Delivering the Next **Generation** of Health Care

Transforming Louisiana health with innovation & leadership

Walking the path with our enrollees every day

Collaboratively delivering integrated person-centered care

Investing & scaling community-based care efforts to expand access

Simplifying provider & LDH relationships to focus on quality care

Louisiana Department of Health

Proposal in Response to RFP #: 3000011953
Request for Proposals for
Louisiana Medicaid Managed Care Organizations

AmeriHealth Caritas Louisiana

Technical Proposal - REDACTED COPY

2.2.1 Table of Contents

Technical Proposal

2.10.1 Executive Summary.....1

2.10.2 Organizational Experience.....7

2.10.3 Enrollee Value-Added Benefits.....55

2.10.4 Population Health.....65

2.10.5 Care Management.....83

2.10.6 Case Scenarios.....97

2.10.7 Provider Network.....113

2.10.8 Network Management.....115

2.10.9 Provider Support.....131

2.10.10 Utilization Management.....145

2.10.11 Quality.....161

2.10.12 Value-Based Payment.....181

2.10.13 Claims Management and Systems and Technical Requirements.....195

2.10.14 Program Integrity.....205

2.10.15 Veteran and Hudson Initiatives Programs Participation.....215

Attachments to 2.10.2 Organizational Experience

Attachment 2.10.2.1-1 Resumes.....221

Attachment 2.10.2.2-1 Organizational Chart.....251

Attachments 2.10.2.3-1 to 2.10.2.3-5 Appendix F
(Material Subcontractor Response Templates and Draft Agreements).....255

Attachment 2.10.2.5-1 NCQA Certificate of Accreditation.....681

Attachments to 2.10.7 Provider Network

Attachment 2.10.7.1-1 Provider Network Listing.....683

Attachment 2.10.7.2-1 Provider Network Capacity.....685

Attachments to 2.10.11 Quality

Attachment 2.10.11.5-1 Sample Clinical Practice Guideline.....689

Attachment 2.10.11.6-1 AmeriHealth Caritas NCQA Ratings 709

Attachments to 2.10.13 Claims Management and Systems Technical Requirements

Attachment 2.10.13.2-1 to 2.10.13.2-7 Data and Process Flows.....713

This page is intentionally left blank.

2.10.1
Executive Summary

Giving Enrollees A Voice: One of our AmeriHealth Caritas Louisiana Care Managers was able to effectively communicate with this enrollee, help him with obtaining appropriate care, and assist him in communicating with his providers. He told her that she gave him his voice.

AmeriHealth Caritas™
Louisiana

2.10.1 Executive Summary

AmeriHealth Caritas Louisiana is a mission-based organization that has served Louisiana communities since Medicaid managed care was first introduced in Louisiana. Today, we connect our enrollees to high quality care that supports them in achieving improved health and overall wellness. For more than seven years, AmeriHealth Caritas Louisiana has lived up to our motto that Care is the Heart of our Work. Our company's mission — to help enrollees get care, stay well, and build healthy communities — is more than just a motto, it is our foundation.

We help people get care, stay well, and build healthy communities.

Throughout our proposal, we describe initiatives tailored specifically for Louisiana based on our experience, time spent on the ground listening to and working with our enrollees, and positive relationships with providers and stakeholders. In this Executive Summary, we demonstrate how these solutions align to the Triple Aim and the Louisiana Department of Health's (LDH's) goals and objectives for the Healthy Louisiana program, as outlined in **Request for Proposal (RFP) Section 1.3**.

Providing Better Care for Louisiana

AmeriHealth Caritas Louisiana combines its extensive knowledge of Louisiana with evidence-based programs to provide care that improves enrollee health outcomes. We share the State's vision and offer whole-person care that fully integrates physical health, behavioral health, pharmacy, and social services to promote health outcomes and a better quality of life. Through our integrated approach, we complete social determinant of health (SDOH) screenings, identify barriers, provide targeted enrollee education, and offer person-centered interventions to engage enrollees in appropriate services and supports. As shown in the following examples we strategically develop and implement evidence-based practices that specifically address the needs of the enrollees and communities we serve.

- **Care Extender Program** — This program provides enrollees who have behavioral health needs and high emergency department (ED) utilization and/or inpatient readmissions with support to manage their care. By providing 24/7 support after discharge, our Care Extenders help enrollees access services to meet their whole health needs and facilitate a successful transition to the community.
- **Virtual On-Going Biometric Monitoring** — Home telemonitoring programs for chronically ill individuals improve enrollee outcomes on key quality metrics. Our virtual biometric monitoring program provides participants with daily monitoring of blood sugar, weight, blood oxygen levels, and blood pressure, as well as timely intervention and assessment of clinical needs. Participants also receive Individual one-on-one health coaching focusing on behavior change modification and care plan adherence.
- **Behavioral Health Interventions For 0-5 Year Old Enrollees** — We continually monitor utilization trends to drive our educational offerings and educate our providers on evidenced-based care. For example, we led an initiative across all Healthy Louisiana managed care organizations (MCOs) to identify and facilitate training opportunities on topics such as pre-school post-traumatic stress disorder (PTSD), Parent Child Interaction Therapy, Child Parent Psychotherapy, and Positive Parenting Practices® to enhance evidenced-based care for enrollees who are 0-5 years old and are in need of specialized behavioral health care services.

To advance high-value care, we encourage providers and enrollees to maintain an open dialogue. These conversations are important to help enrollees select care that is supported by evidence and to reduce duplication of services. To facilitate these discussions, we implemented the American Board of Internal Medicine's (ABIM) Choosing Wisely® initiative's clinical recommendations. These easy to understand recommendations are designed to generate a conversation between the enrollee and provider about the

safest, most appropriate**,** and necessary treatment to address the enrollee's condition. We have taken steps to perform a comparison of our prior authorization requirements to the Choosing Wisely initiative's recommendations to assure alignment and will continue to review as new recommendations are released.

We demonstrate a commitment to service excellence through provider and enrollee satisfaction results. Our providers reported the highest rate of satisfaction among the five incumbent MCOs in Louisiana. **Additionally, 80 percent of providers reported they would recommend our plan to others, the highest rate among the MCOs.** Our commitment to enrollee satisfaction is a reflection in our 2018 Consumer Assessment of Health Care Providers and Systems results, which indicate a health plan rating of 93 percent. We also received an overall rating of 3.5 out of 5 in the NCQA Medicaid Health Insurance Plan Ratings for 2018-2019 and a Consumer Satisfaction rating of 4.5 out of 5. Our overall and Consumer Satisfaction NCQA ratings are tied for highest in the state with another participating Healthy Louisiana MCO.

AmeriHealth Caritas Louisiana maintains a culture of continuous quality improvement and supports innovative approaches to service delivery. This is demonstrated by our early adoption of the Community Health Worker (CHW) program, creation of strategies for engaging enrollees through our community wellness centers, and implementation of the CMS Comprehensive Primary Care Plus (CPC+) program.

We began implementing the CHW model in 2014. We recognized the benefit of using CHWs to provide high-touch support for enrollees with the highest risk levels and began leveraging CHWs to assist enrollees with system navigation and removing barriers to care. In recognition of our leadership, in 2018, we were invited by LDH to be the only Healthy Louisiana MCO to participate in the development of the Blueprint for a Louisiana Demonstration CHW Program.

We were an early adopter of the Centers for Medicare and Medicaid Services (CMS) CPC+ multi-payor collaborative demonstrating our leadership and commitment to improving primary care. AmeriHealth Caritas Louisiana is one of a limited number of MCOs in the state selected to participate in CMS' CPC+.

AmeriHealth Caritas Louisiana is the only MCO in Louisiana to have opened community wellness centers for Medicaid enrollees. We strategically located our community wellness centers in areas with the greatest need. In the centers we offer targeted services, including completion of health needs assessments (HNAs), SDOH assessments, chronic-condition self-management, opioid crisis training, physical activity classes, and financial management. We currently have two community wellness centers in operation and have already committed to opening a third center in Baton Rouge in 2020. We are also committing to opening an additional community wellness center by the end of the new contract period that begins in 2020, which will bring our number of community wellness centers to four.

Our Quality Improvement program is based on the goals and objectives outlined in Louisiana's Medicaid Managed Care Quality Strategy and adheres to NCQA's road map for continuous quality improvement. Using a systematic approach (Plan, Do, Study, Act), we monitor performance, analyze processes and outcomes data, compare results to established benchmarks, and prioritize areas for improvement. Our effective processes have enabled us to continuously enhance our NCQA accreditation status from Interim in 2014 to Commendable in 2017.

AmeriHealth Caritas Louisiana provides enrollees with ready access to care through our comprehensive provider network. We regularly assess and enhance our network to promote timely access to care delivered by culturally competent providers, including the right mix of providers, specialists, and facilities to meet enrollees' needs. For example, in order to address the historic lack of specialists in the rural corridor between Monroe in the northeast part of the state and Lake Charles in the southwest, we contracted in 2018 with several large primary care provider (PCP) and multi-specialty groups.

We use proactive strategies to ensure provider capacity to meet enrollee's needs, including contracting and payment structures that allow us to recruit and retain high quality providers, value-based payments and single case agreements, and data-sharing technology. In line with LDH's goal to decrease fragmentation and increase integration, we reimburse physical health providers for completing behavioral health screenings, and behavioral health providers for conducting physical health screenings. Additionally, we are building capacity of our providers through recent collaborations with the Louisiana Primary Care Association to provide trainings such as Mental Health First Aid and medication assisted therapy.

Promoting Better Health

For many individuals and families in Louisiana, the primary obstacles to better health include access to resources and a strong support system. AmeriHealth Caritas Louisiana's **Next Generation Model of Care**, which is in line with the Triple Aim, focuses on improving the lives and health of Louisiana's Medicaid enrollees by providing access to the best care available, supporting enrollees with overcoming social barriers, and effectively managing costs of care. Through this innovative model of care, we broaden our approach to the SDOH and enhance our community involvement, as we continue to look beyond enrollees' illnesses to their social experiences and environments. The Next Generation Model of Care builds upon our inherent clinical, operational, and innovation strengths to deliver and coordinate enrollees' care services that treat the whole person.

AmeriHealth Caritas Louisiana addresses barriers to care by working hand-in-hand with enrollees to connect them to available resources and strengthen community support systems. Our Community Care Management Team (CCMT) is a support system of registered nurses, licensed social workers, and CHWs who meet with enrollees face-to-face. The CCMT develops and manages the enrollee's care plan and they offer person-centered interventions. Through encouragement and coaching, the CCMT helps enrollees with chronic conditions develop self-management skills.

Our fully-integrated population health management strategy is focused on leveraging community-centric approaches to reduce health disparities and address the SDOH that impact enrollees' ability to engage with the healthcare system. In alignment with Louisiana's Medicaid Managed Care Quality Strategy, our approach is built on the principles of person-centered care, minimally disruptive medicine, trauma-informed care, cultural sensitivity, multi-channel enrollee engagement, Healthcare Effectiveness and Data Information Set- (HEDIS)-based measures, and team-based care, with an emphasis on addressing SDOH. To help us realize this strategy, our Chief Medical Officer, Dr. Rodney Wise, serves on the Louisiana Perinatal Quality Commission, by appointment of Governor John Bel Edwards, through which he shares best practices for successfully affecting infant and maternal mortality.

To support integration across providers and care settings, we made significant investments to build infrastructure and develop capacity within local providers. For example, we foster collaboration between behavioral health and primary care providers; train providers on integrated health assessments such as the PHQ-9, Patient Stress Index, and Screening, Brief Intervention and Referral to Treatment; introduced behavioral health-focused provider training and technical assistance; implemented fully integrated contracting models to encourage co-location and clinic integration; incorporated care management support at community wellness centers; implemented targeted activities such as art therapy; and championed the use of CHWs.

AmeriHealth Caritas Louisiana supports network providers in adopting integrated care models by leveraging our robust data-sharing infrastructure to provide actionable information at the point of care. Through our Provider Portal and electronic health records, providers securely access important clinical information. For example, they can view the Member Clinical Summary, which provides detailed information on the services and medications the enrollee receives. We are expanding the Summary to

include HNA results, enabling providers to prioritize engagement based on needs. Using automated Direct Secure Messaging technology, our providers can also be notified when an enrollee completes the HNA and can view those who have not yet completed it.

We use a systematic, multi-channel, population approach to advance health equity and collect standardized SDOH data. Our CHWs use the SDOH information to connect enrollees to appropriate medical, behavioral health, and social services by assisting with appointment scheduling, attending office visits as requested, and helping enrollees access all necessary services and supports. Our commitment to delivering high quality care that eliminates health disparities is demonstrated by our NCQA Multicultural Health Care Distinction, achieved in June 2017.

Over and above the Healthy Louisiana program, AmeriHealth Caritas Louisiana leadership has decades of demonstrated leadership addressing the population health priorities defined in the Louisiana Medicaid Managed Care Quality Strategy, such as infant mortality, maternal mortality and morbidity, opioid use disorders, obesity, diabetes, hypertension, cardiovascular disease, tobacco cessation, and early childhood health and development, including adverse childhood experiences. We use our population health management strategy to drive continuous improvement in enrollee health by identifying linkages and drawing insights on how key determinants impact health equity and outcomes. We convene local community stakeholders and partners to adapt best-practices and define homegrown solutions, such as the *Control Your Diabetes, Control Your Destiny* initiative that targets community-specific issues.

Lowering Louisiana Health Care Costs

By reducing administrative burden, we enable providers to better focus on delivering the best care, which facilitates enrollee engagement and improves enrollee health outcomes. Our Enrollee Services team and enrollee digital tools provide a convenient and easy way to access options for enrollees to complete their HNA and access our enrollee resources and other tools. Additionally, our boots-on-the-ground team of CHWs help schedule transportation, locate interpreters, and refer enrollees to case management. They also apply our No Wrong Door philosophy to refer enrollees to care management and link them to our community wellness centers.

We work collaboratively with providers on system enhancements to further reduce administrative burdens. For example, our well-established Utilization Management (UM) system offers user-friendly interfaces that allow providers to easily submit and track authorization requests. Additionally, our comprehensive clinical tools promote timely decision-making that considers each enrollee's unique needs, facilitating timely access to needed services. Our UM department received the highest scores among MCOs evaluated in the LDH 2018 Medicaid Managed Care Provider Satisfaction Survey with positive results related to access to staff, review criteria for adverse determinations, and timeliness of the appeals process.

Improving access to healthcare requires a multi-pronged approach that includes aligned financial incentives and value-based payment (VBP) strategies. AmeriHealth Caritas Louisiana first implemented VBPs in 2014 with the launch of our PerformPlus® programs. We continue to expand the number of providers participating in VBP through tailored programs that fit the needs and capabilities of providers based on where they are on the HCP-LAN Alternative Payment Model continuum. Using this approach, we have effectively moved providers along the continuum while maintaining high levels of provider satisfaction. In 2018, AmeriHealth Caritas Louisiana increased provider payments in VBP arrangements by 22.1 percent, a 75 percent increase over our baseline year (2017), far exceeding LDH's requirement for a 10 percent increase in VBP payments by July 2019.

We have processes in place for sharing network performance data via monthly, quarterly, and ad-hoc reports that incorporate a variety of nationally recognized performance measures. Additionally, our provider partners have communicated a preference for information to be uploaded to their electronic health records (EHR) where they can best leverage and maximize performance. Lastly, we use Admission, Discharge, Transfer (ADT) feeds that provide daily notification of ED usage to the Provider Portal. In 2019, AmeriHealth Caritas Louisiana is slated to be the first Medicaid MCO to go live with utilization of a new ADT feed offered through the Louisiana Hospital Association. This relationship will allow real-time notifications of more complete clinical information and an ability to share PCP and Case Manager assignments with hospital ED staff to facilitate discharge.

At AmeriHealth Caritas Louisiana, preventing, detecting, and reporting fraud, waste, and abuse (FWA), "Doing the Right Thing in the Right Way," is a shared responsibility of all employees, subcontractors, and providers. We developed internal solutions and use industry-leading vendors to deploy cutting edge technology, such as data analytic algorithms, to proactively prevent, detect, and recover payments that were paid as a result of FWA. Notably, due to our proactive data analysis and conducting unannounced onsite provider audits, AmeriHealth Caritas Louisiana provided the impetus for the creation of the Behavioral Health Task Force consisting of members from LDH, the Medicaid Fraud Control Unit, and the five Healthy Louisiana MCOs.

Creating A Healthier Louisiana

We demonstrate our alignment to LDH's objectives in RFP Section 1.3, and the Triple Aim, through five themes shown below. In addition to the initiatives demonstrated throughout our proposal, these five themes are highlighted throughout our proposal as a reminder of the unique initiatives and creative thinking we bring to Louisiana Medicaid enrollees.

At AmeriHealth Caritas Louisiana, we work to improve not only our enrollees' health, but also the economic and social issues that act as barriers to care. We emphasize preventive care, health maintenance, and community outreach programs to ensure enrollees can access food, housing, utilities, and other basic necessities. From our boots-on-the-ground CHWs to our behind-the-scenes associates who operationalize our efforts, our mission embodies not only the work we do, but also our culture. **Care is the heart of our work and it is what helps us to create a healthier Louisiana.**

This page is intentionally left blank.

2.10.2
Organizational Experience

Community thought leaders gather at AmeriHealth Caritas Louisiana's Shreveport Wellness Center to share ideas for increasing communication and engagement to improve community health.

AmeriHealth Caritas™
Louisiana

2.10.2 Organizational Experience

2.10.2.1 Proposer Experience

2.10.2.1.1 AmeriHealth Caritas Louisiana's Organizational History

Since the inception of Louisiana's Medicaid managed care program in 2012, AmeriHealth Caritas Louisiana has partnered with the Louisiana Department of Health (LDH), providers, and community organizations to help Louisiana's Medicaid enrollees get the care they need and overcome the social barriers that stand in their way. As we grew, we became a top performer among all Louisiana Medicaid managed care plans in key measures for enrollee and provider satisfaction. In 2016, we earned the highest Health Care Effectiveness Data and Information Set (HEDIS®) rankings of all Healthy Louisiana plans in 10 of the measured categories related to maternity care, child wellness, and medication adherence. **Our 2018 Consumer Assessment of Health Care Providers and Systems (CAHPS) results indicate a health plan rating of 93 percent**. In 2017, the National Committee for Quality Assurance (NCQA) awarded us Commendable accreditation status. In LDH's 2018 Healthy Louisiana provider satisfaction survey, AmeriHealth Caritas Louisiana received the highest rating (of all managed care organizations (MCOs)) from providers when asked if they would recommend our MCO to other providers. Baton Rouge Business Report named our headquarters one of the Best Places to Work for three consecutive years, reflective of a staff and environment filled with passion for our enrollees' care that is the heart of our work.

AmeriHealth Caritas Louisiana is tied for first in the state for both the overall and consumer satisfaction NCQA 2018-2019 Medicaid Health Insurance Plan Ratings.

AmeriHealth Caritas History

AmeriHealth Caritas Louisiana, Inc. is a Louisiana for-profit business corporation licensed as a Louisiana health maintenance organization, and has been operational since February 2012. AmeriHealth Caritas Louisiana is a member of the AmeriHealth Caritas Family of Companies (AmeriHealth Caritas), which includes affiliate health plans that share the same ultimate corporate parents. AmeriHealth Caritas has served low income and chronically ill populations for more than 35 years, including Medicaid managed care populations similar to those in the Healthy Louisiana program. Founded by the Sisters of Mercy as Mercy Health Plan in 1983, AmeriHealth Caritas began as a small, provider-sponsored MCO serving low-income residents of West Philadelphia, and has grown to become a national thought leader at the forefront of integrated, outcome-based Medicaid health care solutions. As of March 2019, AmeriHealth Caritas collectively serves approximately two million Medicaid managed care enrollees through full-risk contracts the District of Columbia and six states. Our New Hampshire and North Carolina affiliates were recently awarded Medicaid managed care contracts.

AmeriHealth Caritas Louisiana is ultimately owned 61.3 percent by Independence Health Group, Inc. (a Pennsylvania non-profit corporation) and 38.7 percent by Blue Cross Blue Shield of Michigan Mutual Insurance Company (a Michigan non-profit mutual insurance company). For more than 80 years, Independence Blue Cross has been engaging people in the community and supporting innovative ways to improve their health. Independence Health Group, Inc. is based in Philadelphia, Pennsylvania and was founded in 2014 (through a restructuring of the insurance company holding system of Independence Blue Cross). Founded in 1939, Blue Cross Blue Shield of Michigan Mutual Insurance Company is headquartered in Detroit, MI. As the largest health insurer in Michigan, serving 4.5 million people in Michigan and 1.6 million more in other states, it offers commercial and Medicare coverage, and wellness-based, dental and vision plans.

Organizational Goals And Mission (Relevance Of Medicaid)

The mission of AmeriHealth Caritas Louisiana and the entire AmeriHealth Caritas enterprise is to help people get care, stay well, and build healthy communities. We are committed to reversing the cycle of poverty and poor health. In line with the Triple Aim, we focus on improving the lives and health of enrollees by providing access to the best care available, offering support to overcome social barriers, and effectively managing costs of care. To achieve this, we have adopted AmeriHealth Caritas' Next Generation Model of Care; using this

innovative model, we broaden our approach to social determinants of health and enhance our community involvement, as we continue to look beyond enrollees' illnesses to address their social needs. **The Next Generation Model of Care builds upon our inherent clinical, operational, and innovation strengths to deliver and coordinate enrollees' care and services to treat the whole person.** We focus on expanding our capabilities to enable our care teams to provide highly informed and responsive individualized and community-based care management activities. This new model enhances our holistic approach to managing enrollees care by:

- Focusing beyond enrollees' health care needs, to include social and environmental experiences — along with supporting their caregivers.
- Applying a **fully integrated population health management strategy that integrates physical health, behavioral health, pharmacy, and social supports** to deploy preventive programs for at-risk members.
- Tackling social determinants to reverse the cycle of poverty and poor health by supporting enrollees' needs for suitable and healthy housing, access to fresh food, transportation, health literacy, personal safety, education, job training, and safe recreation for children.
- Engaging enrollees at all touch points, including providers, call centers, wellness centers, community events, and caregivers.
- Using informatics to develop a complete picture of enrollees, their needs, and outside influences that impact their health.

Technology is a key focus of how we are looking to provide better access to care. Our Next Generation Model of Care is moving us toward our future with vision and purpose. In today's digital age, we have new ways of communicating, capturing data, and insights that benefit our enrollees, providers, and other stakeholders. Technology combined with AmeriHealth Caritas Louisiana's high-touch approach provides a level of service that cannot be matched. For example, AmeriHealth Caritas is working with [redacted] **will empower and educate enrollees and their caregivers in their health care journey using personalized and actionable resources.** [redacted] offers [redacted], connecting enrollees and care givers with their care management teams; [redacted].

AmeriHealth Caritas' Volume Of Business And Current Markets

As of March 2019 AmeriHealth Caritas Louisiana serves approximately 213,000 Healthy Louisiana enrollees. Along with our affiliate health plans, AmeriHealth Caritas currently provides Medicaid services to more than two million full-risk integrated managed care enrollees in Delaware, the District of Columbia, Florida, Louisiana, Michigan, Pennsylvania, and South Carolina (see our response to **2.10.2.4** for the volume of membership in each of our affiliate health plans). AmeriHealth Caritas' New Hampshire and North Carolina health plans were recently awarded Medicaid managed care contracts that begin in September and November 2019 respectively.

2.10.2.1.2 Meeting LDH's Minimum MCO Requirements

Experience Providing Medicaid Managed Care Health Services Seven Years Or Longer

AmeriHealth Caritas Louisiana has more than seven years of experience providing integrated health care services to Louisiana's Medicaid program — helping enrollees get the care they need and overcome the social barriers that stand in their way. Additionally, **our affiliate health plans in and Florida and South Carolina each have more than seven years of experience and in Pennsylvania more than 35 years,** providing integrated health care services to Medicaid managed care programs.

Previous 12-Months Experience With Populations Equal Or Larger Than Louisiana

Our affiliate health plans in Florida, Michigan, and Pennsylvania are in markets that have Medicaid populations equal to or greater than Louisiana.

2.10.2.2 Staff Experience and Organizational Structure

2.10.2.2 Identifying Key Personnel And Management Structure

AmeriHealth Caritas Louisiana has experienced key personnel in place, and an established and effective organizational structure capable of delivering Medicaid managed care services to our local communities. We meet current Healthy Louisiana requirements and will meet all requirements of **Model Contract, 2.1 and 2.3** and **MCO Manual Section 2.1 and 2.3**.

Identifying Key Personnel

As an incumbent, we have extensive experience staffing our health plan to meet specific, local needs of Louisiana Medicaid beneficiaries. Our Talent Acquisition team is responsible for recruiting for AmeriHealth Caritas Louisiana. We leverage AmeriHealth Caritas' experience and best-in-class recruitment tools to identify, recruit, train, and retain key personnel for our program. Our recruitment methods include more than 1,100 job boards, social media campaigns focused on expertise, job sponsorship, search engine optimization, text messaging campaigns, virtual job fairs with real-time access for candidates, proactive candidate sourcing, and a candidate relationship management database. We use state-of-the-art tools, including an applicant tracking system, live and recorded video interviews, candidate driven 360 degree reference checking, analytics that provide a competitor landscape and candidate availability, and candidate relationship management software. To manage position vacancies and attrition, we evaluate talent within the organization to identify successors for critical roles. We assign internal and external experts to executive and key staff talent searches, ensuring we fill roles rapidly with the most qualified candidates. **We are actively recruiting to fill our newly created Housing Specialist position**.

After accepting an offer of employment, candidates undergo a pre-employment screening. At a minimum, the screenings include drug testing (for illegal drugs), Department of Motor Vehicles (DMV) check, and background check. Background checks may include verification of a social security number, education, present/former addresses, professional licensures (mandated by contract and law), and criminal, civil, and public records. The background check also checks/searches federal exclusion lists check to include FACIS (Fraud and Abuse Control Information System) Level 3: OIG, SAM, EPLS, FED REGGS, and ORCA.

Key Personnel's Role In Governance And Operations

All current key personnel are full-time associates dedicated to AmeriHealth Caritas Louisiana, responsible for satisfying LDH contract requirements from our office in Baton Rouge. **Figure 2.10.2.2-1** describes the highly qualified and experienced senior leaders who serve in key personnel roles. Résumés for these key personnel are included in our response as **Attachment 2.10.2.1-1**.

Chief Executive Officer (CEO) — Kyle Viator, MPA
Mr. Viator is responsible for the strategic direction, growth, and leadership of the AmeriHealth Caritas Louisiana health plan, and clear authority over the general administration and day-to-day business activities undertaken to satisfy LDH contract requirements. He receives regular operations and quality reporting from every functional area of the health plan. His responsibilities include understanding contract requirements, ensuring each functional area meets all service levels, directing internal operational functions, strategic direction, growth, financial performance, and acting as liaison to LDH, AmeriHealth Caritas Louisiana, and the broader AmeriHealth Caritas Family of Companies. Mr. Viator reports to AmeriHealth Caritas regional president, Rebecca Engelman, and further up to AmeriHealth Caritas CEO, Paul Tufano.
Chief Operating Officer (COO) — Sherry Wilkerson, MSPH
Ms. Wilkerson manages the daily activities of the operations and administrative staff and provides quality oversight for those functions, including claims management, enrollee services, community relations, and provider services. Ms. Wilkerson has decision-making authority over these areas, and reports to our CEO. She also develops strategic plans, budgets, and management action plans for management decision making.

Medical Director/Chief Medical Officer (CMO) — Rodney Wise, M.D.
Dr. Wise oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to enrollees, developing clinical practice standards and clinical policies and procedures. All population health functions, including care management, pharmacy services, behavioral health, quality, and utilization management, are integrated under Dr. Wise's direction. Dr. Wise also interacts on behalf of AmeriHealth Caritas Louisiana with its enrollee and physician community, physician and health system networks, medical/physician professional associations, government representatives, and advocacy groups to advance clinical excellence and the delivery of cost efficient care. Dr. Wise reports to the CEO.
Behavioral Health Medical Director — Betty Ann Muller, M.D.
Dr. Muller is responsible for providing oversight and leadership over integrated behavioral health activities and takes an active role in clinical and policy decisions. She works closely with other AmeriHealth Caritas affiliate health plan medical leaders to help enrollees access holistic and integrated person-centered care. She guides the development of behavioral health programs and provides administrative and clinical guidance and expertise to AmeriHealth Caritas Louisiana senior management and staff to enhance and improve the quality of services provided. Dr. Muller reports to the CMO.
Chief Financial Officer (CFO) — Shannan Herring
Ms. Herring is responsible for accounting and finance operations of AmeriHealth Caritas Louisiana, including budget development, accounting systems, financial reporting, actuarial work, and all financial audit activities. She also provides ongoing direct support to cost center managers regarding staffing, general, and administrative expenses. Ms. Herring reports to the CEO.
Pharmacy Director — Jeanine Plante, Pharm.D.
Dr. Plante oversees and manages AmeriHealth Caritas Louisiana's pharmacy benefits and services. She collaborates with the AmeriHealth Caritas Louisiana medical officer and director, as well as with AmeriHealth Caritas affiliate health plan pharmacy leaders, including those at affiliate PerformRx℠, to oversee AmeriHealth Caritas Louisiana's pharmacy care benefit integration and quality improvement efforts. Dr. Plante reports to Regional Pharmacy Director Jeffrey Kreitman from affiliate AmeriHealth Caritas Services, LLC's Population Health department.
Contract Compliance and Program Integrity Officer — Lesli Boudreaux
Ms. Boudreaux oversees and manages at the local level all fraud, waste, and abuse and compliance activities and is the primary point of contact with LDH for contract compliance. She provides strategic direction and leadership for the development and implementation of compliance policy and processes and implements complaint investigation policies and procedures, root cause analyses and remediation actions related to complaints and other investigations. Ms. Boudreaux reports to the CEO.

Figure 2.10.2.2-1: *Key Personnel Roles And Descriptions.*

2.10.2.2.2 AmeriHealth Caritas Louisiana's Operating Structure

AmeriHealth Caritas Louisiana's organizational structure aligns with LDH contract requirements and maximizes our ability to act on Louisiana's strategic goals. Our leaders have clearly assigned and documented responsibilities for implementing, managing, and overseeing the activities undertaken to fulfill the requirements in the contract.

2.10.2.2.2.1 Leadership And Governance Of Plan Operations

Our CEO oversees all AmeriHealth Caritas Louisiana functions, key personnel, and staff. AmeriHealth Caritas Louisiana has its own Board of Directors and a local management structure, which enables local decision making. Local associates in Louisiana perform or supervise all major enrollee-facing, clinical, and operational functions. Other functions that are locally based include case management, utilization management, human resources, medical economics, pharmacy, claims processing, quality management and improvement, and government and external affairs.

In addition, AmeriHealth Caritas Louisiana contracts with AmeriHealth Caritas Services, LLC, our affiliate, for certain administrative functions including contact centers/customer service, claims processing, and information systems/data processing, as well as corporate functions, such as legal, corporate finance, marketing, and human resources. AmeriHealth Caritas Services operates as an internal services company and provides these services across the AmeriHealth Caritas enterprise. For more than seven years, we have benefited from the efficiencies associated with shared services and lower costs due to economies of scale. Our relationship with AmeriHealth Caritas Services helps us manage our market-driven case

management program, provider network, quality improvement initiatives, and community partnerships designed in accordance with the Triple Aim to improve population health, improve patient experience, and reduce per capita cost. Enterprise-level resources that support our local AmeriHealth Caritas Louisiana resources, including AmeriHealth Caritas Services and its vendor contractors, are monitored for compliance with the LDH contract requirements by the AmeriHealth Caritas Louisiana CEO or one of the CEO's direct reports.

2.10.2.2.2.2 Organizational Chart Of Operating Structure

An organizational chart of the AmeriHealth Caritas Louisiana operating structure is included in **Attachment 2.10.2.2-1** It includes the following key teams: operations, enrollee services, provider monitoring and supports, population health, finance, fraud and abuse monitoring and compliance, administration and contract management, quality management and improvement and utilization management. We maintain full accountability for the delivery of services provided by our subcontractors. Subcontractors send performance reports to the department to which its services relate, which is accountable to the AmeriHealth Caritas Louisiana CEO, as further described in **Appendix F** attached as **Attachment 2.10.2.3-1 through Attachment 2.10.2.3-5.**

2.10.2.2.2.3 Executing Health Plan Functions Using Key Teams

The following section, **Figure 2.10.2.2-2** includes brief descriptions of each key team depicted on our organizational chart, including the role each team plays in our health plan operations. We inform our key teams' associates and align them with our company mission using the Everyone Makes an Impact series of informational sessions. Through frequent targeted training sessions on topics requested by front line associates, this program is an opportunity to exchange interdepartmental news, learn about program changes and industry developments, and provide feedback to executive leadership. AmeriHealth Caritas Louisiana's local leadership team drives operational oversight. Depending upon the departmental function, AmeriHealth Caritas Services, LLC may augment the work performed in Louisiana.

2.10.2.2.2.4 Dedicating Experienced Staff And Resources To Operations

AmeriHealth Caritas Louisiana engages in detailed resource management to ensure our staffing and resources are capable of fulfilling our enrollees' health care needs. Our staffing levels are currently scaled to serve the current number of AmeriHealth Caritas Louisiana enrollees, and we are prepared to increase our staff in anticipation of another contract term. The success of our work relies upon the skills and leadership of the highly qualified associates and teams described in **Figure 2.10.2.2-2**. Each of our key personnel meets the professional qualifications required by **Model Contract, 2.3.3**.

Description of Team Role	Description of Team Competencies	Team Leadership
Enrollee Services — 76 Full-time Equivalents (FTEs)		
This team manages communications with enrollees and provides prompt resolution of problems or inquiries. They also conduct outreach to provide appropriate education about participation in the health plan. The Enrollee Services Manager oversees this team. The associates on this team report directly to the Administrator/CEO.	Our enrollee services staff has experience and training in providing prompt resolution of enrollee problems or inquiries and ensuring that enrollees have appropriate education about participation in AmeriHealth Caritas Louisiana.	Tricia Grayson, is our Enrollee Services Manager. She is an award-winning health care marketing communications professional with more than 25 years of public relations experience, including more than 10 years of health care communications. Her experience includes coordinating grassroots community outreach and directing culturally competent enrollee engagement.

Description of Team Role	Description of Team Competencies	Team Leadership
Operations — 114 FTEs		
These associates manage the daily operations of information solutions, claims administration, encounters management, and enrollee grievances. They report to the plan COO, who in turn, reports to the CEO. The Claims Processing Staff and Enrollee Services Staff supporting the plan report to the Vice President of Claims (AmeriHealth Caritas Services) with local functional oversight by both the CEO and COO.	The Grievance System Manager has 19 years of health care experience, including compliance and the LDH grievances processes. Our Information Technology Director is trained and experienced in information systems, data processing, and data reporting and has experience maintaining connectivity and reporting to LDH.	COO, Sherry Wilkerson is the team lead for all administrative and operational health plan functions. Ms. Wilkerson has more than 15 years of Medicaid experience in Louisiana. A nurse by training, her experience includes operations management, including planning and analysis, regulatory compliance, and program development. Her applied knowledge of the development of policies and procedures, data and technical services, finance, and fiscal stewardship strengthens the efficacy and efficiency of our operations and administration.
Provider Monitoring and Supports — 95 FTEs		
Our provider team manages communications with our network of providers, resolve problems or inquiries, and provide education. The team includes dedicated resources who support practice transformation with provider offices. This team includes provider complaint and dispute resolution, and uses a multi-pronged approach to identify the need for education from our Provider Claims Educator. This team reports to the health plan CEO. Our Provider Service Line teams report to the Vice President of the Customer Contact Center (AmeriHealth Caritas Services) with local functional oversight by the CEO and COO.	The professionals on this team use their provider contracting, provider reimbursement, and managed health care, or Medicaid experience to understand and be responsive to provider issues.	T. Kelli Nolan, our Claims Administrator, has more than 15 years of Medicaid experience in Louisiana, inclusive of 10 years of management and supervisory experience. She uses her extensive understanding of the implementation of technical solutions and the claim adjudication life cycle to improve encounter acceptance and resolution and meet state deliverables. Ms. Nolan is currently pursuing her certification as a Certified Medical Claims Auditor with the American Academy of Professional Coders. Stacie Zerangue, Director of Provider Network Management leads our Provider Network Management team, using an integrated care lens to engage providers. Ms. Zerangue is a licensed clinical social worker with 26 years of specialty behavioral health experience and 23 years of experience leading physical and behavioral health integration efforts.
Quality Management and Improvement — 16 FTEs		
This team manages quality and uses data and outcomes measurement to guide health plan improvements. The Quality Director reports up through the Senior Vice President for Medical Excellence & Clinical Solutions (AmeriHealth Caritas Services). They have direct accountability to the health plan CEO and CMO.	Our Performance/Quality Improvement Coordinator is a nurse with extensive experience in data and outcomes measurement. Our Maternal/Child Health EPSDT Coordinator is a Louisiana-licensed registered nurse (RN) with 15 years of quality performance experience. These professionals work with a team of RNs and experienced HEDIS specialists to improve quality according to our Next Generation model of care initiatives.	Mary Scorsone, RN, our Quality Management Coordinator, has more than 23 years of experience in clinical and leadership capacities in the health care industry, with extensive understanding of large-scale health care quality improvement, provider services, education, and health care data analysis. She is a licensed RN in Louisiana with a Lean Six Sigma green belt.

Description of Team Role	Description of Team Competencies	Team Leadership
Population Health — 199 FTEs		
The Population Health team includes care management, which provides care management functions for physical and behavioral health care and maternity management. The Community Outreach and Education department includes peer support specialists across the state connecting enrollees to needed care and supports. These teams report to the Vice President of Population Health Clinical Operations (AmeriHealth Caritas Services) with local functional oversight by CEO and CMO. The Population Health team also includes Pharmacy services, which reports through Population Health (AmeriHealth Caritas Services) to the CMO.	The care management team includes professionals with supervisory experience, Louisiana-licensed mental health professionals, and people who live in the communities they serve. The Pharmacy Director's experience includes retail, clinical, and Medicaid managed care experience.	Rachel Weary, RN, MSN, is our Medical Management Coordinator. She has more than 10 years of executive health plan leadership experience. She is a licensed RN in Louisiana and is the President of the Southeastern Louisiana Black Nurses Association. She has a Master of Science in Nursing and for more than five years, she has coordinated our initiatives to manage all Medicaid management requirements under the LDH policies and contract. Grover Harrison directs our Community Education and Outreach initiatives, and has been working to promote wellness and engage enrollees in the Louisiana community for six years. Jeanine Plante, Pharm.D., draws upon more than 15 years of pharmacy management experience to lead our pharmacy services.
Utilization Management — 106 FTEs		
These associates make medical necessity determinations for physical and behavioral health. They manage all required utilization management Medicaid management requirements under federal and state policies, rules, and the contract. Our physician reviewers report to the Vice President for Population Health Medical Services (AmeriHealth Caritas Services). Non-clinical support staff and clinicians who conduct initial reviews report to the Vice President of Population Health Clinical Operations (AmeriHealth Caritas Services). They have direct accountability to the health plan CEO and CMO.	Each of the prior authorization and concurrent review teams include a Louisiana-licensed RN, licensed mental health professional, board-certified addictionologist, and a board-certified psychiatrist.	Yolonda Spooner, MD, and Jada Armstrong, MD, are board-certified physicians that head our utilization management function. Craig Troxclair, MD is a board-certified psychiatric medical administrator who directs psychiatric utilization management.
Finance — 5 FTEs		
This team oversees budget, accounting systems, financial reporting, actuarial work, and all financial audit activities. The business continuity and facilities functions also report to the finance department.	The Business Continuity Planning and Emergency Coordinator has extensive budgeting and logistics management experience and reports to the CFO.	Shannan Herring has more than 12 years of executive-level accounting experience. She has extensive knowledge of budget development and forecasting, management reporting, internal control procedure implementation, audit coordination, financial regulatory reporting, and operational analysis.
Fraud and Abuse Monitoring and Compliance — 15 FTEs		
The AmeriHealth Caritas Louisiana Compliance team directs the coordination of all contract compliance. The corporate Program Integrity team oversees monitoring and enforcement of the fraud, waste, and abuse compliance program to prevent and detect potential fraud, waste, and abuse activities. These teams are accountable to the AmeriHealth Caritas Louisiana Contract Compliance and Program Integrity Officer, the CEO, and the corporate Compliance and Privacy Officer (AmeriHealth Caritas Services) who	Our Contract Compliance and Program Integrity Officer leads a support staff of experienced data analysts, and contractually required special investigations unit (SIU) investigators, including Accredited Health Care Fraud Investigators.	Lesli Boudreaux, our Contract Compliance and Program Integrity Officer, has more than 21 years of Medicaid experience in Louisiana. Her experience includes programmatic leadership, operational management, oversight of contract compliance, and federal and state reporting.

Description of Team Role	Description of Team Competencies	Team Leadership
contributes the knowledge and experience gained from the best practices in other markets.		
Administration and Contract Management — 8 FTEs		
These teams manage the essential administrative and contracting needs of the health plan, including medical economics, government and external affairs, and human resources. These teams report directly to the CEO.	These teams include highly competent professionals in each respective field, including medical economics staff with years of health care experience and economic expertise, licensed attorneys, external affairs professionals with backgrounds in government, legal degrees, and government experience, and seasoned talent acquisition professionals.	Kyle Viator brings 15 years of executive and supervisory experience and 17 years of Medicaid experience to his role as CEO of AmeriHealth Caritas Louisiana. He is currently the board president of the Louisiana Medicaid MCO Association, and has an extensive track record of leadership in service and community organizations. His strategic oversight of all teams includes direction of our administrative and contract management functions.

***Figure 2.10.2.2.-2**: Functional Team Descriptions, Qualifications, And Competencies.*

2.10.2.3 Material Subcontractor Response Template (Appendix F)

AmeriHealth Caritas Louisiana will leverage the expertise of our material subcontractors to fulfill the requirements of certain core functions and value-added services for our enrollees. Our material subcontractors, as shown in **Attachments 2.10.2.3-1 through 2.10.2.3-5** have demonstrated best practices and innovative solutions within their industries and we would be proud to partner with them to continue supporting the Healthy Louisiana program.

MATERIAL SUBCONTRACTOR INFORMATION

Subcontractor Name	Subcontractor Role/s
[redacted]	[redacted] (**see Attachment 2.10.2.3-1**).
[redacted]	[redacted] (**see Attachment 2.10.2.3-2**).
PerformRx, LLC	Provision of comprehensive pharmacy benefit management (PBM) (**see Attachment 2.10.2.3-3**).
Southeastrans, Inc.	Provision of covered non-emergency transportation (NEMT) services (**see Attachment 2.10.2.3-4**).
[redacted]	[redacted] (**see Attachment 2.10.2.3-5**).

***Figure 2.10.2.3-1**: List Of Material Subcontractors.*

2.10.2.4 AmeriHealth Caritas Louisiana's Reference Information

Figures 2.10.2.4-1 - 2.10.2.4-13 provide contact information for each state with which AmeriHealth Caritas has had a Medicaid managed care contract for comparable services within the past three years, in addition to brief descriptions of the individuals we serve, our key responsibilities under each contract, and information about compliance actions taken by the state for each reference.

In accordance with the response to question number 48 in **Addendum #2: Q&A and Revisions**, we are providing descriptions of compliance actions for the term of the current contracts for AmeriHealth Caritas Louisiana and our affiliate health plans. Please note that our affiliate in Florida's contract began on December 1, 2018 and our affiliate in the District of Columbia has had several emergency contracts issued, as such we have included compliance issues from the previous contract terms for those two affiliates.

Louisiana AmeriHealth Caritas Louisiana serves 213,324 individuals, as of March 2019; contract term: February 1, 2015 to December 31, 2019.					
Contact Information		**Type of Individuals Served**			**Key Responsibilities**
Jen Steele Medicaid Director 1-225-342-9240 Jen.steele@la.gov		Families and children; pregnant women; Medicaid expansion adults; Supplemental Security Income (SSI); aged blind, and disabled (ABD); enrollees diagnosed with breast or cervical cancer; foster care children; Home and Community-Based Services (HCBS); waiver population for non-HCBS services only; residential facility and dual eligible enrollees.			Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services. The health plan also manages a limited benefit package of specialized behavioral health and non-emergency ambulance transportation services.
Entity that Issued Noncompliance	**Compliance Action**	**Date of Issue**	**Monetary Penalty**	**Reason for Issue**	**Corrective Actions Taken to Prevent Future Occurrence**
Louisiana Department of Insurance	Penalties	4/1/2015	$1,000	AmeriHealth Caritas Louisiana (ACLA) did not meet the deadline for renewal of its Third Party Administrator (TPA) license.	ACLA paid the penalty imposed for failing to renew its TPA license by the required deadline.
State of Louisiana Department of Health and Hospitals	Warning	4/4/2016	N/A	Did not process member grievances in the timeframes.	ACLA took the following actions: (1) hired a full-time grievance supervisor and a full-time grievance associate; and (2) streamlined its research process to promote direct channels of communication between the Member Grievance team and relevant departmental stakeholders. ACLA also submitted a report to LDH demonstrating that the health plan was processing all member grievances in accordance with contractual standards.
State of Louisiana Department of Health Bureau of Health Services Financing	Warning	1/18/2017	N/A	Did not submit accurate quarterly Specialized Behavioral Health (SBH) Network Reports.	ACLA's Provider Network Management department took the following actions to address the issue, including: (1) updating internal systems to capture all required data elements for the reports at issue; (2) ensuring that all behavioral health providers were instructed to resubmit correct taxonomies; and (3) removing incorrect provider types as options from all reports with the correct provider types identified. By letter dated April 3, 2017, LDH closed this warning without further action.
State of Louisiana Department of Health Bureau of Health Services Financing	Warning	2/22/2017	N/A	Did not update system with the daily Third Party Liability (TPL) records sent from LDH's Fiscal Intermediary (FI) within one business day of receipt.	ACLA's Business Engagement Services and TPL departments took the following actions to address the issue, including: (1) implementing an automated solution that loads all TPL data from LDH; and (2) independently re-validating policy coverage information on the daily TPL incremental file for those records believed to contain incorrect information. By letter dated June 6, 2017, LDH closed the warning without further action.
State of Louisiana Department of Health Bureau of Health Services Financing	Warning	5/16/2017	N/A	Did not process member grievances in the timeframes.	ACLA's Grievance Department took the following actions to address the issue, including: (1) contacting providers directly instead of referring the grievances to Provider Network Management (PNM); and (2) only referring grievances to PNM when they are unsuccessful in reaching the provider after three attempts over a 10 business day period. By letter dated August 1, 2017, LDH deemed ACLA in compliance and closed the warning without further action.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
State of Louisiana Department of Health Bureau of Health Services Financing	Warning	11/21/2017	N/A	Did not validate provider demographic data to ensure current, accurate, and clean data on file for all contracted providers.	ACLA developed an internal workgroup to remediate inaccuracies identified in the provider directory records by LDH. ACLA's remediation plan included the following tasks: • Ensure receipt of comprehensive delegate rosters; • Enhance corporate auditing of provider data maintenance; • Ensure receipt pf organizational provider rosters; • Enhance provider education and reinforcement; • Implement a consistent approach to resolution of provider returned mail; • Develop an electronic mechanism for provider demographic updates; • Hire a full-time employee dedicated to provider data remediation; • Implement a consistent approach to corrective action for providers' that do not respond/attest or update their demographic information; and • Implement an electronic mechanism for members to report problematic provider information.
Louisiana Department of Health (LDH)	Penalties	6/25/2018	$50,000	Did not validate provider directory data to ensure accurate data is on file for all contracted providers. LDH issued a monetary penalty based on secret shopper surveys that LDH conducted of targeted providers.	ACLA took the following actions to address the issue, including: • Conducted a thorough review of the providers surveyed by LDH and removed providers from affiliated locations where they did not work on a regularly scheduled basis; • Implemented an online provider directory feedback tool to provide directory users with a mechanism to report inaccuracies related to directory listings; • Contracted with a vendor to conduct outbound calls to provider offices for the purpose of validating their directory entries; • Enhanced the provider credentialing intake process to perform additional provider data validation prior to loading provider data to the directory.
LDH	Penalties	12/4/2018	$500,000	Did not meet established benchmarks for Quality Improvement in the following categories: • Measure: Nulliparous Singleton Vertex Births (Cesarean Rate for Low-Risk First Birth Women).* MCO Performance: 28.41%. Target: 26.47%. • Measure: Ambulatory Care Emergency Department Visits/1000 MM.* MCO Performance: 86.46%. Target: 68.37%. • Measure is an inverse measure; a	ACLA took the following actions to improve and reduce the Emergency Department (ED) admissions, including: • Creation of department wide workgroups that focus on new initiatives and member/provider barriers that result in high ED utilization; • Sending automated reminder calls to high ED utilizers; • Enhancing the ED diversion outreach program to identify the root cause of an ED visit; • Adoption of an electronic ED information system on a statewide basis; • Real time statewide prescription monitoring system; • Providing enhanced access to the provider directory for urgent care centers; and; • Enhancing after-hours incentivized programs for primary care providers.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
				lower rate is desirable.	The cesarean birth rate target was removed as a performance measure and therefore the remediation plan did not include action related to this measure.
LDH	Penalties	2/15/2019	$50,000	Did not validate provider directory data to ensure accurate data is on file for all contracted providers. LDH issued a monetary penalty based on secret shopper surveys that LDH conducted of targeted providers.	ACLA has implemented, or is in the process of implementing, the following remediation efforts: • Implemented a Provider Data Information Form ("PDIF") to reduce the need for providers to submit written correspondence and minimize time spent calling the Provider Services department to update demographic information. The PDIF helps providers review their information on file, attest to its accuracy, and make any necessary changes. The PDIF also allows ACLA to accept updates made to the provider directory in real time. ACLA has conducted provider webinars in the last quarter of 2018 to educate providers on the PDIF. • Enhanced Provider Delegation process, including: (1) increasing the number of audits and reporting throughout the process to validate the accuracy of the provider data; and (2) holding weekly joint operation calls or meetings with large provider groups to improve the quality and timeliness of the exchange of provider demographic information. • Increased internal Audit Contractor activities: ACLA is continuing its relationship with Square Button, a Hudson vendor, to conduct outbound calls to provider offices for the purpose of validating demographic information used in the provider directory. ACLA uses this data to initiate provider outreach for demographic change verifications.
LDH	Penalties	4/2/2019	$5,000	Did not meet the prompt pay performance standards (rehabilitation claims fell below the 30-day prompt pay performance standard by 1%) for the month of January 2019.	ACLA met the prompt pay performance standards for February 2019. ACLA's Compliance Officer is assessing March 2019, and ACLA's Director of Operations has been assigned to monitor the Claims team's performance to ensure that all performance standards are met. The ACLA Compliance department will continue to monitor these performance standards and, if necessary, issue a formal internal remedial action plan to correct any identified deficiencies.
LDH	Notice of Action	4/16/2019	N/A	Claims for dates of service 1/1/2019 and beyond, billed inappropriately per the requirements of Act 582 to process for payment rather than deny for inaccurate billing impacting the identified encounters.	• ACLA will develop a provider notice to reinforce billing requirements for psychosocial rehabilitation (PSR) claims billed with H2017 with no modifier or with any modifier and community psychiatric supportive treatment (CPST) claims billed with H0036 without modifier HE, HK, or TG. • ACLA will close the facility/entity provider record for those identified providers and apply a no-pay indicator which will eliminate future claim payment when the provider bills inappropriately either without the presence of a rendering NPI or instances where the provider bills using the same NPI or both the rendering and the billing provider.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
					• ACLA will validate the provider registry response file to ensure that BHSPs providing psychosocial rehabilitation (PSR) or community psychiatric supportive treatment (CPST) have been properly submitted and accepted and assure that rendering providers are setup on the MCO Provider Registry as an Entity Type 1 (Individual) with the applicable provider type. This action will eliminate instances where encounters are observed to have a Rendering Provider that uses Provider Type 74, 77 or AG (LGE, MHR, BH Rehab).

Figure 2.10.2.4-1: *Louisiana Contact Information And Descriptions.*

Delaware AmeriHealth Caritas Delaware serves 61,574 Individuals, as of March 2019; contract term: January 1, 2018 to December 31, 2019.		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Kathleen Dougherty Chief Managed Care Operations Department of Health and Social Services [redacted] Kathleen.dougherty@state.de.us	Families and children; SSI; ABD; individuals with functional limitations and chronic illnesses, including nursing home and HCBS waiver enrollees; Children's Health Insurance Program (CHIP); Medicaid Expansion. (Services for Developmentally Disabled become effective July 2019)	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, long-term services and supports (LTSS), and pharmacy services.
AmeriHealth Caritas Delaware does not have any compliance issues to report.		

Figure 2.10.2.4-2: *Delaware Contact Information, Descriptions, And Compliance Actions.*

District of Columbia AmeriHealth Caritas District of Columbia serves 124,362 individuals, as of March 2019; contract term: October 1, 2017 to April 28, 2019 (includes emergency contract extensions).		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Lisa Truitt Director Health Care Delivery Management Administration Department of Health Care Finance [redacted] Lisa.truitt@dc.gov	Families and children, CHIP, and District of Columbia Health Care Alliance (Medicaid expansion).	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
				[redacted]	

Figure 2.10.2.4-3: *District of Columbia Contact Information, Descriptions, And Compliance Actions.*

Florida Prestige Health Plan serves 78,932 individuals, as of March 2019; contract term: December 1, 2018 to December 31, 2023 (prior contract term: January 31, 2014 to November 30, 2018		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Tylee Culpepper Medical/Health Care Program Analyst Agency for Health Care Administration [redacted] Cathy.Culpepper@ahca.myflorida.com	Families and children, SSI, Medicaid services for dual eligible enrollees.	Providing, arranging, and coordinating preventive, primary care, specialty care, acute care, home health, durable medical equipment, behavioral health, and pharmacy services.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
					[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
					[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
				[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

AmeriHealth Caritas Louisiana

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
					[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Florida True Health, Inc. was a joint venture entity between AmeriHealth Caritas and Blue Cross Blue Shield of Florida. Florida True Health held a contract with the Agency for Health Care Administration for Medicaid managed care services, covering 8 of 11 Medicaid managed care regions in the State of Florida; this contract expired January 31, 2019 as the State transitioned to new contracts that were awarded under a competitive procurement process. Florida True Health will continue providing Medicaid managed care services in two regions under a new contract that was awarded under the procurement which began on December 1, 2018.					

Figure 2.10.2.4-4*: *Florida Contact Information, Descriptions, And Compliance Actions.

AmeriHealth Caritas Louisiana

Iowa AmeriHealth Caritas Iowa served 222,485 individuals, as of December 2017; contract term: January 1, 2016 to December 31, 2017		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Mike Randol Medicaid Director Iowa Department of Human Services [redacted] mrandol@dhs.state.ia.us	Families and children; dual eligible enrollees; individuals with functional limitations and chronic illnesses, including nursing home and HCBS waiver enrollees; ABD; CHIP; children in foster care.	Provided, arranged, and coordinated preventive, primary, acute care, behavioral health, pharmacy, and LTSS covered services until December 31, 2017.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]					

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
				[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

AmeriHealth Caritas Louisiana

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
During AmeriHealth Caritas Iowa's negotiations with the Iowa Department of Human Services (DHS) for state fiscal year 2018 capitation rates, our affiliate, AmeriHealth Caritas Iowa identified concerns around rates and the rate projections. AmeriHealth Caritas Iowa worked diligently with the Iowa DHS, proposing numerous alternatives but was not able to reach agreement on rates for state fiscal year 2018. AmeriHealth Caritas Iowa and DHS mutually agreed to terminate the contract, effective November 30, 2017. AmeriHealth Caritas Iowa worked with the Iowa DHS to ensure an orderly transition of services in advance of exiting the program. "From the outset, AmeriHealth Caritas Iowa has been a valued partner as we implemented Medicaid managed care," said Iowa Health Link Director Jerry Foxhoven. "This partnership and collaboration will continue as we work to ensure a smooth transition and continuity of care for Members."					

Figure 2.10.2.4-5: *Iowa Contact Information, Descriptions, And Compliance Actions.*

Michigan Blue Cross Complete serves 209,593 individuals, as of March 2019; contract term: January 1, 2016 to December 31, 2020					
Contact Information			**Type of Individuals Served**		**Key Responsibilities**
Kathy Stiffler Acting Deputy Director Medical Services [redacted] stifflerk@michigan.gov			Families and children, ABD, Children's Special Health Care Services, Healthy Michigan Plan (Medicaid Expansion), Medicaid coverage for dual eligible enrollees in counties not participating with the Medicare-Medicaid Plan demonstration project, and uninsured children of Michigan's working families.		Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.
Entity that Issued Noncompliance	**Compliance Action**	**Date of Issue**	**Monetary Penalty**	**Reason for Issue**	**Corrective Actions Taken to Prevent Future Occurrence**
[redacted]					
[redacted]					
[redacted]					
[redacted]					

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
				[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Figure 2.10.2.4-6: *Michigan Contact Information, Descriptions, And Compliance Actions.*

Nebraska: AmeriHealth Caritas Nebraska d/b/a Arbor Health Plan served 25,856 individuals, as of December 2016; contract term: July 1, 2015 to December 31, 2016.		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Matthew Van Patton Director Division of Medicaid and Long-Term Care [redacted] matthew.vanpatton@nebraska.gov	Families and children, CHIP, ABD, Medicaid-eligible expectant mothers, and foster care children.	Provided, arranged, and coordinated preventive, primary, acute care, behavioral health, and pharmacy covered services until December 31, 2016.
Arbor Health Plan does not have any compliance issues to report.		
AmeriHealth Nebraska, Inc. was a joint venture entity between AmeriHealth Caritas and Blue Cross Blue Shield Nebraska. AmeriHealth Nebraska held a contract with the Nebraska Department of Health and Human Services for Medicaid managed care services that expired December 31, 2016.		

Figure 2.10.2.4-7: *Nebraska Contact Information, Descriptions, And Compliance Actions.*

Pennsylvania Keystone First served (through Vista Health Plan, Inc.) serves 425,650 individuals, as of March 2019; contract term: April 1, 2010 to December 31, 2019.		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Sally A. Kozak Deputy Secretary Department of Human Services [redacted] sakozak@pa.gov	Families and children, SSI beneficiaries, enrollees diagnosed with breast or cervical cancer; newly eligible enrollees who are new to Medicaid due to expansion; enrollees receiving maternity care.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Figure 2.10.2.4-8: *Pennsylvania Contact Information, Descriptions, And Compliance Actions.*

Pennsylvania AmeriHealth Caritas Pennsylvania (through Vista Health Plan, Inc.) serves 285,496 individuals, as of March 2019. Lehigh/Capital Zone; contract term: April 1, 2010 to December 31, 2019. Northeast Zone; contract term: March 1, 2013 to December 31, 2019. New West Zone; contract term: October 1, 2012 to December 31, 2019.					
Contact Information	**Type of Individuals Served**				**Key Responsibilities**
Sally A. Kozak Deputy Secretary Department of Human Services [redacted] sakozak@pa.gov	Families and children, SSI, enrollees diagnosed with breast or cervical cancer; newly eligible enrollees who are new to Medicaid due to expansion; enrollees receiving maternity care.				Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.
Entity that Issued Noncompliance	**Compliance Action**	**Date of Issue**	**Monetary Penalty**	**Reason for Issue**	**Corrective Actions Taken to Prevent Future Occurrence**
AmeriHealth Caritas Pennsylvania (ACPA) Contract					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
AmeriHealth Caritas Northeast (ACN) Contract					
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
AmeriHealth Caritas Pennsylvania (ACPA), AmeriHealth Caritas Northeast (ACN), Keystone First (KF) Combined					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
AmeriHealth Caritas Pennsylvania (ACPA) and Keystone First (KF) Combined					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Figure 2.10.2.4-9: *Pennsylvania Contact Information, Descriptions, And Compliance Actions.*

Pennsylvania AmeriHealth Caritas Community Health Choices (through Vista Health Plan, Inc.) serves 15,080 individuals, as of March 2019; contract term: January 1, 2019 to December 31, 2022.					
Contact Information	**Type of Individuals Served**			**Key Responsibilities**	
Kevin Hancock Deputy Secretary Department of Human Services [redacted] kehancock@pa.gov	Individuals with functional limitations and chronic illnesses, including nursing home and HCBS waiver enrollees and dual eligible enrollees.			Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, pharmacy, and long-term services and supports (LTSS) covered services.	
Entity that Issued Noncompliance	**Compliance Action**	**Date of Issue**	**Monetary Penalty**	**Reason for Issue**	**Corrective Actions Taken to Prevent Future Occurrence**
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]

Figure 2.10.2.4-10: *Pennsylvania Contact Information, Descriptions, And Compliance Actions.*

Pennsylvania Keystone First Community Health Choices (through Vista Health Plan, Inc.) serves 73,092 individuals, as of March 2019; contract term January 1, 2018 to December 31, 2022		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Kevin Hancock Deputy Secretary Department of Human Services [redacted] kehancock@pa.gov	Individuals with functional limitations and chronic illnesses, including nursing home and HCBS waiver enrollees and dual eligible enrollees.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, pharmacy, and long-term services and supports (LTSS) covered services.
Keystone First Community Health Choices does not have any compliance issues to report.		

Figure 2.10.2.4-11: *Pennsylvania Contact Information, Descriptions, And Compliance Actions.*

Pennsylvania PerformCare serves 259,413 individuals as of March 2019 in: Capital Area Behavioral Health Collaborative; contract term: July 1, 2017 to June 30, 2020. Behavioral Health Services of Somerset and Bedford Counties; contract term: July 1, 2016 to June 30, 2019. Tuscarora Managed Care Alliance; contract term: July 1, 2017 to June 30, 2020.		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Scott Suhring Chief Executive Officer Capital Area Behavioral Health Collaborative [redacted] ssuhring@cabhc.org	Families and children, and SSI beneficiaries.	Providing, arranging, and coordinating behavioral health care.
Tia Mann HealthChoices Coordinator [redacted] tmann@bhssbc.us	Families and children, and SSI beneficiaries.	Providing, arranging, and coordinating behavioral health care.
Melissa Reisinger [redacted] 1-717-709-4332 mlreisinger@franklincountypa.gov	Families and children, and SSI beneficiaries.	Providing, arranging, and coordinating behavioral health care.

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]		[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
					[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Entity that Issued Noncompliance	Compliance Action	Date of Issue	Monetary Penalty	Reason for Issue	Corrective Actions Taken to Prevent Future Occurrence
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]	[redacted]

Figure 2.10.2.4-12: *Pennsylvania Contact Information, Descriptions, And Compliance Actions.*

South Carolina Select Health of South Carolina serves 363,936 individuals, as of March 2019; contract term: July 1, 2018 to June 30, 2021.		
Contact Information	**Type of Individuals Served**	**Key Responsibilities**
Joshua Baker Director Department of Health and Human Services [redacted] joshua.baker@scdhhs.gov	Families and children, SSI and CHIP beneficiaries, foster children, and Sixth Omnibus Budget Reconciliation Act coverage for low-income, pregnant women and infants.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.
Select Health of South Carolina does not have any compliance issues to report.		

***Figure 2.10.2.4-13**: South Carolina Contact Information, Descriptions, And Compliance Actions.*

2.10.2.5 NCQA Accreditation

2.10.2.5.1 Demonstration Of AmeriHealth Caritas Louisiana's NCQA Accreditation

AmeriHealth Caritas Louisiana has a Commendable accreditation from the National Committee for Quality Assurance (NCQA). We received an overall rating of 3.5 out of 5 in the NCQA Medicaid Health Insurance Plan Ratings for 2018-2019, which reflects our constant drive for improvement (e.g. received 3 out of 5 in 2017-2018). Our Consumer Satisfaction rating is 4.5 out of 5, which is an improvement over the 4 out of 5 rating we received in the 2017-2018 year. Both the overall and Consumer Satisfaction NCQA ratings are tied for highest in the state among other participating Healthy Louisiana health plans. We believe our improved scores indicate how well our health plan manages and continues to improve upon all parts of the health care delivery system, including physicians, hospitals, other providers, and administrative services in order to continuously improve the quality of care and service we provide to our enrollees. Specifically, in the 2018-2019 year, our NCQA Satisfaction with Health Plan Services rating was 5 out of 5, which we believe is reflective of our commitment to improving our enrollees' health and to providing dependable customer service.

In particular, we believe our efforts to provide culturally competent care are reflected in our receipt of the NCQA Multicultural Health Care Distinction in 2017. This distinction reflects our commitment to standards and best practices of providing culturally and linguistically sensitive services (CLAS). In order to reduce health care disparities, AmeriHealth Caritas Louisiana has a CLAS coordinator and collaborates with our enterprise CLAS committee to address 15 national CLAS standards and NCQA's Multicultural Health Care Standards.

We are committed to being at the forefront of care, as a tenet of our Next Generation model of care, which promotes enhanced care that addresses social determinants of health in addition to physical and behavioral wellness. It is our goal to obtain a five-star rating, and are using quality improvement and innovation, including value-based programs, enrollee incentives, evidence-based interventions, and data-driven analysis, to achieve the goal as further described in our response to **RFP Section 2.10.11**.

A copy of our NCQA accreditation certificate is included as **Attachment 2.10.2.5-1**.

2.10.2.5.2 Demonstration Of Behavioral Health Subcontractor's NCQA Accreditation

AmeriHealth Caritas Louisiana's behavioral health services are not subcontracted. AmeriHealth Caritas' Next Generation model of care truly integrates behavioral health with physical health, pharmacy, and social supports for the benefit of our enrollees. We believe our NCQA accreditations and reviews are reflective of our health plan's well-integrated services.

2.10.3
Enrollee Value-Added Benefits

One of AmeriHealth Caritas Louisiana's bilingual community health educators interacts with attendees at the New Orleans Community Wellness Center open house.

AmeriHealth Caritas™
Louisiana

2.10.3 Enrollee Value-Added Benefits

2.10.3.2 Value-Added Benefit Options

AmeriHealth Caritas Louisiana **proposes to offer all six of the optional value-added benefits (VABs) under the new Contract.** We currently offer four of the six optional VABs, but we propose to enhance our existing offerings, as described in the benefit specific tables below. Our intent is to improve the offerings of VABs. [redacted] We use encounter data to identify and monitor the effectiveness of each VAB in accordance with **Model Contract, 2.5.5.1 and 2.5.5.2.**

We designed our proposed VABs, listed in **Figure 2.10.3.2-1**, to strengthen whole-person care, promote healthy behaviors, and achieve better health outcomes. We engaged stakeholders, including, but not limited to, enrollees, providers, and community-based organizations, in the development and evolution of our VABs. We customize each proposed VAB to meet the needs of our Louisiana enrollees and include evidence-based best practices when available. We will continue to offer transportation for our VABs, **(Model Contract, 2.5.5.3)**, and partner with Louisiana Department of Health (LDH) to develop and modify VABs with the ultimate goal of supporting state objectives related to health outcomes, promoting healthy lifestyles, and reducing costs.

Optional Value-Added Benefit	Currently Offered	Proposed
Dental benefits for adults, including exams, preventive services, and restorative services, but excluding extractions.	X	X
Evidence-based non-pharmacologic alternatives to opioids for chronic pain management services for adults.	X	X
Respite care model targeting homeless persons with post-acute medical needs including addressing strategies for counseling, nutrition, housing stabilization, transitional care, and other services necessary for successful community reintegration.		X
Newborn circumcision benefits.	X	X
Tobacco cessation benefits, not including medications.		X
Vision benefits for adults, including annual exam and glasses or contacts.	X	X

***Figure 2.10.3.2-1**: Optional VABs.*

2.10.3.3 Selected Value Added Benefits

Dental Value-Added Benefit For Adults 21 And Over

AmeriHealth Caritas Louisiana currently offers an adult dental VAB and will continue to offer dental services as a VAB under the new contract as we believe oral health is a key part of overall health. We will continue to identify enrollees with repeat emergency department (ED) visits related to dental pain to educate them on the dental VAB, screen them for other care needs, and assist when necessary in linking them to required services, including a primary care dentist, shown in **Figure 2.10.3.3-1.** In 2018, there were 17,162 unique enrollees who accessed our expanded dental benefit.

Adult Dental	
2.10.3.3.1 Target Population	Enrollees 21 years old and over.
2.10.3.3.2 Scope of Benefit	Existing Louisiana Medicaid Benefit: Emergency and surgical dental services for adults are managed care organization (MCO) covered benefits. Preventive and restorative services such as exams, cleanings, X-rays, and fillings are not MCO covered benefits for Adults 21 and over. Offering this VAB expands preventive and restorative dental services to the 21 and over population to align

Adult Dental	
	with our goals of improving population health, reducing the rate of potentially preventable events such as ED visits and admissions related to dental conditions, and reducing costs associated with acute dental disease.
	Proposed VAB: The adult dental VAB has an annual combined total benefit maximum of $500.00 per enrollee as detailed below. The preventive dental VAB has a combined total benefit maximum of $225.00 per calendar year and includes: • Two routine dental exams. • Two prophylactic cleanings. • One complete set of bitewing X-rays. The comprehensive dental VAB has a combined total benefit maximum of $275.00 per calendar year, and includes fillings, crowns, and other restorative services (i.e. full mouth debridement, planing, and scaling), as referenced in the CPT codes below. Unused portions of the $225.00 preventative dental VAB annual benefit maximum and the $275.00 comprehensive dental VAB benefit maximum do not roll over to the next calendar year.
	CPT Codes: D0120, D0140, D0150, D0180, D0210, D0220, D0230, D0240, D0272, D0330, D1110, D2140, D2150,D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2392, D4341, D4355. NEMT: A0090, A0100, A0120, A0130, A0425, S0215, and T2003
2.10.3.3.3 Copays	None.
2.10.3.3.4 How Provided	We inform our enrollees about the full scope of the adult dental VAB during new enrollee orientation as well as in the Welcome Kit, Member Handbook, and member newsletters. We disclose the name of the subcontractor providing the adult dental VAB to our enrollees in the Member Handbook and whenever we offer enrollee education related to VABs. We also inform enrollees on the process for accessing the VAB, including eligibility and prior authorization requirements, and any limitations or exclusions in the Member Handbook and newsletter, on the Member Portal of our website, and during contacts with Care Management staff, Community Health Workers (CHWS), and Member Services Call Center staff. Our plan representatives, including, but not limited, to Case Managers and CHWs, identify enrollees who are eligible for the VAB and ensure the enrollees or their providers are aware of its availability and how to access the VAB. For example, a Case Manager may identify an enrollee with multiple ED visits for complaints of dental pain and outreach to the enrollee and their primary care provider (PCP) to educate them on the dental VAB. [redacted] We assist the subcontractor in identifying enrollees in a manner that prevents discrimination to provide or coordinate the provision of this VAB, **(Model Contract, 2.13.7.10)**.
2.10.3.3.5 Oversight	AmeriHealth Caritas Louisiana uses a combination of internal quality assurance and performance improvement (QAPI) program activities and subcontractor oversight mechanisms to ensure our VABs are effective and are provided and reported in accordance with contract requirements. In both cases, we use performance effectiveness measures that include a baseline, goals, and a frequency of measurement. AmeriHealth Caritas Louisiana's subcontractor oversight manager, a certified project manager based in Baton Rouge, monitors subcontractor performance to confirm conformance with contract requirements, including National Committee for Quality Assurance (NCQA) standards, and other quality initiatives. For example, we monitor our dental subcontractor's performance in several areas, including Provider Call Center performance (i.e. average speed to answer, abandonment, and blockage rates), timeliness and accuracy of claims processing, and timeliness and accuracy of encounter data submission. We also monitor for conformance with NCQA's delegation oversight requirements such as provider credentialing and re-credentialing, enrollee satisfaction, and complaints. We monitor subcontractor performance monthly to ensure levels meet or exceed those specified in the subcontract, Medicaid contract, and state and federal law. We engage in this monthly review to promptly identify any potential areas of concern. For highly sensitive metrics, subcontractors submit monitoring data

Adult Dental	
	and participate in review meetings more frequently. For the average encounter acceptance rates, for example, subcontractors will submit encounter data twice per week and participate in meetings with AmeriHealth Caritas Louisiana weekly, or more frequently, if needed. We use the findings from the pre-delegation evaluation, annual evaluations, audits, and reports to identify areas of improvement and implement a corrective action plan (CAP) to improve performance if findings warrant. Our subcontractor oversight manager monitors activities continuously throughout the life of the contract, and extends monitoring through post-termination of the contract if the subcontractor continues to provide services during a run-out period.

