNATURE — DATE	SIGNATURE — DATE
PRINT NAME: Kyle Viator	NAME: Bruce D. Greenstein
CONTRACTOR TITLE: Chief Executive Officer	TITLE: Secretary
	OFFICE: Louisiana Department of Health
	PROGRAM SIGNATURE — DATE
	NAME: Drew Maranto

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 12

LAGOV#: 2000683489

LDH #:

MVA

(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

Original Contract Amount: $7,612,384,636.00

Original Contract Begin Date: 01-01-2023

Original Contract End Date: 12-31-2025

RFP Number: 3000017417

AND

Community Care Health Plan of Louisiana, Inc. DBA Healthy Blue

Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $8,262,847,423.00 Current Contract Term: 01/01/23-12/31/25

CF-1
11) Termination Date: 12/31/2025
12) Maximum Contract Amount: $8,262,847,423.00
13) Estimated Amounts by Fiscal Year: FY23: $1,255,868,580; FY24: $2,715,041,399. FY25: $2,823,643,055; FY26: $1,468,294,389
15) Attachments and Exhibits:
Attachment A11 - Model Contract; Attachment C10, In Lieu of Services (ILOS)
Attachment F10 - Provider Network Standards; Attachment G11, Table of Monetary Penalties

Change Contract To: If Changed, Maximum Amount: $11,598,100,244.00 If Changed, Contract Term: 01/01/23-12/31/2026

CF-1
11) Termination Date: 12/31/2026
12) Maximum Contract Amount: $11,598,100,244.00
13) Estimated Amounts by Fiscal Year: FY23: $1,255,868,580; FY24: $2,715,041,399; FY25: $2,823,643,055;
FY26: $2,361,624,761.50; FY27: $1,707,775,254
15) Attachments and Exhibits:
Attachment A12 - Model Contract; Attachment C12, In Lieu of Services (ILOS), Attachment F12 - Provider Network Standards;
Attachment G12, Table of Monetary Penalties

Justifications For Amendment:

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

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

LDH is extending the contract for twelve (12) additional months at the same rates, terms, and conditions of the initial contract term. This amendment extends the contract through December 31, 2026.

This Amendment Becomes Effective: 01-01-2026

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
Community Care Health Plan of Louisiana, Inc. DBA Healthy	**Secretary, Louisiana Department of Health or Designee**
CONTRACTOR SIGNATURE / DATE	SIGNATURE / DATE
PRINT NAME: Christy L. Valentine, MD, MBA	NAME: Bruce D. Greenstein
CONTRACTOR TITLE: President and CEO	TITLE: Secretary
	OFFICE: Louisiana Department of Health
	PROGRAM SIGNATURE / DATE
	NAME: Drew Maranto

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 12

LAGOV#: 2000683510

LDH #:

MVA

(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

Original Contract Amount: $3,374,214,172.00

Original Contract Begin Date: 01-01-2023

Original Contract End Date: 12-31-2025

RFP Number: 3000017417

AND

Humana Health Benefit Plan of Louisiana, Inc. DBA Humana Healthy

Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $3,662,533,912.00 Current Contract Term: 01/01/23-12/31/25

CF-1
11) Termination Date: 12/31/2025
12) Maximum Contract Amount: $3,662,533,912.00
13) Estimated Amounts by Fiscal Year: FY23: $556,667,820; FY24: $1,203,450,903; FY25: $1,251,588,940; FY26: $650,826,249
15) Attachments and Exhibits:
Attachment A11 - Model Contract; Attachment C10, In Lieu of Services (ILOS)
Attachment F10 - Provider Network Standards; Attachment G11, Table of Monetary Penalties

Change Contract To: If Changed, Maximum Amount: $8,289,203,971.00 If Changed, Contract Term: 01/01/23-12/31/2026

CF-1
11) Termination Date: 12/31/2026
12) Maximum Contract Amount: $8,289,203,971.00
13) Estimated Amounts by Fiscal Year: FY23: $556,667,820; FY24: $1,203,450,903; FY25: $1,251,588,940;
FY26: $2,908,466,714; FY27: $2,369,029,594
15) Attachments and Exhibits:
Attachment A12 - Model Contract; Attachment C12, In Lieu of Services (ILOS), Attachment F12 - Provider Network Standards;
Attachment G12, Table of Monetary Penalties

Justifications For Amendment:

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

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

LDH is extending the contract for twelve (12) additional months at the same rates, terms, and conditions of the initial contract term. This amendment extends the contract through December 31, 2026.