***Figure 2.10.3.3-1**: Dental VAB for Adults.*

Evidence-Based Non-Pharmacologic Alternatives To Opioids For Chronic Pain Management Value-Added Benefit

In June 2017, AmeriHealth Caritas Louisiana developed the Living Beyond Pain program, a comprehensive chronic pain management program that includes a range of covered services and prior authorized VABs intended to reduce the risk of opioid dependence. This program provides evidence based, non-pharmacologic alternatives for chronic pain management that reduce enrollee pain levels, improve functioning and self-management of chronic pain, and prevent chronic pain from escalating into a medical emergency. This VAB aligns with our utilization management and care management programs as they strive to improve health outcomes through person-centered care, as shown in **Figure 2.10.3.3-2**. Since its inception, enrollees who have participated in Living Beyond Pain have reported lower levels of pain and less frequent pain pre- and post-intervention. Analysis of total opioid utilization and cost conducted in April 2019, showed a significant reduction between pre- and post-intervention periods:

- Total opioid utilization in the engaged population saw a 30 percent reduction in the pre- to post-intervention period. Related costs decreased by 26 percent.
- Total opioid utilization when medication assisted treatment (MAT) was excluded from the analysis saw a 34 percent reduction. After the first 16 months of the program, related costs decreased by 46 percent.

Non-Pharmacologic Alternatives to Opioids	
Living Beyond Pain	
2.10.3.3.1 Target Population	Enrollees 21 years and older living with chronic pain including: chronic back pain, neck pain, sciatica, lumbago, and chronic pain syndrome. Enrollees may be referred by their Case Manager or provider, or identified through ED claims that indicate 3 or more ED visits within 12 months for chronic pain.
2.10.3.3.2 Scope of Benefit	Existing Louisiana Medicaid Benefit: MCO covered services for enrollees 21 years and older include medically necessary physical therapy provided in a hospital outpatient setting.
	Our current VAB includes: • Adult chiropractic services, including x-rays and 12 manipulation visits annually. If enrollee shows progress, an additional 12 visits may be authorized. • Adult physical therapy services in freestanding facilities, limited to 12 therapeutic treatments with hot or cold packs annually. • Facet joint treatment for chronic pain, by pain management specialists, including epidural steroid injections and radiofrequency ablation. **Additional VAB proposed for new contract**: • Acupuncture, 12 visits annually (without electrical stimulation). • One transcutaneous electrical nerve stimulation (TENS) unit in a lifetime.
	CPT Codes: • Chiropractic Manipulative Treatments: 98940, 98941 • Chiropractic Overview/X-rays: 99204, 99211, 99212, 99213, 98941, 72040, 72070, 72100 • Physical Therapy Treatments: 97010, 97110

Non-Pharmacologic Alternatives to Opioids	
	• Epidural Steroid Injection: 62320, 62321, 62322, 62323, 64479, 64480, 64483, 64484 • Facet joint injection and radiofrequency ablation: 64490, 64491, 64492, 64493, 64494, 64495, 64633, 64634, 64635, 64636 • Other injections: 20552, 20553, 27096, 64405 • Acupuncture: 97810, 97811 • TENS: E0720, E0730, A4595 • NEMT: A0090, A0100, A0120, A0130, A0425, S0215, and T2003
2.10.3.3.3 Copays	None.
2.10.3.3.4 How Provided	All services, including VABs, are authorized by our utilization management team in accordance with findings from the Living Beyond Pain program assessment conducted by the assigned AmeriHealth Caritas Louisiana Case Manager. The Living Beyond Pain assessment also screens for behavioral health needs, particularly those related to the enrollee's chronic pain. Professional services and DME are provided by participating providers and non-participating providers. Living Beyond Pain offers three levels of intervention based on the individual enrollee's needs: • Option one — Intervention includes up to 12 chiropractic visits per year, up to 12 physical therapy visits per year , up to 12 acupuncture visits annually, and one TENS unit. • Option two — Intervention for enrollees with continued chronic pain includes an additional 12 chiropractic visits (24 total) and 12 physical therapy visits (24 total). • Option three — Intervention includes 12 additional chiropractic visits (36 total), epidural steroid injections, as applicable, facet joint treatment, as applicable, and radiofrequency ablation, as applicable. The Case Manager may provide a standing authorization for transportation to pain management services until the enrollee no longer needs these services and supports.
2.10.3.3.5 Oversight	We monitor reduction in ED utilization, reduction in pain related prescriptions, and improvement in functional level and quality of life for enrollees engaged in the Living Beyond Pain program. Our Population Health and Provider Network Management teams have day-to-day responsibility for access to the Living Beyond Pain program and they report to the bi-weekly Care Coordination workgroup. The Care Coordination workgroup reports findings to the CEO, CMO, and quality committees. AmeriHealth Caritas Louisiana's QAPIC, along with the QSC and QCCC, which serve as QAPIC subcommittees, are responsible for oversight of QAPI program activities related to health plan services, clinical quality, utilization management, case management, and pharmacy.

***Figure 2.10.3.3-2**: Non-Pharmacologic Alternatives to Opioids.*

Respite Care Model Targeting Homeless Persons With Post-Acute Medical Needs Value-Added Benefit

AmeriHealth Caritas Louisiana proposes to offer a respite care VAB for homeless enrollees needing post-acute medical services, displayed in **Figure 2.10.3.3-3**.

Our respite care model will address medical services, housing stabilization, counseling, nutrition, transitional care, and other services necessary for community integration. We will leverage the experience of our affiliate health plans in Pennsylvania and the District of Columbia as we develop respite care solutions that help to prevent admission/readmission, address the co-occurring physical and behavioral health conditions that often contribute to homelessness and poor health outcomes, and move enrollees along the path toward permanent housing. Our rapid rehousing strategy will be a key element of our respite model. Our Housing Specialist will help enrollees to achieve long-term housing stability while an assigned Case Manager will help enrollees access necessary post-acute medical and community services as well as other covered services and VABs. For example, we might arrange for a skilled nursing visit or help an enrollee schedule follow-up medical appointments and arrange for transportation to ensure the enrollee

attends the appointment. We see this respite benefit as one-step along a continuum of care and services designed to address the long-term housing, healthcare, and social needs of our homeless enrollees.

We will partner with reputable and experienced providers and community-based organizations throughout the state equipped to meet the needs of this population as we create a respite care model that addresses the unique needs of each enrollee as well as the resources available in each region. These solutions may include mobile support services linked to a Federally Qualified Health Center (FQHC), designated respite beds in existing shelters that can accommodate medical oversight, or identification of other housing options along with a package of wrap around support services. We will obtain ongoing stakeholder input as we employ flexible and innovative approaches that support our enrollees who experience both homelessness and post-acute medical needs.

Respite Care Model Targeting Homeless Persons With Post-Acute Medical Needs	
2.10.3.3.1 Target Population	Homeless enrollees[1], with post-acute medical needs following discharge from a hospital, skilled nursing, or long-term care facility. Enrollees discharged from an ED may be eligible depending upon timeliness of notification.
2.10.3.3.2 Scope of Benefit	Existing Louisiana Medicaid Benefit: There is no MCO covered respite benefit for homeless enrollees with post-acute medical needs. This VAB aligns with our Utilization Management program goal of helping to ensure enrollees receive the right care in an appropriate setting; our Case Management program, which provides coordination of services for enrollees, including those who are homeless; and our population health and social determinants of health initiatives, which support a whole-person approach to improving health outcomes.
	Proposed VAB: [redacted]
	CPT Codes: • Respite Care: T2033 • Food as Medicine Home Delivered Meals: S5170 • NEMT: A0090, A0100, A0120, A0130, A0425, S0215, and T2003
2.10.3.3.3 Copays	None.
2.10.3.3.4 How Provided	Eligible enrollees may already be in case management, or identified through ADT data, concurrent review, discharge planning, and transitions of care setting activities. Once we identify an eligible enrollee, we will refer the enrollee to case management and to our Housing Specialist, who will collaborate with our community housing partner START, to identify appropriate respite placement. Our Case Manager and Housing Specialist will then collaborate with the housing agency to implement a person-centered plan of care that addresses the physical, behavioral, and social needs of the enrollee and supports achievement of long term stable housing. We assist the subcontractor in identifying enrollees in a manner that prevents discrimination against enrollees in order to provide or coordinate the provision of this VAB, **(Model Contract, 2.13.7.10)**. We disclose the name of each subcontractor providing this VAB to our enrollees in the Member Handbook and at any time we offer enrollee education related to VABs.
2.10.3.3.5 Oversight	AmeriHealth Caritas Louisiana uses a combination of internal QAPI program activities and subcontractor oversight mechanisms to ensure our VABs are effective and are provided and reported in accordance with contract requirements. In both cases, we use performance effectiveness measures that include baseline, goals,

[1] https://endhomelessness.org/resource/changes-in-the-hud-definition-of-homeless/

Respite Care Model Targeting Homeless Persons With Post-Acute Medical Needs	
	and frequency of measurement. Our respite care model will require effective communication and collaboration among our case management and housing staff, network providers, and the community agencies that offer housing and other community-based services. Therefore, oversight will require combination of internal performance measures, daily oversight of the housing agency by our Housing Specialist, subcontractor oversight of the housing agency(s), and clinical and financial effectiveness measures (i.e. total cost of care, ED utilization, and inpatient admissions/readmissions). AmeriHealth Caritas Louisiana's subcontractor oversight manager, a certified project manager based in Baton Rouge, monitors subcontractor performance to confirm conformance with contract requirements, including NCQA standards, and other quality initiatives. We monitor subcontractor performance monthly to ensure levels meet or exceed those specified in the subcontract, the Medicaid contract, and state and federal law. We engage in this monthly review to promptly identify potential areas of concern. For highly sensitive metrics, subcontractors submit monitoring data and participate in review meetings more frequently. Our subcontractor oversight manager monitors activities continuously throughout the life of the contract, and extends monitoring through post-termination of the contract if the subcontractor continues to provide services during a run-out period.

***Figure 2.10.3.3-3**: Respite Care Model.*

Newborn Circumcision Value-Added Benefit

AmeriHealth Caritas has offered a value added newborn circumcision benefit since 2015, shown in **Figure 2.10.3.3-4**. We have covered 6,587 VAB circumcisions between 2015 and 2018.

Newborn Circumcision	
2.10.3.3.1 Target Population	Newborn male enrollees.
2.10.3.3.2 Scope of Benefit	Existing Louisiana Medicaid Benefit: Routine circumcision is not an MCO covered benefit. This VAB aligns with our Bright Start® Maternity Management program as we encourage prenatal providers to offer education and counseling related to the risks and benefits of newborn circumcision prior to delivery and provide coverage for parents who choose to have their male infant circumcised. It also aligns with our Cultural Competency Plan, which recognizes that decisions related to circumcision are often grounded in cultural or religious beliefs.
	Proposed VAB: • Circumcision is covered for Newborns up to 28 days of life without prior authorization. • Newborns over 28 days of life with prior authorization.
	CPT Codes: • Up to 28 days of life - 54160 and 54150. • After 28 days of life - 54161, 54162, 54163, and 54450.
2.10.3.3.3 Copays	None.
2.10.3.3.4 How Provided	Newborns up to 28 days of life are eligible for circumcision performed by participating or non-participating providers. Infants over 28 days are eligible if determined to be medically necessary through prior authorization. Circumcisions may be performed in both inpatient and outpatient settings. Pediatric and OB/GYN participating providers are educated on the available VAB.
2.10.3.3.5 Oversight	The circumcision VAB will be evaluated using utilization rates and enrollee satisfaction surveys. AmeriHealth Caritas Louisiana's QAPIC, along with the QSC and QCCC, which serve as QAPIC subcommittees, are responsible for oversight of QAPI program activities related to health plan services, clinical quality, utilization management, case management, and pharmacy. We incorporate performance metrics developed to monitor this VAB into the Annual QAPI Work Plan, periodically reported to the QAPIC, and included in the annual QAPI Program Evaluation.

***Figure 2.10.3.3-4**: Newborn Circumcision.*

TOBACCO CESSATION VALUE-ADDED BENEFIT

AmeriHealth Caritas Louisiana currently offers covered tobacco cessation for our pregnant enrollees and we propose to expand that to include a VAB for any enrollee using tobacco products, reflected in **Figure 2.10.3.3-5.**

Tobacco Cessation	
2.10.3.3.1 Target Population	Any enrollee currently using tobacco products.
2.10.3.3.2 Scope of Benefit	Existing Louisiana Medicaid Benefit: The MCO covered benefit is limited to tobacco cessation medications and, for pregnant women, individual or group cessation counseling, telephone quit-line support, and/or intensive cessation support services. Our tobacco cessation VAB aligns with the goals of our Disease Management, Case Management, and health and wellness programs. Our tobacco cessation VAB will support our enrollees on their journey toward successful tobacco cessation with the goal of improved health outcomes and reduced risk of tobacco related conditions such as cancer, cardiovascular disease, chronic pulmonary disease, and low birth weight infants.
	Proposed VAB: • [redacted] [redacted] We will also participate in Tobacco Free Living's African American Tobacco Cessation Campaign, which is currently being expanded.
	CPT Codes: 99406 and 99407 NEMT: A0090, A0100, A0120, A0130, A0425, S0215, and T2003
2.10.3.3.3 Copays	None.
2.10.3.3.4 How Provided	[redacted] We will educate enrollees on the value-added tobacco cessation benefits available during new enrollee orientation, provide this VAB information in the Member and Provider Handbooks, Newsletters, on our website, and during contacts with Care Management and Member Services Call Center staff. [redacted]
2.10.3.3.5 Oversight	AmeriHealth Caritas Louisiana will share data with the [redacted], to determine the effectiveness of the [redacted]. We will use results to help inform public health officials and other payers of the value of this benefit and how it can be made available to other Louisiana residents beyond our enrollees. AmeriHealth Caritas Louisiana's subcontractor oversight manager, a certified project manager based in Baton Rouge, monitors subcontractor performance to confirm conformance with contract requirements AmeriHealth Caritas Louisiana uses a combination of internal QAPI program activities and subcontractor oversight mechanisms to ensure the tobacco cessation VAB is effective and provided and reported in accordance with contract requirements. In both cases, we utilize performance effectiveness measures that include baseline, goals, and frequency of measurement.

***Figure 2.10.3.3-5**: Tobacco Cessation.*

ADULT VISION VALUE-ADDED BENEFIT

AmeriHealth Caritas Louisiana has offered adult vision as a value-added benefit, reflected in **Figure 2.10.3.3-6.** We recognize the importance of optimal vision to everyday activities, such as driving or administering work tasks. In 2018, 14,083 enrollees accessed our valued-added vision benefit.

Adult Vision	
2.10.3.3.1 Target Population	Enrollees 21 and over.
2.10.3.3.2 Scope of Benefit	Existing Louisiana Medicaid Benefit: MCO covered vision services (age 21 years and older, non-EPSDT) are limited to examinations and treatment of eye conditions, such as infections and cataracts. Our adult vision VAB expands vision services to enrollees 21 and over to align with our health and wellness goal of improving day-to-day functioning by optimizing vison screening and corrections. For example, an annual adult vision exam may result in a diagnosis of glaucoma, macular degeneration, diabetic retinopathy, or developing cataracts, enabling the enrollee to access an appropriate specialist for treatment that could prevent or slow disease, or, in the case of cataracts, restore vision through surgery. **Proposed VAB**: Annual examination and $100 toward glasses or contact lenses once a year. CPT Codes: 92002, 92004, 92012, 92014, 92015, 92060, 92065, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, S0580, V2020, V2025, V2100, V2101, V2102, V2103, V2104, V2105, V2106, V2107, V2108, V2109, V2110, V2111, V2112, V2113, V2114, V2115, V2118, V2121, V2199, V2200, V2201, V2202, V2203, V2204, V2205, V2206, V2207, V2208, V2209, V2210, V2211, V2212, V2213, V2214, V2215, V2218, V2219, V2220, V2221, V2299, V2300, V2301, V2312, V2303, V2304, V2305, V2306, V2307, V2308, V2309, V2310, V2311, V2312, V2313, V2314, V2315, V2318, V2319, V2320, V2321, V2399, V2410, V2430, V2499, V2500, V2501, V2502, V2503, V2510, V2511, V2512, V2513, V2520, V2521, V2522, V2523, V2530, V2531, V2599, V2710, V2715, V2730, V2744, V2745, V2760, V2781, V2799. NEMT: A0090, A0100, A0120, A0130, A0425, S0215, and T2003
2.10.3.3.3 Copays	None.
2.10.3.3.4 How Provided	We inform our enrollees about the full scope of the adult vision VAB during their new enrollee orientation, in the Welcome Kit, Member Handbook, and member newsletters. We disclose the name of the subcontractor providing the adult vision VAB to our enrollees in the Member Handbook and offer enrollee education related to VABs whenever needed. We also inform enrollees on the process for accessing the VAB, including eligibility and prior authorization requirements, and any limitations or exclusions in the Member Handbook and newsletter, on the member portal of our website, and during contacts with Care Management staff, CHWs, and Member Services Call Center staff. Our plan representatives, including, but not limited, to Case Managers and CHWs, identify enrollees who are eligible for the VAB and ensure the enrollees or their providers are aware of its availability and how to access the VAB. [redacted], **(Model Contract, 2.13.7.10)**.
2.10.3.3.5 Oversight	AmeriHealth Caritas Louisiana uses a combination of QAPI program activities and subcontractor oversight mechanisms to ensure VABs are effective and are provided and reported in accordance with contract requirements. In both cases, we use performance effectiveness measures that include baseline, goals, and frequency of measurement. AmeriHealth Caritas Louisiana's subcontractor oversight manager, a certified project manager based in Baton Rouge, monitors subcontractor performance to confirm conformance with contract requirements, including NCQA standards, and other Quality initiatives. For example, we monitor our vision subcontractor's performance in several areas, including Provider Call Center performance (i.e. ASA, abandonment and blockage rates), timeliness and accuracy of claims processing, and timeliness and accuracy of encounter data

Adult Vision	
	submission. We also monitor for conformance with NCQA's delegation oversight requirements such as credentialing and re-credentialing, enrollee satisfaction, and complaints. We monitor subcontractor performance monthly to ensure levels meet or exceed those specified in the subcontract, Medicaid contract, and state and federal law. We engage in this monthly review to promptly identify any potential areas of concern. For highly sensitive metrics, subcontractors submit monitoring data and participate in review meetings more frequently. For the average encounter acceptance rates, for example, subcontractors submit encounter data twice per week and participate in meetings with AmeriHealth Caritas Louisiana weekly, or more frequently if needed. We use findings from the pre-delegation evaluation, annual evaluations, audits, and reports to identify areas of improvement and implement a CAP to improve performance, if findings warrant. Our subcontractor oversight manager monitors activities continuously throughout the life of the contract, and extends monitoring through post-termination if the subcontractor continues to provide services during a run-out period. AmeriHealth Caritas Louisiana's QAPIC, along with the QSC and QCCC, which serve as QAPIC subcommittees, are responsible for oversight of QAPI program activities related to health plan services, clinical quality, utilization management, case management, and pharmacy. Performance metrics developed to monitor value-added benefits are incorporated into the Annual QAPI Work Plan, periodically reported to the QAPIC, and included in the annual QAPI Program Evaluation.

***Figure 2.10.3.3-6**: Adult Vision.*

2.10.3.4 Actuarial Calculations And Certification

Actuarial Calculations (Model Contract, 2.5.5.6.1, 2.5.5.7, and 2.5.5.8)

Figure 2.10.3.4-1 shows our PMPM actuarial calculations for the proposed VABs. AmeriHealth Caritas Louisiana understands we may be directed to revise our proposed PMPM based on any feedback from LDH, following an independent review of any statements of actuarial value provided to LDH, **(Model Contract, 2.5.5.7)**. We understand the proposed monetary value of VABs will be considered a binding Contract deliverable, **(Model Contract, 2.5.5.8)**.

Costs Associated with Optional Value-Added Benefit	PMPM
Adult Dental	[redacted]
Non-Pharmacologic Alternatives to Opioids	[redacted]
Respite Care Model [redacted]	[redacted]
Newborn Circumcision	[redacted]
Tobacco Cessation	[redacted]
Adult Vision	[redacted]

***Figure 2.10.3.4.-1** Actuarial Calculations. Per member per month (PMPM) actuarial value of benefits.*

Actuarial Certification (Model Contract, 2.5.5.6.1)

Figure 2.10.3.4-2 shows our actuarial certification statement.

AmeriHealth Caritas Louisiana
P.O. Box 83580
Baton Rouge, LA 70884

AmeriHealth Caritas Louisiana
Section 2.10.3 Enrollee Value-Added Benefits
Actuarial Certification
PMPM Value

I, Richard Pattinson, of The AmeriHealth Caritas Family of Companies, am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I have developed the valuation of AmeriHealth Caritas Louisiana's additional benefits as detailed in Section 2.10.3.4 of the RFP Proposal.

In my opinion, the PMPM impact of each benefit were developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the proposal.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to –time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Sincerely,

Richard Pattinson

Richard Pattinson, A.S.A., MAAA
Actuarial Services
The AmeriHealth Caritas Family of Companies

***Figure 2.10.3.4-2**: Actuarial Certification Statement.*

2.10.3.5 Executed Statement Of Commitment To Provide Benefit(s) Throughout Contract Term

AmeriHealth Caritas Louisiana will provide the proposed VABs listed above for the entire 36-month term of the initial contract and for any extensions, if applicable. AmeriHealth Caritas Louisiana understands we may propose to change the VABs proposed in this RFP response on an annual basis as pre-approved in writing by LDH. We will submit proposed additions, deletions, or modifications to these VAB to LDH at least six months in advance of the effective date for open enrollment and continue to administer the VABs in accordance with our Contract. We will also identify VABs, and related transportation, in encounter data in accordance with the **MCO Manual,** and **Model Contract, 2.5.5.3.** The VABs proposed in our RFP response, and as amended annually, will be listed in **Attachment C, Value-Added Benefits, Model Contract, 2.5.5.5**.

2.10.4
Population Health

Speaker Vivian Andrews shares her weight loss story with attendees at a Control Your Diabetes event in Shreveport.

AmeriHealth Caritas™
Louisiana

2.10.4 Population Health

2.10.4.1 Understanding And Experience Improving Population Health

UNDERSTANDING OF IMPROVING POPULATION HEALTH

AmeriHealth Caritas Louisiana uses a fully integrated population health strategy, aimed at improving the health of our enrollee population as a whole. **Our Next Generation Model of Care advances this approach to deliver the highest-quality care, provided with compassion and respect for enrollees' dignity**. **The model uncovers the health patterns and social determinants that make up population health, identifying ways to provide services and supports to help enrollees live healthier lives.** Our strategy is designed around the principles of person-centered care, minimally disruptive medicine, trauma-informed care, cultural sensitivity, and team-based care, with an emphasis on addressing social determinants of health (SDOH) and pharmacy needs, and fully complies with the requirements in the **Model Contract, 2.6, and the MCO Manual 2.6**. Our goal is to advance population health equity and focus on priority SDOH through individual- and community-centric approaches that fully align to the Louisiana Department of Health (LDH) Quality Strategy **(RFP, 1.3.2.6; Model Contract, 2.6.3.1.1)**.

AmeriHealth Caritas recently worked with Governing Magazine to publish a white paper titled *Putting the Community Back in Healthcare*, which provides recommendations for state and local governments on the importance of communication in enrollee engagement, and to apply population health strategies successfully. This is reflective of how important addressing barriers to using the population heath approach, in a manner that realizes it full potential, is to AmeriHealth Caritas Louisiana.

We offer strategic thought leadership and continue to convene Louisiana stakeholders in roundtable discussions to promote cross-system collaboration to build healthy communities using the population health approach. **Our strategy combines our extensive knowledge of Louisiana with evidence-based programs to improve health outcomes**. We emphasize prevention while systemically identifying subpopulations with complex needs and implement strategies to improve health status. **Figure 2.10.4.1-1** depicts our approach to collect and aggregate population-level data, and implement advanced analytics to segment our enrollee population.

We apply the information gained from this data analysis to enhance our care coordination, chronic condition management, care management, and community engagement strategies. Our interventions consider the family, social, economic, cultural, spiritual, linguistic, and physical environment factors that contribute to health conditions, behaviors, and outcomes. We work closely with enrollees, providers and community stakeholders to learn about disparities, and identify and implement subgroup and parish-specific interventions to address local needs. An example of our understanding of and experience in population health is our **partnership with Louisiana State University – New Orleans, offering a Population Health Management clerkship for first year and senior year medical students**. Since its commencement in 2017, this clerkship has allowed students to spend a four-week rotation with our health plan, focusing on specific models and strategies of population health.

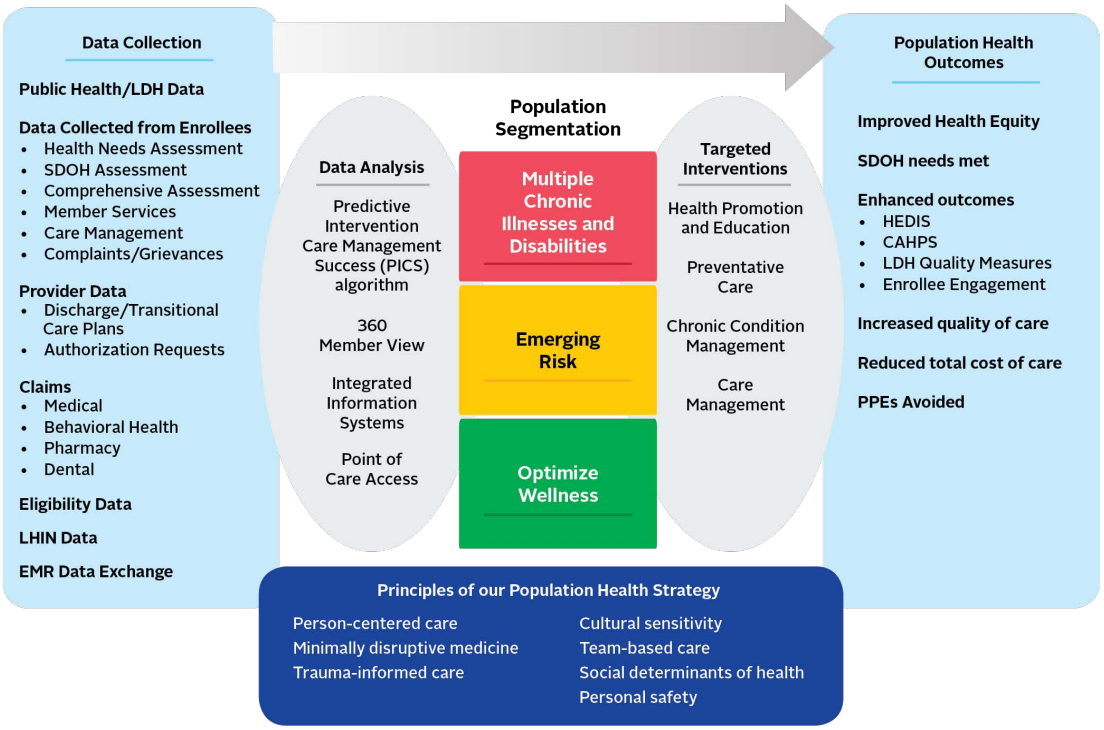


***Figure 2.10.4.1-1**: Improving Health Equity Through Our Population Health Strategy.*

Improving Population Health Through Our Community Wellness Centers

AmeriHealth Caritas Louisiana is the only Healthy Louisiana MCO to build and open community wellness centers for Medicaid enrollees. We analyzed public health and enrollee data and feedback, and strategically located our community wellness centers in communities with the greatest opportunity to increase community connections and build resilience. **Today, we operate community wellness centers in Orleans Parish and Caddo Parish, and will add a third in East Baton Rouge Parish in 2020, and are committing to opening a fourth community wellness center during the new contract period**. Our community wellness centers staff include Case Managers, Bright Start maternity nurses, Community Health Workers (CHW), state eligibility workers, and behavioral health care extenders. We offer targeted programs to address community-specific needs including: health and SDOH assessments; chronic-condition prevention and self-management coaching; nutrition education; trauma informed care training; opioid crisis training; physical activities; parenting classes; personal safety education; art therapy; care coordination; and financial management classes. We continue to refine program offerings based on community feedback and needs.

AmeriHealth Caritas Louisiana became one of the first Medicaid MCOs in Louisiana to obtain NCQA's Multicultural Health Care Distinction on June 22, 2017.

Experience Improving Population Health

AmeriHealth Caritas has 35 years of experience applying population health principles, and seven years of experience serving enrollees in the State of Louisiana. We partner with LDH to meet enrollee needs; examples are detailed in **Figure 2.10.4.1-2**, which demonstrates our local experience improving population health in Louisiana.

Population Health Priorities	Population Health Interventions Examples
Reduce communicable disease	AmeriHealth Caritas Louisiana associates serve on the New Orleans Regional AIDS Planning Committee and Metro Health Education. Our Chief Medical Director, Dr. Rodney Wise, MD was selected to participate this year in a Centers for Disease Control and Prevention (CDC) initiative to increase Pre-exposure Prophylaxis (PrEP) utilization in Louisiana. Our Case Managers provide education and screenings to address rates of new HIV transmission and prevalence of syphilis, viral hepatitis, chlamydia, and gonorrhea. **Our CHWs facilitate educational trainings on Risk Reduction, HIV 101, and HIV Awareness.** We facilitate Hepatitis C screening events that position us as a key partner for the state subscription model that goes live in July 2019. We also launched our Vaccinate Before You Graduate program in conjunction with the American Academy of Pediatrics Louisiana (AAP).
Infant and maternal mortality	We provide family planning, long-acting reversible contraception, comprehensive pre- and post-natal care, EPSDT monitoring, our Bright Start® pregnancy tracker smart-phone mobile app, and host community baby showers to educate mothers about appropriate prenatal and antenatal care. We will expand access to doulas. **Our Chief Medical Officer serves on Louisiana Commission on Perinatal Care and Prevention of Infant Mortality by appointment of Governor John Bel Edwards**.
Opioid use disorders	Our Louisiana Opioid Blueprint uses evidence-based and best practices to prevent and treat opioid use disorders. In addition to implementing state-led initiatives, **we offer our Living Beyond Pain program to provide non-opioid alternatives for pain management**. We expanded access to medication assisted treatment; built capacity and infrastructure for our maternal opioid misuse (MOM) model, which coordinates care for pregnant women with histories of opioid use disorders; and provide training and access to Naloxone in our community wellness centers.
Obesity	We launched targeted interventions to support our enrollees with achieving their goals for appropriate weight management. Our Caritas on the Move initiative hosts community events that promote physical activity and health screenings. The Make Every Calorie Count program offers chronic care management and self-management, certified dietician consultation, gym memberships, and swimming classes. **Our community wellness centers offer nutrition coaching, cooking classes, and exercise classes to address obesity**. We also launched a prevention program for individuals identified as pre-diabetic or at risk for diabetes. We are also partnering with the YMCA to host evidence based diabetes prevention program (DPP) small groups at our Community Wellness Center.
Chronic condition management	Our targeted interventions for chronic condition management include the Control Your Diabetes, Control Your Destiny program; fitness and nutritional programming in our community wellness centers; and **a soon-to-be launched curriculum on chronic condition self-management to train providers on condition-specific strategies to promote enrollee self-management**. We have CHWs who work directly with enrollees in their community.
Tobacco cessation	We promote the Louisiana Tobacco Quit Line to enrollees who currently use tobacco. We heavily emphasize all available assistive medications and over-the-counter supports for enrollees to reduce and quit tobacco use, and offer tobacco cessation counseling at our community wellness centers. W**e are in negotiations to implement a** [redacted] **value-added benefit**.
Early childhood health and development, include adverse childhood experiences	We implement and monitor adherence to the EPSDT periodicity schedule and developmental milestones. Our Behavioral Health Medical Director spearheaded the expanded use of evidence-based practices for 0 to 5 populations; and our Medical Director is working closely with LDH to address congenital syphilis rates in Louisiana. We also offer community training on adverse child experience in addition to medical practitioner and behavioral health clinician training. **Our Buddy Bench program installs benches at local schools to create safe spaces and prevent bullying**. We have built playgrounds to support healthy communities; we also offer a bike and helmet safety program, and our signature Healthy Hoops program addresses child-asthma.
Behavioral health	**We were the first fully integrated health plan in Louisiana and have made significant investments to build our infrastructure and local provider capacity by hiring a behavioral health liaison**; training providers on the use of integrated health assessments such as the PHQ-9, Patient Stress Index, and Screening, Brief Intervention and Referral to Treatment (SBIRT); introducing a Behavioral Health focused Project ECHO training/technical assistance for providers; implementing fully integrated contracting models to facilitate co-location and full integration of clinics; providing care-management support at community wellness centers, offering therapeutic activities like art therapy and championing the use of CHWs.

***Figure 2.10.4.1-2**: Population Health in Louisiana.*

How Population Health Principles Inform And Guide Our Program In Louisiana

We adapted the following population health principles shown in **Figure 2.10.4.1-3** to align with the LDH quality strategy and our AmeriHealth Caritas Louisiana population health strategy.

Principle	How The Principle Informs and Guides the Program
Person-centered care	Our care management staff is trained in Person-Centered Thinking. Our approach is driven by enrollees' needs. We provide information in plain language and support enrollees to direct the care process and make informed choices and decisions **(Model Contract, 2.7.10.1)**. Our CHWs are community-based and meet enrollees in their homes.
Personal safety	Our processes address the physical, psychological, and emotional safety of our enrollees. Beyond medical care, our program considers home and community factors that could impact personal safety, including but not limited to violence, air quality, lead paint, and physical environment (such as dwelling access/egress and bath safety). We also equip community-facing associates with a lone worker safety mobile application to check-in or make emergency calls if they experience a safety concern during in-home and face-to-face visits.
Minimally disruptive medicine	We partner with enrollees to develop individual plans of care to achieve enrollee goals for life and health, while imposing the least burden on their lives. Enrollee choice guides prioritization of activities to ensure the enrollee is not overwhelmed by multiple tasks and changes.
Trauma-informed care	Everyone is impacted by trauma; no one is immune. We educate associates, the community, and field based teams that include Peer Support Specialists to help create a trauma-informed environment that is sensitive to the needs of those affected by trauma.
Cultural sensitivity	Our interventions are guided by an understanding, appreciation, acceptance, and respect for cultural differences and similarities. We draw on community-based values, traditions, and customs of Louisiana to meet diverse enrollee needs **(Model Contract, 2.5.1.10)**.
Team-based care	Our interdisciplinary teams review information, data, and input from team members (including enrollees, CHWs, and professionals of varied disciplines) to make relevant recommendations. Our team-based interventions incorporate input from community leaders, community organizations, state organizations, and associates.
SDOH	We recognize key drivers of health and incorporate SDOH data into our population health model to inform population segmentation and interventions at enrollee and community levels.

***Figure 2.10.4.1-3**: Population Health Principles.*

We use population health principles to inform and guide our strategy for serving Louisiana communities. We apply them when interpreting population health data and analyzing disparities to understand root causes and develop targeted interventions. We will continue to work hand in hand with LDH and the Office of Public Health to further refine our population health management program(s) and submit our fully compliant Population Health Strategic Plan by March 1, 2020 **(Model Contract, 2.6.1)**.

2.10.4.1.1 Identifying Baseline Measures And Targets

We use a relational data model to analyze aggregate enrollee data, identify baseline measures, establish performance targets, highlight linkages between systems, and provide insight across our system of care. Our data model integrates public health data; data collected from enrollees (e.g., Health Needs Assessment (HNA), SDOH assessments, complaints etc.); provider data; claims; eligibility data; hospital admission, discharge, and transfer (ADT), data; and data from the EMR data exchange. We analyze this data to identify trends in health outcomes that may deter our shared goal to achieve the Triple Aim. Our model then segments our enrollee population to produce reports to identify health disparities in the populations described in our response to **Question 2.10.4.1.2**.

Our Quality Management team uses a systematic approach to identify evidence-based practices and implement population health interventions to address disparities. **Figure 2.10.4.1-4** depicts how our population health strategy works in conjunction with the plan-do-study-act model to develop, implement, and measure improvement initiatives. We adopt baseline measures and targets provided by LDH,

Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and National Committee for Quality Assurance (NCQA), including targets found in **Attachment G: Quality Performance Measures** of this RFP**.** When baseline metrics are not provided, our Medical Economics department validates an appropriate sample size and data collection time period to produce a statistically significant sample that serves as baseline measure (e.g. a prior years' worth of data). When available and appropriate, we leverage internal claims data, enrollee interactions (e.g. Member Services Call Center etc.), and provider data (e.g. provider profiles, authorization requests etc.). If internal data is not available for a specific metric, or a comparison population is needed, we leverage external data sources such as the LDH Office of Public Health surveillance data, needs assessment data **(Model Contract, 2.6.3.3)**, or our Johns Hopkins Adjusted Clinical Group System.

To develop objective, internal performance goals, we consider baseline data; then define specific, measurable, attainable, realistic, and time-bound (S.M.A.R.T.) incremental targets that we can reasonably achieve and that produce desired outcomes.

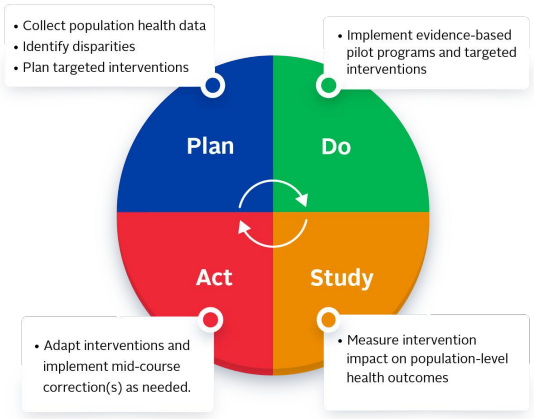


***Figure 2.10.4.1-4**: Continuous Population Health Improvement Process*

2.10.4.1.2 Measuring Population Health Status And Identifying Sub-Populations

AmeriHealth Caritas Louisiana measures the population health status of enrollees through traditional public health metrics and analytic methods such as demographic analyses, population pyramids, mortality rates/ratios, and burden of disease, to contextualize and infer total population considerations. We analyze all available data sources, including those described below, to assess population health status and identify subpopulations.

Social Determinants Of Health (SDOH)

AmeriHealth Caritas Louisiana has developed a proprietary adaptation of the National Association of Community Health Centers' *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*[1] tool to universally screen enrollees for SDOH needs. We use enrollee SDOH information to inform population segmentation and interventions as described in our detailed response to **Question 2.10.4.3**.

Cultural And Linguistic Demographics

AmeriHealth Caritas Louisiana collects and segments enrollee data by cultural and linguistic demographics, including age, race, ethnicity, gender identity, sexual orientation, religion, primary language, disability status, and income level **(Model Contract, 2.6.2.1.1.1)**. Our Culturally and Linguistically Appropriate Services (CLAS) Committee uses population-level health equity data to inform our annual CLAS Strategic Plan **(Model Contract, 2.6.3.1.2)**, which delineates specific programs and interventions to mitigate health disparities experienced in our subpopulations. We evaluate this data through multi-variate

[1] http://www.nachc.org/research-and-data/prapare/

analysis to assess the impact of cultural and linguistic demographics on health outcomes. For example, we stratified our 2017 HEDIS scores in Louisiana and identified under-utilization of cancer screenings among Hispanic and African American populations. We partnered with Feist-Weiller Cancer Center's Partners in Wellness (PIW) to offer mobile cancer screenings and mobile digital mammography across 19 parishes in Louisiana.

Geography

AmeriHealth Caritas Louisiana measures population health equity by geographic location **(Model Contract, 2.6.2.1.1.1)** using geo-mapping and hot-spotting analysis to identify trends in utilization patterns, such as over-utilization of emergency department (ED) visits or under-utilization of primary care services. Our Medical Economics team conducts quarterly drill down analysis to determine root causes and identify potential health disparities. Our quality committees then plan targeted interventions and performance improvement projects to promote health equity for all enrollees.

Segmenting Special Populations

We analyze population health data by key special populations including: eligibility categories as defined in the **Model Contract, 2.4**, Chisholm Class Members, Department of Justice Agreement target population, Department of Corrections re-entry population, and enrollees with Special Health Care Needs **(Model Contract, 2.6.2.2.1.3)**. We review population-specific reports through quality management committees to monitor appropriate access to high quality, person-centered care and ensure that each population has access to entitled benefits, care coordination, services, and supports. We perform drill-down analysis as needed and convene stakeholders to address barriers as they arise.

2.10.4.1.3 Approach To Identifying Key Determinants Of Health Outcomes And Strategies For Targeted Interventions To Reduce Disparities

We consider key determinants to identify health disparities, define root causes, determine the affected population and subgroup, and implement individual level interventions. **(Model Contract, 2.6.1.2.4)**.

Approach To Identifying Key Determinants Of Health Outcomes

AmeriHealth Caritas Louisiana's population health experts work with our Quality team to review population health trends and outliers, conduct drill-down and root-cause analysis, and identify contributing and causal key determinants of health at system and enrollee levels. We apply evidence-based, best practice models in population and public health, such as the Robert Wood Johnson County Health Rankings Model[2] depicted in **Figure 2.10.4.1-5**, including:

- **Health Behaviors** — We collect health behavior data through assessment(s) and enrollee interactions. Case Managers and providers use this information to develop appropriate treatment and referrals to community-based organizations, promoting optimal health.
- **Clinical Care** — We are expanding access to care by contracting with qualified providers, evaluating network adequacy, and monitoring the quality of care through our quality management strategy. For example: we partnered with the Louisiana State University School of Medicine and Public Health to create the Health Policy Fellowship, Population Health Internship, and School of Public Health Internship, to retain physicians and public health talent in Louisiana.
- **Social And Economic Factors** — We assess SDOH needs to ensure access to culturally and linguistically responsive care through our CLAS Strategy.

[2] http://www.countyhealthrankings.org

- **Physical Environment** — ZIP code determines health more than genetic code[3], as exemplified in Louisiana by "cancer alley" along the Mississippi River; lead toxicity and poisoning in drinking water near Shreveport; and burning of sugar cane fields in southern Louisiana resulting in increased complications of asthma and pulmonary inflammation. We review public health data and conduct geo-access analysis to assess trends that may be attributed to the physical environment, including man-made systems and structures. For example, Project RECAST addresses community violence by providing training on principles of trauma-informed care and how to access support services.

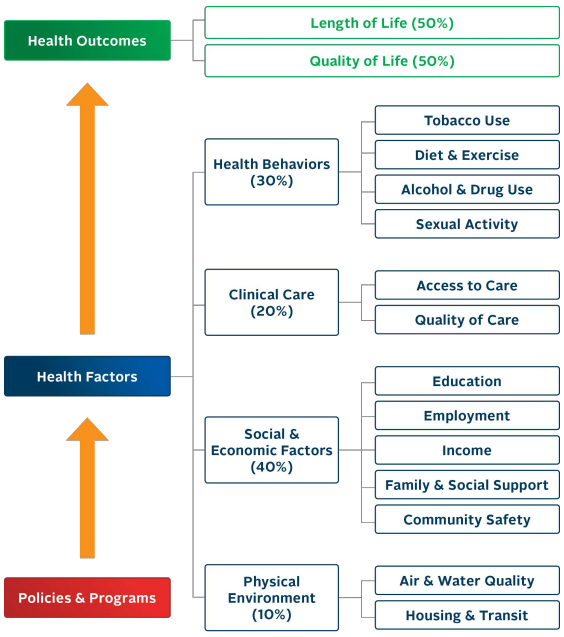


Figure 2.10.4.1-5: *Using Robert Wood-Johnson County-Health Ranks Model.*

Approach To Identifying Strategies For Targeted Interventions

We identify targeted interventions through multiple strategies including:

- **Seeking Input From Louisiana Thought Leaders** — In 2018, we partnered with Governing Magazine and Dr. Peggy Honoré of the Louisiana State University School of Public Health to host a series of roundtable discussions with government officials, providers, public health agencies, and community leaders to discuss strategies for a more person-centered, outcome oriented, system of health care. We developed a white paper, *Putting the Community Back in Healthcare,* that provided recommendations for state and local governments to improve communication and enrollee engagement.

- **Collaborating With LDH** — Our Chief Medical Officer contributed to the development of *Blueprint for a Louisiana Demonstration Community Health Worker Program,* included in this RFP, attesting to the recognition of our plan as an experienced leader in the promotion of community-based solutions to address enrollees' needs.

- **Identifying Evidence-Based Solutions** — We look for evidence-based solutions that are appropriate for addressing the needs of Louisiana, such as those promoted by UPENN IMPaCT model of care, National Association of Community Health Centers' *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*[4] tool, and Penn Medicine Nudge Unit. For example, our Community Care Management team was developed based on Care Coordination Pathways' model and the Camden Coalition of Healthcare Providers.

- **Leveraging Solutions From Our Affiliates** — With over 35 years of experience serving Medicaid enrollees, our affiliates develop and launch successful targeted interventions to address enrollee's needs. We modify interventions to fit specific nuances, needs**,** and resources of Louisiana. One example is our Pathways to Work program, originally developed by our affiliate in the District of Columbia.

[3] https://www.hsph.harvard.edu/news/features/zip-code-better-predictor-of-health-than-genetic-code/
[4] http://www.nachc.org/research-and-data/prapare/

- **Listening To Our Enrollees** — Enrollee stakeholder groups provided input on community-specific solutions to address disparate life expectancy and unmet SDOH needs, identified through hot spot analysis in New Orleans and Shreveport. To address their need for more wellness-focused resources, we opened community wellness centers in key neighborhoods of both cities.

2.10.4.1.4 Integrating Initiatives To Create A Comprehensive Approach

We use highly coordinated, multidisciplinary, and cross-functional methods to integrate population health approaches throughout our organization and network as shown in **Figure 2.10.4.1-6**. Our population health approach integrates with our quality management strategy, which directs prevention, chronic condition management, care management, and targeted interventions. We convene our cross-functional leadership to identify trends and priorities, and strategize solutions for outliers. For example, to address over-utilization of the ED, our leadership took action to implement the following multi-pronged strategy:

- Value based contracting, including incentives to reduce potentially preventable visits.
- Expansion of our Urgent Care network.
- Education for enrollees on the appropriate use of the ED and urgent care availability.
- Advanced telehealth solutions (including facilitating appointments at existing locations or enabling delivery of equipment into enrollees' homes or allowing them to use their own smart device).
- Expanded availability of psychiatric crisis resources.

Integrating Required Components

AmeriHealth Caritas Louisiana has reviewed all procurement documents and we are able to offer a fully integrated approach encompassing all contract requirements. We have existing relationships with Louisiana stakeholders and partners, enabling us to offer a fully integrated system of care and we will continue roundtable discussions to further this collaboration.

***Figure 2.10.4.1-6**: Integrating Population Health Throughout AmeriHealth Caritas Louisiana.*

2.10.4.1.5 Other Considerations

Our population health strategy incorporates strategies to engage enrollees in their health, incentivize providers, and build healthy communities.

- **Enrollee Incentives** — Our healthy behaviors incentive program offers a tiered reward to enrollees for completing a HNA within 30, 60, or 90 days. CARE Cards can be used at any Walmart, Walgreens, Fred's, CVS, Dollar General, Family Dollar, and Rite Aid stores to purchase eligible items, such as baby care, eye care, over-the-counter medications, and healthy foods.
- **Value-Based Payment (VBP) Programs** — Our VBP payment models align payments and incentives with key determinants of population health, such as SDOH, and incentivize providers for promoting health equity. VBP methods are described in detail in our response to **Question 2.10.12**.
- **Preparing For Disasters** — AmeriHealth Caritas Louisiana is committed to reducing risk of trauma and re-traumatization by preparing our enrollees for potential disasters. We promote disaster planning and conduct targeted outreach to enrollees when a disaster (hurricane, for example) is imminent to ensure access to medications and life-saving supports, such as dialysis treatment.

2.10.4.2 First Year Milestones And Timelines

AmeriHealth Caritas Louisiana will continue to work closely with LDH to evolve our Population Health strategy. We will develop a written project plan as part of our readiness and implementation activities, which will include all promises to LDH through the first year of the contract as shown in **Figure 2.10.4.2-1**.

Milestone	Completion Date	Department Responsible
Train providers to include Z-codes in the ICD-10 CM on claims (MCO Manual 2.6**).**	QTR 3 2019	Provider Network
Hire and train additional CHWs, supervisors, and program directors on their roles (MCO Manual 2.6**).**	QTR 4 2019	Population Health
Define and submit our Population Health evaluation plan to LDH for review (Model Contract, 2.6.3.5**)**	QTR 1 2020	Population Health
Finalize population health baseline measures, aligned to contract requirements, HEDIS, NCQA accreditation, and the Office of Public Health outcome metrics	QTR 1 2020	Quality Management
Create joint-plans with LDH to coordinate activities (Model Contract, 2.6.3.3**)**	QTR 2 2020	Chief Medical Officer
Semi-annual report on effectiveness of evidence-based interventions to reduce health disparities (Model Contract, 2.6.4.3.3**)**	QTR 2 2020, QTR 4 2020	Quality Management
Expand our community wellness center model, adding a third center in Baton Rouge.	QTR 4 2020	Enrollee Services
Submit annual Health Promotion and Disease Prevention Report to LDH (Model Contract, 2.6.4.1.3**).**	QTR 4 2020	Population Health

***Figure 2.10.4.2-1**: Population Health Management First Year Milestones.*

Upon award, we will meet with LDH to define additional year one milestones and timelines for completion. We will assign appropriate leadership to each deliverable and provide routine updates to LDH, as required.

2.10.4.3 Using SDOH Data To Improve The Health Of Targeted Populations

We have used SDOH data in Louisiana to improve the health of targeted populations for seven years **(Model Contract, 2.6.3.1.1)**.

Approach To Collecting SDOH Data

AmeriHealth Caritas Louisiana uses a systematic, multi-channel, proactive approach to collect standardized SDOH data on enrollees' educational level, health literacy, transportation needs, housing security, physical safety, and material security, including access to food, utilities, clothing, childcare, phones, and household needs **(Model Contract, 2.6.2.1.1.2, 2.6.2.2.1.1)**. Our Population Health and Enrollee Services associates are trained to universally screen for SDOH needs and connect enrollees to needed services and supports **(Model Contract, 2.6.2.1.2)** using Aunt Bertha and other tools. We collect SDOH data through provider claims, ICD-10 codes, new enrollee welcome calls, HNAs, and interactions with our community-based team(s). We identify and classify enrollees' SDOH needs in-the-moment in three tiers: stable (low risk), vulnerable (medium-risk, needing connection to resources) and crisis (high-risk, needing immediate intervention). This enables us to address individual needs, and segment trends at the population level. We classify enrollee needs as crisis if enrollees do not have resources for utilities, food, or immediate housing.

Data Aggregation (Model Contract, 2.6.2.1)

SDOH data is captured and documented within our population health system and is aggregated into our relational data model, enabling us to see linkages and draw insights between population characteristics, key determinants and health outcomes as described in our response to **Section 2.10.4.1.1.**

Data Analysis To Support Population Health Management (Model Contract, 2.6.2.2)

Once aggregated, we analyze SDOH data through a series of algorithms and analytic tools in the context of our entire enrollee population, their subgroups, and individualized needs. We refresh and review population level SDOH data monthly for our quality management committees to identify trends, and drill-down analysis, as needed.

Data Submission And Reporting (Model Contract, 2.6.2.3)

As requested by LDH, we will participate in initiatives to define and submit reports on SDOH. Internally, we run monthly reports on SDOH to identify emerging trends, conduct root-cause analyses, expand existing programs, or introduce new interventions to meet enrollees' needs. At least annually, we conduct a comprehensive review of our population health management strategy to evaluate its effectiveness and ensure structure, staffing, training, services, and community partnerships appropriately address the needs of current enrollee population and contract requirements. **Figure 2.10.4.3-1** provides a sample of our internal SDOH monthly report, depicting outputs and need categorization.

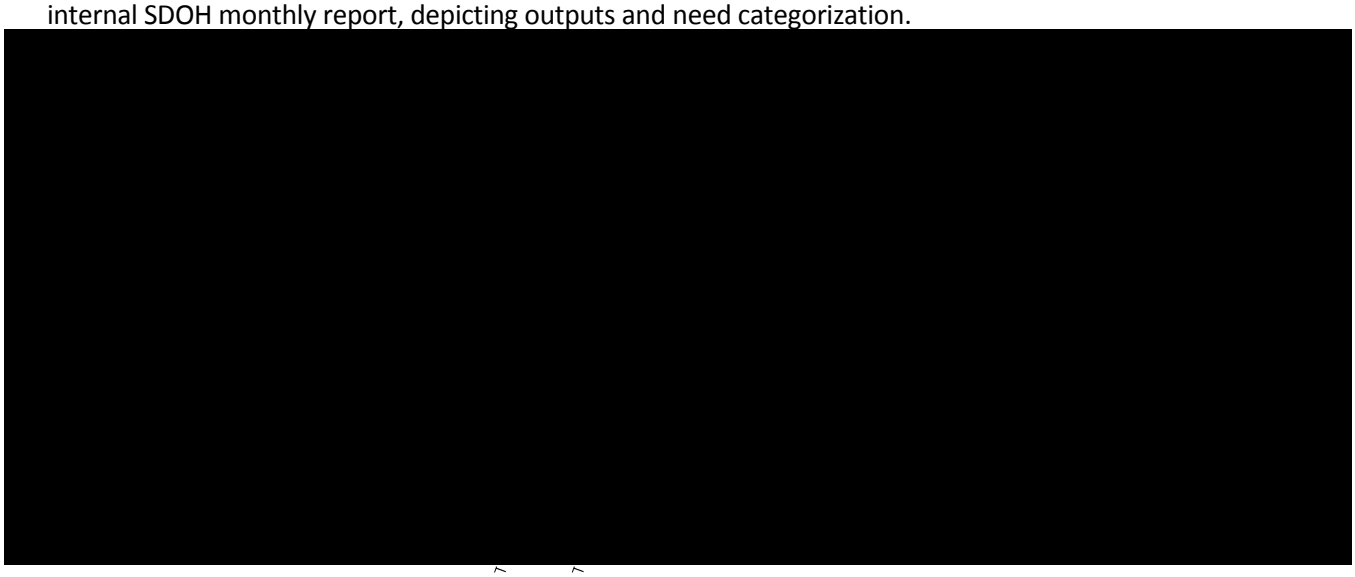


***Figure 2.10.4.3-1**: Systemic Reporting Of SDOH Data – SAMPLE.*

RECENT EXAMPLE OF USING SOCIAL DETERMINANTS OF HEALTH DATA: CARITAS ON THE MOVE

Identifying The Issue — AmeriHealth Caritas Louisiana identified communities with poor health literacy, education deficits and food instability through our SDOH data collection. Food instability has consistently been one of the most significant SDOH identified through assessment of our enrollees. Rural areas often have food and recreational deserts, resulting in even higher rates of obesity due to scarcity of nutritional and affordable food and/or safe areas to play or exercise. Our community outreach team reviewed geographic data to identify communities throughout the state with unmet needs related to food and/or recreational deserts.

The Intervention — We engaged and partnered with community organizations throughout the state to coordinate Caritas On the Move events in communities having a high volume of SDOH needs. Events include, but are not limited to fresh produce access, exercise and fitness events, and nutritious food demonstrations. Caritas on the Move also offers health screenings as well as access and education about other food support programs (i.e. SNAP, WIC). At these events we also connect enrollees to CHWs for

assistance with scheduling preventative and follow-up provider appointments. The Caritas On the Move events introduced and increased community awareness of other specialized programs to address SDOH needs, including our: Food as Medicine, to provide short term meals for enrollees in need of stabilization; Pathways to Work job training for enrollees; and Mission GED to support enrollees educational goals. To date, our community partners have included the Mayor, local elected officials, police, sheriff, fire department, local school boards, and faith-based entities. Through continued engagement after our hosted events, we ensure that local community leaders remain empowered and supported in driving healthy living choices that we promote.

We contract with Hope Ministries, a community-based organization, to offer our Pathways to Work program, a 16-session work preparedness training program for enrollees. They also offer our Mission GED program, which reimburses GED exam fees, and offers courses and study aides supporting GED test preparation for enrollees.

Assessing the Intervention — We monitor HEDIS rates, specifically those related to obesity, diabetes and preventative care in the geographic communities that host our Caritas On the Move events. We follow-up with identified needs through our care coordination and care management teams to support members their SDOH needs. Members enrolled in our Mission GED and Pathways to Work program are tracked through completion of the program.

Outcomes — In the communities we supported our Caritas On the Move initiative helped to drive a 16.67 percent increase in adult BMI assessment; well child visits for 3 and 4 year olds increased 9.11 percent and weight assessment and counseling increased 6.24 percent. While monitoring continuation of these HEDIS results in future years within these communities, we will also have follow-up surveys relative to completion of longer term SDOH interventions.

Applying Our Approach To Improve LDH Population Health SDOH Priorities

We rely on population health data to identify health disparities and implement interventions tailored to specific parishes and communities across Louisiana. For example, we conducted a geography based analysis of health trends and disparities after hosting our Caritas On the Move events and identified the need for a more permanent and substantial investment in the Baton Rouge area. Thus, **we will open a third community wellness center in Baton Rouge in 2020** to offer targeted interventions to address specific population health disparities and needs. We are also **committing to opening a fourth community wellness center during the new contract period**. Additionally, we are committed to analyzing the communities in need with new enrollment base in new contract period to open a fourth Community Wellness Center in Louisiana during 2021. We continue to convene enrollees, providers, and local stakeholders to identify specific needs and monitor community impact through HEDIS and other measures.

2.10.4.4 Contracting With Community-Based Organizations And The Office of Public Health

Today, AmeriHealth Caritas Louisiana is closely connected to Louisiana parishes and communities through formal and informal partnerships with community-based organizations, local health departments and the Office of Public Health. Under this new contract, we will strengthen our existing collaborations and enter into memoranda of understanding, memoranda of agreement and formal contractual relationships that incorporate community-based health and wellness strategies, promote LDH public health programs, and create formal partnerships with community-based agencies **(Model Contract, 2.6.1.2.5, 2.6.3.2.1)**. **Figure 2.10.4.4-1** defines our approach to contracting with community-based organizations and the Office of Public Health to coordinate population health improvement strategies.

Step	Contracting Action	Department Responsible
1	Expand current engagement with community-based organizations to include formal and informal channels of communication (i.e. inviting them to participate on our community coalitions at our community wellness centers, joining their committees, coalitions and being present at community events etc.).	Enrollee Services and Population Health
2	Review existing community HNAs, including those conducted by the Office of Public Health, and our internal data at the local parish and state-level.	Quality Management
3	Conduct a gap analysis of community needs compared to our existing provider network, services available through community-based organizations, and services available through the Office of Public Health.	Provider Network, Quality Management, Population Health
4	Present community feedback and findings from gap analysis to our CLAS Committee for review, and to identify recommendations to strengthen our partnerships and to close identified gaps.	CLAS, Quality Management
5	Define collaborative partnerships, programs, interventions, and performance improvement projects to include in contracts with community-based organizations and the Office of Public Health.	CLAS, Quality Management, Provider Network
6	Engage community-based organizations and the Office of Public Health in contract negotiations.	Operations
7	Execute contracts.	Operations
8	Support implementation and go-live.	Operations, Population Health and Enrollee Services
9	Monitor program effectiveness and outcomes.	Quality Management

***Figure 2.10.4.4-1**: Contracting With Community-Based Organizations And The Office Of Public Health.*

We will develop a written plan for working with community-based organizations and the Office of Public Health to address at least one specific initiative, regionally or statewide, to improve the overall health of enrollees in the community **(Model Contract, 2.6.1.2.7)**. For example, the Office of Public Health has launched a successful pilot using public health nurses to track congenital syphilis cases and connect individuals with appropriate follow-up care. Upon award, AmeriHealth Caritas Louisiana will meet with the Office of Public Health to develop plans to scale this initiative statewide.

AmeriHealth Caritas Louisiana will continue to offer a fully integrated, cohesive population health strategy. Together, we will advance health equity and address priority SDOH across Louisiana.

Partnering with the Office of Public Health to Address Sexually Transmitted Disease/Sexually Transmitted Infection Rates

AmeriHealth Caritas Louisiana used Office of Public Health (OPH) data to identify the disproportionate prevalence of Sexually Transmitted Diseases/Sexually Transmitted Infections in Regions 7 and 8 affecting middle and high school-aged youth. The OPH reported that from 2016 to 2017 chlamydia prevalence increased 10 % gonorrhea increased 11 %. Based on this data, In May 2018 we partnered with the OPH Sexually Transmitted Disease regional task force, Caddo Parish Schools, and others to offer sexual health education, increase access to preventative sexual health resources and promote frequent Sexually Transmitted Disease/Sexually Transmitted Infection testing through our community wellness center. We will use state epidemiology data along with participant surveys to measure its impact.

2.10.4.5 Establishing A Community Health Worker Demonstration Project

2.10.4.5.1 Proposer's Statement Of Interest

AmeriHealth Caritas Louisiana would like to pilot a Community Health Worker (CHW) demonstration project as described in the Louisiana Demonstration Community Health Worker Program Overview and the Blueprint for a Louisiana Demonstration Community Health Worker. We share the State's vision and offer whole-person care that fully integrates physical health, behavioral health, pharmacy, and social services to promote health outcomes and a better quality of life. Through our Community Care Management Team model, we have demonstrated the importance of providing in-person face-to-face case management for our highest risk enrollees since 2014 in Baton Rouge and surrounding parishes, and in New Orleans and Shreveport since 2016. Our model is comprised of registered nurses, behavioral health clinicians, and CHWs.

Early in 2018, **AmeriHealth Caritas Louisiana was chosen as the Healthy Louisiana MCO to participate in the blueprint CHW Demonstration development due to our strong history of demonstrated positive outcomes from the Community Care Management team and commitment to hiring CHWs**. We are committed to partnering with LDH to further advance and implement the proposed project, enhancing our commitment to expand evidence-based, community-engaged solutions for vulnerable enrollees across Louisiana.

2.10.4.5.2 Number And Location Of Community Health Workers

We have aligned the duties and attributes of each non-clinical position listed in **Figure 2.10.4.5.2-1** with the definition provided in the Louisiana Demonstration Community Health Worker Program Overview and the Blueprint for a Louisiana Demonstration Community Health Worker Program. In our experience, it is essential that CHWs have a strong understanding of and connection to communities they serve. Therefore, we specifically recruited and hired individuals for these positions from local communities, giving them a shared background with our enrollees.

Position(Non-Clinical)	Number of FTEs	2.10.4.5.3 Average Enrollee Ratio (Enrollee ratios can fluctuate depending on the intensity of involvement, case acuity, and complexity)	2.10.4.5.4 Primary Activities of CHWs	Location
Community Health Worker	5	1:85	Low to Medium Intensity. Provide face-to-face outreach, education, assessments, assistance with appointments and navigating the continuum of care, coordinate with community service organizations, enrollee advocacy, and resolve barriers by providing social support with a focus on prevention and early intervention.	Statewide
Louisiana Certified Peer Support Specialist	8	1:75	Medium to High Intensity. Assigned to certain Behavioral Health hospitals across the State to conduct face-to-face visits, facilitate discharge plans, and advocate for enrollees.	Targeted locations statewide

Community Health Senior Workers	2	NA	Program development, as well as direct enrollee outreach at events. Areas of focus include; community investment; responsibilities include-Care Crew initiatives, coordination and daily oversight of Medical Intern program, Care Closet, Baby Showers; Whole Person Initiatives; responsibilities include- Pathway to Work, Mission GED, Caritas On the Move, relationship with key community partners.	Statewide
Community Health Workers (non-clinical members of the Community Care Management Team)	4	1:65 (includes targeted, looking for, and engaged status members)	High Intensity. Provide high-touch, face-to-face engagement and education for enrollees with complex care needs, encourage self-management skills, connect to providers, navigate systems of care, link enrollees to community resources, provide coaching for chronic diseases and co-morbid behavioral and physical health conditions.	Baton Rouge, New Orleans (Jefferson and Orleans parishes), Shreveport area (Caddo and Bossier parishes), Lafayette (Acadia, Lafayette, St. Martin, St. Landry and Vermillion parishes)

Figure 2.10.4.5.2-1: *Number And Location of Community Health Workers*.

We are inspired by all of our CHWs, but we want to highlight "Grace" who brings a high level of commitment to our enrollees in her role as a CHW. Grace's passion for her community shined throughout her interview. Grace described her passion for change and how her experiences shaped her ability to relate to others. During her job interview, Grace shared the challenges faced by her community along with creative ideas to meet them. Grace spoke about her community with dignity and compassion, which aligns to our AmeriHealth Caritas Louisiana's mission and values. She co-founded a non-profit to feed the homeless, and was involved in giving away food during the holiday season in partnership with other community organizations. Her willingness to share her knowledge of community concerns, commitment to making the community better, access to community resources and contacts, and relatability to the enrollees we serve fosters positive relationships with enrollees and community stakeholders, facilitating close partnerships that improve the lives of the enrollees and community members.

2.10.4.5.3 Proposer's Community Health Worker/Enrollee Ratio

Please reference **Figure 2.10.4.5.2-1** for AmeriHealth Caritas Louisiana's CHW/Enrollee Ratio.

2.10.4.5.4 Primary Activities Of Community Health Workers

CHWs are invaluable in building trust, engaging enrollees with complex needs, and delivering culturally competent care coordination and navigational assistance to facilitate access to services and community resources. A key element contributing to the success of CHWs within AmeriHealth Caritas Louisiana is the integration of CHWs into the multidisciplinary care team and organizational culture. In addition to improving enrollee care and health outcomes, our community-based teams provide valuable information for, and coordination with, health plan staff and services, as well as providers and community-based organizations, to engage enrollees in appropriate care and improve health outcomes. As outlined in **Figure 2.10.4.5.2-1,** the primary activities of CHWs include providing face-to-face outreach, education, assessments, assistance with appointments and navigating the continuum of care; coordinating with community service organizations; advocating for enrollees; and resolving barriers by providing social support with a focus on prevention and early intervention.

2.10.4.5.5 Community Health Worker Training Standards

AmeriHealth Caritas has drawn on best practices from evidence-based models such as the Pathway Community Hub Model Development, Camden Coalition of Healthcare Providers, and the IMPaCT™ model,

to develop our comprehensive training program for CHWs. This program includes but is not limited to training encompassing topics listed in **Figure 2.10.4.5.5-1**.

Training Topics	
Managed Care 101.	Member rights and responsibilities.
HIPAA — privacy, compliance, and Documentation 101.	Mental Health First Aid.
Overview of common behavioral health and physical health conditions.	Self-care and Supervision.
Care Management and Team-based care: Working effectively with providers.	Strengthening community partnerships.
Community safety — Lone worker safety tools and community facing policy and procedure review.	Universal precautions including trauma informed principles of care.
Specific outreach protocols including escalations and mandatory reporting practices.	Motivational Interviewing and conducting person-centered surveys.
Screening for unmet social determinant of health needs and potential risk factors (suicide and interpersonal violence).	Supporting enrollees living with substance use disorders.
Boundaries in helping relationships and managing self-care and burnout prevention.	Communication principles including de-escalating conflict.
Mandt- preventing, de-escalating, and intervening when the behavior of an individual poses a threat of harm to themselves and others.	Poverty Simulation training to promote a greater understanding of poverty.

Figure 2.10.4.5.5-1: *Community Health Worker Training Topics.*

Health Coach Certificate And Health Navigator Associate Degree

AmeriHealth Caritas Louisiana's Chief Medical Officer is working closely with Dr. Honoré at Louisiana State University to develop a Health Coach Certificate and Health Navigator Associate Degree, in partnership with Delgado Community College. We have verbally committed to use our community wellness center in New Orleans as a training site, and identify enrollee candidates in our Pathway to Work program.

2.10.4.5.6 Building Trust Within Local Communities

Our process to build trust within local communities begins with recruiting, hiring, and training CHWs reflective of the enrollee population. We recruit candidates who are respected by their peers and demonstrate our shared values, a knowledge of parishes served, a commitment to building resilience in others, the ability to navigate multiple systems, and community leadership. In addition, we engage with communities and participate in public forums where we can educate and collaboratively promote health equity. AmeriHealth Caritas Louisiana provides health education, system navigation, and peer counseling, and acts as a resource at health fairs, block parties, and other health focused events. Activities listed below are examples of our work within local communities to build rapport and lasting trust.

Sharing Culturally Appropriate Health Education

Because they live in the communities we serve, CHWs have the unique ability to leverage their knowledge of local cultures and customs to deliver culturally appropriate health education. AmeriHealth Caritas Louisiana CHWs deliver services through one-one-one interactions or in-group sessions that can take place in homes, community settings, and our community wellness centers. They deliver health information alone, or as part of a team of providers, clinicians, counselors, and other health professionals. General topics covered include, but are not limited to, information on available benefits and access, importance of preventive health screenings, establishing relationships with a primary care providers (PCP), emergency preparedness, and healthy behaviors. During every interaction and training, our CHWs demonstrate a

shared understanding of enrollee's experiences, which enables them to build trust and positive relationships with enrollees and community stakeholders.

Providing Informal Counseling And Social Support

AmeriHealth Caritas Louisiana's CHWs serve as integral members of the health care team by providing informal counseling to assist enrollees in establishing personal wellness goals, implementing self-management plans, and modeling support to reach goals. For example, CHWs help enrollees navigate the health care system by providing assistance with appointment scheduling, teaching skills and steps necessary to arrange appointment transportation, and coordinating interpreter services at appointments, if needed. They provide indispensable social support by listening to the concerns of enrollees and their family members. By acting as advocates, they are able to establish vital community and clinical connections, identify and erase barriers to care and service, and find solutions.

Community Wellness Centers

Our community wellness centers are located in Shreveport and New Orleans and we will open a third community wellness center in Baton Rouge in 2020 and are committing to opening a fourth community wellness center during the new contract period. We will analyze our membership's demographics and locations to determine an area in the state will most benefit from our fourth community wellness center. These centers offer a safe, accessible, neighborhood environment for health (behavioral, physical, and social) related activities, and events. Community wellness centers host a variety of enrollee- and community-focused activities throughout the month, such as health screenings**,** education, safety awareness, baby showers, meetings**,** orientations, and exercise sessions**,** tailored to the needs of each community. Enrollees also have access to a computer lab. Our community wellness centers establish a consistent place for social connection and increase social and community responsibility. They offer a convenient space to hold meetings such as the Member Advisory Council, and enable Case Managers to engage in face-to-face meetings with enrollees. In 2018**,** in partnership with Governing magazine and Dr. Peggy Honoré of the Louisiana State University School of Public Health, we hosted a series of roundtable discussions at our community wellness centers to discuss community engagement strategies to foster a person-centered, outcome-oriented system of health care.

2.10.4.5.7 Using Data To Evaluate Program Effectiveness

AmeriHealth Caritas Louisiana evaluates program effectiveness by continuously collecting, tracking, and analyzing outcome measures, enrollee engagement measures, and utilization metrics. We collect, monitor, and analyze metrics such as successful in-person visits and telephone contacts, reasons for unsuccessful visits and contacts, cost and utilization measures, and number of referrals into our programs. As noted with program results below, we evaluate each team separately, as their focus is different. In the proposed demonstration project, we will support overall team evaluation.

> *"I am so excited that I could come to the Wellness Center and receive my mammogram on the mobile unit. I really appreciate the AmeriHealth staff for reaching out to me providing transportation and such personalized care. I did not have to wait. The staff on the van made me feel welcome. This is my first mammogram in 10 years. The Wellness Center gives me somewhere to go and be able to participate in relaxing activities."*
> ***AmeriHealth Caritas Louisiana enrollee, KS***

Community Care Management Team

In 2018, **high risk and emerging risk enrollees who we engaged with our Community Care Management Team**

received 2,069 successful visits in the enrollee's home or community setting, and during provider appointments; and 2,403 successful telephonic contacts. Additionally, the team attempted another 550 community visits and 1,104 calls that were not successful. Reasons for unsuccessful visits and calls include barriers related to working with a transient population; enrollee no-shows; and unscheduled check-ins while the enrollee was not at home or the appointment. The team also completed 361 outreach community visits and 287 outreach calls on behalf of enrollees not yet engaged in the program. There were 275 enrollees meeting inclusion criteria available for analysis engaged in community care management since the start of the program in Louisiana. Overall, this population showed a per member per month decrease of $410.48 inpatient dollars and $278.13 total spend from the year prior to the Community Care Management Team to the year following engagement. Our team has a face-to-face success rate of 69 percent, and telephonic success rate of 63 percent.

Louisiana Certified Peer Support Specialists Team

AmeriHealth Caritas Louisiana conducted an analysis of our peer support program which analyzed enrollee outcomes and expenditures for six months prior to enrollment in our peer support program; and during the six months services were received. **A summary of findings for enrollees participating in the program indicated a 47 percent increase in visits to primary care doctors; a 27 percent reduction in ED visits; a 54 percent reduction in inpatient admissions; and a 24 percent reduction in overall medical and pharmacy costs**.

Community Health Education Team

In 2018, our Community Health Education team received a total of 3,710 internal referrals. Our team had a 43 percent success rate in face-to-face outreach attempts, meeting 1,523 enrollees through home visits, and a 41 percent success rate in telephonic outreach, contacting 1,346 enrollees via phone.

2.10.4.5.8 Provider Coordination

AmeriHealth Caritas Louisiana's CHWs and other Care Management staff connect enrollees to appropriate medical, behavioral, and social services by having direct contact with the care team. This includes assisting with appointment scheduling to increase attendance for seven and 30 day follow-up visits, attending office visits, making sure enrollees have necessary medications and supplies post-discharge, and creating stronger connections to providers and Case Managers. AmeriHealth Caritas Louisiana places CHWs in high-volume clinics and hospitals. For example, our Louisiana Certified Peer Support Specialists are assigned to targeted hospitals across Louisiana. We will expand placement of CHWs within provider sites to engage enrollees, and facilitate plan of care development and management.

2.10.4.5.9 Community Health Worker Program Contact - Application

Rodney Wise, MD
Market Chief Medical Officer
AmeriHealth Caritas Louisiana
PO Box 83580
Baton Rouge, LA 70884
Office: 225-300-9192
Cell: 225-364-5020
Email: rwise@amerihealthcaritasla.com

2.10.4.5.10 Community Health Worker Program Lead - Implementation

Rodney Wise, MD
Market Chief Medical Officer
AmeriHealth Caritas Louisiana
PO Box 83580
Baton Rouge, LA 70884
Office: 225-300-9192
Cell: 225-364-5020
Email: rwise@amerihealthcaritasla.com

This page is intentionally left blank.

2.10.5
Care Management

AmeriHealth Caritas Louisiana's CEO meets with an enrollee and his Care Manager during a Member Advisory Council meeting.

AmeriHealth Caritas™
Louisiana

2.10.5 Care Management

2.10.5.1 AmeriHealth Caritas Louisiana's Care Management Approach

AmeriHealth Caritas Louisiana's Population Health Management (PHM) methodology provides the foundation for our comprehensive and integrated care management approach. AmeriHealth Caritas Louisiana's guiding principles include person-centered care, minimally disruptive medicine, trauma-informed care, cultural sensitivity, and team-based care, with an emphasis on addressing SDOH. We know that **coordinating enrollees' physical health, behavioral health, and pharmacy needs, along with addressing the social determinants of health that they face, in an integrated, holistic manner is the most effective way to manage a their health**, to allow them to live healthier lives. **Our Next Generation Model of Care advances this approach to deliver the highest-quality care, provided with compassion and respect for an enrollee's dignity**.

Our care management approach, led by Rodney Wise MD, Betty Muller MD, Jeanine Plante**,** Pharm.D., and Rachel Weary RN, BSN, MSN, is person-centered, respectful of enrollee and family choices, cultural, spiritual, and linguistic preferences, and meets the requirements of **Model Contract, 2.7** and **MCO Manual 2.7** Care Management. Care management consists of core components focused on enrollees' level of need, including Complex Care Management (CCM), Care Coordination, Bright Start® Maternity Management, Rapid Response Team (RRT), Pediatric/Adolescent Preventive Health Care, Chronic Care Management, and Health and Wellness activities. Each component is designed around a holistic approach that addresses physical and behavioral health, Special Health Care Needs (SHCN) **(Model Contract, 2.7.4)**, pharmacy needs, and social determinants of health (SDOH). Our care management team is comprised of licensed clinical professionals with behavioral and physical health experience. We assign lead Case Managers based on enrollees' priority care needs, identified through the case management process **(Model Contract, 2.7.11.1)**.

We use data analytics, such as predictive modeling tools **(Model Contract, 2.7.3.1)** to identify enrollees who are appropriate for case management. We stratify tiers by risk, based on enrollees' needs and health care triggers **(Model Contract, 2.7.6)**. This approach enables us to effectively and efficiently connect enrollees and their families to the right care and right services at the right time, in the right setting. In 2014, we began providing face-to-face community case management**.** Since that time, we have continued to transform our program to meet emerging needs, advance evidence-based practices, and ensure high-value care and service excellence. AmeriHealth Caritas Louisiana's knowledge and experience in Louisiana drives our commitment to build on our current approach in the new contract period, supporting the Louisiana Department of Health's (LDH) vision to operate as innovators and achieve the Triple Aim. Our 2018 Case Management Satisfaction Survey results showed 92.1 percent of enrollees reported that our case management program helped them better manage their, or their child's, health care condition and meet their health care goals.

AmeriHealth Caritas Louisiana's overall care management approach, shown in **Figure 2.10.5.1-1** complies with current NCQA Complex Case Management standards required for Health Plan Accreditation. We maintain a Commendable level of NCQA Accreditation. Consistent with these guidelines, our program incorporates both an individual and population health management approach with tiered stratification levels that provide support to all enrollees, based on an individualized assessment of care needs, and individual preferences **(Model Contract, 2.7.1)**.

Figure 2.10.5.1-1: *Care Management Approach — Supporting Enrollees With Their Health Care Journey.*

Six essential phases comprise our overall approach to managing enrollees' needs and encompass the following activities: identification, engagement, assessment, care planning, implementation and monitoring. These core elements enhance care coordination, eliminate duplication, and promote self-management skills, helping enrollees more effectively manage their health conditions.

Our policies and procedures provide a roadmap for day-to-day operations. We design these to establish guidelines and best practices using evidence-based protocols that govern all aspects of care management. AmeriHealth Caritas Louisiana's policies and procedures ensure compliance with laws and regulations, give guidance for decision-making, and streamline internal processes. Policies and procedures cover all aspects of PHM, are approved by the Quality of Clinical Care Committee, a sub-committee of the Quality Assurance Performance Improvement Committee (QAPIC), and are submitted to LDH as required for approval **(Model, Contract 2.7.12)**.

Figure 2.10.5.1-2 AmeriHealth Caritas Louisiana HEDIS® 2018 analysis of the effectiveness of our care management program shows that enrollees engaged in care management did better on numerous key health outcome measures than non-engaged enrollees.

Case Management Enrollees Statistically Significant Difference		
Measure	**Difference**	**P Value**
Adult Access to preventive/Ambulatory Health Services (AAP)	24% higher	P<0.01
Prenatal and Postpartum Care (PPC)	27% higher	P<0.05
Metabolic Monitoring for Children and Adolescents on Antipsychotics (AMP)	59% higher	P<0.05
Breast Cancer Screening	24% higher	P<0.01
Chlamydia Screening in Women (CHL)	18% higher	P<0.01
Follow-Up After Hospitalization for Mental Illness - within 7 days (FUH)	50% higher	P<0.01
Children and Adolescents' Access to Primary care Practitioners (CAP)	10% higher	P<0.01

Figure 2.10.5.1-2 HEDIS® *2018 Case Management Analysis*

2.10.5.1.1 Ensuring Timely Completion Of HNAs

AmeriHealth Caritas Louisiana's process for ensuring success and timely completion of Health Needs Assessments (HNA), outlined in **Figure 2.10.5.1-3** is multi-pronged, and inclusive of web-based, phone, mailers, and in-person approaches to ensure enrollees complete the HNA **(Model Contract, 2.7.2.5.2)**. Our Healthy Behaviors program offers a tiered reward designed to motivate enrollees to complete the HNA as soon as possible after enrollment, using behavioral economics. We include directions for completion and information on the importance of the HNA in the enrollee **Welcome Packet**, sent to all new enrollees within 10 business days from the receipt of the 834 file **(Model Contract, 2.13.3.1)**. Our **Member Handbook** offers another opportunity for enrollees to learn about the importance of following through with completing the HNA and our Healthy Behaviors program.

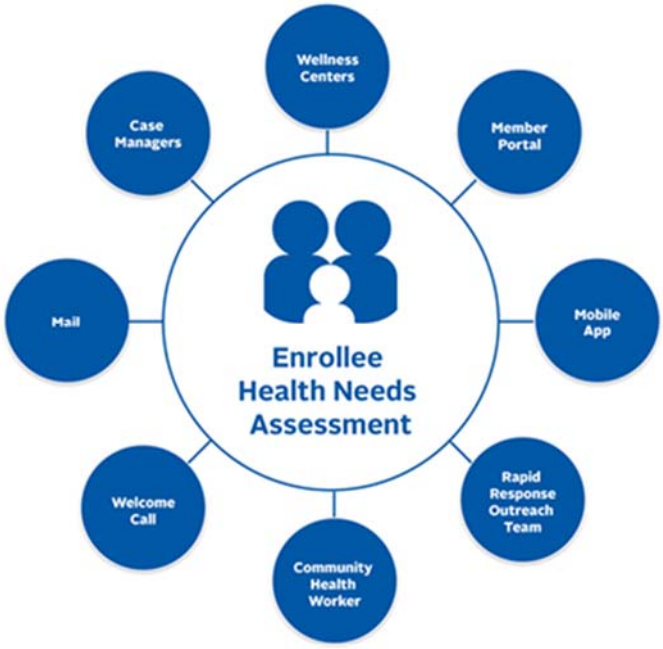


Figure 2.10.5.1-3 *Enrollee Health Needs Assessment.*

Additionally, the Member Portal on our website is an easily accessible avenue for enrollees to

complete the HNA and print a HNA physician summary to share with their primary care provider (PCP). Proactive Welcome Calls conducted by our Member Services Call Center **(Model Contract, 2.7.2.1)**, also collect HNA information. Outbound calls are made within 90 days of an enrollee's effective date and 30 calendar days of the date of enrollment for enrollees with Special Health Care Needs (SHCN). We identify newly enrolled SHCN enrollees quickly by using the 834 transaction file and historical claims files **(Model Contract, 2.7.2.2)**.

We use an HNA gap report to identify enrollees who have not completed the HNA after initial attempts by sending email and text message reminders. We attempt outbound phone calls on at least three different occasions, at different times of the day and on different days of the week **(Model Contract, 2.7.2.3)** to encourage completion within the 90 day period, or within the 30 day period for SHCN enrollees. The HNA gap report is viewable in the Integrated Population Health Platform. At any point during interactions with enrollees, Case Managers, Member Services staff, Louisiana Certified Peer Support Specialist and all other enrollee-facing staff may view HNA gaps and remind enrollees of the importance of completing their HNA. For those enrollees we are still unable to locate or engage, we deploy Community Health Workers (CHW) to attempt to locate the enrollee at the physical address we have on record. Additionally, AmeriHealth Caritas Louisiana's RRT can assist with contacting enrollees to complete the assessment. Enrollees can contact the RRT during regular business hours for assistance and utilize the 24/7 Nurse Advice Line to seek assistance with completing the HNA after hours, on weekends and holidays. In addition to Welcome Calls, AmeriHealth Caritas Louisiana continues to offer new enrollee orientation meetings at our community wellness centers, located in New Orleans and Shreveport. During these orientation sessions, enrollees are encouraged to use one of our on-site secure computers to complete the assessment, if they have not already done so. HNAs are made available in both English and Spanish. Instructions on how to request interpretation and translation in alternative formats and languages can be found in our Member Handbook **(Model Contract, 2.13.6.2.31)** provided to all enrollees.

AmeriHealth Caritas Louisiana's systems are flexible and able to include the common survey-based instrument to be developed by LDH, as required in **Model Contract, 3.1.15.1**.

Sharing HNA Data With Providers

AmeriHealth Caritas Louisiana's network providers are supported by a robust-data sharing infrastructure that provides actionable information through the **Provider Portal**. The Member Clinical Summary found in the Provider Portal provides detailed information on the services and medications the enrollee is receiving, and is expanded to include information reported through the HNA, giving providers enrollee-level access to HNA data **(Model Contract, 2.7.2.4)**. Using automated **Direct Secure Messaging** technology, our providers have the option to be notified directly in the electronic health record of enrollees' HNA responses and enrollees who have not completed the HNA. The Provider Handbook includes information on the HNA, available reports, and expectations for using enrollee reported results as a catalyst to identify health and functional needs. **AmeriHealth Caritas Louisiana will develop a report to export HNA data to LDH upon request (Model Contract, 2.7.2.4)**.

2.10.5.1.2 Using Predictive Modeling, Referrals And The HNA To Identify Enrollees

AmeriHealth Caritas Louisiana integrates multiple data sources to assess the needs of enrollees and determine actionable categories for intervention, including case management. The combination of sources, as described below, are used to identify enrollees who

No Wrong Door Philosophy. *We promote the use of many* doors *that may lead to referring enrollees who can potentially benefit from case management.*

require further follow up and assessment to identify and address their specific needs. Enrollees with SHCNs are offered case management, regardless of information gathered through predictive modeling, the HNA, or a comprehensive risk assessment **(Model Contract, 2.7.4)**.

Predictive Modeling

Our [redacted] is a proactive analytic learning model that goes beyond traditional industry predictive modeling scores, to profile and identify emerging and high-risk enrollees for care coordination and management **(Model Contract, 2.7.3.1)**. Building from a wide range of metrics associated with enrollees' medical and behavioral risks, and gaps in care, [redacted] These include but are not limited to: [redacted] **(Model Contract, 2.7.5.1)**, [redacted] .

The [redacted] design is modular, making it easy to add or remove data from the process and quickly re-rank enrollees using the latest data inputs. The simplicity and flexibility of the [redacted] model allows for consistent application across a wide range of enrollee intervention programs. Depending on purpose, users have the capacity to run queries and select groups of specific enrollees based on intervention purpose. For example, a diabetic outreach program can first select enrollees diagnosed with diabetes, include only enrollees with [redacted], and further narrow the query per geographic area, social determinant factor, PCP affiliation, care gap, or a combination of all four. AmeriHealth Caritas Louisiana works to obtain as much information as possible to improve our systems and processes, including identification of enrollees for case management.

Referrals

We generate referrals from our [redacted] methodology, utilization management reviewers, social workers, Enrollee Services Staff, RRT, and the Community Health Education Team. We also encourage grievance coordinators to refer enrollees to case management through our Integrated Population Health Platform. Providers, including primary care, Behavioral Health, pharmacists, and specialists, and state entities like Office of Adult and Aging Services (OAAS), Office of Behavioral Health (OBH), etc. may directly refer. Enrollees may self-refer, and caregivers are also empowered to make a referral for case management services. When a case management referral is received, we initiate outreach within three - five business days to make contact and complete a comprehensive assessment. If the enrollee agrees, we can schedule an in-person visit to complete the assessment and plan of care. If we are unable to successfully contact the enrollee by phone, we deploy a field-based CHW to attempt to locate the enrollee for an in-person visit. This initial contact aids in establishment of a trusting and lasting relationship with our enrollees.

Providers or office staff can refer enrollees for case management services by telephone or fax. Network Management Account Executives advertise this referral mechanism through the Let Us Know program which encourages provider offices to notify AmeriHealth Caritas Louisiana of enrollees who need additional assistance with health care or non-health care services. Providers are notified of availability of case management services through Provider Newsletters and our web site. Case management referral guidelines are available to providers via the Provider Portal, and through provider training **(Model Contract, 2.7.5.2)**. Additionally, we identify enrollees who could potentially benefit from case

management through our 24/7 Nurse Advice Line, discharge transition Case Managers co-located at local hospitals, and other health plan activities. Enrollees are also referred through community events and wellness days. These activities continue throughout the enrollee membership with AmeriHealth Caritas Louisiana.

Health Needs Assessments Process

The HNA is made available to all new enrollees in multiple formats including the new enrollee welcome call. This provides preliminary health and functional needs information, and is a gateway into further evaluation for care management activities. It serves as the first input to our enrollee profiles and identifies enrollees in need of care coordination or case management services. HNA responses are stored in our Integrated Population Health Platform, which notifies Case Managers when an enrollees' response to a question in the HNA triggers a need for follow-up.

2.10.5.1.3 Enrollee Engagement

Enrollee engagement is a crucial component of high-quality health care services across the continuum, particularly in the management of chronic medical and behavioral diseases. We hire associates that have a natural sense of empathy and caring, and provide advanced training to enable associates to effectively engage enrollees to improve their health care and lives. We seek out associates that have walked in the shoes of our enrollees and have previously, or currently live, work, and play in the same communities. For example, our Community Care Management team (CCMT) is staffed by both clinicians and non-clinicians who live in the neighborhoods they serve, and understand the uniqueness and culture of the community. We understand that meeting enrollees where they are improves treatment participation and that needs fluctuate due to life changing events. AmeriHealth Caritas Louisiana views case management as a fluid course of action that changes over time with the enrollee's needs, engagement, and preferences. Engagement strategies include web, video, texting, social media, other digital technologies, and platforms to increase the relevance, reach, and overall intensity of engagement with enrollees **(Model Contract, 2.7.2.5.2)**. We consider cultural influences when preparing online messaging. Framing content within the context of a person's culture makes the information more familiar, and is more likely to result in action. A foundational principle of behavioral economics is that we all look for the easy choice when making hard decisions. We make our health education information easily accessible and relevant to enrollees, to increase the likelihood that they will act to engage in care. Enrollee strategies described below are designed to engage, educate, and empower enrollees throughout the case management process.

Engaging Enrollees Where They Live

Community-Based Case Management Team (CCMT)

Our CCMT provides valuable information for, and coordination with, other health plan staff and services, as well as other providers in the community – all with the goal of helping enrollees receive the right evidence-based care, in the right place at the right time.

The AmeriHealth Caritas Louisiana CCMT, introduced in 2014, is based on the premises of the Pathway Model Development and the Camden Coalition of Healthcare Providers. The CCMT amplifies the traditional case management continuum by providing high-touch, face-to-face engagement for high-risk enrollees with intensive care needs, including over-utilization of acute services as their primary source of care. Our goal is to decrease overall cost by reducing Emergency Department (ED) utilization and Inpatient (IP) admissions, and coordinate care with community for ongoing care. The CCMT supports the development of enrollee self-management skills through encouragement and coaching for chronic disease management and supports interventions required in tier 3 and 2, intensive case management, for high-risk enrollees **(Model Contract, 2.7.6.1)**. In addition to improving care and health

outcomes of enrollees, our CCMT provides valuable information for and coordination with other health plan staff and services, as well as providers in the community, with the goal of helping enrollees receive the right care in the right place at the right time. The team provides case management and care coordination to help enrollees navigate the service delivery system to access needed medical, behavioral health and social services. The CCMT plays an important role in team coordination, aiming to maximize the support enrollees get from all available resources, without overwhelming or duplicating services. For example, after receiving consent, the CCMT participates in and supports enrollees with their provider appointments. It is important to note that our CCMT approach is family-centered; we recognize the role caregivers play in helping enrollees with chronic conditions. Our CCMT is there every step of the way to find the intersection between challenges, opportunities, and preferences. This allows us to create multiple paths for enrollees, gives them the choice that works best for them, and leads to better health outcomes.

In 2018, enrollees engaged with CCMT received 1,047 successful face-to-face visits, including home, community-based, and provider appointments. Overall, this population had a decrease of 27.4 percent in inpatient admissions and 14.4 percent in total non-pharmacy related costs from the year prior to the year following CCMT.

AmeriHealth Caritas Louisiana Telephonic Case Manager "Lucas" assisted an enrollee that experienced anxiety during physician office visits. After one particularly stressful office visit, the enrollee called Lucas, his assigned Behavioral Health Case Manager, in tears, and was not able to remember why he went to the doctor in the first place. Lucas comforted the enrollee over the phone, and together they decided Lucas would accompany the enrollee to his next appointment. During the subsequent appointment with the Nurse Practitioner (NP), the enrollee began to get upset and shut-down. Lucas supported the enrollee throughout the appointment, making sure he understood what was going on and the treatment being discussed. Both the enrollee and the NP were very appreciative of Lucas' support. After the appointment the enrollee expressed that he felt fully supported and less fearful and anxious. He said, "I trust you." and was more motivated about his wellness.

Case Managers Engaging In Face-To-Face Visits

In addition to our CCMT approach, all of our Case Managers review their caseloads to identify enrollees who would benefit from and consent to a face-to-face meeting. Once identified, the Case Manager makes arrangements to visit the enrollee during a doctor appointment or at another preferred place. This added level of in-person engagement reinforces the commitment between Case Manager and enrollee.

Rapid Response Team

AmeriHealth Caritas Louisiana's RRT model was developed based on best practices to ensure timely resolution of enrollee needs. The RRT is a real-time unit put in place to address enrollee needs without delays. The team is comprised of clinical and non-clinical staff to support care coordination services. We train RRT staff to assist enrollees in investigating and overcoming the barriers to achieving their health care goals. Staff address episodic issues and questions, offer assistance in finding a PCP or specialist, and assist with making physician appointments and arranging transportation. The team receives inbound calls from enrollees and providers through our toll-free phone line, and conducts outbound call campaigns to promote healthy choices and close care gaps. They resolve immediate and/or urgent needs, ensure enrollees are established with a health care provider, and connect them with available social and community services. The RRT serves as a front-line referral source to case management. **During our 2018 RRT outreach campaigns, we successfully assisted 44 percent of enrollees in controlling their blood pressure, 41 percent in taking their ADHD medications, 23 percent in avoiding unnecessary visits to the ED, and 25 percent in controlling their asthma**.

Community Health Workers

CHWs visit high-risk enrollees in the community to engage them face to face. CHWs are a special group of non-clinical associates who assist with locating and engaging difficult-to-access enrollees. CHWs attempt to form a positive rapport, educate enrollees on their plan benefits, and explain our case management program. With consent, the CHW will actively connect the enrollee to their Case Manager or RRT team at the time of their need. CHWs live and work in targeted geographic areas where there are high numbers of chronically ill enrollees who may be hard to reach or difficult to engage. They understand the unique culture of each community they serve and are well received by community members.

*In April 2019 A.J. Farria, an AmeriHealth Caritas Louisiana Peer Support Specialist supervisor, was **awarded the "Making a Difference" award for going above and beyond to uplift Louisiana's most vulnerable populations and the communities in which they live, from the Association for Community Affiliated Plans**, a national association that represents Safety Net Health Plans. A.J. lets the enrollees she serves know there is hope and that recovery is possible. She is open and honest about her own personal struggles to overcome trauma, mental health challenges, and homelessness. A.J. works with community groups to address health and social issues through educational activities that stress the importance of early detection, preventive care, healthy behaviors, and overall personal health awareness.*

Louisiana-Certified Peer Support Specialists

Peer support services are delivered by individuals who share common life experiences with enrollees they serve, which gives them a unique capacity to understand and engage with enrollees. Peer Support Specialists perform duties such as identifying goals, assisting with treatment planning, providing life skills coaching, referring enrollees for community resources, conducting recovery groups, assisting with discharge planning, and engaging enrollees in aftercare. They serve as advocates, mentors, and facilitators, and help enrollees improve their resiliency. AmeriHealth Caritas Louisiana has assigned Peer Support Specialists to hospitals across the state. Each day, hospitals share their daily census of our enrollees so we can make contact and engage the enrollee in discharge planning. When Peer Support Specialists are face to face with our enrollees, they assist with discharge planning, assess SDOH care gaps and discharge barriers, schedule follow-up appointments, coordinate resources, connect the enrollee to AmeriHealth Caritas Louisiana programs, and refer to case management, if needed. Upon discharge, enrollees are asked if they would like to continue peer support services in the community; we continue to provide in-person peer support for an average of 60 days post-discharge.

AmeriHealth Caritas Louisiana analyzed enrollee outcomes and expenditures for six months prior to enrollment in our peer support and CHW programs, and during the six months that enrollees received these services. **A summary of 2018 results showed a 47 percent increase in PCP visits, 27 percent reduction in avoidable ED visits, 54 percent reduction in avoidable inpatient admissions, and 24 percent overall reduction in medical and pharmacy costs**.

Care Extender Program

AmeriHealth Caritas Louisiana Care Extender program is a 24/7 case management model for enrollees facing Behavioral Health and emotional challenges. This program targets enrollees with Behavioral Health diagnoses and high ED utilization and/or inpatient readmissions, and who have been challenging to engage in case management. It provides care coordination and day-to-day coaching**,** to successfully transition enrollees between care settings, while ensuring care is provided in accordance with the discharge plan

(Model Contract, 2.7.6.4). Enrollees eligible for this program are connected to a highly specialized team of four field-based care extenders who are available on a 24/7 basis. In addition to in-person interactions, they provide virtual support via phone and text for up to four months or longer depending on individual need. Enrollees engaged in this program had a 46 percent reduction in preventable inpatient re-admissions, a 26 percent reduction in preventable ED visits, and a 16 percent increase in PCP visits.

Community Wellness Centers

AmeriHealth Caritas Louisiana's community wellness centers provide a comfortable and safe location for Case Managers to meet in person with enrollees and interact with the community at-large. For example, at community baby showers our nurses present on pregnancy related topics that appeal to newly pregnant or recently delivered enrollees. During this time they are available to answer questions, explain the case management process, and introduce available resources for a healthy pregnancy or postpartum period, such as our Bright Start® Maternity Program and the Bright Start pregnancy tracker application**. In addition to the third community wellness center which will open in 2019, we are committed to opening a fourth community wellness center during the new contract period.** After the start of the new contract, we will analyze our membership's demographics and locations to determine an area in the state will most benefit from a new community wellness center.

Tools And Training For Case Management Staff

Engaging in person-centered care requires different approaches which are dependent on each enrollee's unique situation. AmeriHealth Caritas Louisiana associates are trained in person-centered thinking, motivational interviewing techniques, shared decision making, the Mandt System®, and trauma informed care. These methods are effective techniques that are easily integrated into various settings, and successfully used during both telephonic and face-to-face interactions with enrollees. ACLA encourages case management staff to obtain their certification for case management by reimbursing for completion of testing. Additionally, we support case management certification through ongoing education and by allowing time for case managers to study and prepare for the certification exam.

Focused Areas Of Expertise

Bright Start® Maternity Care Coordination Program

The Bright Start program is managed by a dedicated team of Case Managers and Care Connectors with expertise in maternity management. The Bright Start team outreaches to pregnant enrollees and enrolls them based on internal and external assessments stratifying high and low-risk categories. Case Managers coordinate care and address various issues throughout the enrollee's pregnancy and postpartum period, including prenatal education, transportation for prenatal visits, dental, and depression screenings. Enrollees assessed as low-risk receive periodic outreach and educational information via mailings, with access to a Case Manager as necessary. Key elements of the Bright Start Program include:

- Early identification of high risk pregnant enrollees (utilization pharmacy data, medical claims information, and provider assessment submissions) and obtaining accurate contact information.
- Early and consistent perinatal care through the postpartum period.
- Focused education to empower the enrollee to adopt healthy behaviors and adhere to prescribed medical treatments.
- Collaborative relationships with community-based agencies that specialize in services for maternal child health.
- Screening for symptoms of prenatal or postpartum depression (PHQ-9/A and Edinburgh Postnatal Depression Scale).
- Inter-pregnancy education.

Leveraging Technology To Facilitate Engagement

Home-Based Solutions

AmeriHealth Caritas Louisiana provides telemedicine services via phone, computer, or tablet, including smart home technology and other assistive technology, to effectively increase engagement and access in rural and urban populations.

AmeriHealth Caritas Louisiana's in-home telemonitoring solutions provide digital mobile disease management and data analytical services to enrollees using a telemonitoring platform. Adult enrollees diagnosed with poorly controlled diabetes and heart failure that meet criteria for participation in the program are monitored using a digital telemonitoring platform that includes daily monitoring of blood sugar, weight, blood oxygen levels and blood pressure; timely intervention and assessment of clinical needs. Enrollees identified for this program receive an Apple iPhone 5C that connects to biometric devices such as a weight scale, blood pressure cuff, pulse oximeter, and AVIVA connect glucometer. In addition, each participant in the program has secure access to the following:

- Mobile app providing easy access to services such as live video appointments, text messaging, and the enrollee's plan of care.
- Individual one-on-one health coaching, focusing on behavior change modification and plan of care adherence.
- Baseline status change notifications.

***Prenatal and postpartum visit rates increased significantly over time**:*

- *First trimester visit rate increased from 40.4% in 2014 to 66.7% in 2018 (P values <0.0001).*
- *The percentage of greater than eight times of total prenatal visits went up significantly from 75.9% in 2014, to 82.81% in 2018 (both P values <0.0001).*
- *Postpartum visit rate also increased from 32.4% in 2014 to 52.2% in 2018 (P values <0.0001).*
- *Pre-term delivery rate decreased from 14.3% in 2017 to 13.8% in 2018.*
- *Pre-term delivery rate decreased from 14.3% in 2017 to 13.8% in 2018.*
- *C-section rate reduced over the time: 36.3% in 2014 to 34.9% in 2018.*

Enrollees using the platform engage 80 percent of the time and receive an average of 92 touches per month, including both clinician and technology. Since inception, this platform has shown great outcomes: 40 percent reduction in cost and 55 percent decrease in inpatient days.

Two-Way Texting Engagement Strategy

Our two-way text message app is a high-impact, low-cost method of engaging enrollees. It uses a communication method enrollees often prefer, and provides a vehicle for case management staff to maintain one-on-one contact with enrollees, provide appointment reminders, and conduct check-ins between scheduled calls. Our texting app also offers a method to receive inquiries from enrollees. In just three months, since two-way texting was implemented, 20 Case Managers have engaged in two-way texting with 365 enrollees. It has been especially beneficial to connect with working parents of children with special health care needs who have traditionally had difficulty connecting with their Case Manager via another means.

Bright Start Pregnancy Tracker App

AmeriHealth Caritas Louisiana's Bright Start Pregnancy Tracker is a free mobile application that is compatible with both iOS and Android cellular phones. It uses minimal data, adheres to web content for users with disabilities, is written to the fifth grade level, and is available in English and Spanish. The SDOH

survey, community resources look-up, health needs assessment, pregnancy centering tool, and appointment scheduling feature are tools available within the application. The Bright Start application provides real time health advice and allows one-touch dialing to the Bright Start team or 24/7 Nurse Advice Line. This program is available to all pregnant enrollees, and continues through the baby's second year of life. The app has been expanded to support families with children of every age and every stage of development.

Keys To Your Care® (KTYC) Texting Program

KTYC empowers our enrollees to take charge of their reproductive health by providing education on staying healthy during pregnancy and reminders of prenatal and postnatal appointments. KTYC is an evidence-based intervention designed to promote favorable outcomes for both mother and baby. It consists of interactive text messaging, occurring twice weekly in English or Spanish, and includes pregnancy related education and encouragement to make scheduled obstetrician visits. Enrollees can also reply to messages with keywords that return automated responses providing additional educational information, making it easy to engage in care. The KTYC program asks enrollees to opt into the text messaging campaign. After opting in, they receive a welcome text, followed by questions asking for the enrollee's information, including but not limited to: first and last name, enrollee ID, and due date. One to two text messages are sent every week; once the due date is reached and delivery is confirmed, messages align with the gestational age of the baby. Postpartum messages are sent until the 51st day after the baby is born. If the enrollee experiences unexpected events, such as ED visits or hospital admissions, they receive targeted messages.

Social Media

Engaging enrollees in their own care is at the cornerstone of care integration. Realizing that the majority of our enrollees have smart phones and internet access, it is important we interact with them in the way they are most comfortable: Facebook, Twitter, and Instagram. AmeriHealth Caritas Louisiana considers cultural influences when preparing online messaging for all three platforms. Framing content within the context of a person's culture makes the information more familiar, and is more likely to result in action. Within Louisiana, different parts of the state have distinct regional and cultural differences. A Facebook post targeting diabetic enrollees in New Orleans, for example, might include references to making soul food healthier and incorporating fitness with music. We saw the effectiveness of social media firsthand in 2018 when we used Facebook live to share a brief message from an event at our Shreveport Community Wellness Center. Within minutes, we had additional participants who told us they had seen event posts online and wanted to join their friends who were having fun.

2.10.5.1.4 Tier Identification, Management, And Support

The Complex Case Management component of the PHM program provides coordination of services for pediatric and adult enrollees with multiple comorbidities and disease states. Our program integrates physical health, pharmacy, psychosocial, and environmental aspects of enrollees' care, as well as coordination with behavioral health into a single, individualized plan of care. Enrollees are assessed and re-assessed as needed, and moved into different tiers as needs change **(Model Contract, 2.7.6)**. The enrollee's level of health care needs is evaluated as part of the assessment; enrollees are appropriately triaged using objective measures and risk stratification. AmeriHealth Caritas Louisiana has developed a tiered stratification model to use in combination with the Substance Abuse and Mental Health Services Administration (SAMHSA) Four Quadrant Clinical Integration model. The Four Quadrant model supports the clinical integration of medical and Behavioral Health services and focuses on the prevalence of co-occurring disorders. It is not diagnosis-specific, but looks at the degree of clinical complexity and risk/level of functioning. Stratification is performed by placing enrollees with correlated complexities and risk levels

into different quadrants of care. It is a model for how to stratify an enrollee engaged in integrated care. The model helps determine the lead Case Manager based on the enrollee's priority need **(Model Contract, 2.7.11.1)** as indicated within each quadrant. By using these two models we are able to provide evidence-based, high value care that is individualized, and enrollee driven. **Figure 2.10.5.1-4: Case Management Levels and Support** outlines the combined approach and resulting, tier identification, quadrant level, and supporting activities.

Case Management Tier	Tier Objective Measures and Criteria	Quadrant Level	Types of Support and Frequency
Tier 3 - Intensive Case Management for high-risk enrollees	• Top 1% of risk stratification report [redacted]. • 4 or more Co-morbid conditions (Asthma, COPD, SUD, SED, SPMI, Diabetes, and CAD). • Traumatic Brain Injury/ Spinal Cord Injury/ Quadriplegia/Paraplegia. • Trauma/condition with complex discharge needs (multiple DME/Home Health/ Home Therapy/Home Assistance needs). • Home Ventilator Support. • High Risk Pregnancy with Homelessness and/or Current Substance Use. • DOJ Target Population (based on need).	• Quadrant IV – high Behavioral Health needs and high physical health needs (Case Manager with strong Behavioral Health /PH experience as lead). • Quadrant III – low Behavioral Health and high physical health needs (Case Manager with strong physical health experience as lead). • Quadrant II – high behavioral needs and low physical health needs (Case Manager with strong Behavioral Health experience as lead).	• In-person assessment and plan of care within 30 days of identification with monthly in-person updates. • Identification of multi-disciplinary care team. • Multi-disciplinary meeting monthly. • Formal in-person quarterly re-assessment. • Home environment assessment. • SDOH priority assessment. • CHW support as needed. • Peer Support/Housing Specialist/Permanent Supportive Housing (PSH) Liaison, per plan of care. • Coordination with LDH transition coordinator as applicable to plan of care.
Tier2 - Case Management (Medium)	• Behavioral Health admit/discharge • Asthma (1IP and/or 2 of ED visits in prior 6 months). • Congestive Heart Failure with IP/ED history. • High Risk Pregnancy. • Homeless and PH/ Behavioral Health co-morbid condition • DOJ Target Population (based on need).	• Quadrant IV – high Behavioral Health needs and high physical health needs (Case Manager with strong Behavioral Health /physical health experience as lead). • Quadrant III – low behavioral health and high physical health needs (Case Manager with strong physical health experience as lead). • Quadrant II – high behavioral needs and low physical health needs (Case Manager with strong behavioral health experience as lead).	• In-person assessment and plan of care within 30 days of identification, at least monthly case management meetings with quarterly updates. • Identification of multi-disciplinary care team. • Multi-disciplinary meeting quarterly. • Formal in-person re-assessment quarterly. • Focused on support of clinical care and SDOH needs. • Home environment assessment. • SDOH priority assessment. • CWH Support as needed. • Peer Support/Housing Specialist/PSH Liaison as needed per plan of care. • Coordination with LDH transition coordinator as applicable to plan of care.

Case Management Tier	Tier Objective Measures and Criteria	Quadrant Level	Types of Support and Frequency
Tier 1Case Management (Low)	• Recently incarcerated and are transitioning out of custody. • SUD discharge. • Uncontrolled diabetes. • Sickle Cell disease. • HIV, newly diagnosed or non-compliant.	• Quadrant IV – high behavioral health needs and high physical health needs (Case Manager with strong behavioral and physical health experience as lead). • Quadrant III – low behavioral health and high physical health needs (Case Manager with strong physical health experience as lead). • Quadrant II – high behavioral needs and low physical health needs (Case Manager with strong behavioral health experience as lead).	• In-person assessment and plan of care within 90 days of identification. • Quarterly case management meetings. • Home environment assessment. • SDOH assessment. • Annual plan of care updates. • In-person formal re-assessment yearly. • CWH Support as needed. • Peer Support/Housing Specialist/PSH Liaison as needed per plan of care.
Transitional Case Management - Coordination of Services	• Enrollees in case management transitioning between settings of care. • DOJ target population.	• Not applicable.	• Discharge planning for short- and long-term hospital and institutional stays. • Development of transitional plan of care. • Coordination of care and services. • In-person visits as needed per transition plan. • Facility embedded discharge planner if available. • Multidisciplinary team involvement as needed. • Enrollees discharging from PRTF, TGH, or ICF; aftercare services in place 30 days prior to discharge. • CHW support as needed. • Peer Support/Housing Specialist/PSH Liaison as needed per plan of care.

***Figure 2.10.5.1-4**: Case Management Levels and Support.*

Process For Developing Individualized Plan Of Care

The lead Case Manager serves as the key individual guiding the plan of care process and implementation. The process is person-centered with significant input from the enrollee and caregiver, as well as members of the multidisciplinary team **(Model Contract, 2.7.10.2)**. The Case Manager is responsible for coordinating and ensuring proactive information sharing and communication amongst all participants, fostering trusted relationships and establishing shared accountability between the various health care providers, family caregivers, social support agencies, and other relevant entities supporting the enrollee. They are developed thoughtfully, and ensure consistent, continuous quality of care and service that is safe, efficient, and effective through multidisciplinary team collaboration. The plan of care is based on the principles of self-determination and recovery **(Model Contract, 2.7.10.3)**, and includes all medically necessary services, care coordination activities, and supports. The primary goal is to improve individual health outcomes. The plan of care **(Model Contract, 2.7.10.5)** is developed after a comprehensive assessment is completed, including but not limited to, goals, strengths, barriers, needs, and priorities. The individualized plan of care

is a written document, agreed upon by the enrollee, identifying person-centered goals, priorities, and active interventions with timeframes. Plans of care are reviewed and revised upon reassessment of functional need and occur at the frequency based on case management tier **(Model Contract, 2.7.10.4)** as outlined in **Figure 2.10.5.1-4**.

2.10.5.1.5 Case Management Coordination With Providers And State Staff

Coordinating With Providers And State Staff For Continuity Of Care

AmeriHealth Caritas Louisiana Case Managers coordinate with providers and state staff who may be providing case management support to our enrollees, by actively participating in the multidisciplinary team to decrease potential for duplication and fragmentation of care **(Model Contract, 2.7.10.1)**. As requested, we coordinate and participate in multidisciplinary team meetings, with entities including but not limited to, the Department of Social Services, Office of Juvenile Justice, OBH, and LDH Transition Coordinators. In these instances, we collaborate on the plan of care, the discharge and transition plan, and the treatment as we manage the enrollee's care. Additionally, AmeriHealth Caritas Louisiana Behavioral Health Case Managers work collaboratively with the LDH Transition Coordinators to help enrollees in the My Choice program.

Our embedded discharge/transition Case Managers are located in select high-volume hospitals and in an effort to provide on-site collaboration with the hospital case management teams, providers, and specialists caring for our enrollees. Participating in ED rounds is one example of how embedded discharge/transition Case Managers collaborate with hospital care teams. During ED rounds super-utilizers of ED services and potential candidates for our case management program are referred to our RRT for follow up. AmeriHealth Caritas Louisiana is collaborating with the Louisiana Hospital Association on new ADT feeds to provide EDs with the name and contact information of the enrollees assigned to an AmeriHealth Caritas Case Manager. The focus of coordination with providers and state staff is to ensure a stable continuum of care, regardless of whether services are provided through managed care, fee-for-service, other LDH contractors, or community and social support providers as required by 42 C.F.R. § (b) (2) (iv).

"Dwayne," is 21 years of age and was recently admitted to one of our in-network regional medical centers for behavioral health inpatient services. He has a history of serious and persistent mental illness and also suffers from a significant visual impairment. Prior to this admission he was living with his guardian. During this hospitalization it was determined that this living arrangement was detrimental to his well-being. AmeriHealth Caritas Louisiana's behavioral health clinical reviewer and Dr. Muller, our Behavioral Health Medical Director, began to help coordinate discharge planning. Securing a reliable and safe post-hospitalization placement was a top priority. Once Dwayne was ready for discharge, Dr. Muller, scheduled multidisciplinary team meetings at regular intervals with representatives from the medical center, LDH, OCDD staff from four parishes, the School for the Deaf and Blind, and Dwayne's behavioral health advocate. Waiver and group home options were explored. "Tyrone" was assigned as the AmeriHealth Caritas Louisiana lead Case Manager. After many meetings and collaboration between the multidisciplinary team and relevant agencies, Dwayne was accepted into a group home living arrangement. Dwayne toured the group home and was happy with this choice and accepted placement. Tyrone set up all follow-up appointments and arranged transportation. Dwayne is doing well in this group home, working with his counselor, consistently taking prescribed medications, and performing well in school.

Coordinated Systems Of Care

In a collaborative effort between our Behavioral Health Case Management specialists, Behavioral Health UM specialists, and Care Connector Team, enrollees who meet the criteria for Coordinated Systems of Care (CSoC) are contacted telephonically and connected to Magellan for evaluation. If there is a waiting list for CSoC services in the enrollee's region, AmeriHealth Caritas Louisiana's Care Connectors assist with coordination of care. Additionally, our Care Connectors work closely with Magellan to coordinate all care and services upon discharge from CSoC.

DOJ Target Population

As referenced in **(Model Contract, 2.7.7)**, in the new contract period, individuals in the DOJ Agreement Target Population shall be offered transitional case management and Tier 2 or Tier 3 case management as needed. Upon release, we coordinate all care and covered services. All newly enrolled offenders released from custody receive a welcome call and outreach from a CHW team member. If we are unable to locate the enrollee, we follow up with the offender's parole officer. Our Care Coordinator contacts the DOC facility 45 days prior to release and schedules two case management appointments with the offender. Within 30 days of release, case management meetings are held via video-conference. During these meetings, the Case Manager gathers relevant medical, behavioral, and social histories and arranges for post-release continuation of services. Upon conclusion of the case management meetings, a “Healthy Louisiana Case Management Follow-Up Care and Important Information Plan” form is completed and shared with DOC. We continue to follow up with the enrollee post-release to ensure continued access to medications, medical and behavioral services, and relevant community services.

Targeted Case Management

AmeriHealth Caritas Louisiana Case Managers collaborate and coordinate on cases where enrollees are receiving services such as Home and Community Based Waiver services or through OPH. In these instances where LDH takes the lead in the case management process, we actively participate to ensure coordination and integration, and avoid unnecessary duplication of care and services **(Model Contract, 2.7.10.1)**.

2.10.6
Case Scenarios

AmeriHealth Caritas Louisiana's Community Health Education and Outreach team connects enrollees to care.

AmeriHealth Caritas™
Louisiana

2.10.6 Case Scenarios

Use Case 1: Emily

AmeriHealth Caritas Louisiana's whole-person approach is designed to support our enrollees in addressing the challenges that prevent them from living a healthy productive life. We will leverage our population health care management process to complete a heath needs assessment (HNA), identify Emily as high need, engage her in care management, conduct a comprehensive adult health risk assessment, facilitate multi-disciplinary treatment planning, implement the treatment plan, and monitor her success in achieving her self-directed goals. We will also ensure that she and her three small children have access to appropriate services.

IDENTIFICATION

Emily and her three children, who live in St. Helena Parish, have been enrolled with AmeriHealth Caritas Louisiana for approximately 30 days. Emily is a 38 year old woman, whose primary language is English. Her three young children, ages 1, 2, and 4, are all boys. Emily participated in the initial HNA during the new enrollee welcome call and reported having multiple chronic conditions, frequent emergency department (ED) visits for pain, three recent pregnancies, and a need for back surgery. Due to her level of need, our Enrollee Services representative immediately warm-transferred Emily to our Rapid Response Team (RRT) to gather more information and address any urgent needs. The RRT provided Emily with information on our 24/7 Nurse Advice Line, and how to access transportation assistance and other available community resources. Following this interaction Emily agreed to further assistance and was referred to case management.

ENGAGEMENT

Upon receiving the case management referral, we assign Laura, an AmeriHealth Caritas Louisiana Case Manager with expertise in adult medicine, to support Emily in meeting her health and wellness goals. Prior to contacting Emily, Laura reviews information available in our population health platform. She discovers a recent request for back surgery and authorizations for a trial of pain management therapy to address Emily's low back pain, and physical therapy. After reviewing all available clinical information and within three days of receiving the referral, Laura calls Emily to introduce herself. Laura discusses the overall care management approach, subsequent case management process, and care coordination activities that AmeriHealth Caritas Louisiana can provide. Laura's training in motivational interviewing and person-centered thinking enables her to quickly build a positive rapport with Emily who agrees to be enrolled in case management. She learns during the initial conversation that Emily lives in a small apartment with her three young children - George, John, and Levi. Laura and Emily schedule a time to complete the in-person comprehensive assessment. Laura also asks Emily for consent to contact her treating providers to gather Emily's health records in preparation for a multidisciplinary team meeting.

ASSESSMENT

During the in-person meeting with Emily, Laura completes the adult comprehensive health needs assessment (HNA), which includes identification of any social determinants of health (SDOH) and depression screening (PHQ-9). Emily tells Laura that four months ago she was diagnosed with Hepatitis C. Emily states she doesn't know much about Hepatitis C and is worried about this disease. Emily was also diagnosed with hypertension and diabetes during her pregnancy with her second child. Her third pregnancy was considered high-risk and Emily was monitored closely, resulting in a successful pregnancy without complications. She indicated that she would like to understand her family planning options.

Emily reports she has suffered from chronic back pain for the last several years. She remembers hurting her back by lifting heavy boxes when moving into her apartment six years ago and states the pain has become progressively worse after each pregnancy. Emily has received the following treatments to address her back pain: various medications, nonsteroidal anti-inflammatory drugs, and muscle relaxants. Emily tells Laura she has gained a lot of weight over the last 5 years and struggles with not being able to lose the weight. She now weighs 180 pounds and is 5'4" tall. Emily knows the excessive weight is not good for her and knows that losing some weight will help her feel better and be healthier. Emily acknowledges she is worried about her future; she feels overwhelmed most days but tries to keep a positive attitude. She admits she uses the ED more than she should because lack of transportation makes it hard for her to travel to an urgent care or primary care provider (PCP) office. Emily has no family or friends to help during the day, but a neighbor is able to watch her children at night so the ED is her only option. When Laura asks why Emily goes to the ED, she reports that her visits are often for back pain, when she feels like her heart is racing, or when she experiences shortness of breath, which scares her. She also admits she sometimes forgets to take her medications for diabetes (metformin) and hypertension (amlodipine) as she is very busy raising three active little boys.

Emily recently had a consultation with an orthopedic specialist who recommended back surgery. She is nervous about having surgery and would like to know about other available options**. Laura encourages Emily to discuss all her options with her physician and choose the care that is best for her (Model Contract, 2.7.10.5.7)**. Laura also informs Emily that AmeriHealth Caritas Louisiana has approved on-going pain management therapy and physical therapy, which may help to resolve the back pain she experiences. Laura develops a list of available programs, services and supports to be considered as part of Emily's individualized plan of care, as shown in **Figure 2.10.6.1-1**.

Available Options to Achieve Goals	
Needs	**Summary of Emily's Available Services & Supports Options**
Physical Health	• Care Management support. • Primary care physician coordination. • Hepatitis C Management through new Louisiana Department of Health (LDH) Medication Subscription-Based Model. • Telemedicine home monitoring program for diabetes and hypertension. • Make Every Calorie Count. • Control Your Diabetes Control Your Destiny program. • Living Beyond pain program. • Two-way Texting program. • Healthy Behavior program. • Long Acting Reversible Contraceptives (LARC).

Available Options to Achieve Goals	
Needs	**Summary of Emily's Available Services & Supports Options**
Behavioral Health	• Behavioral health Telemedicine program. • Cognitive behavioral therapy for pain.
Social Supports	• Aunt Bertha - website of available social service agencies in her area. • Community Health Worker (CHW) support. • Transportation benefits and how to use them. • Child care services and supports available in the community.

***Figure 2.10.6.1-1**: Summary Of Emily's Available Services & Supports.*

CARE PLANNING

Laura contacts Emily's PCP and orthopedic specialist, after receiving consent from Emily, to discuss current treatment plans and clinical status **(Model Contract, 2.7.10.3)**. She informs Emily's treating providers that she is convening a multidisciplinary team meeting within the next 30 days and would like them to attend or provide input **(Model Contract, 2.7.10.5.1)**. The PCP will participate in the meeting by phone and other treating providers agree to provide input to Laura prior to the meeting. During the meeting, the team will review and discuss all relevant clinical and social information to inform development of the individualized plan of care. Using a person-centered process **(Model Contract, 2.7.10.2)**, Laura leads the multidisciplinary team meeting to develop an individualized plan of care based on Emily's goals for self-determination and recovery **(Model Contract, 2.7.10.3)**. Laura helps Emily to identify her goals **(Model Contract, 2.7.10.2)** based on the comprehensive assessment, PHQ9, her identified strengths, needs and priorities. Emily identifies and prioritizes the **self-directed goals** listed below.

- Long term treatment solutions to address her chronic back pain.
- Support for weight loss and learning to eat healthy on a budget.
- Education on self-management of chronic conditions.
- Access to routine PCP services to assist with symptom management and avoid inappropriate ED use.
- Support to address Emily's feelings of being overwhelmed.

Figure 2.10.6.1-2 represents Emily's agreed upon individualized plan of care.

Emily's Individualized Plan of Care	
Needs	Specific Identified Need and Interventions
Physical Health	**Hepatitis C** — Work with PCP and Case Manager to learn self-management strategies; explore participation in the new LDH Hepatitis C subscription-based model; take medication as prescribed; stay hydrated by drinking 6-8 glasses of water a day; get plenty of rest; eat healthy to lose weight. **Diabetes** — Work with PCP and Case Manager to learn tools to self-manage symptoms of diabetes; monitor blood sugar levels and keep a log; make healthy eating choice; participate in weight loss plan; complete annual dilated eye exam, annual foot exam, and annual HbA1c testing; take medication as prescribed; participate in Control Your Diabetes Control Your Destiny program. **Hypertension** — Work with PCP and Case Manager to learn to self-manage the symptoms of hypertension; maintain a blood pressure log; eat a low salt diet; exercise regularly; take medication as prescribed. **Frequent ED visits or pain** — Work with PCP and Case Manager to manage the symptoms of chronic pain; exercise regularly; receive in-home physical therapy; participate in the Living Beyond Pain program; receive chiropractic therapy. **Obesity** — Work with PCP and Case Manager to achieve a healthy weight; make healthy food choices; learn the importance of counting calories; exercise regularly; enroll in a gym membership through our Every Calorie Count program. **Family Planning** — Discuss the use of a LARC with OB/GYN provider.

Emily's Individualized Plan of Care	
Needs	Specific Identified Need and Interventions
	Preventive Care and Screenings — Receive coaching and education on the Importance of annual exams such as breast cancer screening.
Behavioral Health	**Stress and Anxiety** — Work with PCP and Case Manager to learn strategies for managing symptoms of anxiety; receive in-home behavioral health evaluation through our telemedicine platform and screen for anxiety; participate in cognitive behavioral therapy for pain and individual therapy provided by Florida Parish's Human Services Authority.
Social Support	**Aunt Bertha** — Case Manager to educate Laura on how to use Aunt Bertha to identify community resources and supports. **Transportation Support** — Connect to the transportation vendor for transportation to appointments. **Child Care** — Connect with child care assistance services such as Head Start and Early Head Start programs.

***Figure 2.10.6.1-2**: Emily's Plan Of Care Needs And Interventions.*

IMPLEMENTATION

Emily meets criteria for Tier 3, intensive care management, due to having multiple comorbid, chronic conditions. The multidisciplinary team determines that requires focused attention to address her clinical and social needs and to progress towards self-management **(Model Contract, 2.7.6.1)**. Upon completion of the individualized plan of care, Laura will focus on implementation to prevent adverse outcomes and support Emily in reaching her individual health and self-management goals. To implement the individualized plan of care, Laura will: 1) refer Emily to selected programs; 2) meet with Emily telephonically and in-person monthly; 3) conduct formal in-person quarterly re-assessments to monitor Emily's progress toward her self-directed goals and provide support; and 4) complete attestations of monthly updates to the plan of care for Emily and her PCP.

MONITORING

Laura contacts Emily 1-2 times per week by phone and conducts one monthly in-person meeting **(Model Contract, 2.7.10.5.14)**, as agreed upon during the multidisciplinary team meeting. She updates Emily's plan of care monthly and conducts formal in-person quarterly reassessments. Emily continues to make progress towards self-management and reaching her goals. She follows through with in-home physical therapy and pain management therapy. Emily has not visited the ED during this time. After three months, Emily transitions to Tier 2 case management. She continues to progress toward developing self-management skills and consistently takes her medications as directed. Emily has transitioned to outpatient physical therapy and receives transportation to her scheduled appointments. She is receiving chiropractic treatments as part of our Living Beyond Pain program and has chosen to use a back brace for additional support. Emily has lost 10 pounds and reports being more confident in managing the symptoms she experiences. Laura asks Emily if she would like an AmeriHealth Caritas Louisiana CHW **(Model Contract, 2.7.6.2)** to participate on her case management team. She explains that the CHW will make in-home visits and act as her champion, making sure Emily and her children receive all necessary community supports. Emily agrees to the CHW becoming part of her case management team and states that she looks forward to having additional support to help her achieve her self-directed goals.

During the next in-person quarterly reassessment, Laura determines that Emily meets the criteria for Tier 1 case management. Emily has taken control of her health, has not had any trips to the ED, and is consistently taking her medications as directed. As a result, Emily's blood pressure is consistently within normal range and her diabetes is under control. Emily is participating in the new state **Hepatitis C Medication program** and has completed the recommended treatment. She has scheduled follow-up appointments with her provider for testing and monitoring. Her back pain has been resolved and is no longer an issue. Emily is now using a LARC. With the support of her Case Manager and multidisciplinary team, Emily successfully learned to self-manage her multiple chronic conditions, lost weight, and followed through with her physical therapy regimen, pain management therapy, and chiropractic treatments. Emily reports she is feeling much healthier and has chosen not to pursue back surgery.

Ensuring Access To Appropriate Managed Care Organization Covered Services

Our person-centered case management approach supports enrollees with multiple comorbid conditions to achieve their health and wellness goals. Additionally, our physical and behavioral health medical directors are available to assist with Emily's case, consult with providers, and authorize additional services as needed. AmeriHealth Caritas Louisiana will authorize in-home physical therapy**,** pain management therapy, outpatient physical therapy, chiropractic treatments, and a back brace. In partnership with Emily and her treating physician, we will re-evaluate the need for surgery. Laura will also connect Emily to our Living Beyond Pain program, in-home telemonitoring to help Laura manage the symptoms of diabetes and hypertension. We will also collaborate with the Louisiana Hepatitis C Coordinator to connect Emily to the new LDH Hepatitis C program. Emily can also access in-home behavioral health telemedicine services, as needed, to address feelings of anxiety and to increase her coping skills.

Providing Support To Enrollees Through Case Management And Other Tools

We aggregate all available enrollee data into our population health platform and use advanced analytics to stratify enrollees by risk level. We then assign the level of case management appropriate to meet the enrollee's individualized needs. Emily's community-based Case Manager, Laura, will serve as her primary point of contact with AmeriHealth Caritas Louisiana and will continually assess her needs, engage with the multidisciplinary treatment team, coordinate authorizations for services, and connect Emily to community supports. Laura will use our two-way texting capability to communicate with Emily between calls and visits to check on her status and answer questions she may have during her case management journey. As appropriate, and based on Emily's preferences, Laura will connect her to the following AmeriHealth Caritas Louisiana programs: Living Beyond Pain, Hepatitis C Management program, in-home telemonitoring for diabetes and hypertension, and Make Every Calorie Count.

Resources And Infrastructure To Serve These Individuals In Louisiana

Our population health infrastructure includes nurses, behavioral health clinicians, nonclinical care connectors and community health workers, clinical pharmacists, health plan medical and behavioral health directors, PCPs, specialists, and community agencies. Using a multidisciplinary approach, this team partners with enrollees, caregivers, and parents/guardians to meet enrollees' needs, improving their health outcomes and overall quality of life. Laura and the multidisciplinary team **(Model Contract, 2.7.11.3)** use our Integrated Population Health Platform to review, plan, document, and update Emily's assessment and individualized plan of care and track Emily's progress towards her self-directed goals.

Use Case 2: Elijah

AmeriHealth Caritas Louisiana has existing, close working relationships with local Louisiana resources and specialists to support Elijah's multiple, specialized needs and help him achieve his and his family's treatment goals. Our highly coordinated and collaborative approach to care management engages all available resources, including those offered through public agencies and community partners. We offer Elijah and his parents high quality care to support him in the least restrictive environment. Our integrated care management process guides our approach to meeting Elijah's needs.

IDENTIFICATION

The ED social worker contacts our 24/7 utilization management (UM) department to request an inpatient behavioral health admission for Elijah, and is connected to a licensed mental health professional in our UM department (behavioral health UM). Our behavioral health UM staff requests information from the ED social worker about his presentation. The ED social worker shares details of Elijah's trauma history, including that Elijah has been experiencing unrelenting distressing memories and has made multiple attempts to injure himself. The ED social worker also reports that Elijah's pediatrician has been unsuccessful in stabilizing his symptoms. This is Elijah's third visit to the ED with the most recent visit being 48 hours prior. The ED social worker also shares that Elijah presented to the ED with acute agitation and that his parents do not feel that they are able to meet his needs in the home. Our behavioral health UM staff review Elijah's clinical record and see that our Care Connectors attempted to contact him after the previous ED discharges without success due to having inaccurate contact information. The ED social worker reports that Elijah's father has requested that Elijah be admitted for inpatient care. Our behavioral health UM staff approves the inpatient hospitalization based on medical necessity and to ensure Elijah's safety. Additionally, the behavioral health UM staff submits an urgent referral to care management to support Elijah and his family. The hospital immediately begins to find him a bed and our behavioral health UM staff notifies them that we are able to assist if they encounter barriers. The hospital successfully identifies an inpatient behavioral health hospital near Elijah's home. Given his agitated state, the physician completes a Physician Emergency Commitment and Certificate of Need to ensure a safe and complete transfer.

ENGAGEMENT

Our AmeriHealth Caritas Louisiana behavioral health Case Manager, Harper, contacts Elijah's family shortly after his admission to the inpatient behavioral health hospital to ensure all appropriate consents are signed by Elijah's father. Harper asks about the family's goals for treatment and their current resources to gain a better understanding of the services and supports Elijah and his family need. Elijah's father shares that he does not feel like he is able to meet Elijah's needs without help. Harper explains that she will be supporting Elijah during his inpatient stay and upon discharge and that she wants to make sure Elijah and his parents have all the resources they need to be successful when Elijah returns home.

ASSESSMENT

Harper compiles all available clinical information from Elijah's outpatient providers, previous ED visits, his Office for Citizens with Developmental Disabilities (OCDD) Case Manager, and his current inpatient admission. Harper also schedules a time to meet with Elijah and his parents to complete a health needs assessment (HNA). During the assessment, Elijah's parents reiterate the information reported to AmeriHealth Caritas Louisiana by the ED social worker.

Harper then coordinates and convenes Elijah's multi-disciplinary team to review and discuss all available information and finalize the HNA while he is inpatient. The multi-disciplinary team includes: Elijah and his parents, the inpatient behavioral health facility staff, our behavioral health UM staff, our Behavioral Health Medical Director, Elijah's outpatient pediatrician, and his OCDD Case Manager. During this meeting, the team learns that Elijah has been treated by his pediatrician who has some experience treating children with behavioral issues but he has not received behavioral health outpatient or mental health rehabilitation services. The team also learns that Elijah has been receiving services from a psychologist with OCDD after Elijah's school requested resources to help manage his self-injurious behaviors in the school setting. The team asks Elijah and his parents about their goals. Elijah, his parents, and the team all agree that it is best for Elijah to return home with appropriate supports that will help reduce self-injurious behaviors and address symptoms of trauma. The team discusses all available clinical information and, upon review and the discussion, Harper designates him as Tier 3 due to his high-risk of injury to self.

The multi-disciplinary team develops a discharge plan and transition plan of care to support Elijah's transition from the inpatient setting back to the family's home. His transition plan of care identifies the referrals and/or authorizations that Elijah will need after discharge, appointments and all medications ordered during his inpatient stay. Harper shares available options for his post discharge treatment as detailed in **Figure 2.10.6.2-1**. The multidisciplinary team also agrees to develop a crisis plan, included within the plan of care that outlines steps the family will take to mitigate crisis situations and ensure his safety. Harper will collaborate with OCDD case manager to continuously assess Elijah's needs and status.

Available Options to Achieve Goals	
Needs	Summary of Elijah's Available Services and Support Options
Physical Health	• Primary care physician coordination. • Adhere to the EPSDT periodicity schedule, and schedule well-child visit. • Dietician and nutritional planning.
Behavioral Health	• Psychotropic medication management/ adherence. • Eye Movement Desensitization and Reprocessing (EMDR). • Trauma-focused cognitive behavioral therapy. • Crisis plan. • Care coordination with OCDD. • Applied Behavioral Analysis (ABA). • Coordinate Elijah's educational evaluation for updates to his Individualized Education Plan. • Coordinated System of Care. • Community psychiatric support and treatment. • Psychosocial rehabilitation services. • Screening and Referral to Coordinated System of Care (CSoC). • Telepsychiatry. • Family functional therapy. • Multi-systemic therapy.

Available Options to Achieve Goals	
Needs	Summary of Elijah's Available Services and Support Options
	• Homebuilders.
Parent/ Family Support	• Screen for social determinant of health needs and connect to supports for housing, transportation, education, vocation, personal safety, food etc. • Assess psychiatric health needs, referrals to treatment and annual well-visits, if agreeable. • Education about adverse childhood experiences and trauma informed care. • Peer support services for Elijah's parents, if eligible and willing. • Families Helping Families – caregiver support program.

Figure 2.10.6.2-1*: Informing Elijah And His Family Of His Care Options.*

CARE PLANNING

The multidisciplinary team educates Elijah's father about the benefits of Applied Behavior Analysis (ABA). His father and the team agree to ask the inpatient psychiatrist to complete a comprehensive diagnostic evaluation while Elijah is inpatient to determine if ABA is appropriate. Harper educates Elijah's father about the services available through the Coordinated System of Care (CSoC) and that CSoC will work with the family to find the best behavioral health providers to meet Elijah's needs in the community, identify recreational activities, and offer family support. The team updates Elijah's discharge plan and transition plan of care and develops his outpatient plan of care which includes his crisis plan and all required elements described in **Model Contract, 2.7.10.5**. **Figure 2.10.6.2-2** below detail's Elijah's final plan of care, as agreed upon by his father and the multidisciplinary team:

Elijah's Individualized Plan of Care	
Needs	**Specific Identified Need and Interventions**
Physical Health	**Primary care** — Elijah is scheduled for a follow-up appointment with his pediatrician 30 days following discharge from the inpatient stay. During the visit, he will receive an annual well-child visit and EPSDT services.
Behavioral Health	• **Coordinated System of Care (CSoC)** — Harper screens Elijah which indicates a referral to CSoC is warranted. Harper then submits a referral to Magellan to complete the Child and Adolescent Needs and Strengths (CANS) assessment to determine eligibility. • **Applied Behavioral Analysis** — After obtaining the father's permission, the inpatient psychologist, or psychiatrist performs a comprehensive diagnostic evaluation, and ABA is recommended. Harper identifies ABA providers, from whom Elijah's father will choose, to evaluate Elijah's level of functioning and maladaptive behaviors. The resulting recommendations will include an intervention plan to reduce his self-harming behaviors.
Parent/Family Support	• **Parent support** — Elijah's parents agree to schedule appointments with their own psychiatrist(s) and licensed behavioral health clinicians to support their mental health needs. They also agree to engage peer supports to help them better manage and cope. • **Family Support** — Elijah and his parents agree to participate in family support services coordinated by CSoC. • **Social Determinants of Health** — Elijah's parents complete an SDOH assessment and are connected to Aunt Bertha to access local resources in their community.
Access to Care	• **Care Coordination** — all services continue to be coordinated through the multi-disciplinary team that includes: Elijah, his parents, our Case Manager, his pediatrician, the OCDD Case Manager, and the ABA provider. The CSoC team will take the lead on coordinating Elijah's care in conjunction with the multi-disciplinary team.

Figure 2.10.6.2-2*: Providing Elijah With The Right Care.*

IMPLEMENTATION

Harper follows up with Elijah within 72 hours after discharge from the inpatient facility. She ensures that Elijah successfully attends his scheduled appointments with CSoC for the initial assessment and his outpatient pediatrician within 30-days of discharge. CSoC assists Elijah's parents in choosing a behavioral health provider who can offer psychiatric and therapy services. They can also choose a separate psychiatrist and therapist. CSoC also links the parents to a family support service. Elijah will be connected to activities that he may enjoy to expand his social skills and extracurricular activities. Harper also maintains communication with the multi-disciplinary team and confirms that his CSoC team convenes no less than monthly, given his status at Tier 3. Harper will also monitor that care coordination occurs with the CSoC Wrap Around Agency, Elijah's pediatric psychiatrist, licensed behavioral health clinician, OCDD case manager, ABA provider, school staff, and Elijah's pediatrician. Harper documents adjustments to Elijah's medications, therapies and other treatments as they occur as well as Elijah's progress toward developing new coping skills and experiencing fewer symptoms.

MONITORING

Harper monitors Elijah's progress by participating in monthly CSoC and multidisciplinary team meetings, monitoring his service utilization and coordinating with the team to address any gaps in care. Over time Elijah's medications, ABA, therapy services, and family supports significantly reduce his symptoms. His parents report that the treatment they receive is helping them feel more capable of meeting Elijah's needs. Elijah makes progress with his CSoC and ABA services, and no longer presents at the ED. He is free from self-harming behaviors and self-induced vomiting. Elijah is re-assessed in-person every quarter and updates on his progress are provided to his family and the entire team **(Model Contract, 2.7.6.1)**. After six-months, Elijah successfully completes the CSOC program, and is transitioned back to AmeriHealth Caritas Louisiana care management. Given his progress, he is placed at a Tier 2 case management level. In Tier 2 care management, his multidisciplinary team continues to meet monthly and he continues to be re-assessed quarterly **(Model Contract, 2.7.6.2)**. Within three additional months, at his re-assessment, he is identified as eligible to transition to a Tier 1 level of care management. This transition is agreed upon by Elijah and his family as they continue to work with Harper to achieve his full self-management goals.

Ensuring Access To Appropriate Managed Care Organization Cover Services

Our fully integrated population health strategy engages UM and care management to ensure enrollee access to appropriate covered services. We do this by streamlining prior authorization requirements; screening for and referral to CSoC services; ensuring access to ABA, pediatric psychiatrists, and licensed behavioral health practitioners with expertise in trauma-informed care; enabling our community-based Case Managers to assess enrollees; and coordinating care in the field. Additionally, our Behavioral Health Medical Director is available to review Elijah's case, consult with providers, and authorize additional services as needed to ensure Elijah and his family are fully supported.

Providing Support To Enrollees Through Case Management And Other Tools

Our goal is to connect Elijah to the right care in the least restrictive environment that will enable him to safely achieve his optimal level of functioning. Elijah's behavioral health Case Manager will be his primary point of contact with AmeriHealth Caritas Louisiana and will continually assess his needs, engage the multidisciplinary treatment team and coordinate authorizations for services and connections to community supports. We provide our Case Managers with the tools they need to support enrollees, including our advanced population health management platform, predictive modeling and risk-scoring, automated care gap alerts, and our information and data sharing platform that is available through our provider portal to support coordination across providers.

Resources And Infrastructure To Serve These Individuals In Louisiana

We invest significant resources and infrastructure in the Louisiana provider community through our population health and quality management strategies as well as targeted initiatives to promote the integration of physical and behavioral health services. We offer providers the technology, training, and technical assistance they need to serve enrollees like Elijah by: promoting connectivity to Louisiana's health information exchange; sharing information through our provider portal; offering training such as Mental Health First Aid and trauma-informed care; implementing our practice transformation program; and innovating integrated care contracting and value-based payment models. Our Network Management team will also conduct outreach to the previous EDs that Elijah visited and provide technical assistance and education on the services and supports AmeriHealth Caritas Louisiana offers to enrollees and will direct them to contact us the next time one of our enrollees presents in their ED.

Use Case 3: Raymond

AmeriHealth Caritas Louisiana will use our person-centered care approach to support Raymond's physical, behavioral health, dental and social determinants of health (SDOH) needs, including coordination of his Medicare covered benefits.

We will take a comprehensive, approach to identify and build upon his strengths to promote self-advocacy and resilience as he transitions from his nursing home placement back to independence in the community.

IDENTIFICATION

Raymond is a 65-year old, Medicare eligible enrollee who is currently residing in a nursing home. The Louisiana Department of Health (LDH) Transition Coordinator contacts the AmeriHealth Caritas Louisiana designated state phone line to request that Raymond be assessed for care management in preparation for his return to the community as part of the My Choice Louisiana program.

ENGAGEMENT

AmeriHealth Caritas Louisiana assigns a population health Case Manager, Charles, to visit Raymond in the nursing home to learn more about his needs. Charles has experience working with individuals with serious mental illness and complex co-morbid conditions as a former Assertive Community Treatment (ACT) team Case Manager. Prior to meeting Raymond, Charles reviews Raymond's behavioral health claims history and plan of care in our population health care management system. Upon arrival, Charles spends time getting to know Raymond one-on-one, asking him about his interests, goals and what he would like to accomplish when he returns to the community. Raymond shares that he is excited about returning home to his previous apartment, but is concerned about his ability to take care of himself with no family support. Charles also obtains all the necessary consents to facilitate information sharing with providers involved in his care. Before leaving, Charles interviews the nursing facility staff to understand Raymond's current needs, current treatment, and documents the interventions that have been most effective in meeting Raymond's needs.

After leaving, Charles follows up with AmeriHealth Caritas Louisiana's Housing Specialist **(Model Contract, 2.7.6.4.7)** who investigates and confirms that Raymond was evicted from his apartment during his nursing home stay. Charles requests that the Housing Specialist participate in the care planning and transition process for Raymond to ensure appropriate housing is identified.

ASSESSMENT

Charles completes the review of Raymond's medical records and information coordinated from LDH Medicaid fee for service and Medicare. The documents confirm Raymond's diagnoses and history, which include: schizoaffective disorder, bi-polar sub-type, suicide attempts, and anxiety. Raymond experiences functional deficits and has had many previous trips to the ED. Raymond also has multiple past psychiatric hospitalizations, with the most recent occurring several months ago because he expressed thoughts of

wanting to die. Raymond has high blood pressure, suffers from chronic pain, weakness due to unspecified neuropathy and a history of medication non-compliance. His chronic pain and subsequent weakness limits his ability to ambulate independently; the nursing facility staff confirm that Raymond likes to walk, but tells the staff he is worried that he will fall because of the weakness.

Charles completes a comprehensive assessment, including a PHQ-9 to screen for depression and an SDOH assessment. During the assessment, Charles asks Raymond about his ideal life when he returns to the community, including what medical, behavioral health, social and recreational interests, and supports that he found most beneficial in the past. Raymond states that he is estranged from his family, and reiterates that he is anxious about his ability to function independently and wants to know who will help support him in his new home. Charles probes to determine if Raymond would like to reconnect with his family, and Raymond says 'no.' Charles then uses motivational interviewing skills to offer a brief, solutions-focused intervention to help Raymond identify his strengths and times he has been successful in the community.

As part of the transitional care planning process, Charles determines that Raymond will be assigned to Tier 3, high-risk care management post-discharge based on his clinical history, and current needs. Charles then compiles a list of available services and supports for Raymond and the multidisciplinary team to include as part of the whole person care plan, as detailed in **Figure 2.10.6.3-1**.

Available Options to Achieve Goals	
Needs	**Summary of Raymond's Available Support Options**
Eligibility	• Assist Raymond with accessing available waiver services e.g.: Community Choice Waiver, Adult Day Health Waiver. • Assist Raymond with accessing Long Term Personal Care Supports (LT-PCS) which may be able to assist Raymond until Waiver services are available. • Connect Raymond to the disability advocacy program to assist him with accessing financial assistance from Social Security Administration, if we identify that he is not receiving all of the benefits for which he may qualify.
Physical Health	• Coordinate care with LDH Medicaid fee for service and Medicare to ensure Raymond receives: o Primary care and specialty provider follow up post discharge**.** o Preventive health appointments**.** o Physical/occupational therapy evaluation**.** o Medication education/ adherence monitoring/pharmacy coordination**.** o In home personal response system monitoring (Medicare covered benefit/ waiver)**.** • Non-emergency medical transportation and non-emergency ambulance transportation.
Behavioral Health	• **Schizo-Affective Disorder/ Bi-polar subtype/ anxiety** — Educate Raymond on medication adherence, the ACT team, mental health rehabilitation services, and mental health IOP-like program (HOPE). • **Safety** — Develop a safety plan that includes our behavioral health crisis hotline and behavioral health crisis centers. • **Social/recreational** — Peer supports, our community wellness centers, behavioral health support groups.
Enrollee Support/ Social Determinants of Health	• **Housing** — Housing specialist assistance, permanent supportive housing, and respite-care value-added benefit. • **Food** — SNAP application, home delivered meals, Aunt Bertha to connect to local food pantries. • **Transportation** — Community health worker support, such as: public transportation options, non-emergency medical transportation, ongoing community resources. • **Employment/vocation** — Social support programs at our community wellness centers. • **Personal belongings** — Our care closet program; Connection to community resources for household item/furniture assistance. • **SafeLink cell phone program**.