This Amendment Becomes Effective: 01-01-2026

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
Humana Health Benefit Plan of Louisiana, Inc. DBA Humana	**Secretary, Louisiana Department of Health or Designee**
CONTRACTOR SIGNATURE — DATE	SIGNATURE — DATE
PRINT NAME: John E. Barger III	NAME: Bruce D. Greenstein
CONTRACTOR TITLE: Senior Vice President, Medicaid President	TITLE: Secretary
	OFFICE: Louisiana Department of Health
	PROGRAM SIGNATURE — DATE
	NAME: Drew Maranto

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA-

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 12

LAGOV#: 2000683511

LDH #:

MVA

(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

Original Contract Amount: $10,807,338,057.00

Original Contract Begin Date: 01-01-2023

Original Contract End Date: 12-31-2025

RFP Number: 3000017417

AND

Louisiana Healthcare Connections, Inc.

Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $11,730,803,118.00 Current Contract Term: 01/01/23-12/31/25

CF-1
11) Termination Date: 12/31/2025
12) Maximum Contract Amount: $11,730,803,118.00
13) Estimated Amounts by Fiscal Year: FY23: $1,782,962,495; FY24: $3,854,556,968; FY25: $4,008,739,247; FY26: $2,084,544,408
15) Attachments and Exhibits:
Attachment A11 - Model Contract; Attachment C10, In Lieu of Services (ILOS)
Attachment F10 - Provider Network Standards; Attachment G11, Table of Monetary Penalties

Change Contract To: If Changed, Maximum Amount: $15,936,437,362.00 If Changed, Contract Term: 01/01/23-12/31/2026

CF-1
11) Termination Date: 12/31/2026
12) Maximum Contract Amount: $15,936,437,362.00
13) Estimated Amounts by Fiscal Year: FY23: $1,782,962,495; FY24: $3,854,556,968; FY25: $4,008,739,247; FY26: $2,747,039,005; FY27: $ $2,153,443,375
15) Attachments and Exhibits:
Attachment A12 - Model Contract; Attachment C12, In Lieu of Services (ILOS), Attachment F12 - Provider Network Standards; Attachment G12, Table of Monetary Penalties

Justifications For Amendment:

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

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

LDH is extending the contract for twelve (12) additional months at the same rates, terms, and conditions of the initial contract term. This amendment extends the contract through December 31, 2026.

This Amendment Becomes Effective: 01-01-2026

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
Louisiana Healthcare Connections, Inc.	**Secretary, Louisiana Department of Health or Designee**
CONTRACTOR SIGNATURE / DATE	SIGNATURE / DATE
PRINT NAME: Joseph M. Sullivan	NAME: Bruce D. Greenstein
CONTRACTOR TITLE: Chief Executive Officer	TITLE: Secretary
	OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE / DATE

NAME: Drew Maranto

Rev 2019-12

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 12

LAGOV#: 2000683512

LDH #:

Original Contract Amount: $10,165,292,584.00

Original Contract Begin Date: 01-01-2023

Original Contract End Date: 12-31-2025

RFP Number: 3000017417

MVA

(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

AND

UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Community Plan

Contractor Name

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: $11,033,896,165.00 Current Contract Term: 01/01/23-12/31/25

CF-1
11) Termination Date: 12/31/2025
12) Maximum Contract Amount: $11,033,896,165.00
13) Estimated Amounts by Fiscal Year: FY23: $1,677,039,742; FY24: $3,625,564,330; FY25: $3,770,586,903; FY26: $1,960,705,190
15) Attachments and Exhibits:
Attachment A11 - Model Contract; Attachment C10, In Lieu of Services (ILOS)
Attachment F10 - Provider Network Standards; Attachment G11, Table of Monetary Penalties

Change Contract To: If Changed, Maximum Amount: $12,111,819,475.00 If Changed, Contract Term: 01/01/23-12/31/2026