***Figure 2.10.6.3-1**: Providing Raymond With His Care Options.*

CARE PLANNING

The multidisciplinary team convenes to discuss community transition, post-discharge treatment, and care plan needs. Charles, the psychiatrist from the nursing facility, an AmeriHealth Caritas Louisiana peer support specialist, and an LDH My Choice Louisiana Transition Coordinator attend in-person at the nursing facility **(Model Contract, 2.7.11.3)**. Additionally, our AmeriHealth Caritas Louisiana Housing Specialist, our Pharmacist, the care coordination nurse from his outpatient primary care doctor's office, and a nurse from his outpatient Psychiatrist's office attend over the phone. The team asks Raymond to share his personal goals and needs in his own words, and Raymond reiterates that his goal is to return to his old apartment or another apartment. He expresses that he is concerned over who will support him when he is back in the community. Charles updates the team on the results of Raymond's most recent assessment, including medications and current services being provided. The AmeriHealth Caritas Louisiana Housing Specialist asks Raymond about his housing preferences and identifies that Raymond wants to live in the same apartment complex he used to live in so he can stay near his neighbor who has checked in on him from time to time. Given his mobility needs, Raymond prefers a ground level-unit, with close proximity to the parking lot so he doesn't have to walk a long distance when going to and from his apartment. Raymond and the team discuss the services available to him, agree upon the intervention and services, and document his individualized plan of care; as detailed in **Figure 2.10.6.3-2**.

Raymond's Individualized Plan of Care	
Needs	**Specific Identified Need and Interventions**
Eligibility	• Waiver services - Raymond is referred to AmeriHealth Caritas Louisiana's disability advocacy program to get assistance in applying for waiver services and Social Security/Supplemental Security Income (SSI).
Physical Health	• Coordination with Medicaid fee for service and Medicare facilitate covered physical health benefits, such as: o PCP and specialty provider follow up for post discharge appointments. o Coordination with Raymond's PCP to submit physical/occupational therapy evaluation orders to address gait issues and provide safety training in the home. • Transportation to all follow up appointments and activities. • Education on medication adherence and develop solutions for medication adherence (pill packs/blister packs). • Identify opportunities for in home personal response system monitoring (Medicare covered benefit/ waiver).
Behavioral Health	• **Assertive Community Treatment** — Charles and the My Choice Louisiana Transition Coordinator facilitate the referral to ACT while Raymond remains in the nursing home. The ACT team includes a psychiatrist, peer support specialist, housing specialist, employment specialist, and access to an addictionologist who will offer Raymond appropriate supports to address his needs and create a comprehensive treatment plan of specialized behavioral health services to maintain community placement. • **Permanent Supportive Housing** — The AmeriHealth Caritas Louisiana Housing Specialist coordinates with the ACT team housing specialist and works to identify a ground-level apartment in or near his former complex per his preferences. Tenancy support services would be authorized as part of the treatment/care plan. • **Respite Care Benefit** — 14 to 30 day stay approved to ensure safe and adequate transition to community while long term housing is secured. Our Housing Specialist will collaborate with our respite care partner [redacted] to initiate respite placement. • **Safety Plan** — When Raymond transitions into his apartment, Charles makes sure that Raymond has contact information for his ACT team, AmeriHealth Caritas Louisiana Member Services, the behavioral health crisis hotline, behavioral health crisis centers, his peer support specialist(s), and Charles' contact cell number. • **Transportation** — Raymond may access non-emergency medical transportation and non-emergency ambulance transportation to attend his appointments, if a level of service changes. • **Peer Supports** — Raymond's ACT team includes peer support specialist.
Enrollee	• **Food** – meal delivery of two meals per day for 14 days post-discharge from the Nursing Facility, CHW/Peer

Raymond's Individualized Plan of Care	
Needs	**Specific Identified Need and Interventions**
Support/ Social Determinants of Health	Support to assist with food security via local food pantry. • **Communication** — Facilitate receipt of free SafeLink smartphone with unlimited text messages and calls to us. • **Personal belonging/ household items** — Connection to local community resources such as Goodwill, Unity of Greater New Orleans, and AmeriHealth Caritas Louisiana Care Closet.

***Figure 2.10.6.3-2**: Providing Raymond with the right care.*

IMPLEMENTATION

The team immediately begins to implement Raymond's discharge and transition plan and to coordinate and implement his community-based plan of care. Charles submits a referral to the ACT team, who then meets with Raymond at the nursing facility to perform an intake evaluation. Charles engages our disability advocacy program to help Raymond apply for SSI, if appropriate, and assess his potential eligibility for Waiver services.

Our Housing Specialist coordinates with the Permanent Supportive Housing (PSH) program liaison and ACT housing specialist to identify available housing subsidies and vouchers. The AmeriHealth Caritas Louisiana Housing specialist also obtains authorization for Respite Care coverage, if needed, for up to 30 days, to facilitate safe discharge while long-term housing is secured. All needed authorizations for behavioral and physical health services are facilitated and coordinated prior to discharge from nursing facility including those covered by Medicaid/Medicare.

The housing specialist was able to quickly secure appropriate housing for Raymond while he was in transitional respite care. Charles contacts Raymond in person following discharge from the nursing facility to ensure the treatment/care plan was being implemented and identify any unmet needs. Charles also confirms Raymond's follow-up appointment with his primary care provider and requests that his PCP consider a referral to a neurologist. Charles collaborates with the assigned ACT team to update Raymond's adherence to treatment/care plan goals. In addition, Charles coordinates transportation for Raymond to go to AmeriHealth Caritas Louisiana's care closet with a CHW to select new clothing and become familiar with the local Community Wellness Center to attend ongoing educational/enrollee support events. Charles and our CHW continue to have frequent telephonic and in-person contact weekly to address care plan interventions and barriers to maintaining community placement.

MONITORING

The multidisciplinary team reconvenes in-person monthly and reassesses Raymond's needs quarterly **(Model Contract, 2.7.6.1)**. Raymond's ACT team assumes the lead to coordinate his care in the community, and facilitate access to housing, food security, social, and recreational supports. The ACT team receives ongoing, high touch support from AmeriHealth Caritas Louisiana's Case Manager and Permanent Supportive Housing Liaison. Raymond's ACT team will coordinate waiver services with LDH if Raymond is found eligible.

Raymond's multidisciplinary team shares information seamlessly through AmeriHealth Caritas Louisiana's data sharing platform. Our population health management platform triggers care gap alerts and flags any over- or under-utilization of services for follow-up.

AmeriHealth Caritas Louisiana reviews Raymond's needs in our integrated physical health and behavioral health rounds with our Behavioral Health Medical Director and the Medical Director no less than quarterly. Charles remains an active part of Raymond's treatment team in collaboration with the ACT team. He continually reassesses Raymond's needs and facilitates authorization for ongoing services as needed.

Ensuring Access To Appropriate Managed Care Organization Cover Services

We ensure Raymond's access to care and services through a high-touch, fully integrated multidisciplinary approach. Today, we have a comprehensive network of specialized behavioral health service providers, non-emergency medical transportation and non-emergency ambulance transportation, streamlined prior authorization processes, and highly accessible member support services that Raymond and his team can access to mitigate barriers to care. As a member of the multidisciplinary team, Raymond's Case Manager will coordinate with his ACT team and community-based providers to facilitate and follow-up on all prior authorization requests, Medicare benefits, and ensure timely access to appropriate covered services.

Providing Support To Enrollees Through Case Management And Other Tools

Raymond's AmeriHealth Caritas Louisiana Case Manager works hand-in-hand with his ACT team to obtain service authorizations and coordinate Raymond's services across payers, including: LDH Medicaid fee for service, Medicare, AmeriHealth Caritas Louisiana, OAAS, and any Waivers for which Raymond is determined eligible. Charles maintains high touch communication with Raymond directly and his ACT team - including his psychiatrist, peer support specialist, and housing specialist - to identify emerging and unmet needs. Charles reminds Raymond on how to access support through our member services line, and his multidisciplinary team.

Resources And Infrastructure To Serve These Individuals In Louisiana

AmeriHealth Caritas Louisiana is committed to investing in Louisiana communities to build infrastructure and provider capacity to serve enrollees with complex, co-morbid conditions in their homes and the community. For example, based on enrollees' needs, we expanded access to ACT team services in three geographic regions across Louisiana. We also offer provider and system stakeholder training initiatives to increase the system's capacity and empathy to better understand enrollee's needs, including: Mental Health First Aid, and Trauma Informed Care. Additionally, we have trained and reimburse providers for using integrated health assessments such as the PHQ-9, SBIRT, Patient Stress Questionnaire, and Healthy Living Survey. Moreover, we have spearheaded behavioral health contracting to support providers to offer both physical and behavioral health services through co-located and fully integrated health homes. We offer our practice transformation teams and Project ECHO to help individual providers build their technical capacity to meet enrollees' multiple, co-morbid health needs. Finally, using a population health approach, we assess for SDOH and deploy a wide-range of programs to address enrollees' housing, personal safety, transportation, food, and vocational needs.

This page is intentionally left blank.

2.10.7
Provider Network

AmeriHealth Caritas Louisiana's Care Crew volunteers give of their time during and after work hours to support their local communities.

AmeriHealth Caritas™
Louisiana

2.10.7 Provider Network

2.10.7.1 Provider Network Listing

AmeriHealth Caritas Louisiana has provided in electronic format in lieu of hardcopy, per Addendum #2, Question 8, a list of all providers in our network in **Attachment 2.10.7.1-1 Provider Network Listing**. We have also provided a summary table of provider counts by parish in the State-provided template.

2.10.7.2 Provider Network Capacity

AmeriHealth Caritas Louisiana has provided time, distance, and ratio requirements documentation (in accordance with **Attachment D**), in lieu of hardcopy, per **Addendum #2**, as **Attachment 2.10.7.2-1 Provider Network Capacity**.

This page is intentionally left blank.

2.10.8
Network Management

The AmeriHealth Caritas Louisiana Health Policy Fellowship allows medical students to gain real-world experience and knowledge of health policy.

AmeriHealth Caritas™
Louisiana

2.10.8 Network Management

2.10.8 Ensuring Timely Access To Care

AmeriHealth Caritas Louisiana understands the importance of ensuring enrollees have access to timely and effective primary, specialist, and specialized behavioral health care as well as other health care services, in an appropriate and culturally competent setting within a health care system responsive to the full spectrum of preventive, acute, and chronic health care needs. This includes geographic access, appointment wait times, and all other requirements noted in **Attachment D**, **Model Contract, 2.9**, and **MCO Manual 2.9**. We routinely communicate availability and accessibility standards, including appointment requirements for routine, urgent, emergent care, prenatal, and specialty behavioral health services, via the Provider Handbook, Provider Portal, on-site presentations for newly credentialed providers, continuing education, and provider newsletters.

AmeriHealth Caritas Louisiana promotes timely access to culturally competent primary and specialty care services to align with the goals of the Louisiana Department of Health (LDH). In the sections that follow, we explain our processes for achieving optimal levels of access for enrollees, which include identifying network gaps for time, distance, provider-to-enrollee ratios, after-hours access, and appointment availability; conducting ongoing gap analyses; and monitoring closed panels via internal processes and provider self-reporting.

2.10.8.1 Identifying Network Gaps

AmeriHealth Caritas Louisiana has a network development plan that we update throughout the year. The plan guides our monitoring of network adequacy activities **(Model Contract 2.9.26)**. We continually monitor enrollees' access to care through a cross-functional, proactive approach. A primary component of the approach is the use of GeoAccess GeoNetworks® software to run gap analyses. We submit GeoAccess reports to LDH on a quarterly basis. These reports inform updates to our network development plan. These gap analyses help us to determine priority provider types in need of recruitment. In addition to the above strategies, during on-site visits with PCPs, our Account Executives identify specialists to whom our enrollees may be referred and contact them for contracting.

One example of our strategic network development effort was to address the historic shortage of specialists in the rural corridor between Monroe and Lake Charles, we contracted in 2018 with several large PCP and multi-specialty groups. AmeriHealth Caritas Louisiana added Affinity Health Group, increasing access in Ouachita and surrounding parishes. Affinity clinics include cardiology, diabetes care, orthopedics and orthopedic surgery, pediatrics, and primary care. In central Louisiana, we enhanced our network through and agreements with HCA Rapides, adding physicians and specialists in 13 locations that offer, among other specialties, orthopedic surgery, cardiology, OB/GYN, and pulmonology. Additionally, we contracted with the Pediatric Center of Southwest Louisiana, adding pediatric care in this area and with Imperial Health, which has more than 40 physicians on staff specializing in, among other areas, cardiology, endocrinology, family medicine, neurology, orthopedic surgery, pediatrics, and pulmonary diseases.

In addition, to address certain levels of specialized behavioral health care, we have negotiated with Acadia, a large hospital system to create a continuum of care. This will include its existing inpatient psychiatric hospitals and will add a psychiatric residential treatment facility (PRTF) ASAM 3.7, which will be the first of its kind in the State. The agreement includes a step-down to an IOP for adolescents with behavioral and substance use treatment needs (ages 12 to 17). It also includes a therapeutic group home option for youth who are discharged from the PRTF ASAM 3.7, who meet medical necessity for an IOP level of care, and for whom it may not be appropriate to return home. This provider will help ensure access to needed SBH care

for our enrollees. This is in addition to our more broad based efforts to address access to substance use residential services. We have increased efforts and outreach with existing substance use residential treatment facilities to expand this level of care throughout Louisiana. This includes some existing providers adding new locations, units, and/or beds. For example, Edgefield Recovery Center in Alexandria is in the process of opening additional beds in an existing unit, as well as adding a new location. We are also awaiting final credentialing for a provider who historically only accepted Commercial insurance and is now willing to accept Medicaid enrollees.

Analyzing Data

Our Provider Network Management team analyzes the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 survey, enrollee satisfaction relating to accessibility, and our after-hours access survey data to measure provider performance against the accessibility standards of **Model Contract, 2.9.1.1, Attachment D**. Our annual Accessibility of Services Report presents analysis results and identifies areas for improvement. This report is reviewed and approved by the Quality of Service Committee (QSC). Non-compliant providers are notified of all categories requiring improvement and are given a remediation timeline.

On a daily basis, AmeriHealth Caritas Louisiana gauges enrollees access' needs based on feedback from enrollee- and provider-facing associates, enrollee grievances, enrollee advisory forums, providers, and advocates, such as Behavioral Health Integration Advocacy, the Louisiana Hospital Association (LHA), and the Louisiana Primary Care Association (LPCA). For example, we engage in root cause analysis of enrollee grievances and, when related to language, culture, or disability, provider-facing staff address the issues with the provider community. We also analyze the patterns utilization of out of network providers, emergency departments (ED), as well as inpatient admissions and readmissions to determine if the trends are a result of inadequate access in specific communities.

Provider Satisfaction Surveys

AmeriHealth Caritas Louisiana annually monitors provider satisfaction to identify opportunities for improvement. Our providers reported the highest rate of satisfaction among the five incumbent MCOs, as well as the highest rate of providers indicating they would recommend our plan to others, with 80 percent of providers responding affirmatively. Highlights of the 2018 Provider Satisfaction Survey include the following:

- **Specialists** — 63 percent of providers rated the number of specialists in our network as "Good" or better, the highest rate among MCOs. We also received the highest percentage of providers rating the quality of specialists in our network and the timeliness of reports from those specialists as “Good” or better.
- **Communication/Training/Education** — We scored at or above the statewide average for the rating of "Good" related to provider enrollment. We scored the highest of the MCOs for cultural competency and accessibility of specialty behavioral health trainings.
- **Account Executives** — 90 percent of our providers rated our Account Executives' ability to answer questions as "Good" or better and 91 percent rated their courtesy and responsiveness as “Good” or better.

Time And Distance Standards And Provider-To-Enrollee Ratio Requirements

AmeriHealth Caritas Louisiana uses GeoNetworks® software to generate the number and distribution of provider sites to ensure that we meet established standards quarterly, annually, and as needed. The GeoAccess® report is prepared for each parish, including maps indicating mileage and time standards

along with provider-to-enrollee ratios, and accounts for 100 percent of total membership. We then implement strategies to ensure adequate access to providers and services as specified in **Attachment D**.

In 2018, we exceeded the minimum provider-to-enrollee ratios for PCPs in both urban and rural parishes as measured against the time and distance standards in LDH's Medicaid MCO Provider Network Companion Guide. We recognize that certain access standards will be enhanced in the new contract period, as noted in **Attachment D** and are prepared to adjust our network to identify and fill any newly identified gaps.

Auditing After-Hours Access To Care And Appointment Availability

AmeriHealth Caritas Louisiana annually assesses enrollee access to appointments for primary care, specialty behavioral health services, and specialty care as well as wait times and access to after-hours care. We use this data to measure provider compliance with the access and availability standards against appropriate state and NCQA regulations as well as internal access goals. When we identify gaps, we conduct additional comprehensive analysis, identify barriers and opportunities for improvement, and implement appropriate interventions.

Accessibility Of Services, Appointment Availability, And After-Hours Access To Care

We survey PCP, specialist, and behavioral health practices annually to determine accessibility and availability of appointments. We use the results of this survey to educate providers on best practices and protocols to address root causes for deficiencies, such as insufficient staff or time constraints. We educate providers to direct enrollees to urgent care rather than the ED when appropriate and to communicate expected call-back time to enrollees.

We expanded our urgent care network to 104 urgent care centers in 2018 (a 64 percent increase from 2017) to address access issues that drive potentially preventable ED visits (PPV). With increased access to urgent care centers that are open evenings and weekends, we divert enrollees from EDs when appropriate; urgent care centers serve as a bridge between enrollees' primary care physicians and needed care after hours and on weekends. Our PPV rates were 679 per 1,000 for October 2016 – September 2017 and 649 per 1,000 for October 2017 – September 2018.

Using the 2018 CAHPS® Survey, we measured enrollee satisfaction related to appointment availability. Child enrollee satisfaction related to scheduling appointments with a specialist increased to over 95 percent in 2018 and has shown a progressive increase for the last four years. Per **Model Contract 2.9.3.4**, AmeriHealth Caritas Louisiana educates providers on appointment accessibility standards and timely access to care and services. We monitor provider compliance and take corrective action in the case of non-compliance.

Additional Gap Analyses

Monthly Network Adequacy Reporting And Daily Monitoring

AmeriHealth Caritas Louisiana's Medical Economics team provides monthly network availability reports to all enrollee- and provider-facing associates. This report includes a summary of all provider types and newly enrolled provider and specialty types by parish. Wide internal distribution of the report allows comprehensive, cross-functional awareness of provider availability to associates who work with providers and enrollees. These associates notify Provider Network Management when network providers are not available or are unable to manage a complex case. The Clinical Liaison engages a provider (in or out of network) to provide medically necessary services in a timely fashion and within an adequate distance and drive time from the enrollee's residence. The report is also filtered for provider distribution to assist

providers who are unaware of the availability of physical health or specialized behavioral health services in their area.

Monitoring Closed Panels

Our Provider Network Management team takes a proactive approach to monitoring our network for network gaps. We continuously monitor our closed-panel network providers via internal resources and processes. This includes feedback from Account Executives and our multidisciplinary teams. Self-identification from providers also contributes to our monitoring activities. When providers are identified as having a closed panel, the update is made in our claims system, which triggers a follow-up discussion from their Account Executive about barriers preventing them from opening their panels.

AmeriHealth Caritas Louisiana has conducted biannual mailings of our Provider Validation Form to specific provider types since 2012 as a continued effort to update provider records. In 2018, we launched our electronic Provider Data Information Form (PDIF), available via our Provider Portal, which assists network management in identifying closed panels. Providers can now log in at any time to manage their demographic data and update panel status, an administrative simplification (*Accepting New Patients* in **Figure 2.10.8-1**). During site visits, our Account Executives assist providers in accessing the PDIF application to drive real-time entry, which feeds updates to the provider directory. In addition, we offer regularly scheduled webinar training to drive provider attestation.

We assign Data Integrity Representatives to manage provider demographic data and partner with third-party vendors to access data sources such as LexisNexis Provider Point. We also contract with Square Button, a local vendor that performs data accuracy sampling through outbound calls to our provider network. These solutions help us identify open- and closed-panel providers. Updates or changes certified as accurate are automatically refreshed within our claims system. In addition, our Clinical Liaisons work with providers to accept enrollees even if they have a closed panel.

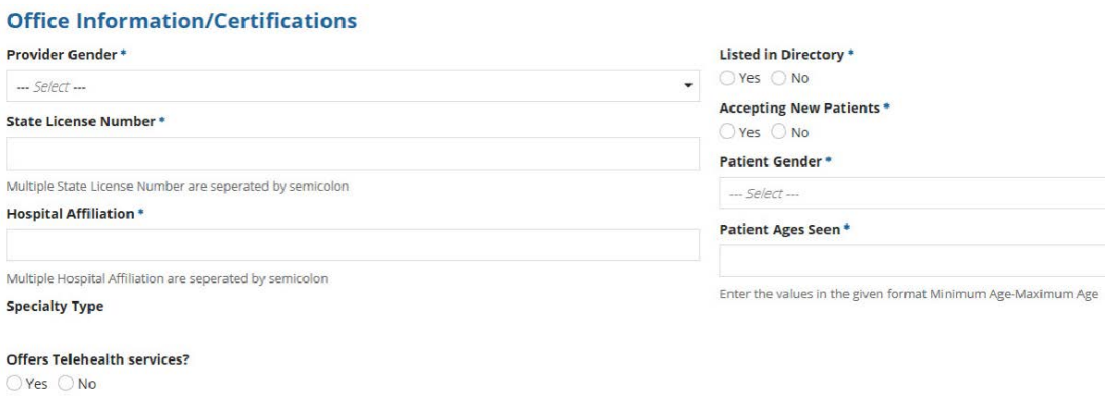


Figure 2.10.8.1-1: PDIF Form. *Providers can indicate on the online PDIF if they are accepting new patients.*

2.10.8.2 Increasing Provider Capacity To Meet Enrollee Needs

AmeriHealth Caritas Louisiana has built and maintains solid provider relationships through outreach, education, and support. We continue to strengthen these relationships to improve access to care and health outcomes. We utilize proactive strategies to increase capacity for existing providers and meet enrollee needs, including:

- Flexible contracting payment structures that allow us to assist existing PCPs in expanding their panels and specialists in increasing their Medicaid patient acceptance rate. These structures include the use

of value-based and alternative payment models, such as enhanced rates, bundled payments, and single case agreements (SCAs).

- Building relationships between Account Executives and providers, creating a single point of contact to assist in reducing administrative burden. In doing this, our network is more willing to increase their capacity in accepting our enrollees and provide needed care.
- Offering specialty behavioral health trainings for limited-access services, including Screening, Brief Intervention, and Referral to Treatment (SBIRT); specialty behavioral health; Mental Health First Aid; and medication-assisted treatment (MAT), to our physical health providers to empower them by increasing their knowledge of integrated care provision.
- Technology designed to increase data sharing, such as Project ECHO® (Extension for Community Healthcare Outcomes) and telehealth.

Increasing Capacity Through Contract Payment Structures

Improving access to health care is a multi-pronged approach that includes efforts to increase the number of contracted PCPs, physical health specialists, and specialized behavioral health providers by advising providers of the value of joining our network. We frequently offer value-based and alternative payment models, such as enhanced rates and shared savings agreements that address data-driven treatment and outcomes, to existing providers.

AmeriHealth Caritas Louisiana also recognized the importance of access to care for our expansion enrollee population in 2017 and the providers' role in that care. We offered enhanced reimbursement to PCPs and specialists for preventive care visits, new patient evaluation and management (E&M) visits, and initial established E&M visits (preventive health services).

We know that physician extenders deliver basic types of health care and are critical when clinics experience high caseloads or long wait times, consequently we may offer them enhanced rates as well. We facilitate SCAs with existing providers to compensate them to accept higher-acuity cases than they otherwise would. AmeriHealth Caritas Louisiana also uses SCAs to accommodate services rendered by in- or out-of-network providers. If services are unavailable or cannot be performed by an in-network provider, or if transition to another provider may be disruptive, Provider Network Management makes same-day contact with alternate providers to begin the negotiation process.

Increasing Capacity Through Experienced Provider Network Staff

One of the most important aspects of our provider engagement strategy is our experienced multidisciplinary team (see **Section 2.10.9.3.1** of our response). Working throughout the state in the communities they serve, our experienced Account Executives provide a high-touch experience for contracted providers. We engage providers through an integrated care lens. Our Provider Network Management team is directed by Stacie Zerangue, a licensed clinical social worker with 26 years of specialty behavioral health experience and 23 years of experience leading physical and behavioral health integration efforts.

Account Executives — Each provider is supported by a local Account Executive trained in behavioral and physical health care who provides outreach, education, and engagement and serves as their point of contact. Our 17 Account Executives, who bring decades of experience to their roles, conduct face-to-face meetings with providers; conduct Joint Operating Committees; and gather feedback and concerns for executive staff review.

Clinical Liaisons — In 2016, AmeriHealth Caritas Louisiana established specialized Account Executive roles called Clinical Liaisons. This team's role is to identify barriers, trends, and opportunities related to access needs, appointment availability, and network gaps as they relate to discharge planning to ensure our

enrollees receive all medically necessary services upon discharge. Each Account Executive also serves as a point of contact for providers who request assistance with linking enrollees with specialized services.

Rapid Response Team (RRT) — The RRT has clinical and non-clinical staff who receive inbound calls from providers and enrollees and support integrated care coordination services in an effort to close care gaps. Specifically, RRT partners with providers to schedule screenings and appointments and coordinates transportation for enrollees to gain access to after-hours clinics.

Communication with providers is not limited to Account Executives, Clinical Liaisons, or RRT. Our executive team, including Chief Medical Officer Dr. Rodney Wise and Chief Executive Officer Kyle Viator, often engage providers in face-to-face meetings to hear concerns and develop solutions to increase provider capacity.

INCREASING CAPACITY THROUGH PROVIDER TRAINING

In accordance with **Model Contract, 2.9.10.5.1.1**, AmeriHealth Caritas Louisiana integrates physical and behavioral health care, along with pharmacy and social supports, to ensure that all medically necessary and social services are available to enrollees in a timely manner. To that end, we offer provider training, focusing on topic areas that increase access to care and help providers thrive in the Medicaid environment. Our internal Provider Support and Services team creates targeted provider training materials, presented in a variety of ways such as in-person, webinars, community-based, and via website for our network's convenience. In line with LDH's goal of decreasing fragmentation and increasing integration across providers and care settings, particularly for enrollees with behavioral health needs, AmeriHealth Caritas Louisiana trainings were expanded in 2015 to address integration of behavioral and physical health. We initiated reimbursement for specialty behavioral health screenings within physical health practices and physical health screenings within specialty behavioral health practices.

Listed below are current and planned trainings; some have been in place since 2017 and others are rolling out in 2019, such as Project ECHO. Overall, our trainings increased by 125 percent from 2017 to 2018.

Medication-Assisted Treatment (MAT) — In the second quarter of 2019, AmeriHealth Caritas Louisiana will become **the only managed care organization (MCO) in the state to partner with the American Society of Addition Medicine (ASAM) to offer MAT training to providers**. In partnership with the LPCA, we will assist providers in getting certification to become MAT prescribers; these trainings will occur in our community wellness centers in Shreveport and New Orleans as well as at other sites throughout rural and urban Louisiana.

Specialty Behavioral Health Screening Tools, The Behavioral Health Provider Toolkit, And ADHD Training Materials — We are launching trainings on evidence-based SBIRT. This educational program promotes alcohol and drug use screening and intervention within the primary care setting and identifies adolescents and adults at risk for developing substance use disorder (SUD). We will roll out the program for both adolescent and adult populations in the second quarter of 2019 through initial trainings followed by three to six months of lunch-and-learns for providers. The Behavioral Health Provider Toolkit, which has been available to providers since 2016, includes information on anxiety and depressive disorders, SUD, suicide prevention, and other specialty behavioral health topics. The ADHD training materials regarding children and adolescents include an informational flyer as well as online materials, accessible via registration, for distribution to enrollees.

Specialty Behavioral Health Trainings —We facilitate specialty behavioral health trainings on four evidence-based practices for children aged 0 to 5 years, in accordance with the **MCO Manual 2.10.4**, which specifies that trainings should include evidence-based practices, promising practices, and emerging best

practices: 1) Pre-School PTSD, 2) Positive Parenting Practices (Triple P), 3) Parent Child Interactional Therapy (PCIT) and 4) Child Parent Psychotherapy (CPP). Additional trainings are currently in development.

Mental Health First Aid (MHFA) — In collaboration with LPCA, we began offering free MHFA courses in 2018. Designed to help the public understand mental health and those going through a mental health crisis, the courses are offered to providers, Community Health Workers (CHWs), community partners, and non-clinical community health center staff.

Increasing Capacity Through Technology Designed to Meet Provider Needs

Consistent with LDH's goal of supporting innovation, we use technology to increase provider capacity — Project ECHO, telehealth, and data sharing/access, which encourage data sharing across the state.

Project ECHO — To advance integrated health care statewide, in 2019 we will launch Project ECHO model, which provides clinicians with knowledge and support to manage patients with complex conditions in their own communities. The first topics of the virtual learning sessions began in 2018 and focus on specialty behavioral health and physical health integration. All levels of practitioners are welcome to participate at no cost, including physicians, nurse practitioners, registered nurses, psychiatrists, social workers, community health workers, pharmacists, and emergency medical technicians. Practitioners will present cases to a team of peers and experts for mentoring and shared learning.

Telehealth — AmeriHealth Caritas Louisiana shares LDH's interest in encouraging the use of telehealth. Telehealth facilitates collaboration between primary care, specialists, and other health care providers, addressing all components of the Triple Aim: improved health outcomes, better clinical experience for enrollees, and lower costs. Using telemedicine, providers can expand their reach into rural and medically underserved areas. We leverage local providers who have invested in this technology and work to remove barriers to delivering care. We offer enrollees access to telehealth services via phone, computer, or tablet. An example of using telemedicine to enhance access to specialty providers is our partnership with Lafayette-based Advance Telehealth to increase access to specialty behavioral health care. Enrollees can access the Advance Telehealth program from their home or from kiosks located in clinics across Louisiana.

Data Sharing and Access — We offer technology resources to drive provider efficiency, enabling them to see more enrollees. For example, AmeriHealth Caritas Louisiana uses ADT feeds that send ED utilization notifications to the Provider Portal where PCPs can view utilization by enrollees on their panel on a daily basis. In 2019, AmeriHealth Caritas Louisiana will be the first Medicaid MCO to go live with utilization of a new ADT feed offered through LHA. This new functionality will share PCP and assigned case manager information with hospital ED staff for discharge planning purposes. Since 2012, AmeriHealth Caritas Louisiana has had a Provider Portal with ever-increasing functionality, including real-time status on claims, actionable care gap lists, and demographic and training opportunities. Additionally, we are investing resources to have information uploaded directly to provider electronic health records (EHRs), where they can best leverage enrollee information, identify care gaps, maximize performance, and improve enrollee health.

2.10.8.3 Using Provider Network Standards To Monitor Compliance

Our approach to network management is provider-centric, whether it's working with providers on remuneration levels or educating them on how to improve after-hours availability. We ensure compliance through tracking and trending. Our strategies for monitoring and ensuring compliance include surveys, office visits, value-based payment structures, training/education, and the use of Clinical Liaisons, Case Managers, and our RRT.

We identify enrollee needs based on reporting and feedback from multiple departments, as well as requests for SCAs. This leads to outreach and formal meetings with potential providers to discuss opportunities and the benefits of joining our network. We use multiple data sources to monitor compliance with the State's network standards, such as GeoAccess, population assessments, provider demographic information, and LexisNexis ProviderPoint. When needed, our RRT and Clinical Liaisons work hand-in-hand to find providers that are a best fit in terms of travel time, wait time, and personal choice.

Monitoring Compliance For Specific Provider Types

Figure 2.10.8.3-1 includes strategies used to monitor compliance with the State's network standards. Our targeted strategies are informed by the data contained in our populated **Provider Network Capacity and Response Template** (included as **Attachment 2.10.7.2**) for specific provider types referenced in **RFP 2.10.8.3** and health disparities as evaluated in our quality management/quality improvement program.

Strategy — Provider Type	Data Source
Monthly network access reporting to monitor geographic access as it relates to time and distance requirements and density standards set forth in Attachment D — **Dermatologists (2.10.8.3.2); endocrinologists (2.10.8.3.3); LMHSs (2.10.8.3.4); neurologists, pediatric (2.10.8.3.5); OB/GYNs (2.10.8.3.6); orthopedists, pediatric (2.10.8.3.7); psychiatrists (2.10.8.3.9)**.**	Provider and enrollee locations
Quarterly geographic access reporting and mapping to monitor geographic access as it relates to time and distance requirements and density standards set forth in Attachment D — **All**.*	Provider and enrollee locations
Monitoring of provider availability and provider directory accuracy as well as identification of opportunities for contracting with non-participating providers— **All**.*	Third-party vendor analysis
Annual gap analysis with appointment availability audit (including wait times) — **All**.*	Telephonic and mail surveying of providers
Annual gap analysis with appointment after-hours access to care — **PCPs (2.10.8.3.8)**.	Telephonic surveying of providers
Demographic validation and compliance with urgent, emergent, and routine appointments (*Behavioral Health Mystery Shopper* surveys) — **LMHSs (2.10.8.3.4); psychiatrists (2.10.8.3.9).**	Telephonic surveys
Monthly provider office visits — **PCPs (2.10.8.3.8).**	Provider profiles
Minimum of quarterly provider office visits — **LMHSs (2.10.8.3.4); psychiatrists (2.10.8.3.9).**	Provider profiles
Annual provider office visits — **Dermatologists (2.10.8.3.2); endocrinologists (2.10.8.3.3); neurologists, pediatric (2.10.8.3.5); OB/GYNs (2.10.8.3.6); orthopedists, pediatric (2.10.8.3.7).****	Provider profiles
Monitoring of panel status, physical access, reasonable accommodations, and accessible equipment (PDIF) — **All**.*	Self-reporting from providers
Quarterly validation with providers regarding status of reassignment and attribution — **PCPs (2.10.8.3.8)**.	Internal enrollee attribution reports
Annual evaluation of our ability to meet the cultural, linguistic, racial, ethnic, and disability needs of our enrollees — **All**.*	Analysis of provider languages spoken and enrollee preferred language (internal databases)
Analysis of underutilization of services and monitoring of providers who historically do not accept Medicaid — **Dermatologists (2.10.8.3.2); endocrinologists (2.10.8.3.3); neurologists, pediatric (2.10.8.3.5); orthopedists, pediatric (2.10.8.3.7).****	Claims data
Analysis of overutilization of services — **All**.*	Claims data
Quarterly valuation of enrollees' use of out-of-network services — **All**.*	Authorization requests data denied claims data
Quarterly analysis of the use of single case agreements (non-participating) — **All**.*	SCA reports
Weekly analysis of providers undergoing recredentialing (scheduled and outcomes) — **All**.*	Recredentialing reports
Grievance trends related to access to care, interpersonal aspects of care, and quality of care — **All**.*	Grievance data

Strategy — Provider Type	Data Source
Analysis of enrollee experience (CAHPS®) — **All**.*	CAHPS survey (mail and telephonic)
Behavioral Health Member Satisfaction Survey — **LMHSs (2.10.8.3.4); psychiatrists (2.10.8.3.9).**	Telephonic and mail surveying of enrollees
**Denotes provider types as specified in RFP 2.10.8.3.1 through 2.10.8.3.10.* ***Also done for cardiologists (2.10.8.3.1), neurologists, adult (2.10.8.3.5), and pulmonologists (2.10.8.3.10).*	

Figure 2.10.8.3-1: *AmeriHealth Caritas Louisiana uses a variety of strategies to monitor network compliance.*

Supporting Providers And Enrollees In Scheduling Appointments

The RRT helps enrollees schedule appointments, provides appointment reminders, and arranges transportation to ensure enrollees have access to care. In addition, our CHWs and Clinical Liaisons offer extra support to providers not meeting appointment standards and assist enrollees receiving complex case management with scheduling appointments. Our Case Managers, RRT, and Clinical Liaisons work together to address barriers to timely access to care and, when necessary, schedule appointments with out-of-network providers, in accordance with **Model Contract, 2.9.5.1.1**. Our RRT, Clinical Liaisons, and Provider Network Management team work together to more efficiently identify specialists able to accept enrollees with special needs. When an enrollee calls the RRT with a need, the Clinical Liaison, Account Executives, and the RRT member work in real time to identify an appropriate specialist and schedule an appointment within 24 hours. We also use behavioral economics tools such as the CARE Card to enhance the provider-enrollee relationship and reduce appointment no-shows.

In alignment with some of our data-sharing initiatives with providers, we have identified a potential project with the LPCA's data aggregation platform, which feeds information directly into the appointment scheduling systems of the state's FQHCs to ensure that providers can prioritize the needs of our enrollees who have care gaps or who are flagged as high-need. As noted in our response to **Section 2.10.8.2**, in 2019 we will begin receiving ADT feeds through the LHA. These feeds bring new functionality that includes real-time notifications and the ability to share assigned case manager information for hospital ED staff to use in discharge planning, including assistance with scheduling follow-up appointments.

Another way that we support enrollees' appointment needs is by holding Wellness Days at our community wellness centers in Shreveport and New Orleans. Enrollees have opportunities to get care that they might otherwise forego due to work or personal obligations during regular business hours. In 2018, CHWs worked with PCPs to hold 15 Wellness Days, which enabled our providers to close 262 enrollee care gaps.

2.10.8.4 Recruiting And Retaining Quality Providers

AmeriHealth Caritas Louisiana uses a variety of strategies to recruit and retain quality providers, among them innovative payment structures, including value-based payments; reducing administrative burden; the strategic use of SCAs; and the use of technology/telehealth. It is our relationships and reputation with providers that allow us to attract them to our network and retain them after agreements are in place. Our providers have a comfort level with us that comes from the personal attention and support they receive. Our recruitment and retention efforts are provider-centric and individualized; we do not use a "one size fits all" strategy for different provider types.

Built into our approach to recruitment and retention is a focus on quality and performance. We continue to monitor provider performance and enter into payment structures based on quality and performance.

Our recruitment and retention strategies in **Figure 2.10.8.4-1** are informed by the data contained in our populated **Provider Network Capacity Response Template** (included as **Attachment 2.10.7.2**) and target the capacity for specific provider types referenced in **RFP 2.10.8.3** and health disparities as evaluated in our quality management/quality improvement program.

Strategy, Provider Type, Metrics	Recruitment	Retention
Outreach to specialists not in our network who have not historically accepted Medicaid.		
Provider Type(s) — Dermatologists (2.10.8.3.2); endocrinologists (2.10.8.3.3); LMHSs (2.10.8.3.4); neurologists, pediatric (2.10.8.3.5); OB/GYNs (2.10.8.3.6); orthopedists, (2.10.8.3.7); psychiatrists,pediatric (2.10.8.3.9).**	X	
Quality Metrics* (as applicable) — Cervical cancer screening; controlling blood pressure (CBP); HbA1c <8 (CDC); Caesarean rate for low-risk first birth women (NSV); follow-up after ED visit for alcohol and other drug abuse or dependence (FUA); depression screening and follow-up for adolescents and adults; PPV; potentially preventable readmissions (PPR); non-recommended cervical screening (NCS); antidepressant medication management (AMM), ages 18 years and older; follow-up after hospitalization for mental illness (FUH); follow-up for children with Attention Deficit Hyperactivity Disorder (ADD); diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD); diabetes monitoring for people with diabetes and schizophrenia (SMD); cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC); adherence to antipsychotic medications for individuals with schizophrenia (SAA); initiation and engagement of alcohol and other drug dependence treatment (IET).		
Strategic use of single case agreements to recruit out-of-network providers and attain a full in-network agreement.		
Provider Type(s) — Dermatologists (2.10.8.3.2); endocrinologists (2.10.8.3.3); neurologists, pediatric (2.10.8.3.5); orthopedists, pediatric (2.10.8.3.7).**	X	
Quality Metrics* (as applicable) — Controlling blood pressure (CBP); HbA1c <8 (CDC); depression screening and follow-up for adolescents and adults; PPV; PPR.		
Use of innovative service delivery models to create levels of care such as IOP-like models for behavioral health and a coalition of licensed mental health specialists (LMHSs) for a potential value-based contract for evidence-based care for youth and adults.		
Provider Type(s) — Licensed mental health specialists (2.10.8.3.4); psychiatrists (2.10.8.3.9).	X	X
Quality Metrics* (as applicable) — FUA; depression screening and follow-up for adolescents and adults; PPV; PPR; AMM; FUH; ADD; SSD; SMD; SMC; SAA; IET.		
Reducing administrative burden: timely and accurate payments contribute to our provider retention rates.		
Provider Type(s) — All specialty types as noted in RFP 2.10.8.3.		X
Quality Metrics* (as applicable) — Colorectal cancer screening/cervical cancer screening; CIS combo 10; CBP; HbA1c <8 (CDC); NSV; FUA; depression screening and follow-up for adolescents and adults; PPV; PPR; NCS; LBP; URI; AMM; FUH; ADD; SSD; SMD; SMC; SAA; IET.		
Identifying and contracting with providers by offering custom, alternate payment methodologies, such as bundled payments (i.e., for cardiologists, endocrinologists, and orthopedists). For more information, see Section 2.10.12 of our response.		
Provider Type(s) — All specialty types as noted in RFP 2.10.8.3.	X	X
Quality Metrics* (as applicable) — Colorectal cancer screening/cervical cancer screening; CIS combo 10; CBP; HbA1c <8 (CDC); NSV; FUA; depression screening and follow-up for adolescents and adults; PPV; PPR; NCS; use of imaging studies for low back pain (LBP); appropriate treatment for children with upper respiratory infection (URI); AMM; FUH; ADD; SSD; SMD; SMC; SAA; IET.		
Through participation in the Managed Care Incentive Payment (MCIP) program, leverage relationships with integrated delivery systems to increase access to their affiliated specialists.		
Provider Type(s) — All specialty types as noted in RFP 2.10.8.3.	X	X
Quality Metrics* (as applicable) — Colorectal cancer screening/cervical cancer screening; CIS combo 10; CBP; HbA1c <8 (CDC); NSV; FUA; depression screening and follow-up for adolescents and adults; PPV; PPR; NCS; LBP; URI; AMM; FUH; ADD; SSD; SMD; SMC; SAA; IET.		
Use of telehealth to simplify and expand delivery of care for physical and behavioral health services.		
Provider Type(s) — Dermatologists (2.10.8.3.2); endocrinologists (2.10.8.3.3); LMHSs (2.10.8.3.4); neurologists, pediatric (2.10.8.3.5); psychiatrists (2.10.8.3.9).**	X	X
Quality Metrics* (as applicable) — Controlling blood pressure (CBP); HbA1c <8 (CDC); follow-up after ED visit for alcohol and other drug abuse or dependence (FUA); depression screening and follow-up for adolescents and adults; PPV; PPR; AMM; FUH; ADD; SSD; SMD; SMC; SAA; IET.		
*Including but not limited to these metrics. **Also done for cardiologists (2.10.8.3.1); neurologists, adult (2.10.8.3.5); and pulmonologists (2.10.8.3.10).		

Figure 2.10.8.4-1: *We use a variety of strategies to recruit and retain quality providers.*

Recruitment And Retention Strategies

Contracting Payment Structures Strategy

We tailor conversations regarding rates to our providers, including discussion of enhanced rates and shared savings, with a tie back to quality. As we build our network to meet access standards, we focus on developing a network of providers to achieve efficient and high-quality health care. We are shaping our network to recognize quality and provide incentive-based approaches. We identify providers whose outcomes align with our quality metrics and engage them in our QEP and Perinatal Quality Enhancement Program (PQEP). Provider-facing teams hand-deliver performance score cards to providers for review against peer performance. Quality and performance metrics that we evaluate to assess provider success in achieving LDH's goals of improving enrollee health include Healthcare Effectiveness Data and Information Set (HEDIS) measures such as adult access to preventative services, well-child visits, and medication management for enrollees with asthma. Our new tiering program offers our PCPs incentives to improve health outcomes and quality of care while lowering costs. PCPs are ranked from 0 to 5 based on performance, with higher-ranked PCPs moving along the alternative payment model (APM) continuum and lower-ranked PCPs receiving quality and practice transformation training. Consistent with LDH's goal of aligning financial incentives for MCOs and providers, we have engaged providers in value-based contracting models for nearly four years.

Recruitment And Retention Strategies In Action: Use Of IOP-Like Programs

Intensive Outpatient Program (IOP) services for behavioral health are not covered by Healthy Louisiana; however, the Hospital Outpatient Program Extension (HOPE) mirrors an IOP (substance use), with covered benefits to offer a step-down from inpatient specialty behavioral health services. Using the HOPE model, we worked with Beacon, a large hospital system, to add an outpatient program that offers a step down from inpatient psychiatric hospitalization; the program is now available in five urban and four rural parishes. Pending the outcome of this program, we will extend this model to other providers.

Reducing Administrative Burden Strategy

AmeriHealth Caritas Louisiana's goal is to continue to improve access to care for enrollees, and reduce administrative burden for our providers as part of that effort. From 2017 to 2018, we reduced the number of services requiring prior authorizations by 20 percent. We implemented a platform that allows providers to enter demographic changes electronically and as needed, increasing administrative ease. Additional efforts include the following:

- Relaxing requirements for specialists that consistently submit prior authorization requests and have been determined as providing quality care.
- Offering a searchable formulary to increase provider satisfaction.
- Reimbursing providers for services facilitated on the same day, unless restricted by law.
- Providing web-based authorizations whereby a provider can enter a prior authorization request for manual review by a nurse or LMHS. We are adding InterQual Connect™ to our Provider Portal by the end of 2019, which will allow us to automate authorization requests and provide more immediate response.
- Ensuring timely and accurate payments, which contribute to provider retention (see **Section 2.10.13.1** of our response).

2.10.8.5 Ensuring Providers Meet Enrollee Multilingual, Multicultural, And Disability Needs

AmeriHealth Caritas Louisiana supports providers in understanding and meeting the diverse needs of our enrollees and ensuring health equity. In accordance with **Model Contract, 2.9.2.1**, we ensure that our network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or behavioral health disabilities [42 C.F.R 438.206(c)(3)]. We also perform an annual review of enrollees' language needs and assess our network's ability to adequately meet them.

Our commitment to culturally competent care is evidenced by our National Committee for Quality Assurance (NCQA) Multicultural Health Care distinction as well as our enrollee programs, often hosted alongside providers, at our community wellness centers and other community locations across the state.

We proactively assess cultural and linguistic needs and deploy staff to identify and recruit providers to fill gaps.

Maintaining A Diverse Provider Network Able To Serve A Diverse Membership

Culturally And Linguistically Appropriate Services

We support providers in understanding and meeting the diverse needs of enrollees and ensuring health equity; our enrollees speak 20 languages and come from varied cultural and racial backgrounds. AmeriHealth Caritas Louisiana proactively provides culturally and linguistically appropriate services (CLAS). We provide supports and services to promote health equity and address disparities based on protected classes.

We maintain an annual cultural and linguistic competency work plan with measurable goals designed to improve CLAS and reduce health care disparities. Our annual work plan is fully aligned with CLAS and NCQA standards. The NCQA evaluates our ability to meet the cultural, linguistic, racial, and ethnic needs of our enrollees; our commitment to health equity and culturally competent care resulted in receiving its Multicultural Health Care Distinction. Our work plan includes:

- Maintaining a CLAS Committee.
- Defining how we achieve each of the 15 national CLAS Standards.
- Developing an annual CLAS Strategic Plan.
- Maintaining a CLAS sub-committee of our Member Advisory Committee.
- Conducting an annual evaluation of our CLAS program.
- Conducting annual disparities analysis of HEDIS performance.
- Conducting annual disparities analysis of our CAHPS satisfaction survey.
- Conducting a routine review of enrollee demographic data to identify emerging trends.
- Conducting annual assessment of network for linguistic availability and accessibility.
- Monitoring performance of language access providers.
- Reviewing complaints, grievances, and appeals related to CLAS needs.
- Holding an annual CLAS training for associates.

The CLAS Committee is a cross-departmental workgroup responsible for providing direction to AmeriHealth Caritas Louisiana's CLAS initiative. The CLAS Committee provides direction to the activities that are relevant to the 14 national CLAS standards and to NCQA's Multicultural Healthcare Standards, which ensure that our enrollees are served in a way that is responsive to their cultural and linguistic needs. The CLAS committee reports to the QSC and meets quarterly.

The Annual Assessment of Provider Network Responsiveness for Language reports have indicated progressive yearly improvements; in 2017 and 2018, the majority of providers by parish rated *Excellent* in meeting the linguistic needs of enrollees. In 2017, Bossier Parish improved significantly due to four additional Spanish-speaking providers.

AmeriHealth Caritas Louisiana provides cultural competency training for physical health and specialized behavioral health providers. We also developed and published on our website a provider cultural competency guide, which is an overview of providing culturally competent care to African-American, Native American, Hispanic, Vietnamese, and Arabic speaking enrollees.

Linguistic Needs Assessment

AmeriHealth Caritas Louisiana proactively assesses cultural and linguistic needs and deploys staff to identify and recruit providers to fill gaps. We perform annual reviews of membership language needs and provide an assessment of our network's ability to adequately meet those needs. We rate the degree to which our providers in each parish who speak a non-English language meet/exceed the ratio of English-speaking enrollees to providers. Our 2018 Network Assessment of Linguistic Needs demonstrated adequate language services for all 64 parishes in the Plan's service area, with all of our provider-to-enrollee ratios among non-English-speaking populations rating *Excellent* or *Satisfactory*. Our 2017 Network Assessment of Linguistic Needs revealed a slightly lower ratio for Vietnamese-speaking populations in Vermillion Parish. To address the lower ratio, we executed internal processes to identify and recruit a Vietnamese-speaking provider in the area. We notified all of our Vietnamese-speaking enrollees in Vermillion Parish of their right to free interpretation services and provided a notification card to present during health care encounters to let the provider know that they need interpreting services. We also provided them our enrollee materials translated into Vietnamese.

On an annual basis, we survey non-English-speaking enrollees on their experiences with interpretation services during health care encounters. We know that when providers share their ethnic background and languages spoken, enrollee access improves. Sharing ethnic background is a provider's choice. Our PDIF captures provider language, which fills cultural gaps in some geographic areas.

Cultural Competency Training

Our cultural competency training, which providers rated the highest among all MCOs in the 2018 Provider Satisfaction Survey, teaches the importance of cultural preferences in providing culturally appropriate care that promotes treatment adherence and health outcomes. The training includes Tribal Awareness education for all Louisiana providers contracted with AmeriHealth Caritas Louisiana. Our training addresses the relationship between internal bias and quality of care. During training, providers examine false truths, myths, and stereotypes that influence their clinical practice. The training equips them to identify internal bias and change behavior to enhance cultural and linguistic competency when providing care (**Figure 2.10.8.5-1**). We inform providers of the racial, ethnic, and language makeup of the areas they serve and provide additional sources of free cultural competency training that fulfill their continuing education credit requirements. Providers receive a copy of national CLAS standards and related federal laws. Training can be provided at the provider's facility, during area/regional trainings, via webinar, during new provider orientation, and at conferences. Since August 2016, we have completed in-person trainings for 450 providers. In

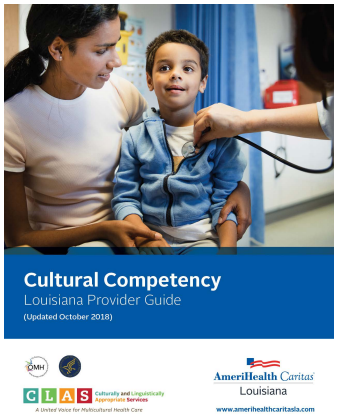


Figure 2.10.8.5-1: *Our cultural competency manual helps providers deliver care that honors diverse cultural backgrounds.*

addition, all of our associates complete mandatory cultural competency training every year. In 2019, we enhanced our cultural competency training by adding Cultural Sensitivity to the program to ensure providers and their staff are aware of the linguistic needs and cultural differences of our enrollees.

NCQA Multicultural Health Care Distinction

To earn the NCQA Distinction in Multicultural Health Care (MHC), we had to meet or exceed standards in:

- Race, ethnicity, and language data collection.
- Access to and availability of language services.
- CLAS program and evaluation.
- Practitioner network cultural responsiveness.
- Reducing health care disparities.

AmeriHealth Caritas Louisiana surpassed the scoring requirement of 70.00 by more than 20 points, earning a final score of 90.25. This distinction put us in an elite group of health plans that demonstrate excellence in tailoring programs and services to meet the unique needs of a diverse membership.

Meeting The Needs Of Enrollees Living With Disabilities

Meeting the disability needs of our membership is as important as meeting their language needs. More than 92 percent of providers have confirmed that their offices have disability access.

In 2017, AmeriHealth Caritas made significant changes to its provider directory across all lines of business in order to better capture the ability of providers to serve enrollees with disabilities. Examples of data elements that were added to provider directories include the following:

- Whether the provider has undergone cultural competency training.
- Whether the service location is on a public transportation route.
- Areas/conditions for which provider has training/experience: deafness or hard of hearing, blindness or visual impairment, physical disability, cognitively disabled, etc.
- Whether electronic prescribing is available.
- Whether the following are ADA-compliant: access to service location, restrooms, medical equipment, exam rooms, etc.

A Story That Demonstrates Our Commitment To Culturally Competent Care *— A gentleman was referred by the Rapid Response Team after being hospitalized for a toe infection, which eventually led to amputation. Because the enrollee does not speak English, his social worker arranged for an interpreter to assist with his assessments. The enrollee visited a wound care center and a podiatrist and today has improved foot hygiene. He stated that it was the first time in perhaps 25 years that he has spoken to anyone in his native language.*

2.10.8.6 Terminating Network Providers Without Cause

We do not often terminate a provider without cause. Any termination made without cause is made in consultation with LDH, particularly for a provider located within a Health Professional Shortage Area **(Model Contract, 2.9.8.3.7)**. In accordance with **MCO Manual 2.9.9**, we give providers 90 days' advance notice of contract termination without cause. Notification is sent by certified mail to the last known mailing address submitted by the provider and includes the effective date of termination. Whether a provider is terminated with or without cause or requests a voluntary termination, we make a good-faith effort to give written notice to enrollees who received care from or were seen by the terminated provider.

MINIMIZING NEGATIVE IMPACT ON ENROLLEES

Our Provider Termination Policy ensures continuity of care and service should a provider termination occur. We ensure disruptions to enrollee care and services are minimized if a major provider is lost and have a contingency plan for covered services lost prior to termination. When a PCP is terminated, we

identify all members linked to the impacted practitioner. Through an analysis of claims we identify enrollees who have seen the terminated provider within the last two years **(Model Contract, 2.9.8.3.9)**. This triggers direct outreach to other providers who accept and serve enrollees in need of the terminated provider's services. The following steps are also taken:

- Written notice, including the expected date of termination, transfer of records, future contact info, etc., is provided to enrollees of the provider's termination.
- Our Enrollee Services and/or Care Coordination teams are made available to help enrollees secure new a provider.
- We inform enrollees of their option to enroll with a new MCO if we are unable to find them a new provider.
- We arrange for covered services from an out-of-network provider when necessary until an in-network provider is established.

This page is intentionally left blank.

2.10.9
Provider Support

AmeriHealth Caritas Louisiana's Control Your Diabetes intervention program includes fresh fruits and vegetables along with nutrition education.

AmeriHealth Caritas™
Louisiana

2.10.9 Provider Support

2.10.9.1 AmeriHealth Caritas Louisiana's Approach To Provider Support

AmeriHealth Caritas Louisiana continually evaluates our processes and strategies to relieve provider administrative burden and increase provider satisfaction and will meet all requirements in **Model Contract, 2.10 and MCO Manual, 2.10**.

Our approach to provider support includes the development of adherence to our annual Quality Improvement Provider Support Plan, which is part of our overall Quality Assurance and Performance Improvement (QAPI) Plan as required in **Model Contract, 2.16.16**. Throughout our response, we demonstrate how we assist providers in clinical transformation and care improvement through in-person, online, and routine/ad-hoc approaches.

AmeriHealth Caritas Louisiana received the highest rate of provider satisfaction among MCOs evaluated in the Louisiana Department of Health 2018 Medicaid Managed Care Provider Satisfaction Survey. *We also had the highest rate of providers indicating they would recommend AmeriHealth Caritas Louisiana to other practitioners.*

We take a multidisciplinary approach to provider support that is tailored to advance state priorities and deliver comprehensive in-person, online, and practice-level collaborative support. Collectively described throughout our response, we summarize our provider facing teams in **Figure 2.10.9.1-1.** We provide details on the leader, functionality, and number of staff in **2.10.9.3.1.**

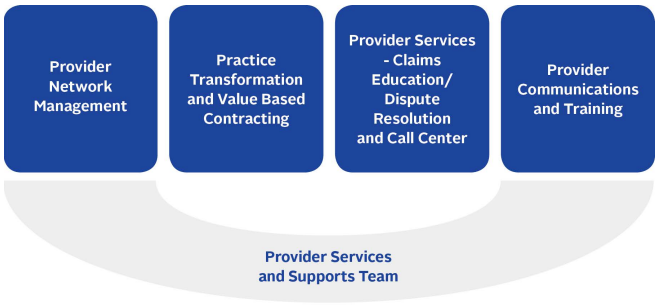


***Figure 2.10.9.1-1**: Provider Services And Supports Team.*

AmeriHealth Caritas Louisiana's Provider Services team takes a personal approach to onboarding new providers. We proactively seek to contract with the highest quality, willing providers for inclusion in our network. To ensure our providers begin with a solid foundation, we build strong relationships through in-person visits, and through the support we offer providers in contracting activities, provider orientation, and network enrollment. Our locally based Provider Support team ensures accuracy in our provider set-up, which ensures seamless network enrollment and minimizes claims denials. The Provider Support team then delivers new provider orientation to ensure providers are acclimated to our plan.

*In 2018, AmeriHealth Caritas Louisiana adjudicated **99.9%** of all clean claims received in 15 days. In 2018 we averaged claim **turnaround time of 3.98 days.***

Ensuring Timely Payment

AmeriHealth Caritas ensures timely and accurate payments through a combination of education, collaboration, and technology. Claim system configuration is led by our Louisiana based Data and Technical Services team responsible for claim administration and alignment with Louisiana Medicaid policy/guidelines and national billing standards. During weekly meetings, our system configuration and

programming staff review national clinical editing guidelines against Louisiana Medicaid clinical editing policy before placing edits into our automated claims processing system. We share billing requirements and instructions for claims submission via the claims filing instruction guide, provider orientation, handbook, newsletter, and during ongoing training in-person and via webinar. Our locally based claims management team manages the end-to-end claims life cycle. **In 2018, we adjudicated 99.9 percent of clean claims within 15 days or less, exceeding the 90 percent required in Model Contract, 2.18.2.1.2**. We are committed to the timely processing of claims and will adjudicate 100 percent of all clean claims within 30 calendar days, as required in **Model Contract, 2.18.2.1.3**.

ENSURING APPROPRIATE PROVIDER SUPPORT

Effectively Managing Provider Relations — As required in **Model Contract, 2.10.3**, we provide timely support to providers through our formal provider relations function and multi-channel provider communication including but not limited to: our provider newsletter, joint operating committees, email, in-person visits, state wide training, webinar training, Provider Services Line, after hours support, and our Provider Advisory Council as required in **Model Contract, 2.10.1.1**. Our field based Provider Services and Supports staff focus on reducing administrative burden, assessment of provider alternative payment model readiness, and rate negotiation.

*As a result of our proactive efforts to minimize provider complaints, **calls decreased 11 %** year-over-year from 2017-2018.*

Effectively Managing Provider Communications — AmeriHealth Caritas Louisiana's Provider Services and Support team has a deep understanding of the provider's role in delivering care to enrollees. All provider-facing staff are trained on Louisiana Department of Health (LDH) and health plan requirements, and leverage every provider interaction (in-person, by phone, via our website or provider portal, and during training) to further build provider relationships and deliver timely tools and resources to support them. We take a proactive approach to minimize provider complaints. Our Provider Services and Support teams have bi-weekly meetings with the Provider Services Line management team to proactively identify claims and denial trends, and address system configuration changes, provider education needs, and training needs. We continuously update the system resource tool our staff uses to respond to provider calls and questions. The Provider Services Line staff have the ability to adjust claims in real-time during provider calls. Since taking these actions, we improved our first call resolution by 24 percent.

Minimizing Prior Authorization Issues — In 2018, we launched and improved our prior authorization and patient-centered platform. Through this effort, we reduced the number of services subject to prior authorization requirements. As described in our response to **2.10.10, Utilization Management**, prior to issuing a denial, our Utilization Management (UM) staff proactively contacts the treating provider to request additional information in accordance with **Model Contract, 2.12.11**. AmeriHealth Caritas Louisiana is adding InterQual Connect™ to our provider portal by the end of 2019. This new feature will allow us to automate authorization requests and provide more immediate responses.

*We listened to our providers and reduced the number of services requiring prior authorization; as a result we **reduced the volume of prior authorizations by 20 %** in 2018.*

2.10.9.1.1 Determining Adequate Provider Relations Staffing

AmeriHealth Caritas Louisiana has a 25 field-based Provider Network Management, Practice Transformation, and Value-Based Contracting staff. The following describes how we determine adequate staffing levels.

For Provider Network Management field-based staff, we employ a staffing model to project base-level

staffing. Based upon the number of providers by provider type (primary care provider (PCP), behavioral health, specialist, hospital and ancillary) and the number of visits projected for each type per year (see response to **2.10.9.1.2** below), we assume 2.5 hours per visit which factors in travel time, meeting time and follow-up time. We then consider factors such as rural versus urban; number of providers at a location; provider locations; claims payment and accuracy trends; quality of service; provider, and enrollee contact reasons, to finalize the number of required staff.

We base our Practice Transformation and Value-Based Contracting staff on the number of providers in value-based contracts and providers' progress on the practice transformation continuum. To ensure we are providing best-in-class service to our providers we continually evaluate our provider relations staffing.

2.10.9.1.2 Strategies For Effective And Timely Provider Communication

Our strategy for effective and timely provider communication is to build and maintain solid provider relationships through outreach, education, and support. Through our provider communications strategies, AmeriHealth Caritas Louisiana keeps our providers informed of our policies and processes, supports provider evolution across the Health Care Payment and Learning Action Network (HCP-LAN) payment continuum, and addresses providers' learning needs. Based on provider feedback and enrollee needs, we provide collaborative care management support and timely communications that help providers operate effectively and efficiently to deliver quality, cost-effective care, and improve enrollees' health and well-being.

We develop provider communications to drive correct coding, reinforce strategies to prevent and detect fraud, waste, and abuse, reinforce billing policies, and alert providers to benefit changes and programs such as our PerformPlus® value-based purchasing (VBP) programs to drive improved health outcomes.

Face-To-Face Provider Support — Since 2012, our statewide provider-facing field staff has conducted regularly scheduled visits to provider sites. We currently conduct monthly visits to PCP offices, quarterly visits to hospitals and specialized behavioral health providers sites, and annual visits to specialists and ancillary providers. Our local staff provide technical assistance on billing practices and clinical programs as well as provider demographic validation.

Secure Provider Portal — Our secure Provider Portal is the primary technology platform that we use collaborating with network providers. The portal gives providers the ability to submit requests and monitor activity related to their enrollees, including:

- Viewing their enrollee panel.
- Verifying enrollee eligibility and benefits.
- Submitting claims.
- Submitting claims adjustment inquiries.
- Submitting requests for prior authorizations.
- Checking the status of submitted claims.
- Accessing a variety of clinical, financial, and administrative reports described in our response to **2.10.9.2.1**.

Assessing The Provider Pulse — Our leadership team, including our CEO, CMO, Behavioral Health Medical Director, COO, and senior staff are highly visible in our communities and are accessible to providers. We regularly meet with key providers, large billing entities that service providers within our network, and LDH to proactively engage in open discussions related to provider concerns. Our Provider Advisory Council meets quarterly to support meaningful dialogue.

Provider Services Line — Our Provider Services Line is staffed from 7 a.m.-7 p.m. Central, Monday-Friday, to answer provider questions, comments, and inquiries. Our off-hours team answers provider calls received after business hours on weekends and holidays. The off-hours team contacts the on call UM nurse for urgent issues. A Medical Director is also on call to address medical necessity determination requests.

Provider Education Program

AmeriHealth Caritas Louisiana continues to deliver in-person education that supports the development of strong provider relationships. We deliver ongoing education to ensure compliance with program standards and the Contract **(Model Contract, 2.10.7.1).** In 2019, we introduced our Provider Learning Continuum program to all providers and their staff. This education program is designed to meet providers where they are and seeks to move the provider and their practice along a quality continuum by providing education, training, core competencies, and practice transformation. We offer onsite new provider orientation and ongoing in-person and webinar training for both clinical and administrative staff.

Administrative Topics Include — provider handbook; claims submissions; health plan policies; Provider Portal; Provider Demographic Information Form, provider access/availability to care managers, community health workers (CHWs); HEDIS coding guidelines; web based tools; licensing and accreditation requirements; re-credentialing, Preferred Drug List, cultural competency and health equity; and after-hours access and appointment availability.

In 2018, to help communities support individuals with mental health needs and to expand integration of care, we collaborated with the Louisiana Primary Care Association to offer free mental health first aid courses. The courses are designed to enhance the understanding of mental health and those going through a mental health crisis. The courses are offered to providers, CHWs, community partners, and non-clinical community health center staff.

Clinical topics include — HEDIS measures and state initiatives to improve quality outcomes; Substance Abuse and Mental Health Services Administration (SAMHSA) approved medically assisted treatment (MAT) in accordance with **Model Contract, 2.9.14.3**, training with the goal of increasing the number of providers who can treat opioid addiction; Project ECHO® (Extension for Community Healthcare Outcomes); benefits of physical and behavioral health screenings; clinical practices guidelines; behavioral health toolkit; use of integrated assessments to drive integrated care; and behavioral health treatment planning and documentation.

We also lead collaborative learning clinics to increase knowledge among participants and access to care for chronic and complex enrollees. We continually monitor trends on utilization to drive our educational offerings and educate our providers on evidenced-based care. For example, we led an initiative to identify and facilitate training opportunities on topics, such as pre-school post-traumatic stress disorder (PTSD), Parent Child Interaction Therapy, Child Parent Psychotherapy, and Positive Parenting Practices® to enhance evidenced-based care for 0-5 year-old enrollees who are in need of specialized behavioral health care services.

2.10.9.1.3 Supporting Providers With High Claims Denial Rates

We use the following mechanisms to support providers with high denial rates including identifying trends, re-educating providers, and effectively communicating changes to providers.

Identifying Denial Trends And Re-educating Providers

Our Provider Services and Support staff monitor weekly reports on service denials by volume and claim type to identify denial trends. When we identify a trend of increasing denials, our Provider Services and Support teams identify the drivers of the trend. If we identify drivers related to provider billing errors, we offer practice level support. If the trends or drivers affect multiple providers, we deliver broad-based education and re-training to our provider network. If we identify internal system configuration needs, we initiate a work request to correct identified issues alerting providers of any applicable changes in claim submission requirements.

Proactive Strategies For Reducing Unnecessary Denials

When we make any changes to claim submission requirements, we give providers a 30-day notice, as required in **Model Contract, 2.10.3.6**. To ensure timely notification to our providers, we use fax blasts, e-alert electronic communication notices, the provider newsletter, joint operating committees, and posting of policies and procedures on our provider website and Provider Portal.

We continually target provider needs in the areas of clinical improvement, education, administration simplification, and quality outcomes. We have a job-aid that identifies the top 10 most common denial reasons with the resolution on how to correct the denial and resubmission of claims when applicable. The guide assists providers with quickly resolving certain denial reasons to alleviate administrative burden.

2.10.9.1.4 Timely Evaluation and Resolution Of Provider Disputes

As required in **Model Contract, 2.18.12**, AmeriHealth Caritas Louisiana has a fully compliant and comprehensive provider complaint system for in- and out-of-network providers to dispute claim denials.

Claims Disputes

AmeriHealth Caritas Louisiana administers provider disputes locally, as an extension of the plan's First Call/Claim Resolution Approach. This approach is intended to reduce provider abrasion within the network and alleviate some of the provider administrative burden of reaching out to multiple people to get their questions/claims resolved. This process gives AmeriHealth Caritas Louisiana and the provider a clear line of sight into claims system issue identification and remediation. For second level reviews, reconsidered requests and independent reviews, local senior claims staff and Medical directors conduct the reviews and identify resolutions.

Enrollee Assignment Disputes

At least monthly, as required in **Model Contract, 2.9.10.3.3**, AmeriHealth Caritas Louisiana shares complete lists of designated enrollees with PCPs through our provider dashboards and panel reports. Upon review of the report, the PCP may dispute our assignment policy, assignment, or re-assignment of an individual enrollee within 15 business days of the assignment.

To support providers with resolving enrollee assignment issues in relation to a VBP arrangement, we have a dedicated email address for providers to submit written requests. Providers receive an immediate automated response and we resolve and provide notification to the provider within 15 calendar days of receipt as required in **Model Contract, 2.17.11.1**.

*AmeriHealth Caritas Louisiana made a concerted effort to identify and address root causes that led to first level disputes, which resulted in **a 35% reduction in provider requested second level reviews in 2018**. Additionally, since the first 11 months of the start of the process, only 5% of the total requests for independent reviews submitted to LDH were in relation to AmeriHealth Caritas Louisiana denials.*

2.10.9.2 Strategies For Delivery System And Payment Reform

AmeriHealth Caritas Louisiana strives to lead delivery system and payment reform using strategies that support providers to improve quality and reduce cost. Our strategies focus on investing in quality care, using technology to educate providers, ensuring enrollee access to alternative sites of care, investing in the next generation of providers, influencing policy developments, advancing alternative payment methods, and delivering effective data to support provider innovation.

Our Provider Champion strategy highlights providers that have made measurable gains in quality metrics. We recently began featuring providers in our provider newsletter to show their commitment to quality service. Provider Champions help market the unique offerings of our organization to their colleagues.

2.10.9.2.1 Primary Care Provider Support Strategies

To enhance the providers' ability to advance along the value-based continuum, AmeriHealth Caritas Louisiana offers comprehensive practice transformation tailored to each alternative payment model participating provider. Our PCP support strategies include:

Delivering Effective Support And Coaching — Our Provider Services and Supports team assists PCPs with core competencies such as billing, HEDIS coding, and basic operations. Our practice transformation team, led by our Practice Transformation Director, supports our PCPs' evolution along the continuum of value-based payments as well as providing support to ensure success in these programs.

Investing In Primary Care Infrastructure — AmeriHealth Caritas Louisiana offers our PerformPlus Primary Care Quality Enhancement program to all PCPs as a first step to value-based contracting. The Quality Enhancement program provides an incentive payment for practices that achieve National Committee for Quality Assurance recognition as a patient-centered medical home as required in **Model Contract, 2.17.8.1**. Additional PerformPlus offerings for PCPs include care management fees that support participation in shared savings/risk arrangements. Our value-based programs promote referral and collaboration characteristics of the patient-centered medical home with the goal of providing Louisiana enrollees with improved access to efficient, timely, and integrated care to meet their needs.

We also invest in CHWs to support providers' offices to support patient navigation of their care needs. For example, CHWs visit provider sites to help schedule enrollee appointments and improve adherence to their care plans between appointments.

> *"[…] We are excited about the pay-for-performance plan, which we worked collaboratively with AmeriHealth Caritas to pilot for behavioral health. AmeriHealth Caritas has developed a strong network of resources which aid in the discharge planning process. AmeriHealth Caritas has a good reputation. When I speak positively to others about our experience with them, I always see a lot of heads nodding."*
> ***William Weaver, Brentwood Hospital CEO and Managing Director***

Providing Alternative Site Of Care Options — We implemented a strategy to reduce inappropriate emergency department (ED) utilization by expanding our urgent care network to address some of the access issues that drive preventable ED visits. As a result of our concentrated efforts, our urgent care network increased by 64 percent from 2017-2018. We also contract with alternative sites of care such as school-based health clinics, which help reduce the number of enrollee no-show appointment occurrences.

Investing In Future Health Leaders — AmeriHealth Caritas Louisiana partners with Louisiana State University in supporting future health leaders through several initiatives including:

- Offering Masters of Public Health students at Louisiana State University Health Sciences Center, Shreveport a unique 200-hour internship rotation and learning experience through our community wellness center in Shreveport.
- Creating a Medicaid managed care rotation in our Baton Rouge offices to familiarize fourth-year medical students at Louisiana State University Health Sciences Center, New Orleans, with managed care operations and population health management.

- Launching our AmeriHealth Caritas Louisiana's Health Policy Fellowship program with the Louisiana State University Health New Orleans School of Public Health and School of Medicine. The program is open to Louisiana State University medical students following completion of their first year of medical school for an eight-week summer fellowship in Washington, D.C. providing students with opportunities for real world applied experiences in the various aspects of health policy.
- We are actively involved with Dr. Peggy Honoré from the Louisiana State University School of Public Health in developing a Health Navigator training program**. The program will provide students with the skills to be important partners when providing assistance directly to the clinical care team, implementing public and community health interventions, and assisting patients as they navigate through the complex health system.** We anticipate our New Orleans community wellness center becoming a training site.

2.10.9.2.2 Behavioral Health And Other Specialty Provider Support Strategies

AmeriHealth Caritas Louisiana is a leader in the integrated care and behavioral health delivery system and payment reform. In 2016, **we were the first managed care organization (MCO) in the state to offer a value-based payment arrangement to behavioral health providers**. Our payment reform strategies for behavioral health and other specialties include:

Advanced Payment Methodologies — For specialty providers we bundle payment and episode payment models that reward providers who improve quality and manage enrollees' cost of care associated with specific episodes of care. These models are flexible and tailored to them to include gain and/or risk-sharing incentives. Bundled payment models are also available for maternity, cardiology, and enrollees with chronic conditions, such as diabetes or asthma. We also offer shared services VBP models that reward integrated delivery systems and specialty care providers, including specialized behavioral health providers, for effectively addressing enrollees' needs across multiple care settings. **The models are designed to eliminate fragmentation and waste as well as improve enrollees' health outcomes**. We share the savings generated by high quality care management and coordination, with providers as a financial incentive for delivering cost-effective care.

Innovative Contracting — We added a level of care to provide behavioral health services in an outpatient setting that previously was only offered to Medicare patients. **We worked with Beacon, a large hospital system, to add an outpatient program as a step down from inpatient psychiatric hospitalization.** The program is now available in five urban and four rural parishes. We will extend this model to other geographic areas and service levels (i.e. substance use) as applicable. Additionally, we worked with another large hospital system, Acadia, and have negotiated a continuum level of care to offer psychiatric residential treatment facility (PRTF), American Society of Addiction Medicine (ASAM) 3.7, which is not currently available in Louisiana. The continuum includes intensive outpatient substance use treatment for adolescents as a step down from the PRTF. Beacon will also facilitate a therapeutic group home where youth may reside while receiving an IOP for an out-of-home placement. This will not be limited to children in state custody.

Leadership In The Payer Community — AmeriHealth Caritas Louisiana's experienced leaders drive collaborations with other Healthy Louisiana MCOs for various initiatives to streamline provider processes and improve the quality of care provided to enrollees. **We are a member of the Louisiana Medicaid MCO Association (LMMCOA), with our behavioral health Medical Director, Dr. Betty Muller serving as the Chairperson of the LMMCOA Behavioral Health Committee.** We led an initiative with our peer MCOs in Louisiana to provide regional provider training on Level of Care Utilization System (LOCUS). We

coordinated, arranged, and hosted the initial training. The trainings provide an overview of the LOCUS assessment tool and how to use it for evaluating and determining an enrollee's appropriate level of care placement for psychiatric and addiction services. We continue to offer LOCUS trainings, as well collaborate with the other MCOs on Healthy Louisiana initiatives. We also led an initiative to identify training opportunities on topics, such as preschool PTSD training, parent management training, Positive Parenting Program®, and child parent psychotherapy to enhance evidenced-based care for enrollees who are 0-5 years old and in need of specialized behavioral health care services. Please **see our response to 2.10.9.1.2** above for additional details on our provider education program.

2.10.9.2.3 Processes For Sharing Provider Performance Data

We have processes in place for sharing network performance data via monthly, quarterly, and ad-hoc reports that incorporate a variety of nationally recognized performance measures as described in our response to **2.10.12**. Our Provider Services and Practice Transformation teams provide face-to-face support on VBP, actionable data, and opportunities for improvement. In addition to our foundational provider profiling, our proprietary PerformPlus suite of value-based purchasing programs include robust provider dashboard and report card components used by both AmeriHealth Caritas Louisiana and our providers to monitor and enhance performance. These performance reports include:

Provider Profiles — We currently profile network providers using a variety of standard and ad hoc reports and metrics selected to monitor performance. We have developed profiles based on utilization data, HEDIS® measures, and other specialized metrics relevant to LDH requirements and priorities. AmeriHealth Caritas Louisiana profiles all PCPs and the top behavioral health and specialty provider types that account for approximately 75 percent of claim volume for all behavioral health and specialty services as required in **Model Contract, 2.9.7.2**. AmeriHealth Caritas Louisiana initiated the collaboration with all MCOs for the standardization of Provider Report Cards to ensure provider convenience and ease of use.

Care Gap Alerts — Alerts identifying missing or over-due clinically recommended services appear when enrollee information (name or ID number) is entered in the system. PCPs can also access alert information from the clinical document tab of the portal.

Provider Portal Data Sharing — Through our secure provider portals, providers have access to their cost and quality performance through quality dashboards and other clinic reports.

HEDIS Report Cards — We provide a HEDIS Performance Measure Summary, which details providers' performance review of individual providers and performance at an aggregate level.

Additionally, AmeriHealth Caritas Louisiana's provider partners have communicated a preference for information to be uploaded to their electronic health records (EHR) where they can best leverage and maximize performance. We use **Direct Secure Messaging (DSM)**, which helps providers achieve their performance goals and improve the quality of care provided to enrollees. We have initiated DSM with a limited group of willing provider practices to test our ability to automate sending enrollees' clinical summaries as updates are made. Providers are able to choose what they receive from a menu of information options including care gaps, encounter notifications, out-of-network admissions, deterioration of health status alerts, failure to treat alerts, and clinical summaries.

2.10.9.3 AmeriHealth Caritas Louisiana's Provider Engagement Model

Our Provider Engagement Model, based on years of Louisiana experience, offers our network providers administrative simplification, efficient issue resolution, and prompt and accurate provider payment.

AmeriHealth Caritas Louisiana views direct provider outreach to identify core concern as the gold standard for provider dissatisfaction. **Our Chief Executive Officer Kyle Viator, Chief Medical Officer Dr. Rodney**

Wise, and Chief Operating Officer Sherry Wilkerson regularly reach out and engage providers to assess satisfaction. AmeriHealth Caritas Louisiana employs a strong Louisiana based provider dispute process and conducts first alert claims resolution meetings weekly. These first alert meetings convene subject matter experts to identify root causes, discuss issues, and determine resolutions with key internal teams. The team initiates provider notifications, as needed to ensure timely resolution and remediation.

2.10.9.3.1 Provider Engagement Staff

There are five teams that comprise our provider engagement staff. Our provider engagement model encompasses many AmeriHealth Caritas Louisiana departments and teams including but not limited to those described in **Figure 2.10.9.3-1**.

Team	Leadership And Area Of Responsibility	# Of Staff *
Provider Network Management Field Based Staff	Directed by Stacie Zerangue with 23 years of leading cross-functional physical & behavioral health integration efforts. This team identifies, recruits, and support providers through the contracting process to ensure enrollee access to physical and behavioral health care.	21
Practice Transformation and Value-Based Contracting Field Based Staff	With over 40 years of experience, Lee Reilly, RN, CCM leads our multidisciplinary Practice Transformation team, responsible for the administration of Quality Enhancement programs, executing value-based contracts, overseeing enrollee attribution programs and associated provider dispute processes, promoting data sharing and value-based payment strategies, and practice transformation support to assist providers in improving performance and movement along the continuum.	4
Provider Services — Claims Education, Complaint/Dispute Resolution, and Provider Services Line	Directed by Kelli Nolan with 15 years of supporting providers with dispute resolution, provider claim resolution, and education, this team is responsible for maintaining the provider complaint system, administering joint operating committee meetings, and driving the implementation and review of provider clinical and claim education strategies and efforts. In addition, Kelli is also responsible for leading Provider Services Line solutions, quality assurance, and outbound/inbound Provider Services Line support.	67
Provider Communications and Training	Directed by Tricia Grayson, with nearly 10 years of experience identifying, developing, and delivering targeted provider education and learning tools, this team is responsible for ensuring consistent and concise provider communication, including the provider website; coordinating cross-functional groups in developing and delivering timely provider training and notices; and updating the Louisiana desktop workflow tool used by provider-facing associates across the organization.	3
Staffing projections based on 375,000 enrollees.		

***Figure 2.10.9.3-1**: Staff Leadership, Roles, and Number of Staff.*

2.10.9.3.2 Local Provider Field Representatives

"I feel and I am certain that I am not alone, that Millissa Harrison is doing a wonderful job as our Account Executive. She is attentive to our needs whether it be emails or phone calls. Not only that, which is all that in itself, she follows up and tracks things until they are resolved. OMG!! This is HUGE! And then she takes the time to come and visit to show her face and build rapport with agencies. Professional, Kind, Knowledgeable...She is an Account Executive Par Excellence! AmeriHealth stands out in my eyes as far as rating the MCOs. There is a strong community presence and that is key! Everyone that I have encountered has been helpful, informative, and professional. You guys rock!"
Kristal Chambers, LPC-S, Assured Behavioral Concepts

Provider Account Executives — Provider interactions are critical to effective engagement efforts. Account Executives are dedicated to primary care providers, specialists, behavioral health, ancillary providers; network hospitals, skilled nursing facilities, and dedicated clinical liaisons. **Our staff are located in the communities they serve and deliver in-person support in all of LDH's nine regions**. As a result of our ability to effectively respond to and resolve problems, in the 2018 Provider Satisfaction survey, 90 percent of AmeriHealth providers were rated positively with the *ability to answer questions* as *good or better* and 91 percent were rated in *courtesy and responsiveness* as *good or better*. We summarized their roles in **Figure 2.10.9.3-1**.

2.10.9.3.3 Mechanisms For Tracking Provider Interactions

AmeriHealth Caritas Louisiana documents all provider interactions, including in-person contact, provider correspondence, site visits, provider training, and provider calls to the Provider Services Line through our workflow management tool. It serves as a mechanism to integrate data across all provider interactions with AmeriHealth Caritas Louisiana staff. It serves as our single system of record for all provider data. This central repository of all communications allows all provider-facing staff to access the communication history for each provider. The history supports consistent communication and rapid issue resolution. We categorize calls broadly and specifically to allow data trending of a particular provider, provider group, or issue. Data that we track includes, but is not limited to, providers' high volume claim denials, claim payment or reimbursement concerns, prior authorization inquiries, and education and training needs.

Our Provider Network Management team, including Account Executives, uses a standardized process to capture interactions with providers. To allow for real-time provider data updates, Account Executives bring iPads to their on-site visits. Information captured during site visits, as well as phone conversations, include providers joining or leaving a group, discussions related to HEDIS measures, practice transformation, panel size, access and availability, claims issue, training provided, and other validations.

Using our Provider Portal reporting functionality we also track electronic interactions with providers that occur through our Provider Portal regarding claims status inquiries, training modules, authorizations, views of the plan central component of the portal, panel status, eligibility inquiries, and reassignment validations.

2.10.9.3.4 Analyzing Provider Feedback And Data To Identify Training Needs

Our Quality Management, Provider Network Management, Practice Transformation Director, and Informatics teams review data and provider feedback to monitor provider performance trends and identify outliers that may require training or remediation. Remediation may include a network-wide alert to educate providers on a specific topic; an on-site visit by field staff to support an individual practice through training; development of a quality improvement plan, or an on-site peer-to-peer meeting with our Chief Medical Officer(CMO), Behavioral Health Medical Director, and/or Pharmacy Director.

The combination of roadshow sessions and regular visits identify patterns of issues and lead to solutions to address root causes. For example, a large health system asked us to reimburse ED telehealth codes to provide additional access to care for behavioral health services. We took this as an opportunity to educate our entire provider network through our telehealth-landing page on our website regarding this policy.

Our Provider Support and Services team meets weekly, including Account Executives and local Claims management staff. The team convenes subject matter experts to identify root causes; discusses issues and resolutions with key internal teams; and initiates provider notifications, as needed to ensure timely resolution and remediation.

On a monthly basis, AmeriHealth Caritas Louisiana's executives from Claims, and Provider Services and Support management hold a health plan business oversight meeting, where provider feedback and health plan operational performance are reviewed to identify emerging issues and develop remediation for areas of concern. This also helps to identify training opportunities for both providers and internal staff.

2.10.9.3.5 Network Provider Satisfaction Metrics

Beyond the annual provider satisfaction surveys, which we describe in our response to **Question 2.10.9.4**, AmeriHealth Caritas Louisiana uses the following key methods to derive metrics to measure the overall satisfaction of our provider network:

Satisfaction With The Provider Services Call Line — Over the years, we have learned that most callers opt not to participate in automated Provider Services Call Line surveys; therefore we use a process that assesses provider satisfaction through a company specializing in capturing and trending satisfaction, using statistically valid samplings of provider outreach calls. This allows us to address individual issues and concerns, as well as use aggregate information from these surveys to trend Provider Service Call Line satisfaction and identify training topics or corrective actions.

Provider Complaints Reporting — The report is submitted to LDH on a monthly basis. AmeriHealth Caritas Louisiana uses the data contained in the report to identify, track, and trend provider dissatisfaction complaints. The report separates provider complaints by category. These categories include claim denials, incorrect claim payments, reimbursement rates, prior authorizations, provider enrollments, credentialing, and other miscellaneous categories.

Audit of Site Visits — Our Provider Services and Support Managers initiate telephonic outreach through weekly post-visit audits. During these calls, managers' survey providers on the Account Executive's knowledge and ability to answer questions; a general rating of the visit effectiveness on a one to five scale; and if the provider has any feedback about the visit.

Other Methods — AmeriHealth Caritas Louisiana also measures provider satisfaction by sharing and trending through a cross-functional workgroup of provider facing teams what we are hearing through our daily interactions including, but not limited to:

- Feedback from providers through Account Executives, Practice Transformation Directors, and other provider-facing staff.
- Feedback from our UM team.
- Feedback from providers received by the Provider Service Call Line staff.
- Quality Assurance Performance Improvement (QAPI) committee feedback.

2.10.9.3.6 Training Providers On AmeriHealth Caritas Louisiana And Medicaid Requirements

AmeriHealth Caritas Louisiana conducts initial new provider training within 30 days of placing a newly contracted provider or provider group on active status.

Approach To Louisiana Medicaid Provider Training

In **Figure 2.10.9.3-2**, we describe our approaches to and frequency of provider training.

Approach	Frequency
Basic training including Medicaid program requirements required in MCO Manual, 2.9.9 and 2.10.4.	Within 30 days of contracting.
On-site refresher training provided by provider relations specialists	Bi-annually.
Regional training sessions held at community wellness centers	Bi-annually.
High claims denial rating, claims training	Quarterly.
Program specific training	On demand.
Webinars	Monthly/on demand.

Figure 2.10.9.3–2: *AmeriHealth Caritas Louisiana's Approach To Provider Training.*

Additional details on our training program can be found in our response to **2.10.9.1.2 Strategies for Effective and Timely Provider Communication**.

2.10.9.4 Provider Satisfaction Survey Results

AmeriHealth Caritas Louisiana takes a continuous quality improvement approach to provider satisfaction. We monitor our providers' satisfaction on an annual basis to assess the strength of our provider relationships, identify opportunities for improvement, and compare our performance against the other Healthy Louisiana Medicaid MCOs. AmeriHealth Caritas Louisiana's Provider Satisfaction results are included in **Figure 2.10.9.4-1**.

In 2018, the LDH-commissioned provider satisfaction survey summarized the results and provided data in order to assess the plan's strength of relationships with contracted practitioners, identify opportunities for improvement and compare performance with other Medicaid Managed Care Organizations (MCOs). AmeriHealth Caritas Louisiana providers reported the highest rate of satisfaction with the MCOs, as well as the highest rate of providers indicating they would recommend AmeriHealth Caritas Louisiana to other providers with 80 percent of providers responding affirmatively.

Prior to the most recent report, AmeriHealth Caritas Louisiana commissioned satisfaction surveys through vendors with expertise in conducting these surveys. Two different vendors were used in 2016 and 2017 causing some variation in measurement. The 2017 report summarized the results and provided data in order to assess the plan's strength of relationships with contracted providers, identify opportunities for improvement, and compare performance with other Medicaid plans as reported globally by the provider. The 2016 report measured provider's feedback on all other Medicaid Health Plans in the state in which the provider participates. Additionally, results were measured against a benchmark comprised of includes data from 38 Medicaid plans nationally. While the survey instruments differed between the 2018 report and prior year reports. However, data was still available in the broad categories in which results were available.

Practitioner Satisfaction Survey Composite Category	2018	2017	2016
Overall Satisfaction		83%	84%
Rated as "very satisfied" or "somewhat satisfied" with the MCO **Would recommend AmeriHealth Caritas Louisiana to other practitioners**	66%* 80%*		
Practitioner Relations/Network Management		78%	81%
Representatives answer questions and resolve problems (rated as "good" or better) **Representatives are courteous and responsive (rated as "good" or better)** ***Provider Service Call Line Ratings*** **Ease of reaching the Call Center** **Process of obtaining enrollee information**	91%* 91%* 90%* 93%*		

Practitioner Satisfaction Survey Composite Category	2018	2017	2016
Claims Processing/Reimbursement Process		81%	80%
Claims Reimbursement Process	72%		
Complaint and Appeals Process	70%*		
Utilization and Quality Management		80%	76%
Pre-authorization and referrals process	61%		
Efficiency of UM Process	35%		
Preventive care and wellness	43%		
Care Management and Care Coordination		83%	81%
MCO Care Coordination	20%		
Recommend DM/CM Program	55%		
Behavioral Health Care Services		79%	N/A
Coordination substance use treatment	67%*		
Coordination rehabilitation	58%		
Coordination of step-down services	61%		
Cultural Competency		76%	84%
Cultural Competency	86%		
*Rated highest among all Healthy Louisiana MCOs			

Figure 2.10.9.3–3: *Practitioner Satisfaction Survey Composite Category.*

Initiatives Resulting From The 2018 Survey To Improve Satisfaction in 2019

Overall providers' satisfaction with AmeriHealth Caritas Louisiana was positive in 2018. We put process improvements place in 2019 for the following areas in which we received low scores:

- **Effectiveness Of Care Management And Care Coordination Programs** — To improve effectiveness of our Care Management programs, our Community Care Management Team increased in 2019 the number of face-to-face meetings with enrollees. **Case Managers, CHWs, and Peer Support Specialists are proactively reaching out to enrollees to arrange to meet them in their homes, community-based settings, and/or during provider appointments**. The intent of the outreach is to ensure that enrollees are making the most of the support available to them and that they are properly engaging in our Care Management programs to obtain the most effective outcomes possible. To supplement those efforts, we are increasing the numbers and types of educational sessions we hold at our community wellness centers for both enrollees and providers (including their staff). In addition to our third community wellness center that we are opening in 2019, **we are also committing to opening a fourth community wellness center during the new contract period**. In anticipation of an increase in enrollment with the new contract, we will analyze our membership's demographics and locations to determine an area in the state that will most benefit from a new community wellness center.
- **Efficiency Of UM Process** — Providers' feedback from the survey revealed that providers felt there are inefficiencies in our overall UM processes. To better meet providers' needs and to increase the efficiency of our prior authorization request process, **we are enhancing our prior authorization processes by adding InterQual Connect™ to our Provider Portal** by the end of 2019. This enhancement automates prior authorization requests and provides real-time, immediate responses. Additionally, prior to receiving the survey results, we recognized providers' concerns with our prior authorization restrictions and began meeting with physicians, durable medical equipment providers, behavioral health providers, and hospitals to address their concerns. **Listening to our providers in those meetings led to us removing nearly 12,000 codes from our list of services requiring prior authorization**.

Initiatives Resulting From 2017 Survey To Improve Satisfaction in 2018

Overall providers' satisfaction with AmeriHealth Caritas Louisiana was positive in 2017. We put process improvements in place in 2018 for the following areas in which we received low scores:

- **Relevance Of Provider Education** — Providers' feedback indicated that they would like us seek their input on what training is conducted. AmeriHealth Caritas Louisiana surveyed providers for their input on what trainings they would like us to conduct. We also reviewed the training materials before each meeting and adjusted the materials, as appropriate, to ensure the training is relevant to the specific provider types in attendance. We also added additional regional provider trainings to their 2018 training calendar.
- **Timing of Review Decisions And Pre-certifications** — Providers' feedback indicated a dissatisfaction with the timeliness of our appeals and prior authorizations, as well as a concern with the consistency of our review decisions. AmeriHealth Caritas Louisiana reviewed our staffing to ensure we had the appropriate staff to meet LDH's required decision timeframes. We also looked at our processes to identify areas in need of improvement. One example of a finding and process improvement that we made is the identification to reduce the complexity of authorizations related to infusion therapy. We found that there was declining reimbursement, substantial administrative burden on providers, and delays in enrollee access to infusion therapy. To address this, we transitioned the approval of infusion therapy to AmeriHealth Caritas Louisiana's PBM, PerformRx℠. By putting clinical analyses related to home infusion medication management in the hands of experts who can identify opportunities to decrease instances of prior authorization of medications, we were able to decrease provider burden, allow for a single prior authorization review, and drive faster delivery of care.

Initiatives Resulting From 2016 Survey To Improve Satisfaction in 2017

Overall providers' satisfaction with AmeriHealth Caritas Louisiana was positive in 2016. We put process improvements in place in 2017 for the following areas in which we received low scores:

- **Alternative Care And Community Resources Options** — Providers expressed a need for more alternative care and community resources to support providing enrollees integrated care. Our first step to addressing this was to design and open a community wellness center in Shreveport, which opened in July 2017. The goal and primary purpose of the center is to provide a community support space where residents may go to learn about healthy living, best eating and exercise practices, high blood pressure prevention, and other health and social supports. The center also holds health fairs and serves as meeting place for organizations that need a place to call home.
- **Provider Services Call Line Knowledge Accuracy** — Providers' cited a concern with the accuracy of responses to their telephone inquiries. AmeriHealth Caritas Louisiana invested in hiring an expert in Louisiana Medicaid policy to create and maintain Online Help (OLH) scripts, which are valuable resource tools for the call line staff to use to answer providers' questions. Additionally AmeriHealth Caritas Louisiana health plan experts began visiting the Call Line center quarterly to conduct training and assist the Call Line staff with resolving provider issues. We also made the decision to co-locate our Provider Services Call Line staff with our claim processing staff. This re-alignment allows us to more easily train our Call Line staff on provider claims questions and creates a natural conduit for better synergy between the teams to resolve provider calls relating to claims processing.

We will continue to monitor our Provider Services and Support processes to identify opportunities for enhancements to improve our relationships with our network providers and their satisfaction with AmeriHealth Caritas Louisiana.

2.10.10
Utilization Management

"On the Move," presented by AmeriHealth Caritas Louisiana, is a series of events that teaches adults and children how healthy activities can be fun.

AmeriHealth Caritas™
Louisiana

2.10.10 Utilization Management

AmeriHealth Caritas has over 35 years of experience applying Utilization Management (UM) principles, and has implemented these strategies in Louisiana since we first began serving the state over seven years ago. Our experienced and locally based UM staff are largely hired from the provider community, giving us a deep understanding and genuine appreciation for people we serve and our provider needs. We have established collaborative relationships with providers to reduce administrative burden, provide a user-friendly UM system to obtain authorizations, and address health factors impacting Louisiana's most vulnerable residents. As a result, AmeriHealth Caritas Louisiana delivers a well-established UM program that focuses on individualized treatment strategies, and provides a truly integrated, evidence-based, person-centered approach, encompassing physical and behavioral health, pharmacy, and social services. We will continue to maintain industry standard UM policies and procedures that comply with state and federal policies and regulations, the Louisiana Department of Health (LDH) requirements set forth in **Model Contract 2.12, MCO Manual 2.12**, the Louisiana Medicaid Provider Manual, and National Committee for Quality Assurance (NCQA) standards.

*Our UM department **received the highest scores among MCOs evaluated in the LDH 2018 Medicaid Managed Care Provider Satisfaction Survey**, receiving positive results for access to staff, review criteria for adverse determinations, and timeliness of the appeals process.*

2.10.10.1 AmeriHealth Caritas Louisiana's Authorization Process

AmeriHealth Caritas Louisiana's authorization process provides a streamlined, comprehensive, integrated mechanism for consideration of services in a timely, cost-effective manner. Non-urgent and urgent requests for new and ongoing authorizations are reviewed to ensure appropriateness of care and consistent decision making. Existing prior authorization, concurrent, and post authorization policies for processing requests align with the LDH definition of medical necessity, and are in accordance with the Service Authorization section of **Model Contract, 2.12.6**, and 42 C.F.R. §438.210 requirements.

*As an enhancement to our request process and to meet provider needs, **AmeriHealth Caritas Louisiana is adding InterQual Connect to our Provider portal by the end of 2019.** This new feature automates authorization requests and provides real-time, immediate responses.*

Processing Service Authorization Requests

Requests for authorizations may be submitted to our UM department by phone, fax, written request by the provider or enrollee, or electronically via the Provider Portal. Our process begins with identifying eligibility and covered services, along with proactively reaching out to obtain sufficient clinical information from the requesting provider, to ensure appropriate clinical decision making. Information we collect for authorization, in accordance with 42 C.F.R. §456.111 §456.211 and the **Model Contract, 2.12.1.27**, includes, but is not limited to, enrollee name, ID number, date of birth, name of physician, planned dates of service, plan of care, clinical information related to initial service and subsequent continued service, dates of any planned procedures, and justification of emergency admission, if applicable. Our qualified staff, including nurses, Licensed Mental Health Professionals (LMHPs) and substance use clinicians, review, document, and approve requested services in a timely manner to accommodate clinical urgency and minimize disruption in the provision of health care.

If sufficient clinical information is not available, our UM department contacts the treating provider to request additional information for purposes of making a determination in accordance with **Model**

Contract, 2.12.11.1. If the treating provider does not provide complete medical history, or if our UM associates are unable to establish medical necessity, they refer to a psychologist or physician for final determination. Our Medical Directors may consult with an external physician reviewer specializing in the services requested or engage in peer-to-peer review with the treating provider prior to making authorization determination. This process offers providers the opportunity to discuss requested services and/or engage in case consultation, as needed. Any decision to deny or authorize a service in an amount, duration, or scope less than what is requested, is made by an AmeriHealth Caritas Louisiana Medical Director or physician designee, and based on medical necessity criteria. AmeriHealth Caritas Louisiana makes these decisions only after evaluation of individual clinical history and health needs, and as needed, consultation with the treating provider. If a service or provider is not available, UM staff may approve alternative, out-of-network services to ensure enrollees obtain the right care. We offer requesting providers to have determinations reevaluated through our informal reconsideration process. This provides an opportunity for the provider to speak with our physicians about the denial and ensure all information is being considered. We promptly notify providers and enrollees of decisions in writing via a Notice of Action, consistent with requirements and time frames in **Model Contract, 2.12.9.4**, 42 C.F.R §438.404, §438.10, §438.210, and § 438.402.

Timing Of Service Authorization Decisions

AmeriHealth Caritas Louisiana UM staff review service authorization requests in compliance with federal regulations and NCQA standards for timeliness of service authorization decisions. Time frames in which we process standard, expedited, and post-service authorization requests, along with new contract guidelines to send written notifications, are in accordance with **Model Contract, 2.12.9** and completed within a timely manner to accommodate clinical urgency, ensure accuracy, and minimize potential disruption in care. Automated features in our Integrated Population Health Platform enable us to manage compliance with decision time frames. UM work queues display determination due date and priority of the request. We measure performance via monthly reports to identify and address any compliance barriers. For the past two years, AmeriHealth Caritas Louisiana demonstrated compliance with contract requirements and received higher than average results for UM decision timeliness, as evidenced by Medicaid Managed Care program transparency reports.

Other Authorization Considerations

We understand the importance of being actively involved and taking a proactive approach to ensure our enrollees are receiving the most appropriate care in the most appropriate setting. This is evidenced by our process for authorizing Psychiatric Residential Treatment Facilities. AmeriHealth Caritas Louisiana's UM department and Behavioral Health Medical Director are actively involved and take a hands-on approach as soon as referrals are received. We know that moving a child from a home setting in their familiar community into a Psychiatric Residential Treatment Facility is difficult. We believe these placements should only occur when all other options and resources are unsuccessful. Authorization for a Psychiatric Residential Treatment Facility placement begins with making sure enrollees have been connected to Coordinated System of Care (CSoC) services in accordance with **Model Contract, 2.12.1.21**. Based on enrollee symptoms, previous services, CSoC interventions and clinical history, we collaborate with the referring LMHP, community resources and other treatment providers in accordance with guidelines and time frames outlined in **Model Contract, 2.12.7** and **2.12.8.6** to identify alternatives to admission. If admission is determined clinically appropriate, our UM team generates prior authorization, including the Certificate of Need (CON) according to **Model Contract, 2.12.8**. Once authorization is given, the UM team identifies specific treatment issues and discharge criteria, and assists in locating and securing admission. Our behavioral health UM Specialists and Behavioral Health

Medical Director closely monitor and track enrollee progress. We collaborate with the Psychiatric Residential Treatment Facility Treatment team, the enrollee's guardian/family, and community resources, including but not limited to Department of Education (DOE), Department of Children and Family Services (DCFS), Office of Juvenile Justice (OJJ), CSoC and outpatient treatment providers, to coordinate a smooth transition and services upon discharge to the next level of care. Over the past year, 30 enrollees have been admitted, with an average length of stay of 146.5 days. Our goal is to provide the necessary level of care, safely transition enrollees to their home community as soon as possible, and ensure support to be successful.

Documenting Authorizations

AmeriHealth Caritas Louisiana's UM department documents authorization requests in our Integrated Population Health Platform. Documentation includes case number, requestor name, date, time, submission method associated with receipt of request, substance of request**,** including electronic copy of faxed or mailed documents, steps taken to review the request; the determination made, including the time, date, and the name and title of the person making the decision; rationale for the decision; and the time, date, and name of person notified. All notes contain the associates name along with credentials.

Figure 2.10.10.1-1 depicts the workflow from initial request to final disposition, including standard and expedited authorizations:

Figure 2.10.10.1-1: *Standard and Expedited Authorization Process Flowchart*

2.10.10.2 AmeriHealth Caritas Louisiana's Utilization Management Process

2.10.10.2.1 Criteria For Determination Of Treatment

Utilization Management Criteria

AmeriHealth Caritas Louisiana utilizes well-defined, nationally recognized review criteria that represent best practices, NCQA standards as identified in **Model Contract, 2.12.1.2**, support medical necessity, and are based on evidence-based clinical criteria to make objective, measurable UM decisions. Our criteria include:

- InterQual® Level of Care Criteria for Acute Adult, Acute Pediatric, Acute Rehabilitation, Subacute and Skilled Nursing Facility, Home Care, Outpatient Rehabilitation, and Chiropractic.
- InterQual® Care Planning Criteria for Pediatric, Adult, Procedures, and Durable Medical Equipment.
- InterQual® Level of Care Criteria for behavioral health: Adult and Geriatric Psychiatry, Child and Adolescent Psychiatry, and Behavioral health Procedures.
- American Society of Addiction Medicine (ASAM) for all Substance Use Disorder (SUD) levels of care.
- National Imaging Associates (NIA) radiology guidelines.
- Internal clinical policies and Louisiana Medicaid Provider Manual Criteria.

We, along with our Quality Committee, thoroughly review, evaluate, and periodically update criteria and clinical guidelines, and submit changes and UM reports to LDH for review and approval in accordance with **Model Contract 2.12.5**.

Applying Utilization Management Criteria To Determine Appropriateness Of Treatment

AmeriHealth Caritas Louisiana ensures consistent application of criteria to determine appropriateness of treatment through comprehensive staff training and Inter-rater Reliability (IRR) testing.

Staff Training — Our training program takes an innovative approach, beginning with a comprehensive competency-based orientation for all clinical and non-clinical UM associates. New hire orientation provides the platform to introduce new associates to the culture of AmeriHealth Caritas Louisiana, with a focus on history, vision, and mission. In addition to new hire orientation, role specific associate training is provided. This training provides a combination of classroom and hands-on practice focused on specific job duties such as procedures, processes, medically necessary criteria, and documentation guidelines. Every UM associate completes eight to twelve weeks of instruction. Additionally, we provide ongoing training which is a critical component of associate development, productivity, and satisfaction. Examples include InterQual updates and refreshers to maintain skills and knowledge of medical necessity criteria, training seminars, and peer-delivered training.

IRR Testing Process — UM clinical staff are assessed for consistency on application of review criteria quarterly, while physician reviewers are assessed twice a year, using the Inter-rater Reliability (IRR) process. Case scenarios for IRRs are developed by a certified InterQual clinical trainer and constructed to assess appropriate, consistent application of criteria, highlight new or existing criteria with nuanced interpretations, and focus on at least one case reflecting a denial. Annual InterQual update training is held for all associates to ensure staff awareness of changes and appropriate application of new criteria sets. The established standard IRR test score for each individual clinical associate is 90 percent or greater. Associates who score less than 90 percent are offered a re-take. If an associate scores below 90 percent on the re-take, remediation training is provided. At the end of training, associates are given a 10 question IRR; if a passing score is not obtained, management begins re-education related to InterQual criteria reviews. **Figure 2.10.10.2-1** provides results of IRR testing for clinical staff in 2018.

IRR Testing 2018	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Concurrent Review Nurses	94%	97%	98%	96%
Precertification Nurses	97%	98%	98%	98%
Physicians	97%	N/A	96%	N/A
Appeals staff	93%	100%	100%	95%
Behavioral Health staff	97%	98%	94%	99%

Figure 2.10.10.2-1: *2018 IRR Results.*

Applying Utilization Management Criteria To Determine Appropriateness Of Site

With over seven years of experience providing Medicaid managed care to enrollees in Louisiana, our UM staff has a deep understanding of the local standard of care and is uniquely positioned to effectively assess appropriate level of care, availability of services, and provider location in the areas we serve. Our primary goal is to ensure enrollees receive high quality, clinically appropriate services at the right level of care, in the right place. UM staff review clinical information provided and apply nationally recognized, evidence-based clinical criteria in a manner customized to the enrollee including complications, comorbidities, psychosocial situation, and home environment to help guide decisions. We work closely with local delivery systems to build and foster positive relationships, and maintain a comprehensive provider network of physical and behavioral health providers to address individual enrollee health care needs. These relationships allow our UM staff and Medical Directors to collaborate more effectively with providers, and identify which provider best meets our enrollees' placement needs.

Reviewing Utilization Management Criteria

In addition to ongoing training and evaluation activities, our UM medical leadership is responsible for reviewing clinical guidelines and criteria as part of their daily responsibilities, to ensure basic components of UM operate in accordance with LDH requirements. Our Quality Assessment and Performance Improvement Committee (QAPIC) oversees: the UM and Quality Management programs, the Quality of Clinical Care Committee (QCCC), which serves as our formal UM Committee (UMC), as well as our utilization review and prior authorization activities and UM functions that are delegated to other entities. The QAPIC, chaired by our Chief Medical Officer, includes physical and Behavioral Health Medical Directors; several participating local providers such as family practice physicians, pediatricians, cardiologists, nurse practitioners, and clinical social workers; as well as other key management staff. On a quarterly basis and as required in accordance with **Model Contract, 2.12.3**, QAPIC and QCCC/UMC meet to review all aspects of UM, including nationally accepted utilization criteria such as InterQual and the American Society of Addiction Medicine (ASAM), and provide recommendations regarding future strategies and improvements**.** This committee also reviews consistency with standards of care in professional groups along with review of utilization data, over-and underutilization outliers, effectiveness of UM activities, and application of medical necessity, to promote quality of care in the most appropriate setting and develop a strong evidence-based UM program.

Reviewing Medical Records

To ensure providers are documenting according to established standards, we conduct medical record reviews to measure compliance with medical necessity and clinical guidelines in accordance with **Model Contract, 2.12.2, 2.12.4**. Standards are outlined in our provider contract, are distributed to providers and their staff, are included in the Provider Manual, and appear on our website. As with other profiling processes, medical record audits present an opportunity to identify trends, issues of concern and areas for improvement. Our Provider Network Management team and Quality department collaborate to design network-level education and initiatives to improve documentation compliance. Performance summary

reports are presented to QAPIC for review and recommendations. We report medical records review results quarterly to LDH in accordance with **Model Contract, 2.12.4.5**. Provider Network Management works with sites falling below expected performance benchmarks, to improve documentation processes. We provide peer-to-peer counseling and implement a corrective action plan prior to a follow-up review in six months. Well-documented medical records facilitate communication, coordination, continuity of care, and efficient and effective treatment.

2.10.10.2.2 Monitoring And Addressing High Emergency Department Utilization

Monitoring High Emergency Department Utilization

Reducing inappropriate Emergency Department (ED) utilization is a priority for both LDH and AmeriHealth Caritas Louisiana. We have worked aggressively to reduce high ED utilization through our existing processes and active programs. To assist in this initiative, we continuously monitor data to identify high and inappropriate ED utilization through a number of different methods.

*Through our multi-pronged approach, **AmeriHealth Caritas Louisiana decreased ED visits/1000 enrollees by 6%**, despite the prevailing trend of increasing ED utilization seen across Healthy Louisiana in 2015.*

Using Admission, Discharge, And Transfer (ADT) Feeds To Identify Enrollees With High ED Utilization —AmeriHealth Caritas Louisiana uses ADT feeds to have timely access to enrollee's utilization of hospitals for ED visits. Our ADT feeds allow us to provide notification to Case Managers as well as referrals to the Rapid Response team, so they can quickly engage enrollees to better determine the reasons for ED use and identify any needs. We have built functionality to direct these alerts to the Provider Portal where a primary care provider (PCP) can identify enrollee ED usage on a daily basis. In 2019, AmeriHealth Caritas Louisiana is slated to be the first Medicaid Managed Care Organization (MCO) to go live with utilization of a new ADT feed, offered through the Louisiana Hospital Association. This relationship will allow new functionality including real-time notifications, more complete clinical information, and an ability to share assigned case manager information for hospital ED staff to use for discharge planning. (**Model Contract, 2.19.3.5)**.

Identifying Enrollees With High ED Utilization Using Predictive Modeling — We identify enrollees as emerging or high-risk for high ED utilization by analyzing ED trends, using predictive modeling, risk-scoring analytics, and referrals from providers. We integrate information from health needs assessment (HNA) results, claims, laboratory results, eligibility files, and third-party data (poverty index and distance mapping).

Identifying Potentially Preventable ED Visits (PPV) — We use 3M's Potentially Preventable Events (PPEs) algorithm for identifying enrollees, as well as other internally defined at-risk populations and target enrollees, with ED visits and complications.

Addressing High Emergency Department Utilization

Addressing high ED utilization begins with a comprehensive understanding of specific issues challenging Louisiana enrollees. With over seven years' experience in the area, we recognize the importance of identifying and targeting high-risk individuals, addressing root causes of barriers to improved health, monitoring health status and adherence to care, pinpointing care gaps, and providing person-centered plans of care that consider the complexities of each enrollee, to help minimize avoidable ED utilization. Common reasons given for ED utilization include access (nights, weekends, physician office not open, etc.), social factors (homelessness), and behavioral health comorbidities (mental illness, opioid prescription, substance use). AmeriHealth Caritas Louisiana utilizes a multi-pronged approach to reduce high ED utilization. These processes include, but are not limited to:

Rapid Response Team (RRT) — RRT consists of care connectors, who support call center functions and case managers. They receive inbound calls and perform outreach to promote healthy choices and close important care gaps, such as screenings, arranging health care appointments and transportation. The team will address immediate enrollee needs, verify that enrollees are established with a health care provider, and refer enrollees to complex care management for continued care coordination services. The Rapid Response toll free phone line is available to all plan enrollees and providers. **In 2018, RRT efforts for successful enrollee engagement contributed to a 23 percent decrease in unnecessary ED visits.**

Urgent Care Network Expansion — In 2018, AmeriHealth Caritas Louisiana expanded our urgent care network by 64 percent to 104 urgent care centers. Targeted expansion efforts were based on geography and ED utilization data. This expansion provides enrollees with options for conditions that can be treated by a care provider in a non-ED setting and allows us to divert PPVs to a more appropriate site of care. **Early analysis of this effort shows positive results, with a 5 percent reduction in PPVs.** PPV rates from October 2016 to September 2018 dropped from 679 to 649, per 1,000.

ED High Utilizer Diversion Program — Through our ED Diversion program, enrollees seeking ED services receive telephonic outreach from the RRT. Team Care Connectors outreach to enrollees that are low risk (using claims data) and to enrollees that are high utilizers (using data from ADT feed). Team Case Managers outreach to enrollees with the highest ED cost, monitor ED activity closely, and provide episodic follow-up with these enrollees. Focus is on PCP follow-up post ED visits, and education on how and where to seek appropriate levels of care. Health risk surveys are completed to assess enrollee needs and drivers of ED care, address SDOH, offer resources, and appropriately refer enrollees to complex care management. **Among ED utilizers enrolled in 2018, there was a decrease of 26.03 percent in ED costs, and 29.87 percent in ED utilization.**

The Care Extender Pilot ***resulted in a 46% reduction in preventable inpatient re-admissions, a 26% reduction in preventable ED visits, and a 16% increase in PCP visits for engaged enrollees.***

Care Extender Program — We offer a fully evidence-based solution to reduce frequency of ED visits through our Care Extender program. This program was piloted in Northern Louisiana to connect enrollees with targeted care management, and to promote community stabilization and success in connecting to outpatient providers. Referrals are based on a list of enrollees with high frequency of behavioral health admissions and ED utilization. Care Extenders are available to the enrollee 24/7 via telephone, text message, and face-to-face to address additional concerns. The goal is to teach enrollees to self-advocate for their needs. Upon completion of the program, enrollees are transitioned into Case Management for on-going supports and services.

SMART Reports — Daily reports incorporate information from ADT feeds, are utilized by care management and rapid response teams to identify enrollees with hospital admissions, transfers and discharges, and facilitate rapid follow up with enrollees to ensure appropriate follow-up after ED visits and hospitalizations. They have been successful in reducing readmissions to the ED.

Telemonitoring — Our telemonitoring solution provides digital mobile disease management and data analytic services to enrollees. Engaging enrollees in self-management using telemonitoring not only supports quality care, but also increases access, enhances communication, and allows earlier detection of key clinical warning signs. Our telemonitoring platform uses mobile applications, remote biomonitoring, and real-time operational analytics to support better care, better health, and lower costs. Since starting this program, preventable ED visits decreased 35 percent in participating enrollees.

"Carl" had a heart attack at 57 due to congestive heart failure; he was diagnosed with diabetes and a thyroid condition at the time of his heart attack. He started using the telemonitoring program on March 21, 2018. During regularly scheduled appointments, the health coach has helped him change his diet, allowing him to achieve his goal weight of 183 pounds. Carl learned to monitor his health using our devices for blood pressure, glucose, oxygen, and weight. Twelve months prior to joining the program, he had four ED visits and his average PMPM was $3,435.73. Since joining the program, Carl's ED visits have decreased to 0 and his average PMPM cost is now $179.85.

Community Paramedicine Services — In the next contract period, AmeriHealth Caritas Louisiana is committed to adding a new level of care by providing community paramedicine services to enrollees through agreements with organizations like Mobile Healthcare by Acadian and Ready Responders. The program is designed to encourage appropriate use of emergency services, reduce unnecessary hospital readmissions, and improve patients' ability to manage their health. Our approach leverages an on-demand, mobile workforce of emergency medical technicians (EMTs), paramedics, and other health professionals to respond and deliver services to enrollees in their homes and ensure they get the care they need.

Behavioral Health Telemedicine — This program is for enrollees who are in need of a Psychiatrist or Psychiatric-Mental Health Nurse Practitioner (PMHNP) for an evaluation or medication management, a behavioral health follow-up after hospitalization, or who are eligible to receive behavioral health telemedicine services. Two different models are available. The in-home model, implemented March 1, 2018, offers a trained technician, including, but not limited to, EMT, licensed practical nurses (LPN) and registered nurses (RN), sent to the enrollee's home to verify their identity and conduct vitals. The technician utilizes a mobile device to connect the provider and enrollee virtually, and serve as support during the session. The kiosk model, implemented April 1, 2018, provides enrollees access to over 100 kiosks, located in clinics throughout Louisiana. Enrollees can go to any local kiosk and receive services. Behavioral health telemedicine increases provider network capacity to provide on-going care.

Embedded Discharge Transition Case Manager — Our Embedded Discharge/Transition Case Manager works in select hospitals and completes face-to-face visits with hospitalized enrollees to address discharge needs. The Case Manager addresses discharge barriers, coordinates with UM and hospital staff, assists with transitions to the next level of care, and connects enrollees to RRT, Case Management, and Community Care Management Teams for additional post-discharge support. We help schedule follow-up appointments and link enrollees to community resources. By engaging enrollees early and providing hands-on support, we decrease unnecessary hospital admissions and reoccurring ED visits.

Certified Peer Support — We know that enrollees often need a continuum of peer support and follow-up care after being discharged from an inpatient setting. When enrollees transition from one level of care to another (such as from inpatient back to the community) without assistance to help them stabilize in their new environment, they are at high risk for ED visits and readmission to a behavioral health facility. We offer seven and 30-day follow-up support to our enrollees after a behavioral health inpatient stay. Our certified Peer Support Specialists engage enrollees in care prior to discharge, to coordinate community-based resources, engage natural supports, and provide health education to ensure enrollees have everything they need to be successful upon discharge. Additionally, our Network prescribers assist with medication management post-discharge appointments via telehealth, which is offered in the manner most convenient for the enrollee (nearby clinic, smart device, or equipment brought to their home). **A summary of 2018 results for enrollees who received peer support revealed a 47 percent increase in PCP visits, a 27 percent reduction in avoidable ED visits, a 54 percent reduction in avoidable inpatient admissions, and a 24 percent overall reduction in medical and pharmacy costs**.

Community Health Workers (CHWs) — AmeriHealth Caritas Louisiana's CHWs play a critical role in improving and extending health care coordination through face-to-face activities such as health education, community navigation, and supporting enrollees during care transition to decrease reoccurring ED visits. The CHW team follows up with enrollees in the community to communicate information from their care manager and assist them in understanding their services and benefits. For example, a CHW may assist in scheduling follow-up appointments or help obtain linguistically appropriate answers to questions related to next steps after being discharged from the hospital or ED. Our goal is to engage these enrollees, identify, and attempt to resolve barriers to care, and reduce ED utilization for improved health outcomes.

Our approach resulted in improved health outcomes as evidence by an overall reduction in ED admissions, re-admissions, and visits. **By the close of 2018, our efforts contributed to a 7.5 percent decrease in potentially preventable admissions (PPAs), a 9.5 percent decrease in potentially preventable readmissions (PPRs), and a 4.3 percent decrease in PPVs**.

2.10.10.2.3 Pre-Admission Screening And Concurrent Reviews

From the point of admission, AmeriHealth Caritas Louisiana's UM review nurses and behavioral health clinicians collaborate with facility case management and UM staff prior to and throughout inpatient stay, to coordinate care and provide appropriate services. To help simplify this process, we work with willing providers to gain access to enrollee Electronic Health Records (EHR) so that data is available to our UM department, thus easing provider administrative burden.

Pre-Admission Screening — UM collaborates with providers to pre-screen and collect information in accordance with **Model Contract, 2.12**, to determine medical necessity for approval in advance of providing services through our prior-authorization process. We review to confirm efficient use of covered services; determine the requested service is the appropriate level of care; and ensure care is delivered in the most appropriate setting. For example, we engage in completing prior-authorization for our Psychiatric Residential Treatment Facility process to determine out of home placement is the most clinically appropriate option, prior to services being provided.

Concurrent Review — Our UM associates perform concurrent reviews telephonically, by fax, through the Provider Portal and/or via access to enrollee EHR, per provider preference. The concurrent review process examines enrollee information to determine appropriateness of treatment, level of care, continued stay, and expected needs at discharge. We know discharge planning is a key component of our concurrent review process. Our Dedicated Discharge Planner ensures enrollees are prepared for a safe transition to the next level of care and/or back into the community. If needed, we assist enrollees with setting up post-delivery meal services through our Food as Medicine program. Our Respite care program supports our homeless enrollees that may have post-acute medical needs. By providing support and services to enrollees post-discharge, we are able to increase community transition success and reduce readmission. Once medically necessary criteria are met, UM clinicians approve requested coverage for admission or continued stay. If UM is unable to approve admission or additional days, we refer to our Medical Director, Behavioral Health Medical Director, or physician for review and determination. If services are approved, the UM clinician will document approval and communicate with the facility or treating physician. In situations where medical necessity is not met for continued stay, but an enrollee has complex medical needs which render it difficult to transition to a lower level of care, our clinical team will continue to approve acute inpatient stay until an appropriate lower level of care can be found.

Pharmacy Prior Authorizations

Pharmacy authorizations are handled by pharmacists at our pharmacy benefits manager (PBM) using LDH's prior authorization criteria. Methods of accepting prior authorizations, reviewing, and making timely

decisions are completed in compliance with directives stated in **CFR 438.3 (s) (6)** and **MCO Manual, 2.12.5**. In recent months, AmeriHealth Caritas Louisiana has lessened administrative burden of prior authorizations by expanding the number of prior authorizations that can be completed online and render an immediate decision. We have created a Gold Card program in which providers with a high prior authorization approval history are allowed to prescribe specific medications without prior authorization requirements being applied.

2.10.10.2.4 Complying With Mental Health Parity Requirements

AmeriHealth Caritas Louisiana's UM team ensures our enrollees receive timely, medically necessary, and appropriate care to maintain and improve overall health in accordance with the Mental Health Parity and Addictions Equity Act. As a result of the December 2015 behavioral health carved in, we integrated medical and behavioral health policies and procedures to ensure parity as well as consistency for internal and external partners. In addition, our QAPIC, UM, Medical Management, and Quality Management experts began reviewing the list of services requiring preauthorization annually, including an analysis review for parity between behavioral health and physical health services. We use the same processes, strategies, evidentiary standards, systems, and timelines in applying non-quantitative treatment limitations to behavioral health benefits and prescription medications as to medical benefits in accordance with federal laws and regulations set forth in 42 C.F.R. 438.905 and 438.910 on Mental Health Parity and Addictions Equity Act, and **Model Contract, 2.3.11.1** and **2.3.11.2**.

In 2017, we completed thorough parity assessments. Findings confirm that we were in compliance with the Mental Health Parity and Addictions Equity Act and no areas of concern were identified. AmeriHealth Caritas Louisiana's success with parity assessments is reflective of our dedication to comply with and monitor the Medicaid managed care parity rule for financial requirements, quantitative and non-quantitative treatment limitations, and availability of information in Louisiana. AmeriHealth Caritas Louisiana will continue to comply with all requirements set forth in 42 C.F.R. Part 438 Subpart K and **Model Contract, 2.3.11**.

We provide fully integrated services between enrollee physical, behavioral, pharmacy, and social support needs. Along with solutions to address social needs, we maintain consistency and drive internal controls for parity in our processes for prior authorization and medical necessity decisions. Our criteria is available to any current or potential enrollee, or contracting provider, to the fullest extent allowed under contractual and proprietary restrictions related to InterQual® and ASAM criteria. By current processes and policy, the specific reason for all medical necessity and benefit denials is delineated in the written notice of adverse benefit determination to enrollees and providers. Access is made available to locations, facilities, records, and files of our processes for review, when required.

2.10.10.2.5 Identifying And Mitigating Over-Utilization

Identifying Over-Utilization

We recognize that managing over-utilization is critical to controlling costs from adverse health events and inappropriate utilization of services, while maintaining quality of health care services. Our UM program is backed by sophisticated data analytic platforms and staffed with experienced integrated clinical UM teams to ensure enrollees receive access to timely services and appropriate evidence-based care. AmeriHealth Caritas Louisiana uses robust analytics to monitor over-utilization of all services, with a particular focus on high-cost services to identify emerging risk enrollees, improper utilization, and fraud. We analyze claims, authorizations, utilization, and health outcomes to help coordinate care and connect enrollees to needed services and supports to improve health and reduce costs.

Mitigating Over-Utilization

AmeriHealth Caritas Louisiana employs several UM initiatives to reduce over-utilization including:

- **Prior Authorization And Medical Necessity Review** — We review presenting conditions to determine if services are medically necessary, covered by the enrollee's benefits and promote delivery of quality care in the most appropriate setting.
- **Peer-To-Peer Review** — Our Medical Directors provide the requesting practitioner and Medical Directors an opportunity to collaborate and discuss medical necessity for care being requested.
- **Medical Necessity Review For High-Cost Procedures (e.g. Imaging)** — Our licensed specialists review high-cost services that result in a sustained reduction in high-cost procedures per enrollee.
- **Fraud, Waste, And Abuse (FWA) Monitoring Activities** — We report suspected FWA to the Special Investigations Unit, who investigates and reports, as appropriate, to the LDH Program Integrity Unit. AmeriHealth Caritas Louisiana uses reporting and data to identify opportunities to avoid unnecessary over billing and overutilization. Trends in overutilization of certain procedure codes, such as pharmacies overcharging for alcohol swabs, have led to more stringent pre-and-post authorization requirements, including maximum reimbursement edits where appropriate.
- **Inter-Rater Reliability Testing** — We evaluate UM activities and documentation at individual and team levels to ensure consistency and accuracy in the application of medical necessity.
- **Value-Based Provider Incentives** — AmeriHealth Caritas Louisiana developed our Quality Enhancement program (QEP), in 2014. This program, as well as our entire suite of PerformPlus® value-based models, measures and incentivizes cost and efficiency, in addition to quality care. We are expanding this program in 2019 by adding a total cost of care evaluation that will further incentivize providers to support enrollees in reducing inappropriate utilization patterns.
- **Mental Health Rehabilitation Report** — Our behavioral health team developed and implemented an internal audit of Mental Health Rehabilitation providers to determine if quality and requirements for staff and agency services, stated in the behavioral health Provider Manual, were met in each record. Audit results are reviewed based on identified deficiencies; decisions are then made to mandate corrective action plans (CAPs) or retain providers in network. Our goal is to identify potential FWA, increase quality of services provided, and reduce utilization of services that are not medically necessary.

2.10.10.3 AmeriHealth Caritas Louisiana's Utilization Management Experience

With more than seven years of experience in the state, we have a deep understanding of the unique health care needs of Louisiana communities, and develop individualized models, programs, and practices to successfully help enrollees access high-quality care needed to best improve their health. Our parent company, AmeriHealth Caritas, has been managing Medicaid programs for more than 35 years, currently serving approximately two million Medicaid managed care enrollees. Over time, we expanded services to provide managed care solutions for Medicare and Children's Health Insurance Program (CHIP) programs to address physical health and behavioral health, pharmacy benefit management, specialty pharmacy, and long-term services and supports (LTSS) for the underserved and chronically ill. AmeriHealth Caritas Louisiana benefits from the expertise, shared systems, and capabilities of its parent organizations and affiliate health plans.

2.10.10.3.1 High Utilization And Increasing Medical Trend Challenges

AmeriHealth Caritas Louisiana monitors utilization and medical trends on an ongoing, routine basis. We find that enrollees who are high utilizers are a significant driver of the increasing medical trend, but only

one part of the challenge. We outreach to high utilizers for care management, often through our Community Care Management team (CCMT). Challenges with high utilizers include locating the enrollee due to housing instability, enrollee acceptance of care management services, multiple complex conditions, and behavioral health or substance use issues. We work to address their challenges, whether medical, behavioral, social, or pharmaceutical, that affect utilization and cost.

The increasing medical trend is related to enrollee actions, provider actions, and the rising unit cost of services, especially in specialty pharmaceutical medications. Through data analysis, increasing trends identified in Louisiana include: ED utilization, behavioral health inpatient admissions, and opioid use, along with high and inappropriate use of lab urine drug screenings. These trends have been challenges. In fact, Louisiana has some of the highest per thousand ED utilization in the country. Our experience has given us the ability to customize solutions to meet enrollees and providers where they are, allowing us to better develop targeted initiatives that provide better health care. For example, to address high and inappropriate use of lab urine drug screening, AmeriHealth Caritas Louisiana performed data analysis to identify aberrant utilization patterns for drug testing. Excessive and indiscriminant testing was linked to certain lab providers. In some cases, remediation resulted in improved performance. In others, separation from the network was necessary. This intervention reduced lab spending by $1.62 PMPM. Additionally, our PerformPlus programs reward providers whose efforts demonstrate efficiently managed care transitions. We reward providers who positively impact avoidable ED utilization. We implemented an enhanced provider reimbursement campaign through which providers receive incentives for services that can be appropriately treated in a non-emergency setting. We have seen a nine-percent reduction in PPVs.

2.10.10.3.2 Managing High Utilization

AmeriHealth Caritas Louisiana utilizes our experience to tackle increasing medical trends and reduce high utilization and lower health care cost. Our key activities include but are not limited to:

Hospital Outpatient Program Extension (HOPE) — This program mirrors an intensive outpatient program with covered benefits to offer a step-down or diversion from inpatient behavioral health services. Treatment is supportive and offers immediate access to aftercare counseling, family session, and medication management assistance. Our goal for this program, which started in 2018, is to stabilize enrollees and prevent ED admissions.

Pharmacy Lock-In — We ensure the appropriate use of Medicaid prescription benefits via a Pharmacy Lock-In program, when evidence indicates enrollees have needs related to prescription medication use. Enrollees are identified using pharmacy utilization data or referrals and are locked in for one year. We currently comply with the **MCO Manual** by utilizing LDH-provided letter templates, providing ample enrollee notification and appeal rights and allowing provider changes. Even though our current program is a Pharmacy only lock-in, we are prepared to incorporate provider lock-in as well. Our pharmacy system is capable of handling both types of lock-ins by providing appropriate messages at point-of-sale (POS).

Behavioral Health Program — This program is designed to provide community-based services to support enrollees in the community, and identify and address high utilization needs. We deploy a Care Specialist team (an interdisciplinary team of health care professionals of multiple license levels) to meet with enrollees in person at their home, by telemedicine, or elsewhere, to provide support needed to keep them out of the ED and institutional care.

ED Reduction Strategies — We implemented numerous ED reduction strategies, including our ED diversion, Urgent Care Centers, Care Extender, and telemonitoring programs, to reduce incidence of non-emergent ED use as further described above in response to **Question 2.10.10.2.2**.

Short Stay Admission Review — Inpatient admissions were reviewed to identify high utilization of inpatient stays of one or two days, to a set of ambulatory care sensitive conditions. A significant number of admissions were identified where care provided could have been safely and appropriately administered in an outpatient setting. To reduce this inappropriate inpatient utilization and improve outpatient management, we implemented a process where requests for inpatient admissions are routed for review through our Medical Director for potential peer-to-peer consultation to determine the most appropriate level of care before authorization is provided.

Community Care Management Team (CCMT) — Amplifies traditional care management continuum by providing high-touch, face-to-face engagement for enrollees with complex care needs including over-utilization of acute services as their primary source of care. CCMT provides information and coordination with other health plan staff and services, as well as providers in the community. The team provides care management and coordination to help navigate and increase access to needed medical, behavioral health and social services, resulting in reduction in ED utilization and inpatient admissions.

2.10.10.3.3 Addressing Low Value Care Use

AmeriHealth Caritas Louisiana has put initiatives in place to promote conversations between providers and patients, and ensure that care is supported by evidence to make sure enrollees are not at risk for receiving low value care, **Model Contract, 2.16.2.3.3**. We review existing research sources, clinical criteria and policies, clinical and technical literature, and consult with board-certified providers from appropriate specialties or professional organizations to identify appropriate industry standard approaches to care. All clinical policies and guidelines are available on our provider website and Provider Portal. We incorporated the Choosing Wisely® initiative, a nationally recognized campaign, in our efforts to reduce unnecessary spending in low value care and strive toward evidence-based, cost effective, and patient-centered care. We analyze over 500 specialty recommendations for applicability to our enrollees and programs. The scope of the recommendations is far and wide, and many recommendations are embedded in our existing programs. For example, our radiology benefit manager submits high-tech imaging requests to evidence-based review criteria and tracks radiation exposure by enrollee. Requests for cough and cold medication, which can be harmful to children, are scrutinized by our pharmacy benefit manager. Bright Start®, our prenatal program, combs medication data for pregnant enrollees for harmful medications, including opioids.

We continuously review our current programs for potential improvement. The following are currently in development or under consideration: review of sinus X-rays, lumbar spine imaging in uncomplicated low back pain, pap tests performed before the age of 21 or annually thereafter, HPV testing before the age of 30 or annually thereafter, vitamin D testing in children and vitamin D screening without serious comorbidities in adults, androgen therapy in low testosterone levels, use of back braces in chronic pain, surgical deactivation of migraine trigger points, passive motion devices following uncomplicated knee surgery, and use of expanded lipid levels. Each of these initiatives is under review by medical management. Any new test or procedure reviewed as part of the Choosing Wisely initiative is intended to generate a conversation between provider and enrollee about what is the safest, most appropriate and necessary treatment, given the enrollee's condition. Introduction of any new initiatives depends on the ability to achieve the goal of the Choosing Wisely initiative, without imposing undue prior authorization burdens on the enrollee or provider or limiting access to tests and procedures. We communicate this information to providers via education seminars or fax blast, and to enrollees via newsletter and website.

2.10.10.3.4 Addressing Long-Term Emergency Department Visits

AmeriHealth Caritas Louisiana focuses on a targeted, evidence-based approach to reduce long term ED visits due to limited availability of behavioral health services. By having community based crisis services to de-escalate, we can complete comprehensive assessments and make treatment recommendations in the community and avoid ED and inpatient admissions. Initiatives include:

- **Crisis Continuum Of Care** — As part of the crisis system of care model, AmeriHealth Caritas Louisiana is currently in the process of working with Compass Behavioral Health to develop a crisis stabilization unit. This unit will accept enrollees directly, avoiding the need for an ED visit, with the goal of de-escalating the crisis within 24 hours. ED utilization for behavioral health emergencies could be dramatically reduced.
- **Behavioral Health Crisis Line** — Our crisis line is a best-in-class, nationally-recognized, American Association of Suicidology-accredited, Louisiana-based crisis line, available 24/7/365. Calls are answered within 30 seconds by an Enrollee Services Crisis Intervention Specialist. The Crisis Intervention Specialist assesses crisis risk and provides rapid, solution-focused therapy to stabilize the caller over the phone. If a caller is unable to be stabilized over the phone and presents imminent danger to self or others, a crisis mobile team is dispatched, where locally available, to meet the enrollee in the community and provide in-person intervention, or 911 is called. This degree of local investment offers enrollees experiencing a behavioral health crisis the ability to de-escalate their current presenting issue and avoid going to the ED.
- **Community-Based Support Program** — AmeriHealth Caritas Louisiana is partnering with an independent provider practice to deliver whole-person health to enrollees who are high utilizers of acute ED and inpatient services. The program covers physical and behavioral health, and addresses social support needs. The practice leverages a team of community-based Care Specialists who connect to a multi-disciplinary team of clinicians via telemedicine, allowing the provider to diagnose and treat enrollees in their homes. Outcomes are expected to deliver between 35 to 50 percent reductions in ED utilization, as demonstrated in other markets served.
- **Medication Adherence** — Our PBM activities are conducted in-house by our affiliate PerformRx℠, and are fully integrated with our physical health and behavioral health coordination efforts. Pharmacists provide information, support services, and resources to educate enrollees about their medications and improve regimen adherence. Pharmacists perform utilization review activities to ensure prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical consequences. Our Population Health management platform uses built-in alerts to identify non-adherent enrollees, signaling the Care Management team to proactively intervene when necessary. Keeping enrollees on their medications, helps keep them out of the ED, thus preventing long-term ED stays.

Phoenix Family Life Centers averaged a 16% denial rate for Mental Health Rehabilitation services due to not meeting medical necessity over the last year. Phoenix Family Life Centers averaged a 16% denial rate for Mental Health Rehabilitation services due to not meeting medical necessity over the last year. AmeriHealth Caritas Louisiana psychologists and behavioral health UM clinicians provided support and education to help improve documentation, and ensure appropriate levels of care were being provided. Since then, they now call our behavioral health UM clinicians to consult when considering transition to a higher level of care, avoiding receipt of a denial determination. In the span of a quarter, their denial rate has decreased approximately 50%.

- **Provider Education** — We support development of strong provider relationships. Initial and ongoing training is provided to ensure compliance with program and contract standards. In 2019, we introduced our Provider Learning Continuum training program to all providers and their staff. This education program meets providers where they are and seeks to move the provider along the continuum by providing education, core competencies, and practice transformation.

2.10.10.3.5 Supporting Providers With High Prior Authorization Denial Rates

AmeriHealth Caritas Louisiana recognizes that high denial rates can have tangible effects on our enrollees and providers. Our efforts begin with a proactive approach of outreach and ongoing education with providers and their staff. For example, when a prior authorization request lacks information necessary for determinations, our UM associates reach out to requesting providers to educate and obtain the specific information needed. We provide the opportunity for clinical consultation prior to denial, as well as education by clearly communicating the reasons for denial and how to prevent future denials. Over the past few years, we have participated in the Louisiana Hospital Association annual provider meeting where we discuss common denial reasons and educate on ways to prevent these from occurring.

To continue our support, we proactively outreach to our providers any time we make a change to prior authorization requirements. We alert our provider network of changes through fax blasts, electronic communication notices, and policies and procedures posted to our provider website and Provider Portal. Our provider-facing field staff review planned changes during routine provider site visits. We facilitate regular Joint Operating committee meetings with participating health systems to provide a forum for addressing and resolving topics identified as needing re-education, including issues related to denials.

We monitor weekly reports on service denials by volume and type of services as well as denial trends by network provider. UM collaborates with Provider Services and Support teams to conduct root-cause analysis and identify drivers of denial trends. When we identify a trend of increasing denials, our Provider Services and Support teams promptly identify drivers of the trend. If we identify drivers related to provider billing errors, we offer practice level support facilitated by our claims educator. If multiple providers are affected, we re-examine claim and authorization data to understand the services being utilized, and deliver broad-based education and training to our provider network. When we identify internal system configuration needs, we initiate a work request to correct issues immediately.

This page is intentionally left blank.

2.10.11
Quality

AmeriHealth Caritas Louisiana associates give their time to pack emergency preparedness kits at Catholic Charities of Baton Rouge.

AmeriHealth Caritas™
Louisiana

2.10.11 Quality

2.10.11.1 Advancing Louisiana Medicaid's Quality Strategy

AmeriHealth Caritas Louisiana has served Louisiana's Medicaid enrollees for over seven years. We currently meet and will continue to meet all requirements outlined in **Model Contract, 2.16** and **MCO Manual 2.16**. Our commitment to quality is evident in our culture of continuous quality improvement, our National Committee for Quality Assurance (NCQA) accreditation status of Commendable, and our NCQA Medicaid Health Insurance Plan Ratings. For the period 2018 – 2019, AmeriHealth Caritas Louisiana earned an overall 3.5 Quality and 4.5 Consumer Satisfaction rating.

Our daily quality management activities are performed by an experienced, and motivated team, led by Mary Scorsone, Director of Quality Management. Ms. Scorsone has over 15 years of experience overseeing quality activities for Louisiana's Medicaid programs. She was instrumental in designing, implementing and coordinating the initial Louisiana Medicaid quality strategy, and the initial Louisiana Managed Care Organization Quality Program. Her Lean Six Sigma Green Belt demonstrates her expertise in current improvement projects. Our leadership team also includes Chief Medical Officer (CMO), Rodney Wise, M.D., Quality Manager, Rhonda Baird, and Healthcare Effectiveness Data and Information Set (HEDIS®) Team Lead, Darla Ratcliff who bring a wealth of Louisiana Medicaid quality experience to our quality program.

For AmeriHealth Caritas Louisiana, quality management goes beyond our Quality Management and Quality Improvement (QM/QI) program. As an organization, we promote a culture of quality through plan-wide quality activities and communications and a "**quality is everyone's job" mind set**. We tailor our QM/QI activities to the needs of Louisiana's communities, providers, and enrollees.

Organizational Commitment To Quality Improvement

AmeriHealth Caritas Louisiana's quality management/quality improvement QM/QI activities are aligned with the Triple Aim and share the goals and objectives outlined in Louisiana's Medicaid Managed Care Quality Strategy, including:

- **Better Care** — Make health care more person-centered, coordinated, and accessible.
- **Healthier People, Healthier Communities** — Improve the health of Louisianans through better prevention and treatment and proven interventions.
- **Smarter Spending** — Ensure high-value, efficient care.

We have maintained NCQA accreditation since 2014, increasing our accreditation level at each review as shown in **Figure 2.10.11.1-1**. Furthermore, during our 2018 renewal survey we **achieved 49.93 points out of a possible 50** towards Health Plan Accreditation standards **(Model Contract, 2.16.14)**.

Our commitment to providing high-quality care for every enrollee is also evident in our NCQA Multicultural Health Care Distinction which was earned in June 2017.

Figure 2.10.11.1-1*: AmeriHealth Caritas Louisiana adheres to NCQA's road map for quality.*

Overall Approach

AmeriHealth Caritas Louisiana's blueprint for quality is founded on our organizational mission, **we help people: Get Care, Stay Well, and Build Healthy Communities.** With this mission in mind we have built a comprehensive quality program for Louisiana that does the following:

- Improves the quality and safety of physical and behavioral clinical care and services for enrollees.
- Systematically develops, monitors, assesses, and acts to improve access to care and quality of services.
- Promotes improved enrollee outcomes through monitoring and evaluation of the efficiency, effectiveness, and safety of the care and services provided to enrollees.
- Reviews data and identifies opportunities for improvement by using cross-functional teams to conduct barrier analysis and identify appropriate interventions, encompassing disparity reduction.
- Provides a seamless enrollee experience to improve satisfaction.
- Conducts thorough oversight of delegated services.

A comprehensive committee structure that provides strategic direction for our QM/QI program guides our quality efforts and ensures quality is an integral part of our operations **(Model Contract, 2.16.4)**.

Integral to our overall approach to achieving the goals of Louisiana's Quality Strategy is our provider support strategy. We acknowledge our providers as true partners in our quest for the delivery of quality care and are leading delivery system and payment reform by investing in and supporting providers to improve quality and reduce costs. Our comprehensive provider support strategy is designed to give providers the training, technology, data, and alternative payment methods needed to provide quality care **(Model Contract, 2.16.16)**.

SPECIFIC STRATEGIES

As an experienced Louisiana health plan staffed by individuals who have lived in and served the state of Louisiana, many for their entire career, we understand that the delivery of quality care requires innovative programs and partnerships that focus on factors that prevent our enrollees from prioritizing wellness. In **Figure 2.10.11.1-2,** we provide the overarching strategies that are linked to Louisiana's Quality Strategy objectives and examples of **proven interventions that we will continue to invest in and enhance** over the course of this contract period to advance that strategy.

	LDH Quality Strategy Objectives	AmeriHealth Caritas Louisiana Strategy	Examples of AmeriHealth Caritas Louisiana Interventions That Advance LDH's Quality Strategy
BETTER CARE	**Ensure access to care to meet enrollee needs**		
	Ensure timely and appropriate access to primary and specialty care.	Nurture provider relationships through outreach, provider support, and data sharing.	PerformPlus® Provider Dashboard and Report Card — allows us and our providers to monitor and enhance performance including: • Provider portal data sharing. • Care gap alerts. • 3M Treo - potentially preventable events predictive modeling. • HEDIS provider profiles. We are committed to ensuring that we provide actionable reporting that meets the provider's needs AmeriHealth Caritas Louisiana initiated the collaboration with all MCOs for the standardization of Provider Report Cards to ensure provider convenience and ease of use.
	Improve Coordination and transitions of care		
	Ensure appropriate follow-up after Emergency Department (ED) visits and hospitalizations through effective care coordination and case management.	Expand education, outreach, and referral programs to address barriers and improve coordination of care following ED visits and hospitalization.	**Admission, Discharge, and Transfer (ADT) feeds to identify enrollees with ED utilization** — provides timely access to ED utilization to facilitate rapid follow-up to ensure enrollees receive the appropriate follow-up after ED visits; includes sending alerts to the provider portal. **AmeriHealth Caritas Louisiana is slated to be the first Medicaid Managed Care Organization (MCO) to go live with utilization of a new ADT feed offered through the Louisiana Hospital Association** allowing new functionality including real-time notifications with more complete clinical information and ability to share case manager information with ED staff.