CF-1
11) Termination Date: 12/31/2026
12) Maximum Contract Amount: $12,111,819,475.00
13) Estimated Amounts by Fiscal Year: FY23: $1,677,039,742; FY24: $3,625,564,330; FY25: $3,770,586,903;
FY26: $1,506,338,510; $; FY27: $ $551,937,395
15) Attachments and Exhibits:
Attachment A12 - Model Contract; Attachment C12, In Lieu of Services (ILOS), Attachment F12 - Provider Network Standards;
Attachment G12, Table of Monetary Penalties

Justifications For Amendment:

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

This amendment contains necessary revisions for several attachments in order to align with all provisions of state and federal laws, regulations, rules, the State Plan, waivers applicable to managed care, and current practice.

LDH is extending the contract for twelve (12) additional months at the same rates, terms, and conditions of the initial contract term. This amendment extends the contract through December 31, 2026.

This Amendment Becomes Effective: 01-01-2026

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR	STATE OF LOUISIANA LOUISIANA DEPARTMENT OF HEALTH
UnitedHealthcare of Louisiana, Inc. dba UnitedHealthcare Co	**Secretary, Louisiana Department of Health or Designee**
CONTRACTOR SIGNATURE — DATE	SIGNATURE — DATE
PRINT NAME: Karl Lirette	NAME: Bruce D. Greenstein
CONTRACTOR TITLE: Chief Executive Officer	TITLE: Secretary
	OFFICE: Louisiana Department of Health
	PROGRAM SIGNATURE — DATE
	NAME: Drew Maranto

Office of State Procurement
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 27, 2025

TO: Theresa Delafosse, Undersecretary
Department of Environmental Quality

FROM: Pamela Bartfay Rice, Esq., CPPO
Assistant Director, Professional Contracts

RE: OSP Pre-Approval for JLCB
Amendment 5 to contract Leaaf Environmental LLC
LaGov PO: 2000590641

The above referenced contract amendment has been reviewed by the Office of State Procurement. The document complies with the State Procurement Code and is ready for submission to the Joint Legislative Committee on the Budget. Upon approval of the contract amendment in accordance with La. R.S. 39:1615 (J), please return the "**Agency Memo to OSP After JLCB Approval,**" along with the stamped contract from the JLCB.

The contract amendment will not receive final approval by OSP until all appropriate approvals are received and each is submitted to OSP in LaGov and/or LESA, as applicable.

If you should have any further questions/comments, please do not hesitate to contact me.

Docusign Envelope ID: 021C8670-92D0-488A-A143-6C2C077A9F7E

LaGov No. 2000590641
Amendment No. 5

AMENDMENT TO THE CONSULTING SERVICES CONTRACT BETWEEN
STATE OF LOUISIANA
DEPARTMENT OF ENVIRONMENTAL QUALITY
(Hereinafter referred to as "Department")

AND

Leaaf Environmental, LLC
2301 Whitney Avenue
Gretna, LA 70056
(Hereinafter referred to as "Contractor")

The Parties have agreed to extend the terms for fulfillment of services to be performed under this contract from January 31, 2026 to July 31, 2026 and to that end Article 2 entitled CONTRACT TERM is amended to read as follows:

Change From:

The term for the fulfillment of services to be performed pursuant to this contract shall be from **August 1, 2021** through **January 31, 2026** as the State exercised an option to extend for up to 24 additional months at the same rates, terms and conditions of the initial contract term, with the approval of the Joint Legislative Committee on the Budget. The total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Change To:

The term for the fulfillment of services to be performed pursuant to this contract shall be from **August 1, 2021** through **July 31, 2026** as the State exercised an option to extend for up to 24 additional months at the same rates, terms and conditions of the initial contract term, with the approval of the Joint Legislative Committee on the Budget. The total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Further, the parties have agreed to set the maximum amount paid to the Contractor by the Department under this contract at $1,093,000.00, an increase of $60,000.00 over the existing contractual amount, and to that end Article 5 entitled PAYMENT TERMS, 1st paragraph is amended to read as follows:

Change From:

The amount which the Department agrees to pay and the Contractor agrees to accept for satisfactory completion of the services to be rendered pursuant to this contract shall not exceed a total sum of **$1,033,000.00**. Work performed by the Contractor

Docusign Envelope ID: 021C8670-92D0-488A-A143-6C2C077A9F7E

during the term of the contract shall be paid at the rates listed in Attachment 2, Schedule of Prices. Travel and other allowable costs shall constitute part of the maximum payable under the terms of this contract.

Change To:

The amount which the Department agrees to pay and the Contractor agrees to accept for satisfactory completion of the services to be rendered pursuant to this contract shall not exceed a total sum of **$1,093,000.00**. Work performed by the Contractor during the term of the contract shall be paid at the rates listed in Attachment 2, Schedule of Prices. Travel and other allowable costs shall constitute part of the maximum payable under the terms of this contract.

Further, by mutual consent of both parties to this Contract, Article 6 entitled FISCAL FUNDING is amended and renamed as follows:

Change From:

6. FISCAL FUNDING

The continuation of this contract is contingent upon the appropriation of fund to fulfill the requirements of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

Change To:

6. TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds to fulfill the requirements of this Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of this Contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act or Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of this Contract, this Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

When funds are not appropriated or otherwise made available to support

Docusign Envelope ID: 021C8670-92D0-488A-A143-6C2C077A9F7E

continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, the Contract for the remaining term shall be cancelled and the Contractor shall be reimbursed in accordance with the terms of the Contract for the reasonable value of any nonrecurring costs incurred but not amortized in the price of services delivered pursuant to the Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or from unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for a penalty to the state for cancellation or early payment of the Contract.

No amendment shall be valid until it has been executed by all parties and approved by the Director of the Office of State Procurement, Division of Administration.

This amendment contains all revised terms and conditions agreed upon by contracting parties. All other terms and conditions of the contract shall remain the same.

This amendment entered into this 28th day of October, 2025, at Baton Rouge, Louisiana.

DEPARTMENT OF ENVIRONMENTAL QUALITY:

Signed by:
Theresa Delafosse 10/28/2025
29A252608408416...
Theresa Delafosse
Undersecretary
Office of Management and Finance

CONTRACTOR:

Signed by:
Jesse Hoppes 10/28/2025
3E0044A746C041A...
Jesse Hoppes, PG, MBA
Leaaf Environmental, LLC

Office of State Procurement
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 29, 2025

TO: Theresa Delafosse
Undersecretary
Department of Environmental Quality

FROM: Pamela Bartfay Rice, Esq., CPPO
Assistant Director, Professional Contracts

RE: OSP Pre-Approval for JLCB
Amendment #2 to contract – Terracon Consultants, Inc.
LaGov PO#: 2000717176

The above-referenced contract amendment has been reviewed by the Office of State Procurement. The document complies with the State Procurement Code and is ready for submission to the Joint Legislative Committee on the Budget. Upon approval of the contract amendment in accordance with La. R.S. 39:1615 (J), please return the "**Agency Memo to OSP After JLCB Approval,**" along with the stamped contract from the JLCB.

The contract amendment will not receive final approval by OSP until all appropriate approvals are received and each is submitted to OSP in LaGov and/or LESA, as applicable.

If you should have any further questions/comments, please do not hesitate to contact me.

Docusign Envelope ID: FA4DCFA5-BBFB-46D9-AFEA-0AD815E6CC41

LaGov No. 2000717176
Amendment No. 2

AMENDMENT TO THE CONSULTING SERVICES CONTRACT BETWEEN
STATE OF LOUISIANA
DEPARTMENT OF ENVIRONMENTAL QUALITY
(Hereinafter referred to as "Department")

AND

Terracon Consultants, Inc.
2822 O'Neal Lane, Building B
Baton Rouge, LA 70816
(Hereinafter referred to as "Contractor")

The Parties have agreed to extend the terms for fulfillment of services to be performed under this contract from January 31, 2026 to January 31, 2028 and to that end Article 2 entitled CONTRACT TERM is amended to read as follows:

Change From:

The term for the fulfillment of services to be performed pursuant to this contract shall be from **February 1, 2023** through **January 31, 2026**. With all proper approvals and concurrence with the Contractor, the Department may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term. Prior to the extension of the contract beyond a thirty-six (36) month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of State Procurement (OSP) to extend contract terms beyond a 3-year term. The total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Change To:

The term for the fulfillment of services to be performed pursuant to this contract shall be from **February 1, 2023** through **January 31, 2028** as the Department has exercised an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term, with approval by the Joint Legislative Committee on the Budget (JLCB). The total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Further, the parties have agreed to set the maximum amount paid to the Contractor by the Department under this contract at $1,155,750.00, an increase of $212,750.00 over the existing contractual amount, and to that end Article 5 entitled PAYMENT TERMS, 1st paragraph is amended to read as follows:

Docusign Envelope ID: FA4DCFA5-BBFB-46D9-AFEA-0AD815E6CC41

Change From:

The amount which the Department agrees to pay and the Contractor agrees to accept for satisfactory completion of the services to be rendered pursuant to this contract shall not exceed a total sum of **$943,000.00**. Work performed by the Contractor during the term of the contract shall be paid at the rates listed in Attachment 2, Schedule of Prices. Travel and other allowable costs shall constitute part of the maximum payable under the terms of this contract.

Change To:

The amount which the Department agrees to pay and the Contractor agrees to accept for satisfactory completion of the services to be rendered pursuant to this contract shall not exceed a total sum of **$1,155,750.00**. Work performed by the Contractor during the term of the contract shall be paid at the rates listed in Attachment 2, Schedule of Prices. Travel and other allowable costs shall constitute part of the maximum payable under the terms of this contract.

Further, by mutual consent of both parties to this Contract, Article 6 entitled FISCAL FUNDING is amended and renamed as follows:

Change From:

6. FISCAL FUNDING

The continuation of this contract is contingent upon the appropriation of fund to fulfill the requirements of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

Change To:

6. TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds to fulfill the requirements of this Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of this Contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act or Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year,

Docusign Envelope ID: FA4DCFA5-BBFB-46D9-AFEA-0AD815E6CC41

or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of this Contract, this Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

When funds are not appropriated or otherwise made available to support continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, the Contract for the remaining term shall be cancelled and the Contractor shall be reimbursed in accordance with the terms of the Contract for the reasonable value of any nonrecurring costs incurred but not amortized in the price of services delivered pursuant to the Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or from unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for a penalty to the state for cancellation or early payment of the Contract.

No amendment shall be valid until it has been executed by all parties and approved by the Director of the Office of State Procurement, Division of Administration.

This amendment contains all revised terms and conditions agreed upon by contracting parties. All other terms and conditions of the contract shall remain the same.

This amendment entered into this 3rd day of November, 2025, at Baton Rouge, Louisiana.

DEPARTMENT OF ENVIRONMENTAL QUALITY:

Signed by:
Theresa Delafosse 11/3/2025
29A252008408416...
Theresa Delafosse
Undersecretary
Office of Management and Finance

CONTRACTOR:

DocuSigned by:
Zack L. Dial, P.E. 10/31/2025
716B8B82E33B428...
Zack L. Dial
Manager Regional Services
Terracon Consultants, Inc.

Office of State Procurement
State of Louisiana
Division of Administration

JEFF LANDRY
GOVERNOR

TAYLOR F. BARRAS
COMMISSIONER OF ADMINISTRATION

October 29, 2025

TO: Theresa Delafosse
Undersecretary
Department of Environmental Quality

FROM: Pamela Bartfay Rice, Esq., CPPO
Assistant Director, Professional Contracts

RE: OSP Pre-Approval for JLCB
Amendment #2 to contract – PPM Consultants, Inc.
LaGov PO#: 2000717177

The above-referenced contract amendment has been reviewed by the Office of State Procurement. The document complies with the State Procurement Code and is ready for submission to the Joint Legislative Committee on the Budget. Upon approval of the contract amendment in accordance with La. R.S. 39:1615 (J), please return the "**Agency Memo to OSP After JLCB Approval,**" along with the stamped contract from the JLCB.

The contract amendment will not receive final approval by OSP until all appropriate approvals are received and each is submitted to OSP in LaGov and/or LESA, as applicable.

If you should have any further questions/comments, please do not hesitate to contact me.