HEALTHIER PEOPLE; HEALTHIER COMMUNITIES	**Facilitate patient-centered, whole-person care**		
	Engage and partner with enrollees to improve enrollee experience and outcomes.	Expand the delivery of community-based services to deliver whole-person care where enrollees are located.	**Community-focused care coordination** — amplifies the traditional care management continuum by providing: • High-touch, face-to-face engagement for enrollees with intensive care needs to address social determinants of health (SDOH) and decrease ED utilization and in-patient admissions. • Coordination of care with community providers. • Support and development of enrollee self-management skills. • In 2018, enrollees engaged with our Community Care Management Team received over 1,000 visits to their homes and provider appointments. Enrollees engaged in this program showed a mean **reduction of 29.7% inpatient admissions per year.**
	Integration of behavioral and physical Health.	Transform the system of care in Louisiana to achieve whole-person, fully integrated health outcomes.	**Integrated health assessments** — advanced clinical training on the use of integrated health assessments allows physical health providers to identify behavioral health needs. Provider reimbursement is offered to complete: • PHQ-9, SBIRT, Patient Stress Questionnaire, and/or the Healthy Living Survey. • Reporting applicable score from the assessment on the claim.
	Promote wellness and prevention		
	Implement effective wellness and prevention programs as outlined in **Model Contract Attachment G Quality Performance Measures.**	Engage and empower enrollees to seek preventive care, complete age appropriate screenings, and make healthy choices.	**Community wellness centers** — enrollee and community-focused activities include health screenings and education, mobile screenings, safety awareness, baby showers, enrollee meetings and orientations, and exercise sessions. Our community wellness center concept is extended beyond our physical centers through On the Move events designed to connect community partners and enrollees in our most needy communities where we do not have a community wellness center. We use quality data to identify individual community needs such as food and recreation deserts. AmeriHealth Caritas Louisiana is the only MCO with community wellness centers for Medicaid enrollees, now located in New Orleans and Shreveport with a third to open in Baton Rouge and a fourth at another location in 2020.
	Improve chronic disease management and control		
	Improve management and control of hypertension, diabetes, cardiovascular disease, respiratory disease, and HIV.	Equip enrollees to effectively self-manage chronic conditions through tools, education, and care coordination.	**Telemonitoring platforms using mobile applications and remote monitoring:** • Improve clinical outcomes for our enrollees with co-morbid and chronic illnesses. • Empower enrollees to control the daily management of diabetes and congestive heart failure. • Increase the likelihood of positive changes in behavior. • Enhance communication and early detection of key clinical warnings. • Enrollees receive an average of 92 touches per month through the platform, including both clinician outreach and targeted automated messages. Since inception, this platform has shown great outcomes: 40 percent reduction in cost and an increase of over 50 percent in gaps closed such as A1C test for enrollees with diabetes.
	Improve quality of mental health and substance use disorder care.	Commitment to training providers to identify, stabilize, engage, treat, and maintain enrollees with substance use disorder.	**Medically Assisted Treatment (MAT) —** • Offering SAMHSA approved MAT training with the American Society of Addiction Medicine at multiple sites in Louisiana with a goal to increase providers who prescribe MAT. • Partner with the Louisiana Primary Care Association to ensure expanded access in federally qualified health centers (FQHCs) and rural health clinics, FQHCs and RHCs.
	Partner with communities to improve population health and address health disparities		
	Stratify key quality measures by race/ethnicity and rural/urban status and	Understand and continually analyze data to reduce disparities.	**Control Your Diabetes Control Your Destiny Program —**HEDIS data analysis revealed a disparity among African Americans with diabetes in specific Shreveport and New Orleans zip codes. Providers and community organizations were engaged for participation and planning. Enrollees with gaps were invited to attend with

	narrow health disparities.		transportation provided if needed. The programs, held at the community wellness centers, were designed to close gaps in diabetes care and improve health outcomes. **Figure 2.10.11.3-1** demonstrates outcomes of the program.
	Advance specific interventions to address social determinants of health.	Match enrollees to the level of support they need to address their medical, behavioral health and social needs.	**Food as Medicine** — provides a 14-30 day supply of nutritionally-complete, condition-appropriate meals delivered directly to eligible enrollees who are: • Identified with food instability through SDOH screening. • Discharged from a hospital or skilled nursing facility with risk of frequent readmission due to chronic conditions. The health-specific menus are dietitian-designed to provide nutritional support for many major health conditions and account for cultural dietary differences. The program was recently expanded to ensure that individuals with housing limitations or homelessness also have access to shelf stable meals distributed through our community wellness centers. In the first six months of the program, enrollees received this intervention within an average of 2 business days from the point of identified need.
SMARTER SPENDING	**Pay for value incentivized innovation**		
	Advance value-based payment arrangements and innovation.	Offer providers a seamless path towards advanced value-based care models.	**Centers for Medicare & Medicaid Services (CMS) Comprehensive Primary Care Plus (CPC+)** — early adoption of CPC+, a multi-payer collaboration for value-based payments, demonstrates leadership within the state of Louisiana and commitment to improving primary care in our communities. AmeriHealth Caritas Louisiana is one of few health plans in the state participating in CMS' CPC+ for Medicaid.
	Minimize wasteful spending		
	Reduce low value care.	Partner with providers to expand the focus on quality care.	**Choosing Wisely®** — We incorporate the American Board of Internal Medicine's (ABIM) Choosing Wisely® initiative's clinical recommendations in our efforts to reduce unnecessary spending in low value care and strives towards evidence-based, cost-effective, and patient-centered care. Initiatives are intended to generate a conversation between the providers and enrollees regarding the safest, most appropriate, and necessary treatment for enrollee-specific conditions. As an example, we are implementing an indiscriminant vitamin D testing policy that restricts testing to patients with diagnoses associated with vitamin D deficiency. Introduction of new initiatives will depend on ability to achieve the goals of Choosing Wisely without imposing undue prior authorization burdens on enrollees or providers or limiting access to tests and procedures.

Figure 2.10.11.1-2: *AmeriHealth Caritas Louisiana Interventions That Advance LDH's Quality Strategy.*

INCENTIVE-BASED QUALITY MEASURES

In addition to our strategies to help advance Louisiana's Quality Strategy and improve outcomes for all measures outlined in **Model Contract Attachment G**, AmeriHealth Caritas Louisiana offers the following framework to address childhood immunization status, cervical cancer screening, colorectal screening, and initiation and engagement of alcohol and other drug abuse or dependence treatment:

Childhood Immunization Status

- Enrollee scorecard initiative.
- Provider profiles/scorecards.
- Wellness day events.
- On the Move events.
- Enrollee text reminders.
- Enrollee gaps in care outreach.
- Healthy behavior enrollee incentives.
- Provider incentives.

Cancer Screenings: Cervical And Colorectal

- Enrollee scorecard initiative.
- Provider profiles/scorecards.
- Wellness day events.
- Enrollee text reminders.
- Enrollee gaps in care outreach.
- Healthy behavior enrollee incentives.

- On the Move events.
- Community wellness center events and screenings.
- At-home testing kits (colorectal screening).
- Provider incentives.
- Mobile cancer screenings.
- Taking Aim at Cancer in Louisiana Coalition participation.

Initiation And Engagement Of Alcohol And Other Drug Abuse Or Dependence Treatment

- MAT provider trainings.
- Screening, Brief Intervention and Referral to Treatment training.
- Enhanced training to ACT teams.
- Identification through claims analysis.
- Integrated physician practice.
- Stabilization through addressing enrollee's SDOH.
- Integrated care coordination.
- Disease-specific case management.
- Community-based peer supports.
- Identification through utilization management.

2.10.11.2 Approach To Improving Quality

2.10.11.2.1 Assessment Of Utilization Rates And Potential For Improvement

Assessing Utilization Rates

In general, under-utilization of high-value health and wellness services, recommended screenings, and chronic condition management leads to over-utilization of more expensive low-value services like ED visits, inpatient admissions, and re-admissions. As part of our quality improvement approach, we routinely monitor and assess under- and over-utilization of services in alignment with LDH's Quality Management Strategy **(Model Contract, 2.16.2.3.3)**. We use the following data sources for our assessment:

- Claims.
- Authorization data.
- Supplemental data from medical record reviews.
- Laboratory clinical results.
- Enrollee and provider demographics.
- Provider profiles.
- HEDIS trending data.

To identify under-utilization of services, we track and trend specific HEDIS and Louisiana Department of Health (LDH) metrics, and other standard industry metrics. For assessment of over-utilization, we track, and trend Potentially Preventable Events (PPE) and other utilization measures such as ED visits/1,000 enrollee months and all-cause readmissions. We also monitor specific procedures and services relevant to our enrollee population that are prone to either over- or under-utilization. Our Quality Clinical Care/Utilization Management (UM) Committee reviews the results of our analysis and recommends activities for improvement **(Model Contract, 2.12.3; 2.12.3.2.7)**.

Assessing Potential For Improvement In Utilization

AmeriHealth Caritas compares results of the data assessments to benchmarks, and conducts segmentation analysis by diagnosis, age, race and ethnicity, parishes where enrollees reside, and provider/facility access and availability. These analyses help us better understand utilization patterns and barriers to receiving the right care, in the right place, at the right time. Examples of these barriers include lack of availability of needed services or access to appropriate care, or issues associated with specific SDOH. Our analyses also help detect potential areas to improve over- and under-utilization rates and identify appropriate interventions to address deficiencies. Examples of opportunities for improvement identified through our over- and under-utilization assessment process include:

- **Prevention And Screening** — Under-utilization of childhood immunizations, cancer, and diabetes screenings.
- **Medication Adherence** — Inconsistent refills of medications for chronic conditions such as cardiovascular disease and diabetes.

- **ED Utilization** — Inappropriate low level and high frequency ED utilization**.**
- **Provider Service** — Over-utilization of indiscriminant drug screening, vitamin D testing, and opioid prescribing; under-utilization of MAT and 17-P.

In the first year of the Contract, we will use our established assessment process to identify additional opportunities to reduce low value care and propose initiatives to promote high value care, consistent with priorities of the LDH Quality Strategy and the Contract requirements. **Model Contract, 2.16.2.3.3**.

2.10.11.2.2 Improving Quality Of Care Through Provider And Enrollee Incentives

AmeriHealth Caritas Louisiana uses financial and other incentives to engage providers and enrollees in health care improvement. These incentives promote high value care such as preventive services, while helping to decrease the occurrence of potentially preventable events.

Decreasing Under-utilization of Cancer and Diabetes Screening Through Use Of Mobile Screening Unit.
Our data analysis identified significant gaps in cancer and diabetes screenings in the Queensborough area of Shreveport. To reach these enrollees in their communities, a mobile cancer and diabetes screening unit was provided through our community wellness center. We collaborated with local providers to assist with scheduling appointments. As a result, 16 % of cancer screening gaps were closed in a month and 40 percent of enrollees who completed diabetes

Provider Incentives — PerformPlus®, our suite of unique value-based programs provides financial incentives for quality health care to primary care providers (PCPs), specialists, hospitals, integrated delivery systems, and health care providers across the care continuum. These programs advance payment reform, improve health outcomes, and align with LDH's Medicaid Managed Care Quality Strategy **(Model Contract, 2.16.16.1, 2.16.16.2.2)**. Our Practice Transformation Team supports providers with data, training, and other support necessary for success in their specific value-based programs. Through dashboards and provider profiles available in the provider portal, providers can identify frequent ED utilizers and recent readmissions as well as review HEDIS results, care gaps, clinical risks, and other enrollee data.

Quality Improvements Achieved Through Value Based Purchasing Program — Since its inception in 2014, our Quality Enhancement Program for PCPs has shown the following improvements:

- *9.8 % increase in the rate of adolescents receiving well-care visits.*
- *10.7 % increase in the rate of children ages 3-6 receiving well-child visits.*
- *7.1 % increase in the rate of children 15 months and younger receiving well-child visits.*
- *17.3 % increase in the rate of enrollees with diabetes receiving a dilated eye exam.*
- *21.7 % increase in the rate of children prescribed ADHD medications receiving follow-up care.*

AmeriHealth Caritas Louisiana initiated the collaboration with all MCOs for the standardization of Provider Report Cards to ensure provider convenience and ease of use.

Enrollee Incentives — The AmeriHealth Caritas Louisiana Healthy Behaviors program incentivizes enrollees to obtain select preventive health care services such as immunizations, prenatal and post-partum visits, cervical cancer, and diabetic screenings. We will implement an innovative evidence-based chronic disease management program that utilizes a mobile app to reinforce behaviors real-time via alerts and the potential to earn and lose rewards. Based on principles of behavioral economics, these programs reinforce

positive behaviors through financial rewards, immediate gratification, and loss aversion to improve enrollee engagement with appropriate healthy behaviors. We also help enrollees identify needed healthy behaviors through a personalized care gap/care reminder report available on the enrollee portal and the AmeriHealth Caritas Louisiana mobile app.

2.10.11.2.3 Targeting Super-Utilizers And Reducing Potentially Preventable Events

Evidence-Based Interventions And Strategies To Target Super-Utilizers

CMS identified super-utilizer programs as one of three effective strategies to reduce inappropriate ED utilization (CMCS Informational Bulletin: Reducing Non-Urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings (01/16/2014)). AmeriHealth Caritas Louisiana defines super-utilizers as those enrollees with 10 or more ED visits and/or four or more inpatient admissions in a period of 12 months. These enrollees experience complex medical, behavioral health conditions and unmet social needs. We use the following evidence-based interventions to target super-utilizers:

- **Integrated Population Health** — Super-utilizers receive tailored care coordination, barrier identification, education and interventions that use evidence-based practices, including motivational interviewing and person-centered-thinking to engage the enrollee in his or her health. The strategy places an emphasis on identifying and addressing social determinants of health.
- **Community Care Management Team (CCMT)** — The CCMT is an integrated team of registered nurses, licensed social workers, and community health workers who deliver face-to-face support to the most complex super-utilizers among our enrollees. We base our CCMT approach on evidenced-based practices from the Care Coordination Pathways model and the Camden Coalition of Healthcare Providers. Our analysis of outcomes data from the CCMT program's beginning in 2014 through November 2018 **demonstrated the following decreases: ED visits by 15.8 percent; potentially preventable ED visits (PPVs) by 13.4 percent; inpatient admissions by 27.5 percent; potentially preventable admissions (PPAs) by 36.3 percent; and potentially preventable readmissions (PPRs) by 21.6 percent.**
- **Integrated Physician Practice** — We will add a risk-based Integrated Physician Practice for our super-utilizer cohort of enrollees. Using principles from the University of Pennsylvania's IMPaCT model and several other evidence-based models, this practice provides a whole person/whole system intervention to address enrollees' physical and behavioral health and SDOH needs through an integrated multidisciplinary team of clinicians, Community Health Workers (CHWs) and other health care professionals. CHWs meet the enrollee in their home, facilitating a high-touch approach, guiding the enrollee through the care plan and creating connections with community resources and supports.

Evidence-Based Interventions And Strategies To Reduce Potentially Preventable Events

Unnecessary and preventable healthcare encounters are expensive and can negatively impact patient experience and quality outcomes. AmeriHealth Caritas Louisiana leverages 3M Treo for identifying potentially preventable events (PPEs) to measure and monitor overtreatment, complications, and unnecessary care. Our evidence-based-strategies to reduce all PPEs include those described for super-utilizers in the previous section, and:

- **Provider Incentives** — Many of our value-based programs include financial incentives for providers to reduce the occurrence of PPEs for their assigned enrollees. We support providers by sharing PPE data for their assigned enrollees through a secure network portal. This facilitates identification and prioritization of patients for outreach and other follow-up to improve health behaviors. In 2017, the Community Partners Program for large PCP groups and FQHC providers, yielded reductions of 22 percent in potentially preventable admissions, 23 percent in potentially preventable readmissions

and six percent in potentially preventable ED visits. (Principles for a Framework for Alternative Payment Models; Sam Nussbaum, MD et al. 1; JAMA. 2018.)

Our evidence-based strategies to address PPVs include:

- **ED Diversion Program** — Identifies enrollees with high ED utilization through claims history. Our case managers work holistically with enrollees to identify factors contributing to their overuse of the ED. Case Managers promote PCP follow-up care, address SDOH needs, and educate enrollees on other available care options, such as urgent care centers. Enrollees who need additional support to address their health care needs are connected to case management or CHW support. Among the top 200 ED utilizers enrolled in the plan for 7-12 months in 2018 who were contacted for case management there was a decrease of 26.03 percent in ED costs, and 29.87 percent in ED utilization.
- **Enrollee-Focused Educational Initiatives** — The greatest reduction in PPVs are achieved by enrollee education programs (Non-ED Interventions to Reduce ED Utilization: A Systemic Review. Morgan et al. Academy of Emergency Medicine. 2013 Oct.). Examples of our educational strategies include:
  - **Expand the urgent care network** to address after-hours and weekend access based on geography and utilization data and educating enrollees of their availability and when to use them.
  - Implement a **Community Health Education Team** to connect with enrollees in the community and help them schedule appointments with the PCP after an ED visit, and provide education on appropriate use of the ED.

Our evidence-based strategies to address PPAs include:

- **Advanced Telehealth Program** — A large evidence-base supports telepsychiatry as a delivery method for mental health services. (Hubley et al, World Journal of Psychiatry. 2016 Jun 22.) AmeriHealth Caritas Louisiana offers services that are available from the enrollee's home or from kiosks located in clinics across the state to increase visits to behavioral health professionals and reduce the no-show rate after a hospitalization or an ED visit.
- **Virtual On-Going Biometric Monitoring** — Home telemonitoring programs for chronically ill individuals improve enrollee outcomes on key quality metrics (Celler et al, Studies in Health Technology Information. 2018). Our virtual biometric monitoring program provides participants with daily monitoring of blood sugar, weight, blood oxygen levels and blood pressure, as well as timely intervention and assessment of clinical needs. Participants also receive Individual one-on-one health coaching focusing on behavior change modification and care plan adherence.

Our evidence-based strategies to address PPRs include:

- **Embedded Discharge/Transition Case Manager** — Systematic review of evidence-based literature demonstrates that hospital-based case management can result in better enrollee outcomes (Terra, S., Professional Case Management 2007 May). Our Embedded Discharge/Transition Case Manager addresses enrollee discharge needs and barriers; coordinates with UM and hospital staff; refers enrollees to the next level of care; assists with post hospital follow-up appointments and links enrollees to community resources.
- **Care Extender Program** — Based on the proven effectiveness of collaborative care (Unützer et al., Am J Managed Care 2008), we offer a Care Extender Program for enrollees identified with behavioral health diagnoses who have high ED utilization and/or inpatient readmissions. The program provides 24/7 coaching and support for up to four months after discharge to ensure that care and services are provided in accordance with the enrollee's discharge plan and needs are met.

2.10.11.3 Improving Clinical Care and Population Health Status

AmeriHealth Caritas Louisiana is committed to continuing our successful implementation of data-driven initiatives to improve the clinical care, health outcomes, and services provided to our enrollees in all

demographic groups. Our quality assessment and performance improvement (QAPI) program applies principles of continuous quality improvement in an organizational wide, systematic approach to quality that uses reliable and valid methods of analysis, measuring, monitoring, evaluation, and improvement. This approach to quality improvement provides a rapid and continuous cycle for assessing the quality and safety of care and service including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and network services. **(Model Contract, 2.16.2.3)**.

2.10.11.3.1 Analyzing Gaps For Improving Management Of Chronic And Acute Conditions And Reducing Health Outcome Disparities

Our QAPI program uses a robust data framework to analyze gaps in delivery of service, quality of care, management of diseases and conditions and health care disparities. We maintain an integrated Population Health Information System to collect, analyze and integrate the data necessary to facilitate the assessment, analysis, and evaluation of quality indicators. Examples of areas where we focus our analysis to identify gaps in care and service include:

- **Service Delivery** — Network access, appointment availability, enrollee complaints/grievances about providers, and call answer metrics.
- **Quality Of Care** — PPEs, quality of care reviews, medical record reviews, HEDIS, and other quality indicators.
- **Condition Management** — Adherence to clinical guidelines, care gaps, and chart reviews.
- **Disparity Analysis** —Enrollee data by cultural and linguistic demographics including: age, race, ethnicity, primary language, and disability status.

Data-Driven Analysis To Identify Opportunities For Reduction In Health Disparities

We gather data and analyze performance related to quality of care and services, measure outcomes, and monitor trends, including patterns of over- and under-utilization over time. Performance results are compared to benchmarks and/or internal goals to identify opportunities for improvement related to the delivery of services, the quality and safety of care, and the management of chronic conditions. We use the data to produce drill-down reports at various levels (regional, provider and facility, and individual enrollee) and by population groups defined by diagnosis, race/ethnicity, language, age, gender, or geography) and compare the quality indicators to benchmarks, objectives or internal goals, and between defined subpopulations.

Sample Data-Driven Initiative: Control Your Diabetes Control Your Destiny—Step One: Data Analysis
AmeriHealth Caritas Louisiana performed data analysis of HEDIS rates for measurement years 2016/2017, stratified by race/ethnicity and geography to determine possible health care disparities. Comprehensive diabetes care was identified as an opportunity to reduce disparities in the Shreveport area.

2.10.11.3.2 Identifying Reasons For Variations In Provision Of Care To Enrollees

Understanding variances in the health care provided to our enrollees is an essential step in our identification of improvement opportunities. Some variation in healthcare is desirable, even essential, since each enrollee is different and should be cared for uniquely. For example, clinical practice guidelines (CPGs) provide a baseline for delivering appropriate care, and we rely on the providers' judgement to applying the guideline to the enrollee's specific situation. New and better treatments and improvements in care processes can also result in beneficial variation.

We investigate variances in care to clearly identify the specific cause for variations. AmeriHealth Caritas Louisiana uses root cause analysis and other quality improvement tools to identify underlying problems or barriers that can be addressed in order to improve service delivery and health outcomes. As part of this analysis, we employ tools such as Ishikawa Cause and Effect Diagrams, Key Driver Diagrams and Process Mapping. Once the root causes are identified, we are able to develop strategies and related initiatives to

address the root causes of adverse variations.

Sample Data-Driven Initiative: Control Your Diabetes Control Your Destiny — Step 2: Identifying Reason for Variation

Our analysis also determined that African-American enrollees in the Shreveport area presented rates below NCQA national average for blood pressure control (22 percentage points below average) and HbA1c ≥ 9 (33 percentage above average.) We identified the barriers to care related to SDOH and culture, including a median household income of less than 50 percent, double the unemployment rate, and almost three times the proportion of individuals on food stamps compared with the nation as a whole. Additional barriers include lack of transportation, unavailability of fresh produce, health literacy limitation, a high fat, high caloric, and high-sodium food culture.

2.10.11.3.3 Implementing Improvement Strategies

Implementing Interventions And Measuring Effectiveness Of Improvement Strategies

Implementing Interventions — After reviewing the results of our gap and barrier analysis, we identify improvement strategies with the highest potential for impacting the identified health disparities and health outcomes among our targeted enrollee populations. We prioritize the potential initiatives based on their alignment with our QAPI program goals and LDH's Medicaid Managed Care Quality Strategy. We also consider the potential impact on enrollee experience of care or service and the per capita cost of care. Once we identify high priority areas, a cross-functional work group reviews data supporting the selections, and considers best practices and the effectiveness of past initiatives when recommending strategies and related initiatives for implementation.

Sample Data-Driven Initiative in Shreveport: Control Your Diabetes Control Your Destiny — Step Three: Implementing Interventions

We implemented the Control Your Diabetes Control Your Destiny program in 2018 to close gaps, reduce disparity and improve health outcomes while enhancing the enrollee experience. Targeted enrollees were invited to attend the program events. Transportation was available as needed. We engaged providers and community organizations by inviting them to participate in the events. The program offered a series of events at the AmeriHealth Caritas Louisiana community wellness center in Shreveport. Community events in January and July included the following: a) cooking classes and recipes; b) traveling farmer's market with fresh vegetables; c) help with keeping up with tests and appointments; d) education sessions; e) free testing; f) support for emotional issues; and g) transportation to doctor's appointments and wellness center events. Other activities included the Diabetes Destination Walk in April that highlighted the importance of HbA1c testing and provided motivation to exercise while having fun. In November, the Diamond Chef Enrollee Cooking Competition encouraged enrollee participants to be creative in healthy meal preparation. Enrollees received diabetic-friendly spices, lean protein options, mobile farmer's market selections, and Healthy Behaviors incentives.

Measuring Effectiveness and Developing Improvement Strategies — We identify both external benchmarks and internal improvement goals for measuring effectiveness of our interventions. Ongoing initiatives are monitored and evaluated throughout the year for re-measurement of outcomes, identification of barriers, and adjustment of the process. We also follow the evidence-based Institute of Healthcare Improvement Model in designing and evaluating the effectiveness of interventions by answering three questions: What are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in improvement?

Sample Data-Driven Initiative in Shreveport: Control Your Diabetes Control Your Destiny — Step Four: Measuring Effectiveness and Developing Improvement Strategies

During 2018, 412 enrollees were invited to participate in the events, 88 responded. Of those enrollees, 40 percent were referred to the Rapid Response Team that scheduled appointments with providers due to elevated HbA1c and/or blood pressure, and connected them with AmeriHealth Caritas Louisiana's Case Management team. Most importantly, the overall rate of HbA1c testing increased among enrollees in the targeted zip codes, as shown in **Figure 2.10.11.3-1.** *For 2018 program events, AmeriHealth Caritas Louisiana enlisted the support of local organizations to help promote intervention events at its Shreveport community wellness center. To facilitate improvement strategies, we will collaborate with community organizations, providers, and enrollees in targeted ZIP codes for improved participation and health outcomes.*

Overall HbA1c Testing Rates For Areas With Control Your Diabetes Control Your Destiny Program					
Shreveport Zip Code	Nov 2017	Nov. 2018	Shreveport Zip Code	Nov. 2017	Nov. 2018
71101	68.75%	70.59%	**71107**	59.46%	73.68%
71103	82.14%	82.76%	**71108**	76.47%	77.78%
71104	72.73%	75.00%	**71109**	70.89%	73.91%
71105	64.29%	88.24%	**71115**	100.00%	100.00%
71106	70.59%	84.81%			

Figure 2.10.11.3-1: *Our Control Your Diabetes Control Your Destiny Program Testing Rates.*

2.10.11.4 AmeriHealth Caritas Louisiana's Approach To QI/QM

Our QM/QI program is an organization-wide endeavor. Cross-functional teams integrate interdepartmental monitoring of processes and activities to improve the quality and safety of clinical care and services that enrollees receive.

2.10.11.4.1 Quality Management/Quality Improvement Plan Description

AmeriHealth Caritas Louisiana's QM/QI plan description describes the framework used to evaluate the delivery of care and services provided to our enrollees. The QM/QI plan description includes goals and objectives that align with our 24 Month Strategic Plan and the Medicaid Managed Care Quality Strategy. It also documents the program structure, scope, and functions **(Model Contract, 2.16.1.1)**.

We administer our QM/QI program using a comprehensive and integrated systematic process of collecting and analyzing information, identifying and acting on opportunities to improve care and service, and monitoring the effectiveness of interventions. Ongoing compliance monitoring ensures that our QM/QI activities remain consistent with applicable laws, federal regulations (42 CFR §438.330(a)(1)), **Model Contract, 2.16.2.1** contractual requirements, and NCQA standards. We review the QM/QI plan annually and provide it to LDH **(Model Contract, 2.16.2.5)**. We also share QM/QI program information with enrollees and providers, including our progress toward achievement of annual goals.

Quality Management/Quality Improvement Goals

AmeriHealth Caritas Louisiana's overall QM/QI goal is to improve the quality and safety of clinical care and services provided to enrollees by establishing a comprehensive quality management structure and program:

- Efficiently collects, analyzes, and reports data.
- Addresses clinical (medical and behavioral) psychosocial and functional needs of enrollees.
- Implements strategies to manage risk.
- Improves access to care and quality of services provided to enrollees, including those with special health care needs.
- Reduces health care disparities.

Quality Management/Quality Improvement Committees

AmeriHealth Caritas Louisiana's committee structure addresses our QM/QI needs. It includes committees, practicing practitioners, staff members, and work groups that are designated as the responsible party for specific aspects of care and services.

Quality Assessment and Performance Improvement Committee — The QAPI Committee oversees our efforts to measure, manage, and improve quality of care and service delivered to enrollees. **(Model Contract, 2.16.5)**. It is chaired by the CMO, and includes the Behavioral Health Medical Director, Director of Quality Management, department directors for integrated medical and behavioral health services, participating medical and behavioral network providers, and Member Advocate representatives. The QAPI Committee chair or his/her designee attends LDH's Quality meetings.

Quality of Service Committee — Reports to the QAPI Committee. The Quality of Service Committee ensures that performance and quality improvement activities related to health plan services are reviewed, coordinated and effective. This committee approves and monitors action plans created in response to any identified variance and reviews the plan's performance dashboard.

Quality Clinical Care/Utilization Management Committee — Reports to the QAPI Committee providing direction and oversight of the clinical quality and appeals, utilization management, behavioral health management, population health management, integrated case management, chronic case management, and pharmacy programs. **(Model Contract, 2.12.3)**.

Culturally and Linguistically Appropriate Services (CLAS) Committee — Reports to the Quality of Service Committee. The cross-departmental CLAS Committee ensures our responsiveness to enrollees' cultural and linguistic needs by providing direction for activities related to the 15 national CLAS standards and NCQA's Multicultural Health Care Standards.

Pharmacy and Therapeutics Committee (P&T) — Reports to the Quality Clinical Care/Utilization Management Committee. While the LDH P&T committee will be responsible for formulary functions, our committee will continue to review selected authorization criteria, monitor prescribing patterns of network providers, drug utilization patterns, develop policies for drug administration, and identify opportunities for provider and enrollee education.

Enrollee Advisory Council — Reports to the Quality of Service Committee. The Enrollee Advisory Council, **(Model Contract, 2.16.15)** provides a regional forum for input from enrollees, advocacy groups, and providers on our programs and policies. The council promotes collaborative efforts to enhance the service delivery system in local communities while maintaining an enrollee focus.

Schedule Of Quality Management Activities

Our quality management work plan specifically identifies the schedule for monitoring system and targeted quality improvement activities, including those related to planning, decision making, intervention, and assessment of results. Our work plan identifies the responsible party and time frame for completing activities and evaluating the impact and effectiveness of the QAPI program. The scheduled review and update includes:

- **All Organizational Program Documents** — QAPI, utilization management, and care management program descriptions and evaluations.
- **Quality And Safety Of Physical/ Behavioral Clinical Care** — Analysis of adverse events, focused reviews, approval of evidence-based CPGs, chart reviews, HEDIS measures, and over- and under-utilization.
- **Enrollees' And Providers' Experience** — CAHPS, behavioral health member satisfaction survey, complex case and disease management satisfaction surveys, and provider satisfaction survey.

- **Compliance with accreditation and regulatory standards** — NCQA, EQRO, LDH, CMS core measures, and EPSDT.
- **Quality Of Service From The Health Plan, Practitioners, And Providers** — call center data, enrollee grievances and appeals, and claims accuracy**.**

The QM/QI team initiates the annual work plan, including the schedule of activities, based on strategic direction from the Board of Directors. The work plan is forwarded to the QAPI Committee for review and recommendations. Work plan activity is reported throughout the year to the QAPI Committee, with quarterly updates to our Board of Directors. Activity and outcomes are reported using internal tools in addition to the reporting tools and specifications required by LDH. **(Model Contract, 2.16.6, 2.16.7)**.

2.10.11.4.2 AmeriHealth Caritas Louisiana's QM/QI Organization

AmeriHealth Caritas Louisiana's QM/QI organization as depicted in **Figure 2.10.11.4-1** fully supports the QM/QI needs of the QAPI program.

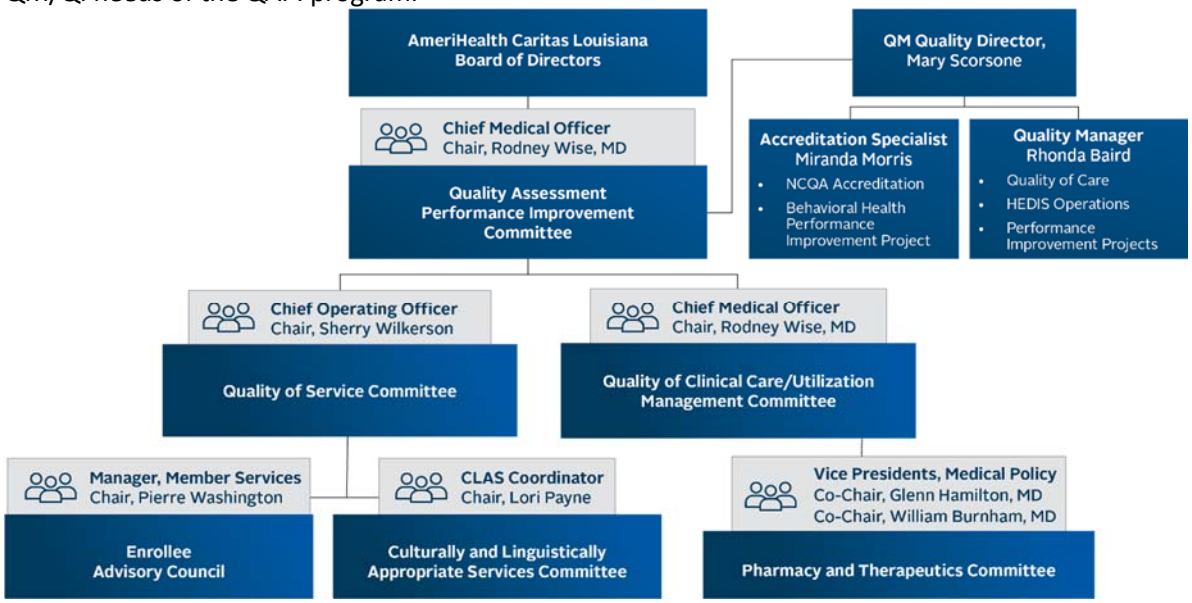


Figure 2.10.11.4-1: *AmeriHealth Caritas Louisiana's QM/QI Program Organization.*

The AmeriHealth Caritas Louisiana Board of Directors provides strategic direction for the QM/QI program and retains ultimate responsibility for ensuring that the QM/QI plan description is incorporated into AmeriHealth Caritas Louisiana's operations. Operational responsibility for the development, implementation, monitoring, and evaluation of the QM/QI program is delegated by the Board of Directors to the AmeriHealth Caritas Louisiana Chief Executive Officer and the QAPI Committee. The QAPI Committee, the AmeriHealth Caritas Louisiana CMO, Behavioral Health Medical Director, and the Director of Quality Management are responsible for planning, designing, implementing, and coordinating QM/QI activities. AmeriHealth Caritas Louisiana's Quality Improvement department, led by the Director of Quality Management, supports the daily operations of the QM/QI program. **Figure 2.10.11.4-2** describes our team of experienced and knowledgeable staff dedicated to and responsible for the QM/QI program.

AmeriHealth Caritas Louisiana Staff Dedicated to and Responsible for QM/QI Program	
Title/Name	**Summary of Responsibilities/Roles**
Chief Medical Officer Rodney Wise, M.D.	Designated physician responsible for the medical leadership, oversight and implementation of the QAPI Program and work plan. Assists in the development and implementation of medical policy, including recommendations for modifications to enhance efficiency and effectiveness. Chairs QAPI and Quality Clinical Care/Utilization Management Committees.
Behavioral Health Medical Director Betty	Designated psychiatrist responsible for the behavioral health leadership, oversight, and

AmeriHealth Caritas Louisiana Staff Dedicated to and Responsible for QM/QI Program	
Title/Name	**Summary of Responsibilities/Roles**
Muller, M.D.	implementation of the behavioral health aspects of the QAPI Program and work plan. Involved in the development and implementation of behavioral health care management.
VPs Medical Policy, AmeriHealth Caritas Services Glenn Hamilton, M.D William Burnham, M.D.	Provides oversight of the P&T Committee, coordinates pre and post-meeting activities of the PBM.
Chief Operating Officer (COO) Sherry Wilkerson	Manages the daily operations of quality of service functions across the health plan, including the operations, claims management, enrollee services, community relations, and provider monitoring and supports departments. Chairs the Quality of Services Committee and serves as a member of the QAPI Committee and Health Outcomes Workgroup.
Director Quality Management Mary Scorsone	Provides leadership and direction for the QM/QI program. Responsible for the operation and administrative success of the program, oversees day-to-day activities, QM/QI staff, accreditation and delegation, coordinates QI initiatives between departments. Participates in LDH Quality Committee meetings and other quality improvement meetings/workgroups. **(Model Contract, 2.16.3.6)**.
Quality Manager Rhonda Baird	Provides oversight and daily administrative management of quality of care, performance improvement projects, and HEDIS operations. Responsible for the planning, development, and implementation of activities related to the HEDIS process, QM program, and corporate/LDH specific initiatives.
Quality Supervisor LaKaley Tillery	Provides direct oversight of the Quality Specialists. Leads the day to day execution of quality improvement initiatives, HEDIS year-round medical record abstraction, provider outreach and education, and HEDIS performance improvement planning.
HEDIS Lead Darla Ratcliff	Utilizes data analytic tools to identify opportunities for improved performance. Implements provider outreach activities in collaboration with the Provider Network Management Team and Community Education team.
Accreditation Specialist Miranda Morris	Provides oversight of new and existing standards to ensure compliance to NCQA standards across all impacted functional areas; supports the design, implementation, and ongoing monitoring of policies, systems, and processes.
CLAS Coordinator Lori Payne	Assists with incorporation of CLAS standards into quality activities and focused analysis and activity development to address health disparities.
Quality Performance Specialist Jennifer Deshotel, LMHP	Coordinates the clinical quality review process for the behavioral health treatment medical record reviews under the direction of the Behavioral Health Medical Director.
Member Engagement Manager Pierre Washington	Responsible for the leadership, management, and implementation of the strategic vision for all services that impact or interface with our enrollees, including facilitating the Enrollee Advisory Council.
Quality Performance Specialist, Clinical (4)	Performs quality of care reviews, and medical/treatment record reviews, assists with QAPI initiatives and data collection/analysis.
Quality Performance Specialist, Non-Clinical (2)	Coordinates and monitors QI program objectives, including the delivery of performance improvement projects for service and clinical activities, integrating the quality improvement plan into all departments.

Figure 2.10.11.4-2: *AmeriHealth Caritas Louisiana QM/QI Staff.*

The Health Analytics team also plays a major role in the QM/QI program, which we describe in **Section 2.10.11.4.3** HEDIS Performance And Other Evidence-Based Initiatives. **Additional resources who support our QM/QI team are leadership and staff roles across the organization, including population health management, provider supports, operations, and enrollee services. QAPI strategies are shared and reinforced with all associates on an ongoing basis via their leadership team members who participate in the committee.** We assess the adequacy of our staffing and make adjustments as needed throughout the year to support program goals.

2.10.11.4.3 HEDIS Performance And Other Evidence-Based Initiatives

AmeriHealth Caritas Louisiana has successfully completed timely HEDIS submissions annually, through a robust data infrastructure, expert team, and proactive approach to continuous improvement.

Capacity For Support

AmeriHealth Caritas Louisiana complies with all HEDIS reporting requirements. We maintain an Integrated Population Health Platform to collect, analyze and integrate the data necessary to facilitate assessment, analysis, evaluation, and reporting of quality indicators. See our response to **Section 2.10.11.2.1** for a description of data sets from our reporting databases available for use in our analyses.

Quality assessment is performed on the claim and supplemental data files by analyzing the import files, applying a trending analysis, and comparing the results. Secure network servers store data which is routinely copied to back-up disks by the Information Technology department.

We use an NCQA-certified HEDIS system to create a reporting repository and generate compliant reports. To expand our data collection capabilities, we are in the process of implementing a new NCQA certified system with enhanced features that include:

- More frequent reporting of HEDIS interim rates**.**
- A comprehensive **business intelligence** platform to improve HEDIS analytics**.**
- A medical record retrieval and abstraction management tool for year-round and hybrid season projects**.**

We have made multiple improvements in our ability to collect data, including reducing administrative burden on provider by offering a mechanism for providers to electronically submit documentation of services related to HEDIS measures. In 2018, 14,858 clinical results made an impact on our HEDIS rates without the need for medical record review.

Availability Of Resources

AmeriHealth Caritas invests significant resources to support reporting of data-driven initiatives and quality performance measures, inclusive of HEDIS. Our HEDIS Strategy and Analytics team produces reports that provide insights into gaps in care and progress toward established goals on performance improvement measures. The team also focuses on increasing the acquisition of digital clinical data through data aggregators and engagement of individual and group providers. In addition, staff within Healthcare Analytics conduct analysis and generate reports to identify over- and under-utilization, conduct statistical healthcare outcome analysis, and support Quality Enhancement Program and other value-based programs.

Medical Record Review — We use a team of in-house associates to conduct medical record reviews for HEDIS. This in-house capacity is an example of our proactive approach to quick resolution of potential data issues. Having the function in-house allows us to maintain close supervision to ensure data integrity and data collection efforts are appropriately prioritized. Our associates are thoroughly trained and monitored to ensure accuracy in the data extraction process. We also access the provider's electronic health record (EHR) when possible to reduce the administrative burden of medical record collection, and offer providers incentives to make this access available.

NCQA-certified HEDIS Auditor — AmeriHealth Caritas Louisiana contracts yearly with an NCQA-certified HEDIS auditor to validate the processes of data collection and reporting in accordance with NCQA requirements. We submit yearly audited HEDIS results to LDH, NCQA, and LDH's External Quality Review Organization (EQRO) according to NCQA's data submission timeline. **(Model Contract, 2.16.8.1)**.

2.10.11.4.4 Our Example Of A Successful Quality Improvement Activity

AmeriHealth Caritas Louisiana identified an opportunity for improvement through rate analysis and data trending of child and adolescent well visits. During measurement year 2017, we performed below the Quality Compass 50th percentile in W15 and W34 HEDIS measures and at the Quality Compass 50th percentile in the AWC HEDIS measure. Following our data analysis, we implemented our Wellness Day Event Quality Improvement Activity as described below using the Plan-Do-Study-Act continuous quality improvement approach.

PLAN — Wellness visits for children and adolescents provide necessary vaccines and health screenings that are fundamental to living healthy lives and reaching appropriate developmental milestones. We developed and implemented the Wellness Day Event quality improvement activity to promote and improve wellness and prevention for our child and adolescent enrollees. The Plan identified high-volume providers to target for Wellness Day events based on practice performance.

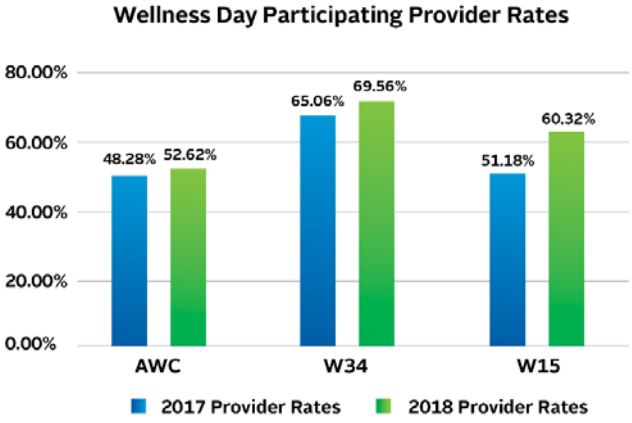


Figure 2.10.11.4-3: Wellness Day Outcomes. *We partner with providers to promote well-child visits.*

DO — AmeriHealth Caritas Louisiana staff collaborated with selected providers in preparing for events by assisting with identification of non-compliant enrollees via the Care Gap Query Report, scheduling appointments and executing follow-up reminder calls. Additionally, staff aided practices on event day with set-up, implementation, and clean up. Our multidisciplinary provider supports team delivered coordinated, strategic support to facilitate enrollee and provider engagement.

STUDY — This initiative helped providers close gaps on event day but more importantly provided the tools and foundation for the provider to continue the activity post event. Wellness Day events provided us an opportunity to receive firsthand feedback from enrollees and educate practices on evidence-based preventive health guidelines. **Figure 2.10.11.4-3** shows notable improvements that participating providers achieved across all three well visit rates from December 2017 to December 2018.

ACT — Analysis of the data as well as positive provider and enrollee feedback supports project continuation and expansion to incorporate areas with high disparities.

2.10.11.4.5 Quality Improvement Plans And Projects

Identification Of Plans And Projects

At the end of each calendar year, AmeriHealth Caritas Louisiana conducts an evaluation of the QM/QI program **(Model Contract, 2.16.2.3.12)**. This evaluation is data-driven, and entails a comprehensive review and analysis of trends and outcomes for all clinical and service performance measures, Performance Improvement Projects, and other studies and activities. Elements in the evaluation include whether statistically significant improvement was achieved and/or whether the results met the initiative objectives. Furthermore, this evaluation assesses the impact of the QM/QI program on enrollees' health outcomes, experience, and per capita cost. Through this evaluation, AmeriHealth Caritas Louisiana identifies new and existing barriers and missed opportunities for improvement using the plan-do-study-act model, shown in **Figure 2.10.11.4-4**.

Identifying Potential Topics

Figure 2.10.11.4-4. *Plan-Do-Study-Act Model.*

As described above, we monitor performance, analyze process and outcome data, compare our results to benchmarks, and prioritize areas of focus for quality improvement. The QM/QI team takes into consideration the following factors when selecting potential topics: AmeriHealth Caritas Louisiana's Strategic Plan's goals; LDH goals and priorities; the most prevalent needs of our enrollees; potential to achieve high impact on enrollees' health status and experience; and potential to reduce identified health care disparities. Using this process we identified the following potential topics: Member Health Scorecard, behavioral economics solution to improve medication adherence, C.A.R.E in Hand (in-office contraception dispensing); and ABIM's Choosing Wisely initiative's clinical recommendations to prevent unnecessary testing for vitamin D deficiency. Potential topics include the opportunities for improvement identified in **Section 2.10.11.2.1** through over- and under-utilization analysis. After identifying the topic, we begin developing the initiative using the plan-do-study-act Model shown in **Figure 2.10.11.4-5**. We demonstrate the application of the approach below, using the Member Health Scorecard initiative as an example.

Applying The Plan Do Study Act Model	
Plan	**Member Health Scorecard** Enrollee awareness is a key driver of positive and effective change in health behaviors. To encourage enrollee engagement and awareness, we will create a dynamic scorecard to promote awareness of recommended preventive care and chronic condition management to prompt action towards positive health behaviors. The scorecard will include health indicators based on compliance status and health tips determined by age, gender, and disease. We will partner with providers to promote collaboration across the continuum of care for consistent communication to the enrollee.
Do	Develop and implement an Member Health Scorecard pilot based on evidenced based guidelines to include: • Activation and awareness. • Health indicators. • HEDIS messaging. • Health tips specific to population.
Study	Evaluate predictions through data analysis and enrollee feedback. Track and trend control group and pilot enrollees to determine compliance status and health outcomes. Determine effectiveness of tool in facilitating gap closures. Gain enrollee insight and feedback through a focus group to supplement development.
Act	Implement needed modifications and expand to broader population.

Figure 2.10.11.4-5: *Applying The Plan-Do-Study-Act Model.*

Monitoring implementation And Outcomes Of Activities

Our Health Outcomes Workgroup provides a formal process to monitor and review plan-wide performance improvement initiatives for effectiveness, as well as to provide oversight of initiative implementation and roll-out. The workgroup includes our CEO, CMO, Behavioral Health Medical Director, COO, Population Health Director, Enrollee Services Director, and Provider Supports Director among other key topic specific

participants. The workgroup ensures that performance and regulatory objectives are adequately addressed and that health initiatives remain on task. Teams identify both external benchmarks and internal improvement goals. Ongoing initiatives, such as our Prematurity PIP Intervention Tracking Measures, are monitored and evaluated throughout the year and/or at least annually for re-measurement of outcomes, identification of barriers, and re-adjustment of the process.

2.10.11.5 Clinical Practice Guidelines

AmeriHealth Caritas Louisiana will coordinate the development of CPGs with other MCOs to avoid providers receiving conflicting information.

AmeriHealth Caritas Louisiana's Clinical Practice Guidelines List

AmeriHealth Caritas Louisiana reviews, adopts, distributes, monitors, and revises uniform and objective evidence-based CPGs and preventive care guidelines relevant to the population that we serve **(Model Contract, 2.16.1.3.2)**. These guidelines facilitate the delivery of consistent, evidence-based, and cost-effective quality care leading to improvement of enrollees' health outcomes and the reduction of low value care. **Figure 2.10.11.5-1** provides a list of our current CPGs**,** including behavioral health CPGs that comply with **Model Contract, 2.12.1.2.**

AmeriHealth Caritas Louisiana Clinical Practice Guidelines
Asthma — Asthma Care Quick Reference, Global Initiative for Asthma.
Behavioral Health — Diagnosis of Attention-Deficit/Hyperactivity Disorder for Children and Adolescent, Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents, Treatment of Attention-Deficit/Hyperactivity Disorder for Children and Adolescents, Management of Bipolar Disorder in Adults, Primary Care Diagnosis and Management of Adult Depression, General Anxiety Disorder, Post-Traumatic Stress, Treating Schizophrenia: A Quick Reference Guide, Treatment of Patients with Schizophrenia, Screening, Diagnosis and Referral for Substance Use Disorders, Practice Parameter for Assessment and Treatment of Children and Adolescents with Oppositional Defiant Disorder, Assessment and Management of Patients at Risk of Suicide.
Bronchitis — Chronic Cough Due to Acute Bronchitis.
Cholesterol — Lipid Screening and Management, Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults.
Chronic Obstructive Pulmonary Disease — Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease, Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease.
Dental — Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents, Topical Fluoride for Caries Prevention.
Diabetes — Management of Diabetes Mellitus, The Journal of Clinical and Applied Research and Education. Diabetes Care.
Heart Failure — ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure, Adults with Heart Failure with Reduced Ejection Fraction.
Hemophilia — Management of Hemophilia.
HIV/AIDS — Recommendations for HIV Prevention With Adults and Adolescents with HIV in the United States, Revised Recommendations for HIV testing of Adults, Adolescents, and Pregnant Women in Healthcare Settings.
Hypertension — Medical Management of Adults With Hypertension; Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults.
Lower Back Pain — Management of Acute Low Back Pain in Adults.
Obesity — Management of Overweight and Obesity in the Adult, Prevention and Identification of Childhood Overweight and Obesity, Screening and Management of Overweight and Obesity, Treatment of Childhood Overweight and Obesity.
Palliative Care — National Consensus Project for Quality Palliative Care.
Preventive Health — Bright Futures Periodicity Schedule (EPSDT), Adolescent and Young Adult Health Risk Behavior Assessment, Routine Preventive Services for Infants and Children (birth - 24 months), Routine Preventive Services for Children and Adolescents (age 2-21), Adult Preventive Services (ages 18-49), Adult Preventive Services (age >=50), Increasing Access to Contraceptive

AmeriHealth Caritas Louisiana Clinical Practice Guidelines
Implants and Intrauterine Devices to Reduce Unintended Pregnancy, Recommended Immunization Schedules, Sexually Transmitted Diseases, Tobacco Use in Children and Adolescents: Primary Care Interventions.
Routine Prenatal and Postnatal Care — Primary Care Interventions to Promote Breastfeeding, Routine Prenatal and Postnatal Care.
Sickle Cell Disease — Evidence-Based Management of Sickle Cell Disease.
Upper Respiratory Tract Infections — Acute Pharyngitis in Children 3-18 Years Old, Antibiotic Prescribing and Use in Doctor's Offices, Uncomplicated Acute Bronchitis in Adults.

Figure 2.10.11.5-1: *AmeriHealth Caritas Louisiana Clinical Practice Guidelines.*

Sample Clinical Practice Guideline

Please see **Attachment 2.10.11.5-1: Sample Clinical practice Guideline — Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents.**

2.10.11.5.1 Developing And Disseminating Clinical Practice Guidelines

Developing Clinical Practice Guidelines — AmeriHealth Caritas Louisiana's CMO participates in the Clinical Policy Committee with other affiliate health plans to review existing research sources including clinical and technical literature, and consult with board-certified providers from appropriate specialties or professional organizations when developing CPGs. Whenever possible, we adopt existing CPGs from recognized professional organizations such as the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Diabetes Association, National Institutes of Health, American Cancer Society, and American Psychiatric Association. AmeriHealth Caritas Louisiana's QAPI Committee, which includes network providers representing various specialties including behavioral health, is responsible for identifying topics for CPG development. The QAPI Committee also ensures that guidelines reflect our enrollees' needs and characteristics and align with local community standards of practice. The QAPI Committee provides final approval on the processes and venues or the distribution of the CPGs to providers, enrollees, and potential enrollees **(Model Contract, 2.12.1.5)**.

Disseminating CPGs To Providers — CPGs are available through our website where providers can review, download, and use them. We inform providers about the availability of our CPGs through notification in the provider manual, the provider newsletter, and other provider communications. Providers may receive additional education through face-to-face interactions, regional provider training, and webinars. When we adopt new CPGs, provider offices receive notification of availability, typically through a fax or email blast.

Disseminating CPGs To Enrollees — Information related to CPGs is included in our enrollee newsletters. This information is also included in the Member Handbook. Enrollees are invited to call Enrollee Services to request a copy or to access the guideline through the AmeriHealth Caritas Louisiana website.

2.10.11.5.2 Incorporating Expert Opinions Into Clinical Practice Guidelines

Our QAPI Committee includes providers in multiple specialties who provide input on local standards of practice when they are reviewing proposed CPGs. As appropriate, we call upon additional medical experts possessing the appropriate board certification and/or expertise relevant to the CPG topic and target population to assist in the decision making process.

2.10.11.5.3 Evaluating/Encouraging Adherence To Clinical Practice Standards

Evaluating Provider Adherence

AmeriHealth Caritas Louisiana uses a multidimensional approach to monitor provider adherence to CPGs. At the individual provider/medical group level, we monitor HEDIS and other LDH defined metrics to identify gaps in expected care based on CPGs. We include provider level results in bi-annual Provider

Report Cards for PCPs and OB/GYNs and as metrics on performance-based/value-based contracts and Monthly HEDIS Performance Provider Report Cards. We share actionable data with our providers so that they can conduct enrollee outreach and close gaps in care according to evidence-based guidelines. In addition, AmeriHealth Caritas Louisiana monitors compliance with CPGs for specialized behavioral health services providers. **(Model Contract, 2.12.1.6)**. The monitoring process includes a medical record review related to behavioral health and substance abuse disorders for a random sample of providers. Non-compliant providers are educated on the CPGs, re-surveyed after six months, and/or required to develop corrective action plans. **Figure 2.10.11.5-2** provides our 2018 compliance rates.

Clinical Diagnosis	CPG Compliance Rate	Clinical Diagnosis	CPG Compliance Rate
Major depressive disorder	86.10%	**Schizophrenia**	86.67%
Attention deficit/hyperactivity disorder	73.37%	**Post-traumatic stress disorder**	96.67%
Substance abuse	100%	**Bipolar disorder**	95.47%
Generalized anxiety disorder	97.73%	**Oppositional defiant disorder**	86.47%

Figure 2.10.11.5-2: *2018 Behavioral Health CPG Compliance Rates*

MONITORING PROVIDERS' COMPLIANCE WITH CPGS.

Encouraging Provider Adherence To Clinical Practice Guidelines

AmeriHealth Caritas Louisiana requires all contracted providers to use relevant clinical practice and evidence-based guidelines. We encourage provider adherence by:

- Engaging them in the CPG review and approval process.
- Including CPG related process and outcomes metrics in performance/value-based provider payments and incentives, for both clinical and behavioral health providers.
- Selecting, rewarding and promoting a Quality Champion based on statistically significant improvement in their quality performance.
- Providing access to alerts on their patients' care gaps via portal and through direct feeds to EHRs.

We have adopted the American Board of Internal Medicine's (ABIM) Choosing Wisely® initiative's clinical recommendations towards promoting evidence-based, cost effective, and patient-centered care. The Choosing Wisely principles promote a conversation between providers and enrollees by helping enrollees choose care that is supported by evidence, not duplicative of other tests or procedures, free from harm and truly necessary. For example, in our prenatal program Bright Start, we identify pregnant enrollees using harmful medications including opioids and initiate a conversation between the provider and the enrollee. **(Model Contract, 2.16.2.3.3)**. Other Choosing Wisely initiatives include Pap tests performed before age 21 and lumbar spine imaging for uncomplicated low back pain.

2.10.11.5.4 UPDATING AND REVISING CLINICAL PRACTICE GUIDELINES

AmeriHealth Caritas Louisiana conducts ongoing surveillance of new clinical evidence and updated protocols based on national trends and outcomes from national medical entities. At least annually, our QAPI Committee reviews and updates all adopted CPGs, as appropriate, taking into consideration local community standards of practice as well as any change in population characteristics.

2.10.11.6 AmeriHealth Caritas NCQA

Please see **Attachment 2.10.11.6-1 AmeriHealth Caritas National Committee for Quality Assurance Ratings.**

2.10.12
Value-Based Payment

The winner of the inaugural AmeriHealth Caritas Louisiana Diamond Chef competition (part of the Control Your Diabetes, Control Your Destiny program) poses with her trophy.

AmeriHealth Caritas™
Louisiana

2.10.12 Value-Based Payment

Value-Based Payment Strategic Plan

AmeriHealth Caritas Louisiana began implementing alternative payment methodologies in 2014 with the launch of our PerformPlus® Value-Based programs. PerformPlus is our comprehensive suite of value-based payment (VBP) programs, which include Health Care Payment - Learning Access Network (HCP-LAN) Categories 2C, 3A, 3B, and 4A.

We designed PerformPlus to support care and payment transformation in Louisiana. Today, AmeriHealth Caritas Louisiana partners with providers across the state, in various specialties, with different panel sizes and patient populations in value-based care.

*In 2018, AmeriHealth Caritas Louisiana increased provider payments in VBP arrangements by 22.1%, **a 75% increase over our baseline year** (2017) exceeding LDH's requirement for a 10% increase in VBP payments by July 2019.*

A cornerstone of our VBP strategy is to meet providers where they are; tailored programs fit the needs (and capabilities) of provider partners based on where they are on the HCP-LAN Alternative Payment Model (APM) continuum. We design VBP programs that align with provider needs to ensure provider success, and set a strong foundation for continued growth in value-based care. We reward providers for improving health care in the state of Louisiana. Our program goals align with the Louisiana Department of Health's (LDH) goals to improve the health of populations, enhance the experience of care for individuals, and effectively manage per capita care costs. AmeriHealth Caritas Louisiana will meet all requirements set forth in **Model Contract, 2.17** and **MCO Manual 2.17.**

Over the last five years, we have established a strong foundation for value-based care. In 2016, we were the first managed care organization (MCO) in the state to offer a value-based payment arrangement to behavioral health providers. In 2018, we paid over $4.3 million to reward providers for improved cost and quality outcomes. Our VBP strategy focuses on continued expansion of our use of value based purchasing and the use of partial and full risk arrangements. We will continue building on that foundation to promote health care transformation in Louisiana.

AmeriHealth Caritas Louisiana submitted our initial VBP Strategic Plan to LDH in August of 2018, and will submit new plans annually by November 1, as required in **Model Contract, 2.17.5**. We deploy strategies and associated tactics detailed in our plan to achieve goals:

- Increase offering of innovative program options, emphasize Category 3 and 4 arrangements.
- Expand to providers new to VBP arrangements.
- Accelerate provider evolution along the APM continuum in consideration of provider readiness for financial risk.
- Improve quality, cost, and enrollee satisfaction outcomes.

Throughout our response we describe efforts and results to date toward those goals, plans for continued growth in provider participation, expansion of current programs to new provider types, and innovative new programs that support providers' evolution along the HCP-LAN APM continuum.

2.10.12.1 VBP Models To Meet 2020 Provider Payment Thresholds And Provider Incentive Earnings Impact

We continue to build upon our current VBP strategy and programs through innovative development and implementation of new APM models, and current model enhancement. Throughout our response, we

describe how we will meet requirements in **Model Contract, 2.17.2**. Programs in **Figure 2.10.12.1-1** are in place prior to the Contract execution.

AmeriHealth Caritas Louisiana VBP Programs In Place At The Time Of Contract Execution	
HCP-LAN Category	**VBP Program**
Category 2 Fee-for-service – Link to quality & value	**Perinatal Quality Enhancement Program (PQEP)** Our PQEP model provides incentives for participating obstetric and midwife practitioners with a minimum of 15 live births in a six-month measurement period that deliver high quality care focused on prenatal/postpartum care, STI screening, 17P administration among eligible mothers, C-Section rate, and severity of illness components in recognition of expertise required to manage complex pregnancies. **Provider Type:** OB/GYNs and certified nurse midwife practitioners.
Category 2 Fee-for-service – Link to quality & value **or** **Category 3** APMs built on fee-for-service architecture	**Comprehensive Primary Care Plus (CPC+)** CPC+ is a multi-payer care delivery and payment model focused on aligning provider incentives across Medicare, Medicaid & commercial insurance. Practices approved for participation may participate in either Track 1 or Track 2 of CPC+. Track 1 is the choice for practices ready to build the capabilities to deliver comprehensive primary care. Track 2 is targeted to practices that have built these capabilities, and are poised to increase the comprehensiveness of care, and to improve care for patients with complex needs. **Provider Type:** PCPs.
Category 3 APMs built on fee-for-service architecture	**Community Partners Program (CPP)** CPP is designed to improve patient health, reduce unnecessary costs, and promote accountable care. The program contains both quality and cost efficiency incentives. **Provider Type:** FQHCs, large primary care groups, and others with infrastructure to use data for population health management
Category 3 APMs built on fee-for-service architecture	**Quality Enhancement Program (QEP)** OEP provides incentives in shared savings in Category 3 to PCPs that deliver high-quality and cost-effective care; quality customer service; convenience; and accurate and complete health data while effectively managing risk-adjusted total cost of care. This program provides higher reimbursement to PCPs that are recognized as a patient-centered medical home and maintain an open panel; providers that permit our access to their EHRs; and those who use Community Health Worker resources. **Provider Type:** PCPs, Patient Centered Medical Homes (PCMHs).
Category 3 APMs built on fee-for-service architecture	**Bundled Payments For Episodes Of Care** Our bundled and episode payment programs reward providers that improve quality and manage the cost of care associated with specific episodes of care. These arrangements can include gain- and risk-sharing incentives. We can support bundled payment programs for more than 90 healthcare episodes. **Provider Type:** PCPs, Specialty Care Providers, Integrated Delivery Systems.
Category 3 APMs built on fee-for-service architecture	**Shared Savings Programs (SSP)** SSPs reward integrated delivery systems and specialty care providers for effectively addressing the needs of enrollees across multiple care settings which eliminates fragmentation and waste and delivers better clinical outcomes. We share the savings generated by high quality care management and care coordination with the providers as a financial incentive for delivering cost effective care. **Provider Type:** Integrated Delivery Systems, Accountable Care Organizations (ACOs), Specialty Care and Behavioral Health Providers.

AmeriHealth Caritas Louisiana VBP Programs In Place At The Time Of Contract Execution	
HCP-LAN Category	**VBP Program**
Category 3 APMs built on fee-for-service architecture **or** **Category 4** Population-Based Payment	**Partial- Or Full-Risk Programs** Partial (Category 3) or Full-Risk (Category 4) programs target integrated delivery systems and ACOs. These programs focus on specific populations using clinical risk grouping algorithms including specific clinical risk group cohorts for partial risk arrangements. Providers responsible for care, including participating PCMHs receive a portion of the savings. Agreements can include upside-only or two-sided risk. We base bonus payments for full risk models on predetermined or trend-based medical loss ratios. **Provider Type:** Integrated Delivery Systems, ACOs, FQHCs, large primary care groups, and others with infrastructure to use data for population health management.

Figure 2.10.12-1: *AmeriHealth Caritas Louisiana Value-Based Payment Programs. In Place At The Time Of Contract Execution*.

EMPHASIS WE PLACE ON PROVIDER EVOLUTION ALONG THE APM MODEL CONTINUUM

Helping providers advance along the APM continuum is critical to successful payment and care transformation. We approach each provider practice individually to assess capabilities and characteristics of their patient population. The AmeriHealth Caritas Louisiana Practice Transformation Team (PTT) administers initial and annual assessments to evaluate leadership commitment to participation in a VBP program, readiness for risk, identification of planned performance improvement strategies, use of health information technology to support clinical processes, demonstration of favorable trends in cost of care management and utilization of a team-based care approach. Our PTT (described in detail in response to **Section 2.10.12.4**) helps providers build competency through comprehensive data analytics and timely sharing of actionable data for population health management.

Over the last several years, we have leveraged our success in building provider relationships, as evidenced by our top-ranked provider satisfaction survey results, to make great progress moving providers along the continuum. Recent achievements include:

- Eight AmeriHealth Caritas Louisiana provider practices serving nearly 30,000 enrollees have advanced from Category 2C to Category 3 since 2017.
- Evolved our QEP program offering to include a total cost of care component.
- Scheduled advancement to ACO-like arrangements.

Provider Evolution in Practice *– Children's International Medical Group*
This QEP program PCP achieved excellent quality scores on their report card. We recognized their outstanding achievements with our Provider Quality Champion award. Based upon achievement of measurable improvements in enrollee quality measures, the Practice Transformation Team and PCP strategized about other potential models, including a Medical Loss Ratio (MLR) program. Agreement to this advanced model demonstrated the provider's readiness to move along the APM continuum. The PCP is a very engaged partner; they use the provider dashboard to monitor HEDIS results, clinical reports (care gaps, ED use, hospital discharge information), and financial spend reports to drive enrollee outreach initiatives.

PerformPlus® New Innovative Value-Based Care Models

In addition to our current suite of PerformPlus® programs as described in **Figure 2.10.12.1-1**, our VBP goals for innovation and acceleration include introducing new VBP arrangements over the initial three Contract years. Including but not limited to:

[redacted] —

[redacted]

Partial or Full Risk with ACO (Category 3 or 4) — This clinically integrated program is a collaboration with [redacted] designed to develop active and ongoing clinical initiatives focused on delivering quality, performance, efficiency and value to the enrollee. The program is available to providers engaged in development and implementation of an active and ongoing program to evaluate and modify practice patterns of participating physicians and other participating providers. We design incentives to create a high degree of interdependence and cooperation among providers, to control costs, ensure quality, and improve enrollee satisfaction.

PROVIDER INCENTIVE EARNINGS IMPACT

We designed our PerformPlus® portfolio to allow providers to progressively assess and improve readiness to receive incentives based on quality measures. We continually work with providers to advance their readiness to accept and succeed in higher risk programs. This includes broadening the opportunity for all providers to participate in VBP arrangements and moving toward both upside and downside risk. In 2018, 22 percent of AmeriHealth Caritas Louisiana's provider incentive payments were connected to VBP programs, which already exceed the requirement in **Model Contract, 2.17.2.1.1** of at least 20 percent and $4 million or more in provider incentive payments in 2020. We expect to build upon this success. **Figure 2.10.12.1-2** illustrates expected and maximum payments, and maximum losses providers may experience in 2020 by HCP-LAN Category.

[redacted]

[redacted]

2.10.12.2 Quantitative, Measurable Improvements In Clinical Outcomes

Through our PerformPlus® programs, we reward providers whose efforts demonstrate effective ambulatory care coordination, support enrollee adherence to planned care, and efficiently manage care transitions. We reward providers who positively impact potentially preventable event (PPE) outcomes: ED utilization, acute care admissions, and readmissions. Realizing that improved outcomes are beyond clinical and financial results, we incentivize providers who properly submit social determinants of health (SDOH) codes to support whole-person care.

Working with provider partners to tailor our VBP programs, we have laid the foundation for improved outcomes with increasingly complex populations. When Louisiana's Medicaid Expansion took effect, AmeriHealth Caritas Louisiana recognized many of our VBP providers would be assuming risk for a population with unchecked health conditions. We implemented an enhanced provider reimbursement campaign, through which providers received $4.8 million in incentives for establishing relationships with over 51,000 new Medicaid expansion enrollees.

Even while assimilating the expansion population into membership, we were realizing improved outcomes for this sub-population. In the first full year of Medicaid Expansion, our PerformPlus® providers positively impacted PPE outcomes for their enrollees, as shown in **Figure 2.10.12.2-1.**

Potentially Preventable Events - 2017 reporting	Percent Reduction
Potentially Preventable Admissions (PPAs).	8
Potentially Preventable Readmission (PPRs).	3
Potentially Preventable Emergency Department Visits (PPVs).	9

Figure 2.10.12.2-1: *2016 PPE Impact - performance in aggregate of VBP providers reported in CY 2017.*

AmeriHealth Caritas Louisiana's Impact on Quality Measures

By combining provider experiences and strengths, we set goals with the highest likelihood of success. Successful experiences improve provider engagement. Our Community Partners program outcomes in 2017 (reported in 2018) demonstrated significantly improved HEDIS rates. We realized 22.1 percent improvement for well child visits for ages 3-6 years; 10.4 percent increase in breast cancer screenings, a 12.7 percent increase in cervical cancer screenings, and 13.2 percent improvement for appropriate upper respiratory treatment.

QUALITY MEASURES AMERIHEALTH CARITAS LOUISIANA SEEKS TO IMPROVE

AmeriHealth Caritas Louisiana works collaboratively with providers to improve quality outcomes for our enrollees and align with LDH's Quality Improvement goals as described in **Model Contract, Attachment G.** We will leverage collaborative provider network efforts such as LDH's Managed Care Incentive Payment program to drive toward the Triple Aim. While we tied for first in the state among Medicaid plans with an overall 3.5 Quality NCQA 2018 – 2019 rating, we recognize opportunities for improvement in our HEDIS measures, as well as other key outcome measures, as detailed in **Figure 2.10.12.2-2**. As such, we are committed to targeting the following quality outcome measures with annual goals that drive significant statewide improvement trends in our value based contracts.

Categories	Measures
Wellness	• Colorectal Cancer Screening/ Cervical Cancer Screening. • Childhood Immunization Status: Combo 10.
Chronic Disease	• Controlling Blood Pressure. HbA1c <8 (CDC).
Maternal	• Cesarean Rate for Low-Risk First Birth Women (NSV).
Behavioral Health	• Follow-Up After Emergency Department Visit for substanc use or dependence. • Depression Screening and Follow-Up for Adolescents and Adults.
ER Utilization	• Potentially Preventable Emergency Department Visits (PPVs).
Readmissions	• Potentially Preventable Readmission (PPRs).
Reduce Low Value Care	• Non-recommended Cervical Screening (NCS). • Use of Imaging Studies for Low Back Pain (LBP). • Appropriate Treatment for Children with Upper Respiratory Infection (URI).

Figure 2.10.12.2-2: *Quantitative, Measurable, Clinical Outcomes Targeted for Improvement.*

2.10.12.3 How We Will Expand Value-Based Payment Arrangements

AmeriHealth Caritas Louisiana will build on our existing foundation of value-based care through a multifaceted approach, including: VBP program evaluation and education to increase provider participation, innovation in new VBP offerings, and acceleration of VBP growth with existing partners. We will target providers that have engaged with our teams, demonstrated ability to effectively use data for performance improvement, and initiated practice transformation strategies to drive measurable improvements. [redacted] Through our multidisciplinary approach to performance improvement and provider engagement, we will meet or exceed targets for VBP Thresholds as outlined in **Model Contract, 2.17.2** by establishing LDH preferred programs required in **Model Contract, 2.17.9.** We will achieve VBP program growth utilizing three overarching strategies:

- Evaluating and educating provider practices not yet participating in VBP programs to increase provider participation.
- Accelerating provider transitions to advanced APM models.
- Implementing innovative new programs, leading multi-payer collaboration.

Our specific goals, and tactics detailed in **Figures 2.10.12.3-1 through 2.10.12.3-3** follow.

STRATEGY 1: EDUCATE PROVIDERS TO PROMOTE VALUE-BASED CARE PRINCIPLES

Prior to promoting care and payment transformation, it is crucial to build an understanding of value-based principles. Education and evaluation promotes VBP growth across all of our models, including LDH preferred models referenced in **Model Contract, 2.17.9**.

Our strategy, goals, and tactical approaches to promoting provider understanding of value-based care are detailed in **Figure 2.10.12.3-1**.

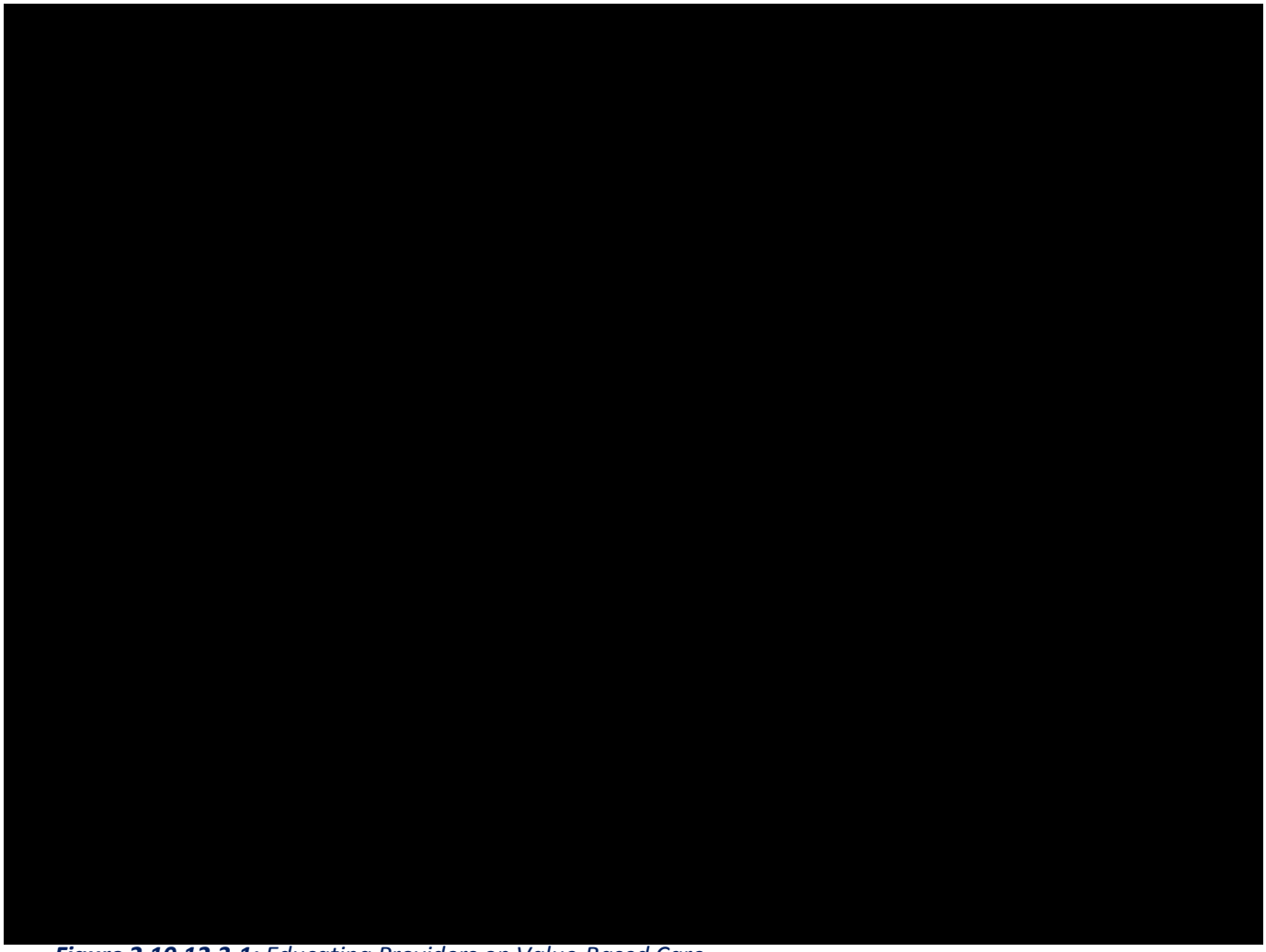


Figure 2.10.12.3-1: *Educating Providers on Value-Based Care.*

An example of how we promote our VBP goals is through Mental Health First Aid training, designed to promote better understanding of mental health and how to recognize when someone is in crisis. The Family Clinic's interest in behavioral health integration led directly to development of their customized and individualized bundled payment program.

We worked with a PCP group who participates in the CPC+ program. The group was developing care practices to improve treatment for depression and anxiety. After the group attended AmeriHealth Caritas Louisiana Mental Health First Aid training, our practice transformation team saw their excitement about their integrated behavioral health program. From this experience, we developed a bundled payment program around depression screening using the PHQ-9 tool, anti-depressant medication management, and follow-up after hospitalization. This program is now available to AmeriHealth Louisiana PCP and Behavioral Health providers.

STRATEGY 2: ACCELERATE PROVIDER TRANSITIONS TO ADVANCED APM MODELS

Supporting the acceleration of providers' transitions along the APM continuum promotes VBP growth in advanced APM models.

Our specific strategy, goals, and tactical approaches for supporting provider transition to advanced APM models are described in **Figure 2.10.12.3-2**.

Figure 2.10.12.3-2: Support Provider Transition To Advanced APMs.

The evolution of our PerformPlus QEP program is an example of how we encourage providers to participate in preferred payment arrangements. When first introduced, the program was designed to improve provider quality performance. We have helped providers understand the tenets of the program and supported their growth as participants. High-performing providers have demonstrated readiness for more advanced APM models; we are enhancing our QEP program in response.

The enhanced program will transition an increasing majority of our primary care providers from a Category 2C to a Category 3 model. While the current QEP program measures for preventable events contribute to the total cost of care, the QEP model incorporates measures tied to effective management of risk adjusted total cost of care targets.

We are committed to supporting providers in their efforts to evolve along the APM Continuum. Leaders at every level, including our Practice Transformation Team, Actuarial, Finance, Quality, Medical Directors, executive team and others, contribute to provider advancement. A case in point is Care South.

Care South expressed an interest in a MLR value-based agreement to their local Account Executive. As part of the consideration process, AmeriHealth Caritas Louisiana actuaries modeled their historical and current MLR trend results, and assessed the panel threshold. We reviewed results with the CEO and Quality Director, and provided an overview of identified cost drivers. Our Practice Transformation Director demonstrated HEDIS and enrollee clinical summaries, care gap, admission, discharge, and ED utilization through the Provider Portal, and showed them how to interpret report data. The Practice Transformation Director supported development of engagement strategies to promote care gap closure, evolve the medical home model, and encourage appropriate utilization of resources. Initially, the group did not have enough attributed members to meet the MLR program threshold. Through practice transformation work, we assessed non-attributed enrollees accessing Care South's services, and we are utilizing the new enrollee assignment algorithm to reassign non-attributed enrollees and build sufficient membership to allow transition from the QEP to the MLR program.

STRATEGY 3: DESIGN AND IMPLEMENT INNOVATIVE NEW VALUE-BASED CARE MODELS

Offering a comprehensive portfolio ensures we have a program for every provider, at every point of the VBP continuum. Continuous program innovations allow us to introduce new and creative VBP programs. In 2020 we plan to offer new programs for post-acute care providers in our PerformPlus® Open Arms program**;** our PerformPlus SUD providers through New Beginnings - Substance Use Disorders (SUD) treatment Incentives**;** and oncology providers. We detail the steps we will take to implement our innovative new programs in **Figure 2.10.12.3-3.**

Goal	2020	2021	2022
Evaluate ongoing models for rural providers and those with smaller panel sizes that may not be in a position to move along the continuum to a financial risk model.	Target specific opportunities for improvement applicable to the rural/small panel size practices to promote VBP success and innovation. *Program name:* [redacted] **(Model Contract, 2.17.9.1.1, 2.17.9.1.2, 2.17.9.1.4)**.	Evaluate pros and cons of models and provider engagement/success. Update/modify strategy as appropriate. *Program name:* [redacted] **(Model Contract, 2.17.9.1.1, 2.17.9.1.2, 2.17.9.1.4)**.	Assess provider spend and graduated opportunities for earning performance incentive payments. *Program name:* [redacted] **(Model Contract, 2.17.9.1.1, 2.17.9.1.2, 2.17.9.1.4)**.

Goal	2020	2021	2022
Develop VBP models to promote the principles of accountable care with [redacted]. **Potential providers:** [redacted].	Identify potential provider partnerships with [redacted] *Program name:* [redacted].	[redacted] *Program name:* [redacted]	[redacted] *Program name:* [redacted].
[redacted]	Expand number of providers that have Population Health management measure as part of VB program. *Program name:* [redacted].	Identify priority populations and incorporate related measures in VB programs. *Program name:* [redacted].	Couple downside risk arrangements that align with incentives with care delivered in the VB program. *Program name:* [redacted].

Figure 2.10.12.3-3: *Design and Implement New Value-Based Care Models.*

In an identified area of the state that did not have the optimal number of pediatricians in our network, we partnered with a well-respected local practice to develop a new model to meet their needs.

> *The Pediatric Center of Southwest Louisiana joined our network on 1/1/19. During the contracting phase, they indicated wanting an alternative payment model as soon as their contract became effective. We developed an MLR program for them and built it around their existing quality strategy, to easily integrate with their high quality focused operations. The practice transformation team worked closely with practice leadership to educate on: using clinical data available, making targeted outreach calls, closing care gaps, and addressing immediate care needs.*

2.10.12.4 Supporting Providers In Successful Delivery System Reform

AmeriHealth Caritas will continue to leverage experience working with VBP partners in Louisiana and other markets to support providers in successful delivery system reform through our VBP arrangements.

Leading Multi-Payer Collaboration

AmeriHealth Caritas Louisiana is leading delivery system and payment reform in various ways including but not limited to:

Provider profiling and data sharing- AmeriHealth Caritas Louisiana initiated collaboration with all MCOs as called for by the first quarter of 2019 for the standardization of Provider Report Cards to ensure provider convenience and ease of use. This collaborative approach produces real-world results by driving enrollee outreach solutions improving engagement. We look forward to advancement and development of standardized provider profiling to support data sharing in VBP arrangements as outlined in MCO **Model Contract, 2.17.12**.

CPC+ - AmeriHealth Caritas Louisiana was **an early adopter of Medicaid CPC+.** We were one of very few MCOs who applied for program participation in the first invitation from CMS for payer applications, and one of a limited number of health plans in the state **participating in CMS' CPC+ for Medicaid**. As required in **Model Contract, 2.17.5.3.3**, AmeriHealth Caritas Louisiana's VBP strategy aligns with CMS APMs and multi-payer VBP models.

Multi-payer collaboration is a critical component of the CPC+ model. **Model Contract, 2.17.7.3** requires participation in LDH directed VBP Workgroups and payment reform initiatives. AmeriHealth Caritas Louisiana has taken a leadership role in these workgroups and initiatives. **We hosted and facilitated the first Louisiana Payer partner collaboration meeting.** Lee Reilly, our Practice Transformation Director, developed the CPC+ Payer Partner collaboration roadmap and milestones, tracked progress against goals and coordinated monthly payer partner meetings through the first of the five year CMS CPC+ initiative. Lee attends and participates in regional and national meetings, as well as a local learning collaborative.

TRANSFORMATION SUPPORT

Our practice transformation team focuses on primary care practice transformation, assistance with data and report interpretation, and other activities supporting provider VBP readiness and performance improvement.

Practice Transformation Director

Our Practice Transformation Director, Lee Reilly, leads a multidisciplinary team comprised of local account executives, medical informatics, quality improvement, and behavioral health staff, as well as other subject matter experts to support practices as they build capacity for continuous quality improvement. Born and raised in Louisiana, Lee has ten years of first-hand experience in provider practices, and more than twenty-three years of health plan experience in various capacities. She has been a certified case manager for sixteen years and is committed to delivering quality care to communities she serves.

Practice Transformation Team

Our practice transformation team includes four dedicated associates who continuously update and reevaluate our APM programs through regularly scheduled face-to-face meetings, and ad hoc interim communications (phone and email). This team visited 115 practices in 2018 to provide expert support, including:

- Coaching providers through on-site practice transformation coaches with expertise in quality improvement, population management, service coordination, and data analysis.
- Implementing integrated health care and medication management strategies, including opioid use programs, where appropriate.
- Demonstrating tools for rapid-cycle improvement and patient registries for identifying care gaps and tracking outcomes.
- Assisting with proactive, data-driven identification of enrollees likely to benefit from targeted interventions, and help empower enrollees to participate in their own health improvement.
- Promoting primary care practice attainment of PCMH Recognition or Accreditation through technical assistance and data as required in **Model Contract, 2.17.8**.
- Providing initial and ongoing training on our PCP assignment and provider attribution methodologies and processes as required in **Model Contract, 2.17.7.4.**

Our partnership with the Daughters of Charity was highlighted through a joint presentation by Lee Reilly and other AmeriHealth Caritas leaders together with DCHC leaders at the National Association of Community Health Centers 2018 national conference.

"Lee Reilly is a valuable contact for us at Daughters of Charity! She helps us understand our status on quality measures by providing reports at our weekly meetings and walking us through the data. She goes above and beyond by strategizing ways that we can improve and educating us on resources available through AmeriHealth Caritas. She stays engaged in between meetings by answering any of the questions we have through phone or email. Our team is improving its processes for managing our enrollee panel because of the information Lee provides."

Anna Villanueva, Family Nurse Practitioner

In addition to our detailed strategies, goals, and tactics, we created our Provider Learning Continuum training program in 2018. This program is available to all providers and their staff. Through this initiative, we prioritize provider education needs and provide timely and relevant information in the preferred, most convenient way (email, face to face, phone, or on-demand). As a part of our Provider Advisory Council, a Learning Continuum Workgroup will assist in the creation, implementation, and review of provider education strategies and efforts. We ask participating providers to give input and feedback on training topics, provider education materials, and dates and locations of provider education workshops and events.

Technical Assistance And Data

We support providers in the transition to value-based care and reimbursement through transparent and responsible data sharing practices. To enable providers to continuously monitor performance, we provide interactive and customizable self-service performance dashboards; data is refreshed and updated for providers at least monthly, as required in **Model Contract, 2.17.7.2**. We provide dashboard user training and technical assistance by phone or in person. We also offer ad hoc claims data that includes comprehensive raw claims extracts and supplements dashboard data, allowing a provider to import AmeriHealth Caritas data to integrate with their own clinical data and other payer data, for a consolidated view.

AmeriHealth Caritas Louisiana equips providers participating in our PerformPlus programs with population-level data available on demand through a web-based dashboard with self-service drilldown reporting capabilities to the facility, provider, and enrollee levels. Our PerformPlus dashboard capabilities, described in **Figure 2.10.12.4-1** below, include key VBP performance indicators, clinical and risk stratification, care gap reports, and enrollee profiles.

Dashboard Components	Description
Aggregate and claims-level detail	Historical and rolling 12-month risk-adjusted enrollee utilization and claims-level data.
Clinical risk groupings	Clinical model that assigns each enrollee to mutually exclusive risk categories to predict health care costs and utilization by integrated delivery system, provider group, disease cohort, and enrollee.
Gaps in care measures	Disparity between health care needs and health care services.
HEDIS measures	Industry-standard quality and performance measurements.
Other quality performance measures	Additional quality metrics used as components for VBP programs, including neonatal intensive care unit days per thousand, cesarean section rates, and cost-efficiency management.
Patient profile complete with detail data	Detailed, enrollee-specific utilization data, including risk score, clinical category, demographics, preventable data, and cost values.
Potentially preventable events	Events deemed potentially preventable include admissions, readmissions, preventable services, Emergency Department visits, and complications.
Self-service reports	Customizable reports that display historical detail data or aggregated rolling 12-month enrollee- and provider-level information, such as care management patient lists, population health data, newly chronic enrollees, and no office visit in the last six months. Report parameters can be customized at the network or provider level to support internal and

Dashboard Components	Description
	provider quality management.
Total cost of care	Total actual inpatient, outpatient, provider, and pharmacy costs, as compared with total expected costs per enrollee per month.
Utilization data	Actual utilization data for admissions, Emergency Department, specialists, and pharmacy benefits, as compared with total expected utilization at a PMPM level.

***Figure 2.10.12.4-1**: PerformPlus Dashboards.*

DIRECT SECURE MESSAGING

Provider partners have communicated preference for information to be uploaded to their electronic health record (EHR) where they can best leverage and maximize performance. Today, many providers use direct secure messaging for transitions in care and referrals. Certified EHRs can now accept HIPAA secure direct messages and insert data into the enrollee's medical record. Consequently, we see direct messaging as a low-touch/high-value opportunity to efficiently communicate important enrollee information.

AmeriHealth Caritas Louisiana has initiated this exchange with a limited group of willing provider practices to test our ability to automate sending enrollee clinical summaries as updated, based on utilization. Using direct messaging to the provider's EHR makes it easier for providers to achieve performance goals and improve quality. As we grow our participating providers in this program, we will be able to choose what they want to receive from a menu of information options including:

- **Care Gaps** — Providers may choose which preventive services they want to receive and when.
- **Encounter Notifications** — ADT (admit, discharge, transfer) notifications on all attributed enrollees or only those for high-risk.
- **Out of Network Admissions** — Providers can receive real-time alerts for enrollees who have been admitted to a facility outside the provider's delivery system.
- **Deterioration Of Health Status** — Alerts are sent when a significant deterioration in the health status of an enrollee is detected by AmeriHealth Caritas Louisiana.
- **Failure To Treat** — Alerts are sent when an enrollee has been newly assigned to a provider's panel but not had an initial visit in the agreed upon time frame.
- **Clinical Summary** — For any of the above options a clinical summary can be attached that includes dispensed medications, visit history, labs, SDOH, care gaps, and care team information.

AmeriHealth Caritas Louisiana will continue to develop and offer a broad variety of VBP models, ensuring programs meet the full array of our provider needs. Our team works closely with individual provider partners to customize models, design programs that align with the Triple Aim Initiative, and promote lasting relationships. We design programs to evolve with providers as their experience with delivering value-based care grows.

This page is intentionally left blank.

2.10.13
Claims Management and Systems and Technical Requirements

AmeriHealth Caritas Louisiana associates participate in a National Alliance on Mental Illness (NAMI) walk.

AmeriHealth Caritas™
Louisiana

2.10.13.1 Customizing A Louisiana Specific Claims Adjudication System

A trusted partner since the inception of Louisiana's Medicaid managed care program in 2012, AmeriHealth Caritas Louisiana has proven our deep comprehension of the Louisiana Medicaid program, applicable state administrative rules, and statutes, and is currently administering a Louisiana-specific system for adjudicating claims.

AmeriHealth Caritas Louisiana has read, understands and can meet or exceed the requirements outlined in **Model Contract, 2.18 and 2.19, the MCO Manual**, **Section 2.18 and 2.19,** and all other **accompanying manuals, and guides**. Our claims processing procedures were developed in compliance with Louisiana administrative rules and statutes, including, but limited to, RS 46:442 – 365-day period for claim submission, RS 46:460.36 – MCO local pharmacy reimbursement, RS 46:460.41 et seq – Claims payment for care rendered to newborns, RS 46:460.70 et seq – Claim filing and payment, RS 46:460.72 – MCO provider notice requirements, RS 46:460.73 – MCO payment accountability, and RS 46:460.81 et seq – Independent review process.

AmeriHealth Caritas Louisiana has established strong relationships with Louisiana Department of Health's (LDH) staff, providing LDH with experience, results, trust, and peace of mind. Our current operations leadership, and many provider-facing staff were previously employed by the State's fiscal intermediary, claims processing, and provider services agent. These leaders include our: Chief Operating Officer, Sherry Wilkerson (more than 15 years of Louisiana Medicaid experience); Claims Educator, Kelli Nolan (more than 15 years of Louisiana Medicaid experience); and Claims Administrator, Cassandra Grace (more than 6 years of Louisiana Medicaid Systems/Medicaid Management Information System (MMIS) experience and 15 years of experience with a Louisiana-based commercial insurer).

We are a long-term partner to the state with a deep understanding of the Louisiana Medicaid program and have a commitment to exceptional performance. **With a rate of 99.97 percent clean claims paid within 15 days and 99.99 percent clean claims paid within 30 days during State Fiscal Year (SFY) 2018, AmeriHealth Caritas Louisiana has exceeded its own high performance and that of all Medicaid MCOs as reported in the most recently available Medicaid Managed Care Transparency Report for SFY17.** Also, per the Healthy Louisiana Claims Report published in October 2018, AmeriHealth Caritas Louisiana led all MCOs with an initial encounter acceptance rate of 98.2 percent in 2017. Our internally calculated 2018 rate improved to 98.6 percent.

We look forward to building upon our current high degree of compliance with the claims management functions in place today by taking appropriate steps to meet the new Contract requirements. For example, our experienced staff implements Louisiana state specific requirements and will continue to work with LDH to increase claims efficiency. AmeriHealth Caritas Louisiana continuously strives to increase our auto-adjudication rate by: monitoring inventory, providing monthly reports to Louisiana operation leadership, encouraging providers to bill electronically, and analyzing and reviewing manually processed claims to identify opportunities to enhance system configuration. Through these efforts we are prepared to process **100 percent clean claims within 30 calendar days of receipt (Model Contract, 2.18.2.1.3)**.

AmeriHealth Caritas Louisiana currently exceeds the contractual requirements for submitting complete non-vendor and pharmacy encounter data as measured by a comparison to cash disbursements. While the performance of some vendors do not meet the current requirement, we are working closely with LDH and its contractors to ensure we remedy this small percentage of our overall encounter volume delivered through vendors. In order to meet the new encounter data contract requirement, AmeriHealth Caritas Louisiana will implement additional technical assistance and increased potential penalties for

subcontractors based on their performance. AmeriHealth Caritas Louisiana will continue to collaborate with LDH on encounter issues (such as duplicate encounter logic) to meet the enhanced requirement to **submit Encounter Data within a one percent error threshold measured by a comparison of cash disbursements (Model Contract, 2.18.15.3.2)**.

AmeriHealth Caritas Louisiana has already begun to develop a project plan in preparation for the implementation of the state-wide credentialing verification organization (CVO). We are prepared to ensure readiness and lend our previous expertise in implementing a centralized verification process. We welcome the opportunity to assist in the streamlining of Medicaid provider credentialing, including the efficient migration of data into our systems to support the accurate and timely payment of claims, and provider demographic information in the provider directory. Our previous experience with implementing a centralized credentialing process along with our regular collaboration with our state partners will ensure we meet the requirement of **accepting the credentialing decisions of the CVO Credentialing Committee within 30 calendar days of receipt of an approved credentialing decision, and load providers into the claims processing system (Model Contract, 2.9.29.3)**.

Adjudicating Claims Timely And Accurately While Meeting Requirements

We ensure timely and accurate payments through a combination of education, collaboration, and technology. Our Louisiana-based Operations Team leads the claim system configuration and is responsible for claims administration and ensuring alignment with payment mapping, Louisiana Medicaid policy and guidelines, and national billing standards. We review national clinical editing guidelines against Louisiana specific clinical editing policies before clinical editing is placed into production. We also hold weekly workgroup meetings between our Louisiana-based system configuration team and system programmers to facilitate automated claims processing and partner with providers to reduce complexity and promote electronic interaction. Systems configuration and editing also include monitoring LDH encounter edit requirements (e.g. taxonomy codes, National Drug Code, etc.), ensuring claims adjudicated will result in quality encounter data. **(Model Contract, 2.18.15.16)**.

Our clearinghouses validate claims submitted by providers for completeness. For compliancy with the Health Insurance Portability and Accountability Act (HIPAA), we reject and return claims lacking information in the required data fields to the provider. Once processed through the clearinghouses, we transmit claims in a HIPAA 5010 X12 837 file format and load them into TriZetto's Facets™ (Facets) for verification of the accuracy of provider National Provider Identifier (NPI), enrollee identification numbers, diagnosis codes, and procedure codes.

AmeriHealth Caritas Louisiana accepts claims through avenues including Change Healthcare and NaviNet®. We primarily partner with Change Healthcare, which has a large footprint in provider offices and receives pass-through claims from virtually every other clearinghouse. We educate providers on billing requirements and instructions for claims submission via the claims submission guide, provider orientation, handbook, newsletter and ongoing training.

Facets incorporates numerous edits and processing routines during the claim adjudication process. Facets checks enrollee eligibility and verifies services are covered. The claim is then auto-adjudicated using claims editing criteria, prior authorization data, coordination of benefits, and third party liability (TPL) requirements, as applicable.

AmeriHealth Caritas Louisiana uses an automated tool, Robotic Process Automation, which uses the Unified Functional Testing HP Quick Test Pro technology, for batch claims reprocessing. Using our customized proprietary framework, this Robotic Process Automation technology enables us to efficiently perform systematic payment updates to multiple claims when necessary. It helps us meet contractual

requirements for timeliness of reprocessing claims due to retro changes to updated fee schedules or code sets and claims impacted by an identified claims processing error **(Model Contract, 2.18.5, 2.18.8.3 and 2.18.8.5)**. We also use the tool for mass adjustments to provider data, increasing efficiency and accuracy to initial and ongoing provider data maintenance. Through automation we can process changes 24/7/365.

Claims Submission And Processing

Our administration platform, Facets, is the foundation of our MIS, and is fully HIPAA compliant. While claims can be submitted via paper, our system also supports claims submission electronically. Facets can also send paper or electronic remittance transactions to providers in the HIPAA compliant 835 transaction set standard format. Providers have the ability to check claim status via the Web, IVR, or they may speak directly with our representative on the phone or in person.

Our affiliate pharmacy benefit manager (PBM), PerformRx manages AmeriHealth Carita Louisiana's Medicaid Pharmacy claims through Darwin, a fully HIPAA compliant single integrated claims processing platform. The processing engine and platform consolidates the entire user interfaces and modules of functional components (formulary, reporting, network, prior authorization, etc.). The system provides both hard and soft edits that can be applied to various categories and is fully customizable and flexible with the capability of applying emergency edits within one day. Other categories for edits include eligibility, drug formulary status, drug interaction, duplicate prescription, and age.

Darwin supports secure file transfer protocol (SFTP) file transfers through either push or pull between the PBM) client SFTP servers. The system supports a multi record eligibility layout to accommodate all lines of business (Part D, Medicaid, Exchange, and Commercial) in addition to client custom layouts. Real-time eligibility updates to membership is supported through our web services application programming interfaces or directly within the Darwin Membership module.

Further, AmeriHealth Caritas Louisiana will work with our material subcontractors to ensure adherence to guidelines for other mandated services such as vision and non-emergency medical transportation.

QUALITY AUDITING FOR ACCURACY

To ensure we process claims according to Louisiana Medicaid policies and guidelines, our dedicated Quality Auditing department is accountable for reviewing pre and post-adjudicated claims for Contract requirements, procedural, and payment accuracy **(Model Contract, 2.18.14)**. In 2018, AmeriHealth Caritas Louisiana achieved a payment accuracy of 99.8 percent ensuring alignment with Louisiana Medicaid claims processing policies and guidelines.

Potential issues are escalated to the Louisiana-based Claim Resolution team and analyzed, with the majority of the remediation completed in real-time, allowing claims to be paid correctly the first time. Our Claim Resolution team reviews denial trends weekly by claim type, provider, and denial reason. Upon notification, a provider related claim issue is submitted to the Louisiana Claim Resolution team to identify root cause. Once identified, the Claims Analyst determines the impact of the issue. If the issue impacts a single provider, the claim resolution team contacts the provider to advise of resolution steps. If the issue impacts a broad group of providers, a provider notice is created and distributed to impacted providers. If we identify a general billing error, the identified error is included in regularly scheduled billing and claims education sessions are offered in person or by webinar. If we identify a systemic issue, we take immediate action to remediate. We initiate a provider notice to advise of the findings and the anticipated resolution date. Our comprehensive audit program includes:

Stratified Health Plan Audit Program — Monthly random sample of at least 385 electronic and paper claims processed in the previous month.

Manually Adjudicated Audit Program — Daily random sample of at least 2 percent of each claim examiner's processed work.

High-Dollar, Pre-Disbursement Audit Program — Claims with total billed charges of $50,000 or greater.

New Hire Quality Onboarding Audit Program — Random sample of 5-30 percent of claims processed daily for each new associate.

Encounters Quality Audit Program – Our encounters team has dedicated data analysts responsible for encounters analytics, auditing and reconciliations. All encounters submitted are reconciled to the claims processed to ensure accurate, complete submissions. Multiple reconciliations are performed to include acceptance rates by both the number of encounters submitted as well as reconciliations to the Cash Disbursement Journal (CDJ).

2.10.13.2 Management Information System Overview

AmeriHealth Caritas Louisiana operates an automated Management Information System (MIS) that meets or exceeds current program requirements and is prepared to support new program requirements outlined in the **Model Contract, MCO Manual**, **Systems Companion Guide, all accompanying manuals**, all applicable state and federal laws, and can continue to meet or exceed new program requirements as documented in **Figure 2.10.13.2-1**. Our MIS has the ability to accept and process provider claims, verify eligibility, collect and report encounter data, and validate prior authorizations and pre-certifications that comply with LDH and federal reporting requirements**.** In addition to her role as Claims Administrator, Cassandra Grace serves as AmeriHealth Caritas Louisiana's Information Technology Director, which helps to ensure that priorities are timely identified and appropriately addressed. Ms. Grace will continue her role of managing daily MIS operations, working collaboratively with LDH, its contractors and AmeriHealth Caritas Services support teams.

2.10.13.2.1 - 2.10.13.2.4 Management Information System

As a current partner, we have used a stable and compliant MIS since the inception of Louisiana's Medicaid managed care program in 2012 and have updated the MIS to meet new LDH requirements. Our MIS is secure, configurable, and scalable, enabling us to adjust to changes in contract requirements and enrollment. We have demonstrated our MIS configurability and scalability with the introduction of Louisiana Medicaid managed care (2012), pharmacy services (2012), behavioral health services (2015), retroactive enrollment management (2015), limited benefit package plan (2015), as well as the addition of the Medicaid Expansion population resulting in a 33 percent increase in enrollment (2016).

Figure 2.10.13.2-1 describes the MIS we will use in performance of our contract obligations, mapping MIS functions to **Model Contract** requirements**.** Data and process flows for all key business processes are cited and described in **Figure 2.10.13.2-1** with more inclusive depictions of systems and subsystems reflected in **Attachment 2.10.13.2-1 through Attachment 2.10.13.2-7.** All platforms leverage our hardware architecture (**Question 2.10.13.2.2**), described in **Figure 2.10.13.2-2**.

MIS Platform Time Utilized (2.10.13.2.1)	Function (Contract Requirement)	System Architecture Specifications (2.10.13.2.2) Data Interfaces (2.10.13.2.3)
Core Administration Platform Years: 20 **(see Attachment 2.10.13.2-2).**	Enrollment (2.4, 2.19.10)	**TriZetto Facets™ (Facets™) Specifications** — Automatically assigns enrollees to specific benefit plans, ensuring they receive appropriate services. Eligibility and enrollment information is updated in Facets™ within the timelines specified in the **Model Contract**. **Facets™ Interfaces** — Integrates with our population health management platform, external trading partners for 24/7/365 real-time eligibility inquiry (270/271), the Provider Portal, our interactive voice response platforms, and LDH for real-time exchange of enrollee information (changes of address and dates of death). Provides daily eligibility updates to all downstream platforms and subcontractors.

MIS Platform Time Utilized (2.10.13.2.1)	Function (Contract Requirement)	System Architecture Specifications (2.10.13.2.2) Data Interfaces (2.10.13.2.3)
		IBM Websphere Transformation Extender (WTX) Specifications — Performs Electronic Data Interchange (EDI) processing, enforcing Health Insurance Portability and Accountability Act (HIPAA) 5010 ASC X12 transaction standards. **WTX Interfaces** — Translates inbound HIPAA 5010 ASC X12 834 eligibility and TPL files into a consumable format for Facets™ enrollment processing.
	Claims Processing (2.18)	**Facets claims processing** — Allows for the automation of nearly all payment scenarios, including LDH-specific requirements. Facets processes claims submitted electronically or on paper. Facets claims adjudication edits enforce eligibility, provider, encounter data, and authorization requirements with more than 3.1 million claims processed in Louisiana in 2018. **Facets Interfaces** —Iintegrates with our population health management platform for enforcement of authorization requirements.
	Encounter Data Management (2.18.15, 2.18.17.3, 2.18.17.4)	**AmeriHealth Caritas Louisiana Encounter Data System Specifications** — Produces and submits medical and pharmacy encounter data in HIPAA and National Council for Prescription DrugPPrograms (NCPDP) compliant formats; manages subcontractor encounters submissions; ensures encounter files are compliant with companion guides and payment rules; processes response files and manages error corrections and resubmissions. Our Cash Disbursement Journal (CDJ) process reconciles encounter data to financial statements to ensure encounter submission completeness. **Encounter Data System Interfaces** — Integrates with Facets, Data Warehouse, subcontractors, and LDH.
Integrated Population Health Platform Years: 7 **(see Attachment 2.10.13.2-3).**	Utilization Management/ Service Authorization Care Management/ Care Coordination (2.6, 2.7, 2.8, 2.12)	**ZeOmega® Jiva™ (Jiva) Specifications** — Supports the Utilization Management, Service Authorization, Care Management, and Care Coordination functions to effectively manage care for enrollees and enable true integrated care. Jiva provides access to medical, pharmacy, laboratory results, behavioral health information (where appropriate) as well as Race, Ethnicity and Language (REL) data. Case Managers also utilize Jiva to collect and view information about social determinants of health. **Jiva Interfaces** — Integrates with our core administration platform, our customer service platform, and the Health Information Exchange (HIE) gateway.
		HIE Gateway Specifications — Alerts case managers and providers to key events enabling effective transitions in care. **HIE Interfaces** — Exchanges Admission, Discharge and Transfer (ADT) and Continuity of Care Document (CCD) transactions with state HIEs. We exchanged over 250,000 ADT messages with the Louisiana Health Information Exchange (LaHIE) since 2016.
Customer Service Platform Years: 11 **(see Attachment 2.10.13.2-4).**	Customer Service Systems (2.13.10, 2.14.10)	**Jacada™ Integrated Agent Desktop (IAD) Specifications** — Provides staff in our multilingual contact center a centralized view of enrollee information stored in multiple systems, enabling them to manage and document enrollee and provider inquiries. IAD enables staff to view and capture data related to social determinants of health and race, ethnicity and language. **IAD Interfaces** — Integrates with our population health management, core administration, and document management platforms.
		Avaya Call Management and Interactive Voice Response (IVR) Specifications — Avaya Call Management supports automatic call distribution based on availability and skill sets of contact center staff. IVR provides telephonic self-service capabilities to enrollees and providers (e.g. eligibility verification, ID card requests, etc.). **IVR Interfaces** — Integrates with our core administration platform.
		Enrollee Engagement Platforms Specifications — The **Enrollee Portal** provides self-service capabilities, such as Health Needs Assessments (HNA), a searchable online provider directory, medication management, and appointment and prescription reminders. It is built using W3C best practices for HTML and CSS focusing on Section 508 compliance so enrollees can use assistive technology and any browser or device. Our **Member Mobile application** offers similar capabilities on Apple and Android devices. The **Bright Start® Plus mobile application** enables enrollees to monitor, communicate, and receive key information about their pregnancies and overall wellness.

MIS Platform Time Utilized (2.10.13.2.1)	Function (Contract Requirement)	System Architecture Specifications (2.10.13.2.2) Data Interfaces (2.10.13.2.3)
		Enrollee Engagement Platform Interfaces — Integrates with our core administration and integrated population health platforms.
Corporate Services Platform Years: 20 **(see Attachment 2.10.13.2-5).**	Financial Systems (2.11)	**Oracle® PeopleSoft Financials (PeopleSoft Financials) Specifications** — Supports accounting, general ledger, and financial statement production. **PeopleSoft Financials Interfaces** — integrates with our core administration platform to post claims payment transactions to the general ledger.
		Facets Specifications — Adjudicates claims. **Facets Interfaces** — Integrates with Change Healthcare for claims payment and with PeopleSoft Financials for general ledger and financial reporting.
Provider Network Management Years: 6 **(see Attachment 2.10.13.2-6).**	Provider Systems (2.9, 2.10, 2.19.11)	**Appian™ Provider 360° Specifications** — Integrated business process management (BPM)/enterprise workflow platform manages the provider lifecycle, including recruitment, enrollment, and maintenance. **Provider 360° Interfaces** — Integrates with our core administration, credentialing, and enterprise document management platforms.
		Contract Manager Specifications — Automates the way contracts are created, negotiated, amended, viewed, distributed, and audited. **Contract Manager Interfaces** — Not applicable.
		CACTUS Specifications — Manages provider credentialing and re-credentialing. **CACTUS Interfaces** — Integrates with Provider 360° and CVO.
		NaviNet® Provider Portal Specifications — Secure provider portal enabling self-service for administrative (eligibility, benefits, authorizations, claims investigation) and clinical (care plan, care gaps, clinical summaries, ADT alerts) transactions. **3M Treo** — Secure provider portal enabling self-service for providers to access enrollee-level and population health-level data. **NaviNet® Provider Portal Interfaces** — Integrates with our core administration, integrated population health and Appian™ BPM platforms.
Reporting and Analytics Platform Years: 15 **(see Attachment 2.10.13.2-7).**	Data Sources (2.6.2)	**Data Warehouse Specifications** — Central repository of integrated data (administrative, clinical, pharmacy, vision, lab, dental, and electronic health record (EHR) used for data analysis and reporting, including HEDIS. **Data Warehouse Interfaces** — Integrates with our core administration and integrated population health platforms as well as subcontractors, lab, and EHR systems.
		Apache™ Hadoop® Data Lake Specifications — A scalable big data platform that maintains information at the lowest level of detail to accelerate data preparation to quickly deliver advanced analytics and business insights. **Data Lake Interfaces** — Integrates with core administration and integrated population health platforms as well as pharmacy and HL7 lab, immunization, and allergy data.
		Clinical Data Repository (CDR) Specifications - Stores enrollee clinical profiles and information to facilitate clinical analyses. **CDR Interfaces** — Integrates with our population health management platform, Provider Portal, HL7, subcontractors, and EHR systems.
	Reporting Tools (2.1.8, 2.6.2)	**Tableau Specifications** — Used for self-service analysis for data exploration and visualization as well as scheduled dashboards and ad hoc analysis. **SAP® Objects Specifications** — Produces scheduled and on-demand operational reports. **SAS® Specifications** — Produces advanced analytics and reporting, including HEDIS. **Reporting Tools Interfaces** — Integrates with Data Warehouse, Data Lake, and CDR.

Figure 2.10.13.2-1: *Management Information System.*

AmeriHealth Caritas' hardware and systems provide dynamic allocation of resources, fault tolerance, high availability, and centralized management. Our best-in-class industry hardware vendors include HPe, Cisco, F5, Palo Alto, VMware, Citrix, Dell EMC, Pure Storage, NetApp, Solar Winds, Verint, and Avaya. We proactively patch hardware against vulnerabilities and invest in hardware replacement, maintenance, and support. Our hardware architecture specifications are shown in **Figure 2.10.13.2-2**.

Hardware Component	Hardware Architecture Specification (2.10.13.2.2)
Data Center	Our primary and secondary data centers are built with power, cooling, and monitoring redundancies. The architecture is continually monitored for potential failures. Data and transactions are preserved through near real-time data replication to our secondary data center.
Data and Voice Network	Our enterprise data network utilizes multiple carriers in both data centers to provide redundant Multiprotocol Label Switching (MPLS) and internet connectivity through multiple high-availability firewalls. Our enterprise voice network includes Avaya Private Branch Exchange/Enterprise Survivable Servers (PBX/ESS) and remote Local Survivable Processors (LSP). Our voice infrastructure load balances calls between data centers to ensure the call is always completed.
Server	Clustered servers are grouped together so if any active server fails, a secondary server assumes operations, minimizing impact to critical applications. Virtualized servers are automatically migrated from one physical server to another as needed to protect or scale operations.
Storage	We leverage Dell EMC, NetApp, and Pure technologies to provide redundant and fault-tolerant storage to our servers. If a storage failure occurs, our technology seamlessly transitions to a redundant, high-performance storage device.

***Figure 02.10.13.2-2**: Hardware Architecture.*

2.10.13.2.5 Resources Dedicated To Medicaid Management Information System Exchanges

Resources dedicated to MMIS exchanges include the Louisiana-based operations team led by our Information Technology Director, the Managed File Transfer team, the 24/7 Network Operations Center (NOC) and production support teams for each MIS function including: enrollment; provider claims; encounters; etc. The Managed Transfer Team utilizes Tidal Enterprise Scheduler to automate and schedule file exchanges as well as IBM's Sterling File Gateway (SFG) to manage secure file exchanges through SFTP with the LDH MMIS. The NOC monitors MMIS exchanges 24/7/365 and acts immediately if any processing step fails or if a file transfer is not successful.

2.10.13.3 Attestation Of Availability Of Data Elements For Reports

AmeriHealth Caritas Louisiana attests to the availability of the data elements required to produce management reports **(Model Contract, 2.19.1.3)**. We currently comply and will continue to comply with Louisiana reporting standards as outlined in the **MCO Manual, Systems Companion Guide Appendix E MCO Generated Reports,** as well as the **Managed Care Reporting Deliverables** at http://ldh.la.gov/index.cfm/page/1700. Our reporting and analytics platform provides information on areas including utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 CFR §438.242(a)] **(Model Contract, 2.19.1.2)**.

2.10.13.4 Anticipated System Changes Or Enhancements

We will comply with requirements per **Model Contract**, **2.19.6.3** and **2.19.7,** including LDH notification and implementation timeframes for system changes and issues. To ensure operational continuity, we implement system changes and enhancements, from analysis and design to quality assurance testing, using our industry-standard Software Development Life Cycle (SDLC). Because we currently meet LDH requirements, we do not need to replace our MIS systems or subsystems. As a continuing commitment to

our innovation, person-centered care, and to simplify provider and LDH relationships, we plan to enhance our MIS through initiation of several projects during the next contract period including, but not limited to those in **Figure 2.10.13.4-1.**

System	Enhancement
2.10.13.4.1 Enrollment	• Complies with all current and new Contract requirements and no changes are contemplated at this time.
2.10.13.4.2 Claims Processing	• [redacted]
2.10.14.4.3 UM/Service Authorization	• Supports the State's implementation of a CVO. **(Model Contract, 2.9.29.3).** • Implements Interqual Connect to give providers clinical rationale for medical necessity as well as expanding the number of services for prior authorization auto-approval.
2.10.13.4.4 Care Management/ Disease Management	• Rolls out Direct Secure Messaging (DSM) to more providers and expands the set of alerts sent to the EHR of an enrollee's provider when the enrollee visits the Emergency Department (ED). • Interfaces with the Louisiana Health Information Network Encounter Notification System (LHIN-ENS) to increase the volume, frequency, and quality of ADT alerts received when an enrollee visits the ED. • Links Aunt Bertha Community Resource Directory referrals to automated outreach campaigns to provide a "closed loop" ensuring referred services are being utilized to address social determinants of health. • Pilots data exchange with the Louisiana Primary Care Association's data aggregation vendor to send data to federally qualified health center's EHRs to improve their ability to take timely action on enrollee care gaps. • Implement Intelligent Call Routing to recognize enrollees who do not have an HNA and route them to a care coordinator to provide an opportunity for completion of the assessment.

Figure 2.10.13.4-1: *Planned System Enhancements.*

2.10.13.5 Interfacing With Other Information Technology Systems

We will comply with **Model Contract**, **2.19.2 and 2.19.3**. Our data integration capabilities enable high-frequency, high-capacity, secure information exchange across multiple platforms and with external stakeholders such as state agencies, providers, community organizations, MCOs, health information exchanges, clearinghouses, and enrollment brokers. In 2018, we successfully exchanged over 88,000 messages with LaHIE (4.6 million nationwide); over 115,000 files in Louisiana (over 1.6 million files nationwide); and over 3.9 million real-time transactions in Louisiana (over 54 million nationwide). Our data exchange platforms are based on health care industry interoperability standards (e.g. ASC X12N EDI and HL7). We use Tidal Enterprise Scheduler to schedule and automate the processing of data exchanged with our trading partners and IBM's SFG to manage secure file exchanges through SFTP.

We use WTX, including the HIPAA adapter to validate incoming and outgoing EDI HIPAA 5010 ASC X12N transactions up to WEDI/SNIP level 7. This includes the following transactions and standard code sets:

- **HIPAA 5010 ASC X12N Transactions** — 820 Payroll Deducted and Other Premium Payment; 834 Benefit Enrollment and Maintenance; 835 Health Care Claim Payment/Advice; 837-I Health Care Claim: Institutional; 837-P Health Care Claim: Professional; 837-D Health Care Claim: Dental; 277CA Health Care Claim Acknowledgement.
- **HIPAA 5010 ASC X12N Real-Time Transaction Types** — 270/271 Health Care Eligibility and Benefit Inquiry and Response; 276/277 Health Care Claim Status Request and Response; 278 Services Review Request for Review/Response.
- **Standard Code Sets** — ICD-10; HCPCS; CPT-4; National Drug Code; Logical Observation Identifier Names and Codes; Home Infusion EDI Coalition Product Codes; ADA Current Dental Terminology; Diagnosis-related Group; Claim Adjustment Reason and Remittance Remarks Codes.

Figure 2.10.13.5-1 shows our current interfaces with LDH's system, our network providers, and material subcontractors.

Type of interface	Format	Frequency	From	To
Eligibility	EDI 834	Daily, Weekly, Monthly	Maximus	ACLA
Eligibility	EDI 834	Daily	ACLA	Subcontractors
Premium Payment	EDI 820	Weekly	LDH	ACLA
Premium Payment - Maternity	EDI 820	Weekly	LDH	ACLA
Institutional Encounter Data	EDI 837I	Weekly	ACLA	LDH
Professional Encounter Data	EDI 837P	Weekly	ACLA	LDH
Vision, Transportation Encounter Data	EDI 837P	Monthly	ACLA	LDH
Dental Encounter Data	EDI 837D	Monthly	ACLA	LDH
Pharmacy Claim Encounter File	NCPDP	Weekly	ACLA	LDH
Encounter Response Data	EDI TA1/999	Weekly	LDH	ACLA
Encounter Response Data	EDI 835	Weekly	LDH	ACLA
Health Care Claim Payment/Advice	EDI 835	Twice per week	ACLA	Network Providers
Direct Secure Messaging	DSM	On demand	ACLA	Network Providers

Figure 2.10.13.5-1: *Current Systems Interfaces.*

MEETING MODEL CONTRACT REQUIREMENTS

Figure 2.10.13.5-2 outlines compliance with **Model Contract, 2.19**.

Contract Item	Description	Compliance
2.19.1 General System and Technical Requirements	Addressed in response to **Section 2.10.13.2**. We perform capacity planning using projected claim, phone call, prior authorization, and data exchange transaction volumes as well as projected staffing and system capacity requirements.	**Confirmed**
2.19.2 HIPAA Standards and Code Sets	Addressed in response to **Section 2.10.13.5**.	**Confirmed**
2.19.3 Connectivity	Addressed in response to **Section 2.10.13.5**.	**Confirmed**
2.19.4 Hardware and Software	We maintain hardware and software compatible with current LDH requirements, including call center operations, claims EDI operations, authorized services operations, and enrollee services operations.	**Confirmed**
2.19.5 Network and Back-up Capabilities	Our networks use appropriate security measures to prevent breaches by an external entity. Near real-time data replication from our primary to our secondary data center ensures ready retrieval/recovery of data. Power protection through uninterruptible power supplies (UPS) and generators can supply continuous power.	**Confirmed**
2.19.6 Resource Availability and Systems Changes	Our NOC is staffed 24/7/365 to provide Systems Help Desk services to LDH, its Fiscal Intermediary (FI) and enrollment broker staff**, exceeding LDH's requirements of 7:00 a.m. - 7:00 p.m. weekdays**. NOC staff can access on-call support staff for each MIS platform to support any area of the MIS. Systems Changes are addressed in response to question 2.10.13.4.	**Confirmed**
2.19.7 Systems Refresh Plan	Addressed in response to **Sections 2.10.13.2.2 and 2.10.13.4**.	**Confirmed**
2.19.8 Other Electronic Data Exchange	We scan paper claims and other paper correspondence via Optical Character Recognition (OCR) and convert paper claims into a HIPAA 5010 ASC X12 837 file format. A searchable document management system indexed by enrollee ID maintains images of paper claims and other paper correspondence.	**Confirmed**
2.19.9 Electronic Messaging	Email is continuously available, compatible with LDH and complies with national standards for sending and receiving protected health information (PHI).	**Confirmed**

Contract Item	Description	Compliance
2.19.10 Eligibility and Enrollment Data Exchange	Addressed in response to **Section 2.10.13.2**.	**Confirmed**
2.19.11 Provider Enrollment	We utilize LDH-supplied provider type, specialty, and sub-specialty codes in data communications including weekly Provider Registry File and Primary Care Provider Linkage files. We perform provider exclusion background checks.	**Confirmed**
2.19.12 Information Systems Availability	We provide LDH with read-only, secure real-time access to our system. We use redundancy, resiliency, and scalability as central design principles in our physical infrastructure, network, databases, servers, and applications to ensure the availability of our systems and data. Users have 24/7/365 access to the MIS outlined in **Figure 02.10.13-1.** Our telephone systems utilize an active/active configuration to ensure undisrupted access to the contact center by enrollees and providers. During our 2018 annual Disaster Recovery (DR) test, data was recovered in our secondary data center in **9 hours and 0 minutes, exceeding the LDH contractual obligation of 72 hours.**	**Confirmed**
2.19.13 Contingency Plan	Our contingency plan includes test scenarios simulating the damage or destruction if central computer installation and resident software are destroyed or damaged, testing the integrity of transactions active in the live system at the time of the outage, the integrity of data maintained in the live and archival systems, and access to the systems.	**Confirmed**
2.19.14 Off Site Storage and Remote Back-up	To prevent data loss, we utilize Oracle Data Guard, as well as Sybase and Microsoft SQL Server log shipping for near real-time data replication to our secondary data center. We store tape backups at a secure off-site facility.	**Confirmed**
2.19.15 Records Retention	We maintain online retrieval and access to documents and files for audit and reporting purposes for 10 years in live systems and an additional four years in archival systems with audit trails maintained for more than six years. We comply with information requests.	**Confirmed**
2.19.16 Information Security and Access Management	The Identity Management team manages access to information, including enrollee PHI, using hierarchical business roles and applies HIPAA-compliant minimum necessary rules. Our security controls and processes exceed industry requirements and are validated annually through external assessments such as HIPAA Security and Privacy Rule Assessment, Department of Insurance (DOI) as well as accreditation agency and state-level cybersecurity audits and third-party penetration testing. The company completed a Systems and Organization Controls (SOC2, type 2) Type 2 assessment, based upon the Security Principle and will expand attestation to include Confidentiality, Integrity and Availability in 2019 in accordance with new State requirements. **We achieved a BitSight (an independent cyber security benchmark) rating of 810 — the highest rating in the managed care industry as of March 2019.** We create audit trails in accordance with federal, state and Contract requirements to track modifications to system information. Automated tools identify suspicious activity. We configure limits on unauthorized access attempts to automatically lock accounts and alert security personnel. Our facility physical security controls include badged access, recording digital cameras, access control systems, closed-circuit television (CCTV), security personnel, intercom, fire retardant and intrusion detection systems. We will conduct a security risk assessment and communicate the results to LDH no later than fifteen (15) calendar days after the Contract award.	**Confirmed**

***Figure 2.10.13.5-2**: Model Contract Requirements.*

2.10.14
Program Integrity

AmeriHealth Caritas Louisiana associate preparing food for flood victims.

AmeriHealth Caritas™
Louisiana

2.10.14 Program Integrity

2.10.14.1 Preventing Fraud, Waste, And Abuse With A Comprehensive Prevention Program

The AmeriHealth Caritas Louisiana Fraud, Waste, and Abuse (FWA) Prevention Program is designed to meet or exceed the requirements set forth in: **Model Contract, 2.20; MCO Manual 2.20;** 42 CFR § 438.608; the Louisiana Medical Assistance Program Integrity Law, La. R.S. 46:437.1 through 437.14; Title 50 of the Louisiana Administrative Code, Part I, Subpart 5 (Provider Fraud and Recovery); 42 CFR Part 455 (Program Integrity: Medicaid); and 42 U.S.C. § 1320a-7, 1320c-5 and 1396a(a)(68) (Approval of Certain Projects).

Executing The Fraud, Waste, And Abuse Prevention Program With Dedicated Teams

AmeriHealth Caritas Louisiana's leadership structure involves multiple teams in a collaborative effort supported by the Compliance and Program Integrity teams to promote compliance and prevent FWA. This structure addresses any FWA issues in the current program effectively and efficiently and has the capability and experience to continue to innovate to meet the requirements of the new Model Contract.

The AmeriHealth Caritas Louisiana Program Integrity Officer

Our Louisiana-based **Program Integrity Officer, Lesli Boudreaux, also serves as our health plan's Contract Compliance Officer. Ms. Boudreaux has more than 20 years of Medicaid experience in Louisiana**, including eligibility, customer service, enrollment broker and managed care oversight; providing a strong foundation to oversee our monitoring and enforcement of the FWA compliance program pursuant to state and federal rules and regulations. This dual position ensures the Louisiana Department of Health (LDH) has one point of contact at AmeriHealth Caritas Louisiana to address both contract compliance and FWA issues. Ms. Boudreaux also oversees each subcontractor to monitor whether they are properly emphasizing FWA prevention, detection, and reporting. Ms. Boudreaux is empowered to assess records and independently refer suspected enrollee, provider, or subcontractor fraud and abuse cases to LDH and other duly authorized enforcement agencies. Ms. Boudreaux reports directly to the AmeriHealth Caritas Louisiana's Chief Executive Officer (CEO) and our Board of Directors.

The AmeriHealth Caritas Program Integrity Team

AmeriHealth Caritas has an established enterprise-wide Program Integrity team with a proven record of preventing, detecting, investigating, and mitigating FWA. As detailed in our response to **RFP Section 2.10.14.1.3**, the Program Integrity team uses both internal solutions and industry-leading vendors to deploy cutting edge technology against FWA. Both AmeriHealth Caritas Louisiana and our Program Integrity vendors, functioning under AmeriHealth Caritas direction and oversight, have implemented advanced analytics and data mining technology to perform both prospective and retrospective payment monitoring. The Program Integrity team uses the following cross-functional teams to ensure the accuracy, completeness, and truthfulness of claims and payment data: Special Investigations, Client and Vendor Management, and Program Integrity Operations teams.

Special Investigations Unit

The Special Investigations Unit (SIU) is responsible for preventing and detecting fraud and abuse throughout the claims payment processes. The SIU investigates allegations such as billing for services not rendered, alteration or forgery of documentation, misrepresentation of services provided, and receipt of benefits due to potentially fraudulent actions. Per **Model Contract, 2.20.5**, the SIU reports all confirmed or suspected FWA tips to LDH, the Medicaid Fraud Control Unit (MFCU), and any other appropriate agency as required by the Model Contract. AmeriHealth Caritas Louisiana and its subcontractors are committed to

reporting suspected incidents of FWA to the MFCU and LDH no later than three business days following discovery.

The SIU has implemented comprehensive policies and procedures to prevent, detect, and address potential or suspected fraud and abuse in the administration and delivery of services, including:

- Ongoing evaluation of claims and data mining to detect aberrant behaviors in provider billing, prior authorizations, and member utilization patterns.
- Pre-payment review of providers suspected of fraud and abuse.
- Post-payment review of claims to include participating and non-participating providers.
- Announced and unannounced onsite provider audits.
- Periodic sampling of claims, random and focused, to validate the propriety of payments.

The SIU also conducts targeted medical chart reviews that may include specific dates of service, probe sampling, and claims sampling derived through statistically valid sampling methodology. **In 2018, the SIU successfully identified approximately $1.6 million for recovery through prepayment cost avoidance (via edits and medical record reviews) and the identification of overpayments.**

The AmeriHealth Caritas Louisiana Program Integrity Officer and SIU staff are actively engaged in collaboration with its partners in federal, state, and local agencies, including LDH and the MFCU. This collaboration includes in-person meetings to discuss suspected fraud and abuse issues with LDH, the MFCU, and other state or federal agencies charged with identifying, investigating, or prosecuting suspected FWA. **Notably, due to our proactive data analysis and conducting unannounced onsite provider audits, AmeriHealth Caritas Louisiana provided the impetus for the creation of the Behavioral Health Task Force** consisting of members from the LDH, the MFCU, and the five Healthy Louisiana MCOs. AmeriHealth Caritas Louisiana investigators were integral in the arrest and conviction of multiple individuals in connection with behavioral health FWA.

The SIU is staffed with experienced investigators and analysts, across multiple specialties; who are Certified Professional Coders, Registered Nurses, Certified Fraud Examiners, and Accredited Health Care Fraud Investigators, ensuring that we are able to approach investigations from a broad range of perspectives. The SIU already meets the staffing requirement of having at least one full-time investigator for every 50,000 enrollees and is committed to ensuring that full time investigators are physically located in Louisiana in the new Contract period per **Model Contract, 2.20.1.11**. The SIU currently has five dedicated investigators and a dedicated SIU Manager who oversees their work. Collectively, this group has over 80 years of experience, including many years in various law enforcement roles. Our SIU Manager was recently appointed to the National Health Care Anti-Fraud Association (NHCAA) training committee and works with other industry FWA experts and the NHCAA to develop training for national and global investigators.

Program Integrity Operations Unit

The Program Integrity Operations Unit reconciles billing data to drive savings, identify, and seek potential recoveries, and document cost containment. The Program Integrity Data Analytics, Program Integrity Recovery and Reporting, and Credit Balance Recovery teams support this work. The Program Integrity Data Analytics team performs prospective and retrospective data mining to validate the accuracy of claims payments. The Recovery and Reporting team develops and distributes internal and state reports related to FWA services. They are accountable for intake, management, and monitoring of overpayment recovery projects. The Credit Balance Recovery team pursues provider credit balances through a series of provider

outreach methods to ensure that we secure timely recoveries. This team understands the new significant requirements LDH is implementing and is ready to meet them, including but not limited to:

- Returning any money paid for services provided by an excluded provider within 30 days of discovery to LDH.
- Correcting encounters within 14 days of notification by the state of an overpayment.

Client And Vendor Management Unit

The Client and Vendor Management team evaluates and reports the effectiveness of claims edits and secures support to pursue opportunities in identifying FWA. This unit leverages internal resources and maintains relationships with external vendors to enhance a comprehensive oversight model. We use advanced data-mining technology to perform both prospective and retrospective claims and payment monitoring. Other activities include:

- Facilitating monthly meetings to provide updates on payment integrity savings and recoveries.
- Leading the approval and implementation process for payment integrity-related claim edits.
- Supporting and maintaining relationships with payment integrity subcontractors.
- Monitoring the industry continuously for new solutions to identify FWA.

ADDRESSING THE REQUIREMENTS OF A FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM

In accordance with 42 CFR §438.608(a) and **Model Contract, 2.20.2.2**, the AmeriHealth Caritas Louisiana compliance program includes all of the following elements.

Reporting and Investigating Suspected Fraud and Abuse

We have multiple internal and external mechanisms for reporting suspected FWA cases as required by **Model Contract, 2.20.1.12**. Some of these reporting mechanisms include:

- The AmeriHealth Caritas Louisiana website that offers a link to report potential FWA 24/7/365.
- An anonymous Fraud, Waste, and Abuse Hotline that is available 24/7/365.
- Open door and strict non-retaliation policies that support in-person reporting.
- A grievance and appeal system available to enrollees and providers.
- A well-publicized email address for the dedicated purpose of reporting fraud, which is available to enrollees, providers, contractor employees, and the public on our website, per **Model Contract, 2.20.2.4**.

These mechanisms provide lines of confidential communication between AmeriHealth Caritas Louisiana, its associates, providers, subcontractors, and enrollees to escalate any potential concerns or issues that may arise, promptly and effectively. In 2018, the SIU received 237 tips through these reporting mechanisms.

Using internal resources and external vendors, the Program Integrity team executes prospective reviews by performing claim editing before making payments to providers. We also perform data mining for FWA retrospectively. We employ various distinct processes for prepayment reviews, data mining, post-payment reviews, and recovery operations. [redacted]

Fraud, Waste, And Abuse Compliance Plan

AmeriHealth Caritas Louisiana maintains a comprehensive compliance program under the current contract that is readily able to meet the new requirements of the **Model Contract, 2.20.2.2**. Our compliance program works to monitor that our subcontractors are compliant with all federal and state requirements to prevent and detect FWA. Our compliance program is detailed in the FWA Compliance Plan; Annual

Work Plan; Code of Conduct and Ethics; and policies and procedures which detail specific AmeriHealth Caritas Louisiana Compliance, Privacy and Program Integrity responsibilities and protocols. AmeriHealth Caritas has a culture of compliance in all that we do, embedded in policies and procedures, embraced by our leadership, and implemented through open lines and communication and training. Our compliance program complies with 42 CFR 438.608 as follows:

- Written policies, procedures, and the Code of Conduct and Ethics.
- A designated Compliance Officer.
- A Regulatory Compliance Committee on the Board of Directors.
- A comprehensive and mandated training and education program for the Compliance Officer, senior management, and employees for the federal and state standards and Contract requirements.
- Effective lines of communication between the Compliance Officer and employees.
- Procedures for a prompt response to detected offenses and for corrective action initiatives.
- Well-publicized disciplinary guidelines, which are consistently applied.
- Robust and ongoing internal monitoring and auditing of Contract compliance, including potential risks.
- Procedures for prompt notification to LDH when AmeriHealth Caritas Louisiana receives information about changes in an enrollee's circumstances that may affect eligibility or a provider's circumstances that may affect the provider's eligibility to participate in the program.

AmeriHealth Caritas Louisiana submits the FWA Compliance Plan as part of readiness reviews, annually thereafter, and upon updates or modifications to LDH for approval at least 30 calendar days in advance of making them effective.

Prohibited Affiliations

AmeriHealth Caritas Louisiana acknowledges that neither we nor our subcontractors may knowingly have a relationship with any individual or entity with whom affiliation is prohibited, per **Model Contract, 2.20.3**. We attest monthly that we have screened all employees and subcontractors as specified in the Debarment/Suspension/Exclusion section, which includes complying with these requirements:

- Not knowingly having a relationship with a debarred, suspended, or otherwise excluded individual or entity.
- Not having a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with prohibited individuals or entities.
- Not employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with prohibited individuals or entities.
- Not being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8).

Payments To Excluded Providers

In accordance with our FWA Compliance Plan, AmeriHealth Caritas Louisiana conducts monthly searches of the Office of the Inspector General (OIG's) List of Excluded Individuals/Entities (LEIE), Louisiana Adverse Actions List Search, The System of Award Management (SAM) and other applicable sites as may be determined by LDH, to capture exclusions and reinstatements that have occurred since the previous search, per **Model Contract, 2.20.3.7**. We report any exclusions identified to LDH within three business days and return any money paid for services provided by an excluded provider within 30 days of discovery, per **Model Contract, 2.20.4**.

Reporting

In accordance with **Model Contract, 2.20.5**, reporting includes, but is not limited to:

- The number of complaints of FWA, neglect, and overpayments that warrant preliminary investigation.

- The number of complaints reported to the Contract Compliance Officer.
- All audits performed and overpayments identified and recovered, by us and/or our subcontractors.
- Overpayments made by LDH within 60 calendar days from the date that we identify the overpayment.
- All unsolicited provider refunds, including any payments submitted by providers for overpayments identified through self-audit or self-disclosure.

Rights Of Review And Recovery By Contractor And LDH

AmeriHealth Caritas Louisiana investigates and reports all possible acts of provider FWA for all services under **Model Contract, 2.20.6**, including subcontracted services. We comply by ensuring that:

- We have the right of review and recovery for 365 days from the date of payment of a claim via automated review.
- We have the right to audit, review, and investigate providers for five years from the date of service of a claim via “complex” review.
- AmeriHealth Caritas Louisiana ensures approval by LDH before seeking provider recoveries.
- We will complete all of our complex reviews within 240 days of the date we opened the case unless we obtain authorization to extend from LDH.
- We provide ongoing notification to LDH of the results of reviews as well as instances of suspected fraud, collection status, or audits.

In addition, we comply with all requirements of La. R.S. 46:460.72-460.73, including the requirement to void all claims and encounters associated with FWA to reduce per-member, per-month rates, resulting in prompt return of overpayments to the state.

2.10.14.1.1 Training To Prevent, Detect, And Report FWA

At AmeriHealth Caritas Louisiana, preventing, detecting, and reporting FWA**, "Doing the Right Thing in the Right Way,"** is a shared responsibility of all employees, subcontractors, and providers.

Training Employees To Prevent, Detect And Report FWA

We empower employees to prevent, detect**,** and report FWA using initial and ongoing training.

Training At New Hire Orientation

The AmeriHealth Caritas Louisiana Compliance team hosts a live new hire orientation that includes FWA training specific to AmeriHealth Caritas Louisiana, including a review of the plan's organizational chart with an emphasis on identifying the Program Integrity Officer and the SIU Investigators who work in Louisiana. Employees learn the procedures for the timely and consistent exchange of information with LDH. The Program Integrity Officer, or her designee, emphasizes the importance of both collaborating and cooperating with our partners at LDH and the MFCU. New hire training already addresses all topics required by **Model Contract, 2.20.2.2.4.** We also specifically train our enrollee-facing staff, including Enrollee Services and Grievances and Appeals teams, on how to escalate potential FWA issues that they receive from enrollees to the SIU for investigation.

Compliance Training Modules Required At New Hire And Annually

All AmeriHealth Caritas Louisiana employees, including contingent work force members and the Board of Directors, are required to complete the following new hire training modules within 30 days of the beginning date of employment and annually thereafter:

The Code of Conduct and Ethics Attestation and Conflict of Interest Disclosure — Requires attestation that employees have read and agree to abide by the Code of Conduct and Ethics. Employees must also disclose potential and actual conflicts of interest.

Confidentiality, Privacy and Security Agreement — Requires employees to attest to their agreement to treat all information they receive during the course of their employment as confidential, comply with all company confidentiality policies, and not access confidential data without a job-related need to do so.

FWA — Explains the impact of FWA on the healthcare industry and each employee's role in prevention, detection, and reporting of FWA, including how to recognize indicators of FWA.

Compliance Laws — Reviews the False Claims Act, the Fraud Enforcement and Recovery Act, the Anti-Kickback Statute, the Physician Self-Referral Law (Stark), and the Louisiana Medical Assistance Programs Integrity Law. The training also covers whistleblower protections under these various laws.

Embracing a Culture of Compliance — Explains the company's culture of compliance, outlines the seven elements of an effective compliance program, and describes the consequences of non-compliance.

HIPAA — Explains HIPAA, including what constitutes protected health information (PHI), permissible uses, and disclosures of PHI, and how HIPAA impacts each employee's role.

Security Awareness – **Physical Workplace Security** — Explains the role of Corporate Security, how to identify potential threats and risks at the workplace, and building access security and procedures.

Security Awareness – **Information Cyber Security** — Explains social engineering, social engineering attacks, and employees' responsibility to safeguard protected and confidential information.

Ad Hoc Training Held Throughout The Year

To further an ongoing culture of compliance, AmeriHealth Caritas provides additional ad hoc training during the year, including:

Compliance and Ethics Week — The Compliance team hosts this annual event focusing on activities that express and reinforce our commitment to "*Doing the Right Thing in the Right Way.*" It provides a forum for employees to interact with Compliance team staff.

Compliance Lunch and Learns — The Compliance team hosts quarterly sessions regarding significant compliance and FWA topics. In 2018, topics included Confidentiality and Non-retaliation; Employee Gifts, Honoraria, and Political Activity; Social Media in the Workplace; and Fraud, Waste and Abuse: The Who, What, Why and How of the Special Investigations Unit (conducted by SIU staff).

Fraud Prevention Awareness Week — Interactive training activities encourage substantial employee participation in this annual event that focuses on fraud prevention and the SIU's role. Past events have involved LDH and MFCU. **We were the first Healthy Louisiana MCO to conduct this event.**

Compliance Corner — Our Compliance Office publishes this quarterly newsletter to provide updates about important privacy, security, contract compliance, risk management, and regulatory issues.

Fraud Fighter Award Program — We launched this program in 2017 to recognize the successful use of fraud training through affirmative reporting of suspected incidents of FWA. In 2018, our employees earned 12 Fraud Fighter awards, each of which resulted in the opening of an investigation.

Training Subcontractors To Prevent, Detect, And Report FWA

Annually, the Compliance team provides the Code of Conduct and Ethics; certain compliance, privacy, and security policies; and the eight compliance training modules our employees take to all subcontractors that provide services to AmeriHealth Caritas Louisiana. Upon engagement and annually thereafter, subcontractors must attest that they received our training and policies, and that either:

- Their trainings and policies presently meet or exceed our training and policies (subject to audit).

- They have distributed our training and policies to all their employees and subcontractors, and will abide by the training, policies, and procedures we have provided.

As part of this annual process, our Compliance team also requires all subcontractors to disclose ownership and control information in accordance with 42 CFR Part 455. Through this process, we reinforce our requirement that subcontractors must timely escalate potential and actual FWA issues.

Training Providers To Prevent, Detect, And Report FWA

We have implemented proactive and retroactive processes to educate providers on FWA. Prospectively and as part of provider onboarding, providers are trained on FWA issues, including an explanation of types of activities that are fraudulent or abusive, and the duty and mechanisms to report FWA to AmeriHealth Caritas Louisiana, LDH and/or MFCU. Through regularly held provider seminars and meet and greet events, we train providers on FWA prevention, detection, and reporting. We provide additional training and resources in the Provider Manual and through newsletters and fax blasts.

Retrospectively, an integral part of our training includes tracking and trending of potential aberrant billing behaviors that we identify and use to deliver specialized training and education to our providers. AmeriHealth Caritas Louisiana refers to this as the provider corrective action program. This program identifies providers who, while not currently the subject of SIU investigation, we have flagged as possible outliers in connection with certain billing behaviors. Identified providers are required to receive training on appropriate billing policies to ensure billing compliance. They are subject to ongoing monitoring to ensure that they have remediated identified issues. If the providers still appear as billing outliers or have not demonstrated a trend towards improvement by the date upon which they have promised to remedy the issue, we escalate the matter to SIU for potential prepayment review or the initiation of an investigation.

2.10.14.1.2 Engaging Enrollees To Prevent, Detect, And Report FWA

AmeriHealth Caritas Louisiana values our enrollees and we strive to ensure that they recognize this and are able and willing to assist our efforts in safeguarding their health and safety.

Engagement through education — We teach enrollees what FWA is, how to recognize and report it, and why it is so important that they become engaged in efforts to recognize and report potential FWA. We provide this information included on our website, in Member newsletters, and in the Member Handbook. Our Program Integrity Officer and Communications department coordinate to publish appropriate additional educational materials on FWA through newsletters and articles made available on the website about topics such as FWA reporting, identity theft schemes, and unlawful patient recruiting programs.

Engagement through the explanation of benefit (EOB) process — In compliance with LDH requirements, we send EOB notices to a two percent sampling of claims to enrollees to validate that they have received the billed services. If an enrollee responds to an EOB notice that he or she did not receive any of the identified services, the SIU team reviews the claim for a potential investigation. We also use this mechanism to educate enrollees on FWA issues in the context of their specific concerns.

Engagement through open and accessible communication channels — Our Fraud, Waste, and Abuse Hotline and our online reporting tool are well publicized and allow enrollees to anonymously report issues 24/7/365.

2.10.14.1.3 Using Data Analytics To Prevent And Detect Fraud

AmeriHealth Caritas Louisiana uses internal data mining and the algorithms of our subcontractors and vendors to prevent and detect fraud as further described in this section.

Prospective Cost Avoidance

The Program Integrity team performs prospective claims editing to increase the accuracy of claims payments. Our Medical Directors and Medical Policy employees review new clinical edits on an ongoing and routine basis before introducing them into the prospective editing process. The process includes high priority claim tagging to ensure timely and accurate payments to providers.

Change Healthcare — Change Healthcare's Coding Advisor solution seeks to reduce overpayments for routine, low cost, level of care services by leveraging information about providers' coding behavior to determine peer-to-peer provider outliers for specific modules. Modules include, but are not limited to, new and established patient office visits, consultations, overutilization of modifiers, and J-codes. This solution helps us to detect FWA and is not part of our claims adjudication process.

Cotiviti — Outpatient, professional, and durable medical equipment (DME) claims pass daily through analytic engines, post-adjudication and pre-check run. We regularly add applicable clinical edits to the claims processing system, based largely on National Correct Coding Initiative (NCCI) standards.

Optum Claims Edit System Summary — This mid-adjudication clinical editing software automatically reviews and edits physician and facility claims. The Claims Edit System provides extensive editing rules built upon nationally recognized sources, including Current Procedural Terminology (CPT) and NCCI guidelines to streamline claims processing, reduce errors, and improve payment integrity. The system features flexible editing logic to allow Louisiana-defined rules and reimbursement policies.

Internal CCM — An internal Claims Cost Management (CCM) team performs a prepayment data mining process that reviews claims multiple times per week. Edits focus on maintaining compliance with provider contract language, LDH's and Centers for Medicare & Medicaid Services (CMS') reimbursement methodologies, system configuration issues, and identification and trending of provider billing errors.

Retrospective Data Mining And Recovery

The Program Integrity team also uses both internal and external resources to perform retrospective data mining for waste. Our internal staff performs data mining and recovery operations that focus on potential overcharges, including outpatient charges billed during inpatient stay, payment greater than the billed charges, duplicates, and incorrect Coordination of Benefits payments. Our retrospective data mining and recovery operations include the following four internal and external layers of review.