Docusign Envelope ID: ECF5C411-0BCD-4BB9-ACD0-1293B77AE2EF

LaGov No. 2000717177
Amendment No. 2

AMENDMENT TO THE CONSULTING SERVICES CONTRACT BETWEEN
STATE OF LOUISIANA
DEPARTMENT OF ENVIRONMENTAL QUALITY
(Hereinafter referred to as "Department")

AND

PPM Consultants, Inc.
1600 Lamy Lane
Monroe, LA 71201
(Hereinafter referred to as "Contractor")

The Parties have agreed to extend the terms for fulfillment of services to be performed under this contract from January 31, 2026 to January 31, 2028 and to that end Article 2 entitled CONTRACT TERM is amended to read as follows:

Change From:

The term for the fulfillment of services to be performed pursuant to this contract shall be from **February 1, 2023** through **January 31, 2026**. With all proper approvals and concurrence with the Contractor, the Department may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term. Prior to the extension of the contract beyond a thirty-six (36) month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of State Procurement (OSP) to extend contract terms beyond a 3-year term. The total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Change To:

The term for the fulfillment of services to be performed pursuant to this contract shall be from **February 1, 2023** through **January 31, 2028** as the Department has exercised an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term, with approval by the Joint Legislative Committee on the Budget (JLCB). The total contract term, with extensions, shall not exceed five (5) years. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Further, the parties have agreed to set the maximum amount paid to the Contractor by the Department under this contract at $1,155,750.00, an increase of $122,750.00 over the existing contractual amount, and to that end Article 5 entitled PAYMENT TERMS, 1st paragraph is amended to read as follows:

Docusign Envelope ID: ECF5C411-0BCD-4BB9-ACD0-1293B77AE2EF

Change From:

The amount which the Department agrees to pay and the Contractor agrees to accept for satisfactory completion of the services to be rendered pursuant to this contract shall not exceed a total sum of **$1,033,000.00**. Work performed by the Contractor during the term of the contract shall be paid at the rates listed in Attachment 2, Schedule of Prices. Travel and other allowable costs shall constitute part of the maximum payable under the terms of this contract.

Change To:

The amount which the Department agrees to pay and the Contractor agrees to accept for satisfactory completion of the services to be rendered pursuant to this contract shall not exceed a total sum of **$1,155,750.00**. Work performed by the Contractor during the term of the contract shall be paid at the rates listed in Attachment 2, Schedule of Prices. Travel and other allowable costs shall constitute part of the maximum payable under the terms of this contract.

Further, by mutual consent of both parties to this Contract, Article 6 entitled FISCAL FUNDING is amended and renamed as follows:

Change From:

6. FISCAL FUNDING

The continuation of this contract is contingent upon the appropriation of fund to fulfill the requirements of the contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

Change To:

6. TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds to fulfill the requirements of this Contract by the legislature. If the legislature fails to appropriate sufficient monies to provide for the continuation of this Contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act or Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year,

Docusign Envelope ID: ECF5C411-0BCD-4BB9-ACD0-1293B77AE2EF

or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of this Contract, this Contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

When funds are not appropriated or otherwise made available to support continuation of performance in the following fiscal year of a multiyear contract for professional or consulting services, the Contract for the remaining term shall be cancelled and the Contractor shall be reimbursed in accordance with the terms of the Contract for the reasonable value of any nonrecurring costs incurred but not amortized in the price of services delivered pursuant to the Contract. The cost of cancellation may be paid from appropriations made specifically for the payment of such cancellation costs or from unobligated funds of the using agency.

With respect to all multiyear contracts for professional services and consulting services pursuant to this Subsection, there shall be no provisions for a penalty to the state for cancellation or early payment of the Contract.

No amendment shall be valid until it has been executed by all parties and approved by the Director of the Office of State Procurement, Division of Administration.

This amendment contains all revised terms and conditions agreed upon by contracting parties. All other terms and conditions of the contract shall remain the same.

This amendment entered into this 3rd day of November, 2025, at Baton Rouge, Louisiana.

DEPARTMENT OF ENVIRONMENTAL QUALITY:

Signed by:
Theresa Delafosse 11/3/2025
29A252608408416...
Theresa Delafosse
Undersecretary
Office of Management and Finance

CONTRACTOR:

DocuSigned by:
Shawn P. Ivey 11/3/2025
B3FE46B2BD3B4AC...
Shawn P. Ivey
PPM Consultants, Inc.