Internal Claims Overpayment Recovery System (CORS) Data Mining — The CORS program is a proprietary desktop software application which serves as the system of record for the majority of the Program Integrity team's retrospective recovery activity. We also use CORS to complete claims recovery-related functions, including internal project recovery letter generation to providers, communication and tracking of vendor-identified projects, vendor invoicing, and overall internal and external project reporting. CORS also tracks internal post third-party liability (TPL) recoveries. The process tracks any new TPL added monthly but goes back 10 months in compliance with the Contract.

HMS® Data Mining — We use HMS® for retrospective data mining, medical record reviews, TPL cost avoidance, and medical and pharmacy carrier direct recoveries. HMS® uses claims eligibility, provider, and TPL files for sophisticated analytics to identify potential overpayment of professional, outpatient, and facility claims.

HMS® Coordination of Benefits (COB) Identification and Recovery — HMS® performs COB activities on records that LDH has approved. HMS® does not seek recovery from providers where the date of service is older than 10 months, except when the primary carrier is traditional Medicare, Tricare, or Champus. HMS® may pursue other primary payors for a total of 36 months.

Cotiviti Data Mining Recovery — Cotiviti performs claims data-mining and recovery processes using proprietary analytics to identify potential overpayments.

Optum Credit Balance Reviews — Optum performs credit balance reviews at hospitals and facilities on our behalf to identify and recover overpayments based on their investigation of Accounts Receivables reports.

SIU – Harnessing the Power of Technology through the STARSSentinel Program

The SIU utilizes a lead detection and pattern analysis system known as STARSSentinel (Sentinel), which is an early-warning detection system used to flag providers and members who warrant investigation. Sentinel uses rules, algorithms, and pattern detection capabilities to evaluate, identify, compare, and rank providers and enrollees who score on one or more rules or algorithms generating qualified leads for investigation. These algorithms aim to identify potential FWA issues including duplicate claims, suspect Evaluation and Management (E&M) codes, unbundling of services, procedure upcoding, and inappropriate or suspicious prescription drug refills. Sentinel also produces reports for use in SIU case activity.

SIU uses Sentinel to identify potential controlled medication FWA issues, including the use of opioids and potentiators that increase the reactions of opioids. As part of our commitment to aligning with LDH and CMS priorities, our data mining targets prescription of opioids, reviews pain management clinics**,** and conducts targeted referrals in order to address areas that are particularly vulnerable to FWA. Our automated, early warning fraud and abuse detection and overpayment protection capabilities identify leads for further SIU investigation. We continuously monitor and audit claims data to detect abnormal provider billing and enrollee utilization patterns, using ad hoc claims queries to mine data for specific schemes and scenarios. We periodically sample claims for additional review to determine the appropriateness of payments. Once the SIU discovers an allegation of potential fraud, it promptly initiates an investigation of all documented incidents of suspected or confirmed fraud that occurred over the entirety of the program.

2.10.14.1.4 Identifying High-Risk Claims And Providers

Our FWA prevention program includes a component to identify and evaluate high-risk claims to ensure that there are no payment integrity issues. We have also adopted processes to identify abnormal provider utilization practices, because our program focuses on both high-risk claims and high-risk providers.

Defining And Identifying High-Risk Claims

AmeriHealth Caritas Louisiana defines high-risk claims both quantitatively (based on the dollar value of the claim) and qualitatively (based on the service being provided). [redacted]

[redacted] Information sharing sessions with

other FWA professionals and law enforcement identify current trends in the industry, which assist us to adapt our data mining to respond to both current and evolving issues.

2.10.14.1.5 Experience Executing Provider Recovery Collection

As required under the Contract and the False Claims Act, AmeriHealth Caritas Louisiana requires that providers submit overpayments within 60 days from identification. We use provider education and timely pursuit of overpayments we identify. We use our proprietary CORS to record recovery activities, claims adjustments, data mining, and claims validation. We report, update, and review the status of claims recovery activity daily. If we are unsuccessful in recovering funds through offsetting against future claims, our internal Credit Balance unit sends collection letters to providers. Our staff also performs multiple attempts to reach the provider. If these attempts are unsuccessful, we escalate collection efforts, including, but not limited to potentially sending the claim to a third party to assist the health plan with timely collections. These activities complement additional SIU activities that identify overpayments, subrogation, and provider self-reporting.

2.10.14.2 Delivering Timely And Accurate Reports As A Proven Partner

AmeriHealth Caritas Louisiana's reporting program is structured to provide timely, accurate and complete reports to LDH and the teams involved in reporting are provided with the resources needed to accomplish this. We have a dedicated Regulatory Reporting team, in addition to data reporting analysts within both the Program Integrity Operations and SIU teams. We are committed to providing accurate and timely reporting in accordance with 42 CFR § 455.17 and **Model Contract, 2.3.8.2**. Our processes currently include monthly internal reporting and monthly executive review meetings with health plan leadership, and we are prepared to meet the monthly reporting standards required by **Model Contract, 2.20.5**.

For example, a recent process implemented to improve our data analytics and oversight includes requiring the identification of ordering, referring, rendering, and prescribing providers, as may be applicable, on all claims submitted for payment. The indication of a specific, not a group provider, on claim forms enhances data analyses by reducing false-positives for billing outliers on groups, pinpointing when an individual provider is an outlier for impossible day scenarios (i.e. 36 hours of service in one calendar day), and when a provider is excluded or debarred from Medicaid participation. Other improvements are:

- A local Medical Economics team that proactively publishes monthly and quarterly reports that increase our leaders' awareness of emerging and concerning trends that may require investigation.
- A custom-designed provider billing data dashboard**,** using multiple prospective editing and retrospective claims audits**,** which provide**s** a holistic view of individual provider or facility billing behaviors. We use this data to ensure we apply timely education, remediation, or other corrective measures that may be necessary to prevent continued aberrant billing behaviors.

These measures to improve our data analytics and oversight will result in improved reporting.

2.10.15
Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs Participation

Our community baby showers are a positive way to help expectant moms understand the importance of caring for themselves and their babies. Benefits are explained, and attendees in need receive essentials such as diapers and car seats.

AmeriHealth Caritas™
Louisiana

2.10.15 Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs Participation

2.10.15.1 Commitment To Partnering With Small Entrepreneurships

Since AmeriHealth Caritas Louisiana was selected as one of the first managed care contracts with the Louisiana Department of Health (LDH) starting in 2012, we have shown a commitment to supporting diverse and disadvantaged businesses. AmeriHealth Caritas Louisiana, while not a certified small entrepreneurship, works diligently to contract with small businesses under the Louisiana Initiative for small entrepreneurships (Hudson Initiative), and with Veteran-owned and Service-Connected Disabled Veteran-Owned small businesses (LaVet) whenever possible. In total, AmeriHealth Caritas Louisiana has invested nearly $4 million over the last six years with our Hudson and Veteran-certified suppliers, a number we are committed to growing as new innovations in health care provide pathways for emerging businesses. A 2017 recipient of the National Committee for Quality Assurance's (NCQA) Multicultural Health Care distinction, AmeriHealth Caritas Louisiana has supported and will continue to support diversity, cultural competency, and inclusion in our business partnerships, enrollee initiatives, program development, and hiring practices. We do this because it reflects our values and we believe it's the right thing to do.

> *The exposure from the partnership [with AmeriHealth Caritas Louisiana] has helped build LA Construction Company['s] brand and help build the confidence to pursue other commercial build outs. The process to build the community [wellness] center created another format and business model for the company to use moving forward. This has helped us prepare for larger scale projects and we are grateful.*
> ***Lance Thomas, Owner***
> ***LA Construction Company, LLC***

2.10.15.1.1 Veterans Initiative Small Entrepreneurship

AmeriHealth Caritas Louisiana is not a certified Veterans Initiative small entrepreneurship.

> *Having a partnership with a company like AmeriHealth [Caritas Louisiana] can make all the difference in the world to a small business' bottom line.*
> ***Sonia Dubois, Founder & CEO, Dubois & Associates, LLC***

2.10.15.1.2 Hudson Initiative Small Entrepreneurship

AmeriHealth Caritas Louisiana is not a certified Hudson Initiative small entrepreneurship.

2.10.15.1.3 Partnering With Certified Small Entrepreneurships

AmeriHealth Caritas Louisiana intends to continue using certified small entrepreneurships in the performance of contract work resulting from this solicitation, whenever possible. We have developed positive relationships with our existing certified small entrepreneurships such as Feigley Communications, Inc., Lemonade Creative Marketing, and Square Button Consulting and look forward to our continued partnership. We are committed to increasing our support of our neighbors through the addition of new certified small entrepreneurships such as The Printing Source, Inc. and TradducioNOLA, LLC. We have used calculations of the anticipated contract dollar values based on the total contract revenue for a 375,000 enrollee assignment.

2.10.15.1.4 Acknowledging Points Allotted

AmeriHealth Caritas Louisiana understands and acknowledges the allotment of points for this section.

2.10.15.2 Proposer's Veterans And Hudson Initiative Small Entrepreneurship Status

AmeriHealth Caritas Louisiana is not a certified Veteran nor Hudson Initiative small entrepreneurship.

2.10.15.3 & 2.10.15.4 Partnering With Veterans Or Hudson Initiative Small Entrepreneurship

Our small entrepreneurship subcontractors are an integral part of our investment in the communities we serve. Our goal is to provide opportunities that will nurture their growth and build lasting relationships. As part of our commitment to invest in the communities where we live and work, AmeriHealth Caritas Louisiana **has partnered with certified Hudson and Veteran Initiative suppliers successfully since the start of our first managed care contract, increasing our annual spend by over 120% between 2012 and 2018.** For 2019, we anticipate a commitment of approximately [redacted] with these businesses, nearly double from the prior year, which can be attributed to our commitment to opening a new Community Wellness Center.

Figure 2.10.15-1 highlights the names, work descriptions, and anticipated contract values for our selected Hudson Initiative vendors. Our Veteran Initiative vendors are cited in **Figure 2.10.15-2**. Overall, we will spend more than $10 million with Hudson and/or Veteran Initiative vendors over the next three years under the new contract (2020-2022).

Hudson Initiative Subcontractors	Work to be Performed	Anticipated Dollar Value			
		2020	2021	2022	Subtotal
A & E Market L.L.C.	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
Advanced Medical Equipment, Inc.	Durable Medical Equipment Sales and Rentals	[redacted]	[redacted]	[redacted]	[redacted]
ASSURING DESTINATIONS LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
Auzenne Transportation Services	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
Cassidy's Pharmacy, Inc.	Retail Pharmacy	[redacted]	[redacted]	[redacted]	[redacted]
City Medical Management Services, Inc	Outpatient Mental Health Rehabilitation Services	[redacted]	[redacted]	[redacted]	[redacted]
Corporate Business Supplies, Inc.	Office furniture for all of our locations including the new Community Wellness Center.	[redacted]	[redacted]	[redacted]	[redacted]
Crescent City Pharmaceuticals, Inc.	DME/HME	[redacted]	[redacted]	[redacted]	[redacted]
Desiderata Kitchen, LLC	Catering for meetings and events.	[redacted]	[redacted]	[redacted]	[redacted]
Dubois & Associates, LLC	Printing services including but not limited to Member welcome kits.	[redacted]	[redacted]	[redacted]	[redacted]
Feigley Communications, LLC	Social media, to enhance enrollee education, radio, television, and digital marketing and services.	[redacted]	[redacted]	[redacted]	[redacted]
Frazee Recruiting Consultants, Inc.	Temporary staffing services including for general labor for our facilities.	[redacted]	[redacted]	[redacted]	[redacted]
Hawkins Transportation Services LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
Impress Marketing Studios, LLC	Community outreach and office signage.	[redacted]	[redacted]	[redacted]	[redacted]
Infinity Engineering Consultants, LLC	Mechanical, electrical, plumbing consulting and design services.	[redacted]	[redacted]	-	[redacted]
Jakes Transportation LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]

Hudson Initiative Subcontractors	Work to be Performed	Anticipated Dollar Value			
		2020	2021	2022	Subtotal
Joiful Counseling Services, LLC	Outpatient Mental Health Services.	[redacted]	[redacted]	[redacted]	[redacted]
K & J Transport Services LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
KLM TRANSPORTATION SERVICES LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
LA Construction Company, LLC	Construction and building maintenance; the 2020 spend is for the construction of the Baton Rouge Community Wellness Center.	[redacted]	[redacted]	[redacted]	[redacted]
Lauve's PDHC LLC	Pediatric Day Health Care Services-nursing and therapy services to medically fragile children	[redacted]	[redacted]	[redacted]	[redacted]
Lemonade Creative Marketing, LLC	Educational materials for enrollees and providers, and promotional items for outreach and marketing.	[redacted]	[redacted]	[redacted]	[redacted]
Let Us Do It Cleaning Service, LLC	Janitorial services for our Shreveport Community Wellness Center.	[redacted]	[redacted]	[redacted]	[redacted]
Medi Trans, LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
MJSC professional services	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
Preventive Measures Transportation Service, LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
Reliable care transportation LLC	Non-Emergency Medical Transportation	[redacted]	[redacted]	[redacted]	[redacted]
RP Investment Group, LLC	Janitorial services for our New Orleans Community Wellness Center.	[redacted]	[redacted]	[redacted]	[redacted]
Script Specialists, LLC	Pharmaceutical product and laboratory services.	[redacted]	[redacted]	[redacted]	[redacted]
Square Button Consulting, LLC	Outsourced call center services for targeted administrative support such as for provider directory validation.	[redacted]	[redacted]	[redacted]	[redacted]
Teal Office Products, Inc.	Office supplies.	[redacted]	[redacted]	[redacted]	[redacted]
The Printing Source, Inc.	Company printing services.	[redacted]	[redacted]	[redacted]	[redacted]
The Shred Corner, LLC	Document shredding services.	[redacted]	[redacted]	[redacted]	[redacted]
TraduccioNOLA, LLC	Oral Translation Services for enrollees whose primary language is not English.	[redacted]	[redacted]	[redacted]	[redacted]
Totals		[redacted]	[redacted]	[redacted]	[redacted]

Figure 2.10.15-1: *List of Hudson/Veteran-certified vendors, description, and contract values.*

Veteran Initiative Subcontractors	Work to be Performed	Anticipated Dollar Value			
		2020	2021	2022	Subtotal
Hollins Janitorial Services, LLC	Janitorial services for our Baton Rouge Community Wellness Center.	[redacted]	[redacted]	[redacted]	[redacted] 00
Totals					[redacted]

Figure 2.10.15-2: *List of Veteran-certified vendors, description, and contract values.*

SOURCING AND SUPPORTING QUALIFIED SMALL BUSINESSES

AmeriHealth Caritas Louisiana has worked diligently to not only secure commitments from our existing Hudson and/or Veteran-certified vendors, but to also support and strengthen their businesses through extensive efforts by our local and corporate sourcing teams. We do this through such initiatives as our Mentor Protégé Program. The Mentor Protégé program supports AmeriHealth Caritas Louisiana's small diverse business partners by creating an opportunity for our Executive Leadership Team to counsel and

provide supportive services to identified protégés. We focus on building competencies in areas such as strategic business practices, product innovation, talent management, organizational development, and financial management.

Rather than simply hiring the small businesses for certain deliverables, we are committed to investing in their sustainability as a part of our commitment to building healthier communities. For example, in 2020, we will partner with the Southern Region Minority Supplier Development Council to begin offering shared office space in our Community Wellness Centers for our Hudson/Veteran Initiative vendors who lack sufficient meeting spaces at their existing facilities.

Having added AmeriHealth [Caritas Louisiana] to our portfolio has increased our business tremendously.
Shika Sims, Owner
Let Us Do It Cleaning Service, LLC

We also have long-standing initiatives we utilize to source and offer ongoing support to new and existing diverse business partners, including:

- **Southern Region Minority Supplier Development Council** — We participate in Southern Regional Minority Council events throughout the year, including matchmaking sessions with local diverse small businesses. We also sponsor events in order to connect with these vendors and network within the business community.
- **Supplier Diversity Program** — The Supplier Diversity program team, which is a part of AmeriHealth Caritas Services, seeks out opportunities for inclusion to support AmeriHealth Caritas Louisiana's initiatives. Qualified suppliers are assessed for availability, quality of services, and cost-effectiveness, as well as their workforce diversity, community involvement, and values to see how well they align with our mission.
- **Supplier Diversity Council** — AmeriHealth Caritas' Supplier Diversity Council is an associate workgroup that meets regularly to highlight successes, analyze future opportunities, and develop goals for utilizing small diverse businesses for AmeriHealth Caritas Louisiana.

2.10.15.5 Appendix G, Veteran And Hudson Initiatives

AmeriHealth Caritas Louisiana acknowledges the guidelines provided in **Appendix G: Veteran and Hudson Initiatives.**

Years ago, when AmeriHealth [Caritas Louisiana] was preparing to move into its Baton Rouge offices, Corporate Business Supplies was approached to participate in the selection process regarding the needed furniture installation for the new office. The opportunity allowed for an expansion of our furniture operations and helped contribute to our growth[.] It's served as a "flagship" project that we've referenced time and time again […] and we've been successful winning bids partly because of our work with AmeriHealth [Caritas Louisiana].
Alfonso Gonzalez II, President, Corporate Business Supplies, Inc.

Attachments to 2.10
Technical Proposal Requirements

Giving Enrollees A Voice: One of our AmeriHealth Caritas Louisiana Care Managers was able to effectively communicate with this enrollee, help him with obtaining appropriate care, and assist him in communicating with his providers. He told her that she gave him his voice.

AmeriHealth Caritas™
Louisiana

Attachments to
2.10.2 Organizational Experience

AmeriHealth Caritas™
Louisiana

Attachment 2.10.2.1-1 Resumes

This page is intentionally left blank.

Kyle C. Viator

Chief Executive Officer

Work Experience

Market President,
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
2015 – Present

- Directs AmeriHealth Caritas Louisiana's strategic direction, growth, and leadership, including but not limited to the daily operations of the Population Health, Operations, Information Technology, Quality Management and Improvement , Marketing, Fraud and Abuse Monitoring and Compliance, Government and External Affairs and Human Resources departments.
- Manages health plan outcomes, employees, and the achievement of all profitability and membership goals.

Director of Plan Operations & Administration,
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
2014 – 2015

- Provided direct oversight and leadership for internal operational functions.
- Served as primary liaison between the state agency, AmeriHealth Caritas Louisiana and corporate.
- Acted as second in command to the health plan's Executive Director.
- Ensured that local and corporate resources delivered on all commitments to meet contractual obligations.
- Proactively identified risks that would have impacted the health plan's ability to meet enterprise and local strategic and financial goals and developed strategies to mitigate the risks.
- Supported the execution, in collaboration with the Regional Chief Financial Officer and Chief Medical Officer, of cost containment initiatives by developing action plans and tracking results.

Executive Director,
Community Health Solutions of Louisiana (Baton Rouge, Louisiana)
2013 – 2014

- Provided leadership and coordination for all aspects of health plan which served nearly 25 percent of all members in the Louisiana Medicaid Managed Care program, Bayou Health.
- Ensured adherence to program requirements as well as timely and accurate reporting from Community Health Solutions of Louisiana to the state.
- Monitored and oversaw all aspects of program performance.
- Coordinated the resolution of operational issues and supervised assigned staff.
- Coordinated provider/member education for Community Health Solutions of Louisiana.

- Served as the primary representative of Community Health Solutions of Louisiana at legislative sessions, industry conferences, and other related functions.

Director of Patient Financial Services,
Louisiana State University Health Care Services Division (Baton Rouge, Louisiana)
2012 – 2013

- Directed the statewide management of patient billing functions and operations including: patient accounting, registration, billing, accounts receivable, and collection programs of the medical centers under the jurisdiction of the Louisiana State University Health Care Services Division.
- Monitored proposed and final federal and state legislation impacting the revenue cycle of the Louisiana State University Health Care Services Division facilities and strategically implemented changes as needed.
- Collaborated with Reimbursement, Managed Care Contracting, Budget, and other Health Care Services Division directors to ensure that changes implemented would have provided sufficiently for departmental needs.
- Developed, implemented, and maintained systems of accountability and measurement controls for the accurate compilation of operational and financial monitoring reports. Ensured the provision of adequate controls and services, and ensured program effectiveness in relation to revenue results, agency goals, and quality improvement objectives within patient financial program areas.

Director of Government Policy and Payments,
Louisiana State University Health Care Services Division (Baton Rouge, Louisiana)
2011 – 2012

- Monitored activities of major governmental payers and provided technical assistance to hospital system staff in complying with policies and procedures of these programs.
- Provided direction and education to staff throughout seven hospital systems related to the establishment with six new payers contracted to administer Medicaid services.
- Participated in contract negotiations to ensure relationships with new payers took the unique needs and assets of the safety net system into account.
- Established an oversight mechanism to ensure that payers were in compliance with contracts and were readily addressing issues identified by hospital system representatives.

Medicaid Deputy Director,
Louisiana Department of Health and Hospitals (Baton Rouge, Louisiana)
2010 – 2011

- Directed all aspects of the Medicaid provider reimbursement policy and procedures and management of the agency's budget arm.
- Oversaw $6.5 billion in federal and state funds for Medicaid administration and services.
- Managed a staff of more than 100 managers responsible for oversight of the state's largest professional services contract and the management of the statewide Medicaid provider network.

Louisiana State Children's Health Insurance Director of Operations/Medicaid Eligibility Supports Section Chief,
Louisiana Department of Health and Hospitals (Baton Rouge, Louisiana)
2004 – 2009

- Provided administrative and fiscal management for the Louisiana State Children's Health Insurance (LaCHIP) which served more than 125,000 children under age 19.
- Responsibilities included marketing, outreach, and customer service to ensure that all Medicaid/LaCHIP eligible families were enrolled in available public health coverage.
- Developed and directed budgeting for $200 Million program for federal and state reporting and forecasting.
- Managed staff of approximately 60 employees, handling various Medicaid and CHIP eligibility support functions.

Medicaid Outreach Coordinator,
Louisiana Department of Health and Hospitals (Baton Rouge, Louisiana)
2002 – 2003

- Managed statewide outreach for all programs within the Department of Health and Hospitals Medicaid Program, particularly LaCHIP.
- Provided technical and program direction to nine designated Regional Outreach Coordinators and other statewide eligibility field staff.
- Performed outreach duties, including informing the enrolled Medicaid population of services available to them and any subsequent changes to those services.

Public Information Officer,
Louisiana Department of Health and Hospitals (Baton Rouge, Louisiana)
2001 – 2002

- Worked closely with the top department officials to provide timely and accurate information to the news media and stakeholders.
- Researched and developed new internal and external communications initiatives for the department..
- Coordinated daily departmental media relations and performed crisis communications duties.

Publishing and Communications Associate,
Haynie and Associates (Baton Rouge, Louisiana)
1999 – 2001

- Oversaw operations of affiliate company, Louisiana Governmental Studies, the state's premier governmental research and publishing company.
- Developed and implemented public relations and grass-roots programs for clients during legislative sessions.
- Coordinated development of new company website.
- Conducted extensive desktop publishing, research, and writing for publications.
- Coordinated production and marketing efforts for publications.

- Closely monitored progress of client's legislation through the legislative process.

Deputy Press Secretary,
United States Senator Ron Wyden (Washington, D.C.)
1998 – 1999

- Appraised media of the senator's schedule and accomplishments.
- Sought and received media coverage actively.
- Assisted with creation and implementation of the senator's schedule.
- Arranged staff interviews with the senator.

Education and Training

Louisiana State University Public Administration Institute (Baton Rouge, Louisiana)
2000 - 2003

- Degree: Masters of Public Administration

Louisiana State University (Baton Rouge, Louisiana)
1995-1997

- Bachelor of Arts, History
- Minor - Political Science

University of Louisiana at Lafayette
1993-1995

- Major - Social Studies education

Licenses, Certifications, and Memberships

Current Affiliations:

- Board President, Louisiana Medicaid Managed Care Organization Association
- Board of Directors, Serve Louisiana

Prior Affiliations:

- Board of Directors, Louisiana Association of Health Plans
- Leadership Committee, National Covering Kids & Families Network (CKF)
- Steering Committee, Louisiana Child Poverty Prevention Council, Louisiana CKF
- Louisiana Association of Nonprofit Organizations Community Leaders Program
- National Association of Public Hospitals Fellows Program
- Louisiana Interagency Council on Homelessness

Sherry M. Wilkerson, MSPH

Chief Operating Officer

Work Experience

Director, Plan Operations & Administration, Chief Operating Officer,
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
2016 – Present

- Facilitates daily management of operational activities for multiple support functions, including Data and Technical Services, Community Health Education and Plan Operations.
- Identifies operational efficiencies, meets regulatory and client expectations and develops a “best practice” approach for all operations.
- Manages configuration and claims support services, including enrollee grievances, provider disputes, and community health education, community investment, navigation, and innovation.
- Chief liaison between the business unit and corporate policies and standards.
- Assesses organizational strengths and weaknesses to recommend enhanced operating model.
- Developed operational vision, objectives, and policies and procedures to support the overall strategic plan for the business unit.
- Ensured cost effective, client-responsive programs were developed and maintained, identified improvement opportunities and oversaw implementation of changes throughout shared services.
- Consistently achieved business unit financial targets and requirements based on service level, state, compliance, and contractual agreements.
- Spearheaded new system and product implementations.

Director, Provider Network Management,
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
2011 – 2016

- Developed the provider network, ensuring network adequacy and appointment access, development of network resources in response to unmet needs, and adequacy of the provider network to provide member choice of providers.
- Responsible for the annual network development plan and all related statutory reporting.
- Led network planning and strategy efforts to support the successful transformation of the various delivery systems; provided direction to the health plan's Network team, including all development responsibilities.
- Ensured compliance with contracting, credentialing, and privileging policies and procedures.
- Led planning and strategy in the successful development of the provider network including contracting, credentialing, and provider communications.

Provider Relations,
Molina Medicaid Solutions (Baton Rouge, Louisiana)
2004 – 2011

- Served as primary point of contact between health plan and contracted provider network.
- Established and maintained relationships with facilities, physicians, and ancillary providers serving as contractual networks of care for members.
- Responsible for network development, network adequacy, and provider training and education in alignment with all relevant federal, state and local regulations.
- Engaged with highest priority, highest volume, and highest visibility providers to ensure provider satisfaction.
- Responsible for reporting and analyzing data and assisted in the development of internal desktop processes, policies, and procedures in conjunction with the manager.
- Resolved escalated provider inquiries, educated providers on new protocols, policies, and procedures.
- Provided assistance to less experienced Provider Relations Representatives to help resolve complex provider issues.

Education and Training

Walden University (Minneapolis, Minnesota)
2012 – 2013

- Master of Science in Public Health

Walden University (Minneapolis, Minnesota)
2000 – 2002

- Bachelor of Science in Organizational Communications

Bates Technical College (Tacoma, Washington)
1990 – 1992

- Associate of Science in Nursing

Licenses, Certifications, and Memberships

- Executive Leadership LINC, 2016-2017
- Dale Carnegie Leadership LINK, 2015-2016
- Louisiana Association of Non-Profit Organizations Community Leaders Program
- Capital Area United Way Gottlieb Society
- Volunteer, Capital Area United Way Program Investment

Rodney Bryan Wise, M.D.

Medical Director/Chief Medical Officer (CMO)

Work Experience

Medical Director/Chief Medical Officer (CMO),
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
2015 – Present

- Represents AmeriHealth Caritas Louisiana in all aspects of state provider and member quality and strategy development initiatives.
- Works with corporate staff to align efforts to improve care, quality, and outcomes within the Medicaid population.
- Directs all major clinical and quality management components of the health plan.
- Directs the integration of all Population Health functions, including Care Management, Pharmacy Services, Behavioral Health, Quality, and Utilization Management.

Senior Medical Director; Medical Director, Utilization Management,
Blue Cross Blue Shield of Louisiana (Baton Rouge, Louisiana)
2012 – 2015

- Directed all aspects of clinical care, network development, and value based programs for the largest commercial plan in Louisiana.

Medical Director, Louisiana Medicaid,
Louisiana Department of Health and Hospitals - Bureau of Health Services Financing / Medicaid (Baton Rouge, Lousiana)
2009 – 2012

- Served as Chief Medical Officer and provided direction and supervision to all aspects of healthcare for 1.2 million Louisiana Medicaid recipients.
- Led medical direction for program design, implementation, operation, and quality assessment for Bayou Health, the Medicaid managed care program.

Medical Director, Maternity Program,
Louisiana Office of Public Health, Maternal and Child Health Program (New Orleans, Louisiana)
2003 – 2009

- Served as consultant to the Department and Program on all aspects of public health initiatives involving women's health, pregnancy, and reproductive care.
- Led program in Population Health initiatives.

Director, Department of Obstetrics and Gynecology,
Louisiana State University Hospital – Monroe (Monroe, Louisiana)
1989 – 2009

- Clinical emphases included prenatal screening, ultrasound, and prenatal diagnosis.
- Administrative Director of Obstetrics and Gynecology services

Faculty Member, Department of Obstetrics and Gynecology, 1985-2012
Louisiana State University Health Sciences Center – Shreveport (Shreveport, Louisiana)
1985 – 2012

- Faculty member of Obstetrics and Gynecology at Louisiana State University Health Sciences Center – Shreveport.
  - E. Earle Dilworth Endowed Professor, July 2006-September 2009
  - Tenured Professor, July 2005-September 2009
  - Associate Professor, July 1995-June 2005
  - Assistant Professor, September 1989-June 1995
  - Instructor, July 1985-August 1989
- Served in multiple clinical and administrative roles.
- Led the hospital's Quality Committee.
- Was recognized with Endowed Professor status for work in advancing Public Health principles.

Education and Training

Louisiana State University Health Sciences Center- Shreveport (Shreveport, Louisiana)
1988 – 1989

- Fellowship, Clinical Genetics

Louisiana State University Health Sciences Center- Shreveport (Shreveport, Louisiana)
1981 – 1985

- Residency, Obstetrics and Gynecology

Louisiana State University, School of Medicine - Shreveport (Shreveport, Louisiana)
1977 – 1981

- Doctor of Medicine
- Graduated with honors

Northwestern State University of Louisiana (Natchitoches, Louisiana)
1973 – 1977

- Bachelor of Science, Pre-medicine/Zoology
- Magna cum laude

Licenses, Certifications, and Memberships

- Louisiana State Board of Medical Examiners, # 16388
- American Board of Obstetricians and Gynecologists, Diplomate, 1987 - present
- American Congress of Obstetricians and Gynecologists
  - Junior Fellow, 1985 - 1988
  - Fellow, 1988 - present
- Louisiana Perinatal Commission- Member
- American College of Obstetricians and Gynecologists, Louisiana Section- Advisory Committee

- American Medical Association- Member, Delegate to AMA House of Delegates (1991-1995)
- Louisiana State Medical Society- Member, Board of Governors (2002 - 2008)
- Ouachita Medical Society- Member, President (1995 - 1996)
- Louisiana Coalition for Maternal and Infant Health- Member, Board of Directors (1990 - 2009)
- Louisiana Chapter March of Dimes
- National Perinatal Association- Member, Board of Directors (2000 - 2007)
- Alpha Omega Alpha, Medical Honor Society- Member
- Phi Kappa Phi, Collegiate Honor Society- Member
- Beta Beta Beta, Biological Honor Society- Member

This page is intentionally left blank.

Betty Ann June Muller, MD
Behavioral Health Medical Director

Work Experience

Behavioral Health Medical Director,
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
April 2016 – Present

- Directs all behavioral health activities and takes an active role in clinical and policy decisions.
- Supports the provision of quality and the clinically sound system of care services to all individuals in the system of care.
- Serves as medical advisor for clinically related activities in Integrated Health Care Management.
- Serves as a liaison to state agencies and partners, community and network Providers.
- Ensures that organization medical policies and procedures adhere to contractual obligations.
- Establishes prior authorization of clinically appropriate use of psychopharmacology monitors/assists and has oversight for pharmacy benefit manager activities.
- Performs clinical case reviews in conjunction with the clinical department.
- Develops and implements education and training programs for PCPs focused on commonly encountered youth and adult behavioral health issues frequently treated by PCPs.
- Develops education and training for mental health and substance use disorder screening programs using evidence-based tools.
- Oversees, monitors, and assists with the management of psychopharmacology pharmacy benefits manager (PBM) activities.
- Coordinates with the Medical Director, Utilization Management, and the Quality Management and Improvement programs for the integration of quality care.

Associate Clinical Professor of Psychiatry,
Tulane University School of Medicine (New Orleans, Louisiana)
1984 – 2018

- Faculty position.
- Taught and worked within the division of psychiatry.

Child Psychiatric Consultant,
Lafourche Mental Health Center (Raceland, Louisiana)
1999 – 2018

- Performed psychiatric evaluations and medication management.
- Led the child and adolescent treatment team.
- Provided direct supervision to the residents rotating in clinic.

Medical Director, Child and Adolescent Psychiatric Consultant,
Metropolitan Human Services District, Child & Adolescent Services (East Bank of New Orleans, Louisiana)
2010 – 2018

- Responsible for providing oversight of the resident education program.
- Responsible for providing oversight of child and adolescent clinical services.
- Performed psychiatric evaluations and medication management.
- Led the child and adolescent treatment team.
- Provided direct supervision to the residents rotating in clinic.

Education and Training

University of Colorado Health Sciences Center (Denver, Colorado)
1982 – 1984

- Fellow in Child Psychiatry

Vanderbilt Medical Center (Nashville, Tennessee)
1980 – 1982

- Resident in Psychiatry

Vanderbilt Medical Center (Nashville, Tennessee)
1979 – 1979

- Post-graduate residency in Pediatrics, January-December (inclusive)

Vanderbilt Medical Center (Nashville, Tennessee)
1978 – 1978

- Post-graduate residency in Psychiatry, July-December (inclusive)

Tulane University School of Medicine (New Orleans, Louisiana)
1974 – 1978

- Doctor of Medicine

Louisiana State University (Baton Rouge, Louisiana)
1970 – 1974

- Bachelor of Science
- Phi Beta Kappa
- Alpha Epsilon Delta National Health Preprofessional Honor Society

Licenses, Certifications, and Memberships

- Medical License, State of Louisiana, 014674 - 1978
- Medical License, State of Tennessee, 12950 - 1980
- Medical License, State of Colorado, 24974 - 1982
- Certified by the American Board of Psychiatry and Neurology in Psychiatry - 1985
- Certified by the American Board of Psychiatry and Neurology in Child Psychiatry - 1986
- American Academy of Child Psychiatry

- American Psychiatric Association
- Louisiana Psychiatric Association

This page is intentionally left blank.

Shannan O. Herring

Chief Financial Officer

Work Experience

Director, Finance,
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
2017 –Present

- Responsible for oversight of all accounting and finance, including financial operations, managing operating budget, overseeing accounting systems, financial reporting, and all internal and external audits.
- Provides membership, financial results, and support during the budgeting process
- Serves as the main point of contact and develops partnerships with other departments including Implementations, Sales, Account Management, Informatics, Customer Service, and corporate accounting regarding membership.
- Manages and supports a team of finance professionals.
- Collaborates with all levels of management and outside vendors in order to resolve funding issues, accounts receivable balances, and any finance related issues
- Provides ongoing direct support to cost center managers regarding staffing and around general and administrative expenses.

Chief Financial Officer Controller,
Physicians Medical Center, LLC (Houma, Louisiana)
2016 – 2017

- Responsible for financial operations of a 30-bed acute care hospital.
- Managed business office, medical records, purchasing department, and accounting staff members.
- Responsible for internal and external audit compliance.
- Prepared monthly journal entries and financial statements for corporate review.
- Prepared monthly operating reports and quarterly forecast.
- Managed all financial reporting, cash management, budgeting, and forecasting for hospital.

Corporate Controller,
Progressive Acute Care, LLC (Mandeville, Louisiana)
2013 – 2016

- Managed and coordinated financial reporting and budgeting functions for four rural hospitals and corporate operations.
- Prepared consolidated monthly financial statements for board presentation.
- Performed data analytics and prepare operating benchmark and key indicators reports.
- Prepared corporate annual operating budget and oversight of the preparation of fourhospitals' budgets.

- Managed the preparation of third-party cost reimbursement reports, and reviewed accounts payable disbursements for approval.
- Prepared monthly cash flow projections and managed Electronic Health Record funds received by hospital.
- Managed corporate insurance policies.
- Supervised and coordinated all aspects of annual audit for corporate and for four hospitals

Director of Accounting,
Coventry Health Care of Louisiana (Metairie, Louisiana)
2006 – 2013

- Responsible for coordinating and managing the accounting functions for four states (Louisiana, Mississippi, Arkansas, and Tennessee) for a Fortune 500 company with $25 million net income.
- Supervised the completion and accuracy of general ledger accounts and financial statements.
- Prepared $20 million annual operating budget and forecast for four states.
- Analyzed selling, general and administrative expenses (SG&A) trends, revenue, and obligations incurred to predict future revenue and expenses.
- Directed the timely completion of all requested schedules and information requests for Coventry Health Care Corporate Finance.
- Maintained and created internal policies and procedures to comply with Sarbanes Oxley guidelines.
- Coordinated all local plan internal and external financial audits, including audits with Louisiana Department of Insurance.
- Ensured accurate and timely completion of all financial regulatory data submissions.
- Reviewed and approved all accounts payable invoices and expenses.
- Coordinated the process for preparing new reporting to comply with Federal Health Care Reform regulations.

Assistant Controller,
Universal Health Services – Chalmette Medical Center/Methodist Hospital (Chalmette, Louisiana)
2005 – 2006

- Managed the daily operations of accounting department, including all revenue and expense reporting, accounts payable, payroll, and monthly financial reporting requirements.
- Ensured the accuracy of financial reporting.
- Prepared monthly financial variance analysis worksheets. Reviewed and approved all bank reconciliation and journal entries.
- Monitored fixed asset entries.
- Coordinated corporate internal audits.
- Prepared year-end tax schedules and reports.

- Reviewed sales tax returns.
- Reviewed and approved all accounts payable invoices and expenses.
- Oversaw the operations of the outsourced physician practice billing for Emergency department physicians.
- Assisted the Chief Financial Officer in the annual budget process.
- Prepared spreadsheets and procedures in accordance with Sarbanes Oxley guidelines.
- Prepared quarterly Department of Health and Hospitals statistical reports.
- Supervised accountants, accounts payable, and payroll staff members.

Education and Training

University of New Orleans (New Orleans, Louisiana)
1989 – 1994

- Bachelor of Science, Accounting

This page is intentionally left blank.

Jeanine Plante, Pharm.D.

Pharmacy Director

Work Experience

Market Pharmacist,
AmeriHealth Caritas Louisiana (Baton Rouge, Louisiana)
2015 – Present

- Insures compliance with state Medicaid contract requirements, participates in meetings with state agencies, and responds to regulatory issues.
- Leads the implementation of pharmacy-related clinical program initiatives and clinical policy.
- Serves as the liaison between the pharmacy benefit manager and the local network pharmacies.
- Serves as the subject matter expert for questions regarding the drug formulary or claims processing system.
- Contributes pharmacy-related articles for the member and provider newsletters.

Staff Pharmacist
Ochsner Medical Center (Baton Rouge, Louisiana)
2010 – 2016

- Prepared and dispensed medications using safe and cost-effective therapeutic decision making.
- Acknowledged for order entry accuracy and low error rate.
- Assessed, evaluated, monitored, and adjusted drug therapy according to hospital renal dosing policy.
- Responsible for dosing all Warfarin, Vancomycin, and Aminogylcoside regimens.
- Provided drug information to healthcare providers.
- Responded to consultation requests and offered therapeutic alternatives to non-formulary medication orders.
- Oversaw pharmacy technicians to ensure the proper processes are followed and patients receive their medications in a timely manner.
- Reviewed dosing guidelines with physicians, nurses, and upper management.
- Improved the consistency of physician order forms such as the magnesium replacement orders and post orthopedic orders.
- Helped develop new standard orders for clinic use.
- Developed dosing protocol and reference material for the use of paralytic agents in the intensive care unit that is used by both nursing and pharmacy staff.
- Assisted the clinical staff in preparing for pharmacy and therapeutics committee by completing drug use evaluations and drug comparisons.
- Served as a patient advocate. Along with staff from other departments, developed policies to improve patient satisfaction during the hospital stay.

Clinical Pharmacist,
Blue Cross and Blue Shield of Louisiana (Baton Rouge, Louisiana)
2012 – 2015

- Lead the preparation and facilitation of the Pharmacy and Therapeutics Committee meetings.
- Managed the development and provided active maintenance of the drug formulary.
- Developed clinical policies and implemented drug utilization management tools and techniques.
- Headed the initiative to control spending associated with the rising costs of compounded medications.
- Prepared the pharmacy department to participate in its first ever URAC accreditation review and oversaw the pharmacy processes necessary to maintain that accreditation.
- Managed the drug formulary information in the Pharmacy Benefit Management claims system, annual printed formularies and Blue Cross and Blue Shield of Louisiana website.
- Served as a subject matter expert for questions regarding the drug formulary or claims processing system.

Pharmacy Manager,
Walgreens (Gonzales, Louisiana)
2004 – 2010

- Oversaw different aspects of third-party billing.
- Completed necessary steps for medication payment approval and collaborated with physicians to choose alternative medications according to the patient's insurance formulary.
- Discussed drug therapy with physicians and provided patient consultation.
- Processed prescriptions accurately and efficiently.
- Managed pharmacy department staff responsible for implementing new initiatives received from corporate level management.
- Consistently recognized for reaching customer service and inventory goals.
- Coordinated the creation of flu clinics at the store which made vaccinations available to dozens of patients weekly.

Education and Training

Xavier University of Louisiana (New Orleans, Louisiana)2003 – 2007

- Doctorate of Pharmacy

University of Houston (Houston, Texas)
1997 – 2001

- Bachelor of Science in Psychology

Licenses, Certifications, and Memberships

- Louisiana Pharmacy Licensure, License Number 018317
- Academy of Managed Care Pharmacy, 2014- Present

- Louisiana Association of Health Plans, 2012- Present
- American Society of Health-System pharmacists, 2006- Present
- Kappa Psi Pharmaceutical Fraternity, 2004- Present

This page is intentionally left blank.

Lesli Boudreaux

Contract Compliance and Program Integrity Officer

Work Experience

Director, Compliance and Regulatory Affairs,
AmeriHealth Caritas Louisiana (Baton Rouge, LA)
2019 – Present

- Directs the planning and management of the Compliance Program.
- Develops, implements, and maintains a contract compliance monitoring tool which includes all contract requirements, the assignment of responsible internal stakeholders, and documentation of compliance.
- Directs the implementation and execution of initiatives designed to resolve identified Louisiana Department of Health and Hospitals (DHH) contract compliance issues and to implement new DHH contract requirements and operational initiatives.
- Oversees, monitors, and enforces all fraud, waste and abuse (FWA) activities. Recommends controls to address FWA. Conducts confidential internal investigations at the direction of executive management, the Corporate Legal andCompliance offices, and/or Human Resources. Works closely with internal and external auditors, financial investigators, and claims processing.
- Works effectively with federal, State, and local investigative agencies on FWA cases to ensure best outcomes, while adhering to regulatory protocols on case records. Resolves fraud and abuse program questions, problems, and concerns from members, providers, and DHH. Monitors reports to regulatory agencies monthly, quarterly, and annually.
- Provides strategic advice and guidance on contract and regulatory policy matters to enable the companyto achieve annual operating plan goals and objectives and maintain compliance with contract requirements and Louisiana Medicaid regulations. Negotiates issue resolution between the company and DHH.
- Oversees monitoring process for compliance with State regulations and provides strategic direction and guidance to ensure timely and accurate implementation of all mandated changes.
- Analyzes and summarizes Medicaid policy emerging in response to federal health care policy. Provides guidance and recommendations and directs the implementation of initiatives to come into compliance with emerging policy.
- Manages the annual DHH contract language negotiation and amendment process, acilitating timely review and comment on proposed changes.
- Oversees the development and implementation of contract management and administration procedures, including maintenance of contractual records and documentation, such as receipt and control of all contract correspondence.
- Ensures that all signed contracts are communicated to all relevant parties to provide contract visibility and awareness. Provides interpretation to support contract implementation.

- Directs and oversees the implementation of initiatives to come into compliance with new contractual requirements resulting from the annual amendment process.

Healthcare Consultant,
Sullivan & Jacobs (Denham Springs, LA)
2016 – 2018

- Advised Nebraska Department of Health & Human Services, Lincoln, Nebraska.
- Curam Eligibility and Enrollment Solution – business rules, requirements mapping, testing, project management.
- Assisted with Readiness Review activities for Nebraska's three managed care organizations that began operations on 1/1/17.
- Drafted and submitted advanced planning documents (APDs), including tri-agency A-87 exception allowance.
- Served as Project Lead on Medicare's Social Security Number Replacement Initiative.
- Served as Project Lead on electroning Asset Verification System (eAVS) implementation.
- Held requirements sessions and compiled Request for Proposals for Long Term Care Case Management.

Medicaid Program Manager 4, Health Plan Relations ,
Louisiana Department of Health and Hospitals (Baton Rouge, LA)
2015 – 2016

- Oversaw the Medicaid Managed Care program, including all coordination, implementation, and ongoing operations for Bayou Health and the Dental managed care program.
- Oversaw the statewide Enrollment Broker contract manager. Ensured that the enrollment and disenrollment of more than 1 million Medicaid and CHIP members were effectively educated, provided choice counseling, and correctly and timely linked to one of the five Bayou Health plans of their choice. Delivered legislative reporting relative to the effectiveness of the Bayou Health initiative, which was required annually. Delivered monthly reporting to the DHH Secretary and Medicaid Director related to distribution of membership between the health plans.
- Liaised with the fiscal intermediary as required for system edits and inquiries needed to provide coordinated care to the Bayou Health members and ensure appropriate provider payments.
- Oversaw the Grievance, Appeals, and State Fair hearings for all Bayou Health plans and the Dental managed care program. Ensured compliance with contract requirements and State and federal law.Identified areas in need of improvement, at both the programmatic level and the individual provider and member levels.
- Oversaw of the statewide Central Appeals Unit, responsible for handling all member appeals related to eligibility determinations and service delivery. This centralization required coordination between Medicaid Eligibility, the Division of Administrative Law, Medicaid Managed Care, the fiscal intermediary, and five Bayou Health plans. Ensured timelines were adhered to and policy and procedures were accurately applied.

- Planned and tracked Budget to ensure sufficient fund availability needed to fulfill the section's responsibilities.
- Oversaw the preparation of federal and State reports as required by the U.S. Centers for Medicare and Medicaid Services (CMS), as well as reports required by statute for the Louisiana Legislature.

Medicaid Program Manager 4, Medicaid Member Services,
Louisiana Department of Health and Hospitals (Baton Rouge, LA)
2013 – 2015

- Oversaw the statewide Enrollment Broker contract manager. Ensured that the enrollment and disenrollment of more than960,000 Medicaid and CHIP members were effectively educated, provided choice counseling, and correctly and timely linked to one of the five Bayou Health plans of their choice. Delivered legislative reporting relative to the effectiveness of the Bayou Health initiative, which was required annually. Delivered monthly reporting to the DHH Secretary and Medicaid Director related to distribution of membership between the health plans.
- Liaised with the fiscal intermediary as required for system edits and inquiries needed to provide coordinated care to the Bayou Health members and ensure appropriate provider payments.
- Oversaw the Grievance, Appeals, and State Fair hearings for all Bayou Health plans and the Dental managed care program. Ensured compliance with contract requirements and State and federal law. Identified areas in need of improvement, at both the programmatic level and the individual provider and member levels.

Medicaid Program Manager 4, Medicaid Eligibility Supports,
Louisiana Department of Health and Hospitals (Baton Rouge, LA)
2009 – 2013

- Managed the operations of the State Children's Health Insurance Program (SCHIP) in Louisiana. Monitored and maintained the State Plan and ensured that the Program was operating in accordance with the plan. Regularly prepared analyses and reports for CMS, the State Legislature, DHH executive management, and other interested parties relative to enrollment, expenditures, and budget for this federal-state program, which, unlike Medicaid, had a spending cap.
- Directed efforts to create increased public awareness of LaCHIP and other Medicaid programs. Approved marketing and outreach campaigns for these public programs including contracting for television, radio, and print advertising. Provided oversight of outreach efforts of LaCHIP Outreach Coordinators in each of the nine geographic regions of the state, as well as community based organizations who contracted with the agency on the Covering Kids & Families project.
- Oversaw the management of arrangements with more than 450 community based organizations who acted as certified Medicaid application centers who assisted thousands of eligible families with applying for LaCHIP or Medicaid every month.

- Provided direction for grassroots Medicare Savings Program outreach initiatives that had been initiated under the Robert Wood Johnson Foundation State Solutions Reaching Out Grant in every region of the state.
- Provided direction for a large Medicaid Infrastructure Grant that supported efforts to assist persons with disabilities to secure and maintain employment, and provided direction for the State's Medicaid Purchase Plan that provided full medical coverage for individuals with disabilities who were employed.
- Provided direction for a federally funded CHIPRA Grant for targeted outreach to increase enrollment of eligible children in underserved populations into LaCHIP and Medicaid.
- Oversaw the management of statewide customer service functions for the Medical Vendor Administration including toll-free hotlines for LaCHIP, LaMOMS, Take Charge, and General Medicaid information, as well as for the state Medicaid teletypewriter (TTY) line, which amounted to approximately 40,000 calls per month. Provided direction for centralizing functions that assisted families in obtaining and maintaining public health coverage through electronic resources that were available at times that are convenient to them.

Medicaid Program Manager 2, Medicaid Eligibility Supports,
Louisiana Department of Health and Hospitals (Baton Rouge, LA)
2009 – 2009

- Oversaw statewide grants related to LaCHIP and Medicaid eligibility. Developed work plans, communicated with external stakeholders, and hired, trained, and directly supervised grant staff to ensure the goals of the grants were accomplished. Worked with other state agencies to increase collaboration and improve the experience of common clients.
- Managed budget development and annual expenditures for LaCHIP and prepared budgetary projections for executive management. Tracked enrollment and disenrollment trends to determine implications for the goal of increasing the number of insured children in Louisiana. Reviewed changes to federal and State laws and regulations to determine potential impact on LaCHIP.
- Administered the LaCHIP Affordable Plan, including providing functional supervision, consultation, and broad direction to statewide field staff to ensure compliance with program requirements. Managed statewide outreach and public relations efforts for consumers, businesses, and collaborating agencies. Developed and monitored programmatic and budgetary matters related to services, equipment, and materials. Monitored contract with the Office of Group Benefits to process LaCHIP Affordable Plan payments and claims.
- Directed statewide marketing and outreach to the general public about the availability of various programs administered through the Medical Vendor Administration. Ensured that the public was informed through grassroots outreach and communications through mainstream media venues. Managed LaCHIP marketing and outreach campaigns handled internally and by external providers with annual contracts that totaled $750,000. Oversaw more than 400 community-based organizations that acted as enrolled application centers.

Evaluated effectiveness of media campaigns and advised executive management on ongoing marketing strategies.

- Monitored the Medicaid Purchase Plan, and provided functional supervision, consultation,and broad direction to statewide field staff to ensure compliance with program requirements.
- Managed statewide outreach and public relations efforts for consumers, businesses, and collaborating agencies. Develops and monitors programmatic and budgetary matters related to contracts, services, equipment, and materials.
- Administered the Medicaid Infrastructure Grant (MIG) in Louisiana by providing broad supervision to statewide staff. Managed statewide outreach and public relations related to the MIG for consumers, business, and collaborating agencies. Developed and monitored program and budget recommendations related to MIG projects. Collaborated with department personnel, staff from other agencies and sites, and state-to-state infrastructure partnerships.

Medicaid Program Supervisor, Medicaid Eligibility Supports,
Louisiana Department of Health and Hospitals (Baton Rouge, LA)
2008 – 2009

- Directed the supervision, training, evaluation and hiring of 14 professional level staff who responded to contacts through the statewide Customer Service Unit (CSU) call center for the Medical Vendor Administration (MVA), including toll free hotlines for LaCHIP, LaMOMS, Take Charge, Medicare Savings Programs, Medicaid Purchase Plan, general Medicaid programs, and the State Medicaid TTY Line. CSU also provided support for persons applying for coverage through the Online Application (OLA) system and the main telephone lines at all but one local Medicaid office. Ensured a high level of quality assurance of incoming and outgoing phone calls using daily call monitoring, review of real time activities of the phone lines, and analysis of reports generated by the Automated Call Distribution (ACD) phone system. Served as confidential assistant for two secretaries of the Louisiana Department of Health and Hospitals.
- Monitored performance, interviewed applicants and conducted or organized training specific to the required assignments. Coordinated schedules and work assignments. Reviewed personnel matters and developed appropriate procedures and practices. Monitored staff development,ensuring that appropriate training and performance tools were made available to staff. Researched health care issues, including state and federal legislation, policy papers and internal reports to develop briefing notes, talking points, media quotes, summaries, responses and impact statements.
- Coordinated the communication of eligibility status updates and changes including, information left by the clients/applicants through the advanced features option of the ACD system, Administrative Renewals, address changes on mass mailings to statewide populations, and emailed requests made through any of the Medicaid websites for assistance with eligibility or coverage related issues.

Education and Training

Louisiana State University
2009 – 2011

- Graduate courses in Public Administration

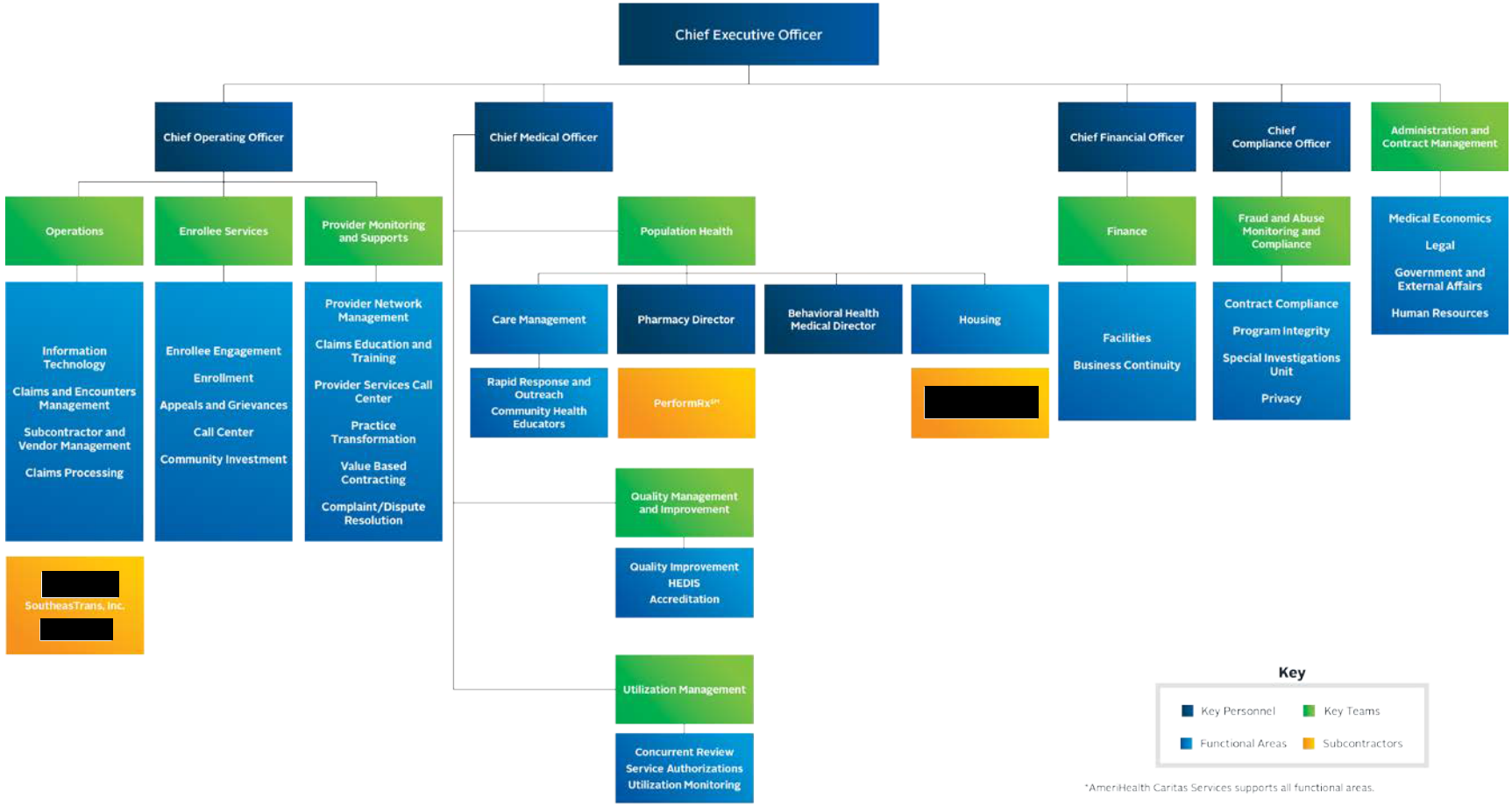
University of Louisiana, Lafayette
1988 – 1992

- Bachelor of Arts, Secondary Education

Attachment 2.10.2.2.-1 Organizational Chart

This page is intentionally left blank.

Attachment 2.10.2.2-1 Organizational Chart



This page is intentionally left blank.

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-1

[redacted]

Appendix F Material Subcontractor Response Template

This page is intentionally left blank.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
AmeriHealth Caritas Louisiana
Material subcontractor name:
[redacted]
Description of the Proposer's role and material subcontractor's role:
AmeriHealth Caritas Louisiana is responsible for the sourcing, vetting, selection, and oversight of all material subcontractors, reporting on performance, providing ongoing support, and ensuring that they comply with the subcontractor agreement. [redacted] ' daily activities will be conducted in concert with our Operations team. [redacted]
Explanation of why the Proposer plans to subcontract this service and/or function:
AmeriHealth Caritas Louisiana has determined that subcontracting these services is the most efficient, cost-effective way to provide these Medicaid covered services to our enrollees, while complying with service requirements/standards as set out by the Louisiana Department of Health. [redacted]
A description of the material subcontractor's organizational experience:
[redacted]
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
Prior to approval by AmeriHealth Caritas Louisiana and the Louisiana Department of Health, [redacted] will be evaluated, including screening for state and federal exclusions, review of ownership disclosures, review of trainings and policies, accreditation standards, and completion of all necessary documentation. [redacted] must demonstrate that they possess the infrastructure, organization, financial stability, and processes necessary to fulfill their role, while aligning with our requirements and the Model Contract. For [redacted] our local Vendor Management team will collaborate with the Delegation Oversight department to oversee onboarding, auditing and monitoring, guided and supported by an enterprise delegation oversight policy maintained by the Corporate Quality department. Dedicated staff will monitor [redacted] performance against documented performance standards each month. Minimally, we require performance consistent with the requirements of the Medicaid contract and any applicable accreditation standards, i.e. NCQA. Annually, [redacted] will be audited to ensure that their credentialing, UM, and other business processes and procedures continue to meet our requirements. The results of these audits are compiled and submitted to the appropriate Quality committees, along with any recommendations. In order to ensure an appropriate return-on-investment (ROI), our Medical Economics department works with UM, care management, and other relevant teams to assess patient outcomes and program ROI analyses, provider/plan goal alignment and pay-for-performance initiatives, and other analytics related to [redacted]. Further, we constantly monitor for any reported or identified instances of fraud, waste and abuse, and third-party liability (TPL) to ensure that claims and payments are accurate, timely, and appropriate.

Instructions: The MCO should attach the executed contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Subcontract Provisions, Introductory Paragraph, pg. 65
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Contract
3	Specify the effective dates of the subcontract agreement.	Contract
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Subcontract Provisions, Par. 41, pg. 85
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Subcontract Provisions, Par. 41, pg. 85
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Subcontract Provisions, Par. 41, pg. 85
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Subcontract Provisions, Par. 44, pgs. 85-86
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Subcontract Provisions, Par. 39, pgs. 85
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Subcontract Provisions, Introductory Paragraph, Pg. 65

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Subcontract Provisions, Introductory Paragraph, Pg. 65
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Subcontract Provisions, Par. 4(i), pg. 68
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Subcontract Provisions, Par. 40, pg. 85
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Contract
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Subcontract Provisions, Par 16, pg. 77
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Subcontract Provisions, Par. 8(g), pg. 75
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Subcontract Provisions, Par. 4(j), pg. 68
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Subcontract Provisions, Par. 23, pgs. 79-80

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Subcontract Provisions, Par. 5(d), pg. 69
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 2.9.6. The completed disclosure of ownership should be attached for executed contracts.	Subcontractor Provisions, Par. 5(m), pg. 71
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Subcontract Provisions, Par. 4(c), pg. 68
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Subcontract Provisions, Par. 4(e), pg. 68
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Subcontract Provisions , Par. 30(b), pg. 84
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Subcontract Provisions, Par. 30, pgs. 83-84

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Subcontract Provisions, Par. 4(b), pgs. 67-68
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Subcontract Provisions, Par. 21, pg. 79
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Subcontract Provisions, Par. 4(g), pg. 68
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 68
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 68
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Subcontract Provisions, Par. 4(k), pg. 68
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Subcontract Provisions, Par. 12, pgs. 76-77
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Subcontract Provisions, Par. 29, pgs. 82-83

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Subcontract Provisions, Par. 28, pgs. 81-82
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Subcontract Provisions, Par. 3, pgs. 65-66 and Par. 45, pg. 86
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Subcontract Provisions, Par. 3, pgs. 65-66
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Subcontract Provisions, Par. 15, pg. 77
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Subcontract Provisions, Par. 32, pg. 84
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Subcontract Provisions, Par. 4(d), pg. 68
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Subcontract Provisions, Par. 26, pg. 81
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Subcontract Provisions, Par. 3(c), pg.66
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Subcontract Provisions, Par. 42, pg. 85

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Subcontract Provisions, Par. 4(a), pg. 67
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Subcontract Provisions, Par. 38, pgs. 84-85
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Subcontract Provisions, Par. 43, pg. 85

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Subcontract Provisions, Par. 5(e), pg. 5

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-1

[redacted]

Draft Agreement

This page is intentionally left blank.

NOTE: THIS AGREEMENT IS BINDING UPON EACH PARTY AT THE TIME THAT THE PARTY SIGNS THIS AGREEMENT, PROVIDED THAT THIS AGREEMENT REMAINS SUBJECT TO THE APPROVAL OF THE STATE OF LOUISIANA, AND MAY BE AMENDED BY THE PARTIES TO COMPLY WITH ANY REQUIREMENTS OF THE STATE OF LOUISIANA. [redacted] ACKNOWLEDGES THAT THE REQUIREMENTS OF THE STATE OF LOUISIANA, THE STATE CONTRACT, AND APPLICABLE LAWS AND REGULATIONS, AS AMENDED FROM TIME TO TIME, ARE INCORPORATED.

[redacted]

THIS AGREEMENT is made and entered into as of the ____ day of _____, 2019, by and between AMERIHEALTH CARITAS LOUISIANA, INC. (hereinafter "Health Plan" or "ACLA"), a corporation organized under the laws of the State of Louisiana, and [redacted] a corporation organized under the laws of Arizona ([redacted]).

WHEREAS, through a contract with the State of Louisiana's **Department of Health ("LDH" and the "Contract")**, Health Plan is engaged in the business of providing or arranging for the provision of prepaid health services, including without limitation, eye care services to Program (as defined below) recipients enrolled in a managed care plan operated by Health Plan pursuant to the State of Louisiana's Healthy Louisiana Program; and

Confidential [redacted]

Confidential [redacted]

Confidential [redacted]

WHEREAS, Health Plan is entering into an exclusive agreement with [redacted] whereby [redacted] is the only administrator for the services covered under this Agreement for Health Plan's eligible Members, to the extent that [redacted] is capable of providing such services;

WHEREAS, [redacted] Participating Providers are not entering into an exclusive agreement with [redacted] for the provision of Covered Services (defined below) to these Members.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, Health Plan and [redacted], intending to be legally bound hereby, agree as follows:

I. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

A. Adverse Benefit Determination – Any of the following:

☐ The denial or limited authorization of a requested service, including, but not limited to determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

☐ The reduction, suspension, or termination of a previously authorized service.

☐ The denial, in whole or in part, of payment for a service.

☐ The failure to provide services in a timely manner, as defined by the State.

☐ The failure of an MCO to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

☐ The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

B. AGENCY or **LDH**. The State agency that administers the Program(s) under which ACLA is obligated to provide or arrange for the provision of Covered Services.

C. AGENCY or **LDH CONTRACT**. The contract or contracts between ACLA and the Agency, as in effect from time to time, pursuant to which ACLA is responsible for coordinating health care services and supplies for Program recipients enrolled with ACLA.

D. APPEAL. A review by [redacted] of an Adverse Benefit Determination.

E. CLEAN CLAIM. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

F. COMMENCEMENT DATE. The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that the [redacted] Providers have been successfully credentialed by [redacted] and that all required regulatory approvals have been obtained by ACLA.

G. COVERED SERVICES. Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by [redacted] Providers, as described more specifically in Exhibit A. Covered Services shall be furnished in the amount, duration and scope required under the Program.

H. EMERGENCY MEDICAL CONDITION. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

I. EMERGENCY SERVICES. In accordance with 42 U.S.C. §1395dd(e), §1396u-2(b)(2) and 42 C.F.R. §438.114(a), covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations and Title XIX of the Social Security Act and that are needed to screen, evaluate, and stabilize an emergency medical condition. If an emergency medical condition exists, the

Contractor is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the "prudent layperson" standard shall apply to both in-network and out-of-network coverage.

J. GRIEVANCE. An expression of enrollee dissatisfaction about any matter other than an adverse benefit determination as defined in this Contract. Examples of grievances include, but are not limited to, dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

K. MEDICALLY NECESSARY SERVICES. Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

L. MEMBER. A Medicaid or LDH client who enrolls in the Contractor's MCO under the provisions of this Contract.

M. PARTICIPATING PROVIDER. A provider that has a signed network provider agreement with a MCO.

N. PROGRAM. The 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.

O. QUALITY MANAGEMENT PROGRAM. The ongoing process of ensuring that the delivery of MCO covered services is appropriate, timely, accessible, available, medically necessary, in accordance with established guidelines and standards, and reflective of the current state of medical and behavioral health knowledge.

P. UTILIZATION MANAGEMENT PROGRAM. Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Utilization Management is inclusive of utilization review and service authorization.

II. OBLIGATIONS OF [redacted]

A. [redacted].

1. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

III. OBLIGATIONS OF HEALTH PLAN

A. Compensation to [redacted]

1. Health Plan shall pay [redacted], and [redacted] shall accept as payment in full for services rendered hereunder and to Members, the amounts set forth in **Exhibit D** hereto. [redacted] shall be solely responsible for payments to Participating Providers for the provision of Covered Services to Members, and neither Health Plan, except as described herein, nor LDH shall be liable to providers for services rendered to Members, whether Covered Services or non-Covered Services.

2. The total monthly payment shall be paid to [redacted] by the fifteenth (15th) day of each month in which services are to be provided. Such payments to [redacted] may be based on an estimated number of Members and adjusted retrospectively after each month's payment by Health Plan based on the actual number of Members for each month identified as eligible in the records of Health Plan as transmitted to [redacted]

B. Health Plan agrees to supply [redacted] monthly full files on or before the first (1st) day of each month, with eligibility data reflecting additions, changes and deletions covering data at least up to and including the fifteenth (15th) day of the preceding month. Health Plan shall also provide [redacted] with daily updates to eligibility data as made available by Health Plan. Such eligibility data shall be transmitted in a mutually agreed format and manner. [redacted] will update its eligibility files with the updated Health Plan data within two (2) business days and will provide on-line and/or telephonic eligibility information to its Participating Providers.

C. [redacted] agrees that Health Plan may, in its discretion, use [redacted] name, address and telephone number as well as the names, addresses and telephone numbers and specialties of Participating Providers in Health Plan's marketing and informational materials, including, without limitation, Health Plan's provider directory. Nothing in this Agreement shall be deemed to require Health Plan to conduct any specific marketing activities on behalf of [redacted] and Participating Providers or to identify [redacted] or Participating Providers in any specific marketing or informational materials.

D. Benefit Design and Interpretation: Coverage Decisions: Health Plan shall be solely responsible for informing [redacted] of the benefit design of its managed care plan, as determined by LDH or other applicable Government Agency, including establishing benefits and any permitted copayments. In the event of an appeal of a service reduction or denial, Health Plan shall be solely responsible for interpreting the terms of and making final benefit determinations under its managed care plan.

E. Enrollment and Assignment of Members; Member Communications:

1. Member Communications. Health Plan shall be responsible for communicating with all Members upon enrollment to the Health Plan. Health Plan shall provide benefit information to Members concerning the type, scope and duration of benefits to which Members are entitled.

2. Member Rights and Responsibilities. Health Plan is responsible for informing Members of their rights and responsibilities, providing Members with Membership cards and Member handbooks, and distributing periodic communications to Members that may be required to be given to Members by any Government Agency. Health Plan shall also process Member Appeals and Grievances and respond to inquiries and requests from Members (collectively "Member Services"). Health Plan shall partner with [redacted] in the investigation of Appeals and Grievances.

F. Distribution of Required Documents: Health Plan shall distribute to Members any disclosure forms, plan summaries or other material required to be given to plan subscribers by any Government Agency or other regulatory authority. Such materials shall be distributed as required under applicable law.

IV. TERM AND TERMINATION

A. Term: The term of this Agreement shall commence on the Commencement Date for a two (2) year term ("Initial Term"), and shall automatically renew for additional one (1) year terms thereafter (each a "Renewal Term"), unless terminated as provided for herein.

B. If Health Plan materially breaches this Agreement by failure to satisfy its payment obligations set forth in **Section III.A** above and further described in **Exhibit D** hereto, and such material breach continues for a period of thirty (30) days after written notice is given to Health Plan of the claimed breach, then [redacted] may, upon written notice to Health Plan, terminate this Agreement. Failure to pay amounts which are the subject of a good faith dispute regarding the amount of compensation to be paid to [redacted] shall not be considered a material breach under this **Section IV.B**.

C. If either party materially breaches this Agreement in any manner other than a payment default specified in **Section IV.B** above, and such material breach continues for a period of forty-five (45) days after written notice is given to the breaching party, specifying the nature of the breach, the steps necessary to cure it and requesting that it be cured, the other party may upon written notice to the breaching party terminate this Agreement.

D. After the Initial Term of this Agreement, either party shall have the option to terminate this Agreement at any time, for any or no reason, upon no less than one hundred twenty (120) days prior written notice to the other party.

E. Either party may terminate this Agreement at any time in the event that the other party shall apply for, or consent to, appointment of a receiver, trustee or liquidator of the party to a substantial part of its assets, is the subject of a voluntary or involuntary petition in bankruptcy, or shall admit in writing its inability to pay its debts, file a petition or an answer seeking reorganization or arrangements with creditors or to take advantage of any insolvency law.

F. Termination by Health Plan. Should [redacted] fail to perform the functions as set forth in this Agreement and any Exhibits thereto, Health Plan may terminate this Agreement or the applicable delegated function, as of the date written notice is given to [redacted] or such later date as may be specified in the notice, provided, however, that [redacted] shall be provided with the opportunity to cure any deficiencies identified by Health Plan in an agreed upon time period, which may be extended upon mutual agreement and good faith efforts of the parties. If the deficiencies are identified by LDH, any other regulatory agency or accreditation organization, [redacted] shall abide by any official directive given by such regulatory agency or accreditation organization, be it the opportunity to cure said deficiency within the cure period provided by the regulatory agency or accreditation organization, if any or immediate revocation of the agreement.

G. Immediate Termination by Health Plan. Health Plan may immediately terminate this Agreement as of the date written notice is given to [redacted], or such later date as may be specified in the notice, without the need to provide for a cure period, if:

1. Health Plan or LDH determine, in their sole discretion, that the health, safety or welfare of Members is or may be jeopardized by continuation of this Agreement;
2. [redacted] commits fraud or a material misrepresentation in an application or report submitted to Health Plan or in any report filed with any person, corporation, partnership, association, Government Agency or any other entity relating to the provision of services or in any other manner related to this Agreement;
3. Upon the elimination by LDH of the benefits to be provided by Health Plan, issuance of an order by the LDH to terminate this Agreement, or upon termination of the LDH Contract. Notwithstanding the foregoing, in the event that only part of the benefits are eliminated by LDH, Health Plan may, at its sole discretion, continue this Agreement with respect to any remaining benefits.
4. In the event of the cancellation, revocation, suspension or restriction of any insurance, license, certificate or other authorization required to be maintained by [redacted] or Health Plan in order to perform the services required under this Agreement or upon [redacted] or Health Plan's failure to obtain such license, certificate or authority, including but not limited to either party's being expelled, disciplined, barred from participation in, or suspended from receiving payment under the Medicare Program or any state's Medicaid Program, or in the event that either party is convicted of any felony or of any crime related to the provision of health care services.

H. Effect of Termination.

1. In the event of termination of this Agreement and for a period not to exceed ninety (90) days, [redacted] shall not be relieved of its service obligations to Members then receiving treatment from Participating Providers through [redacted] until the completion of such treatment and Health Plan shall not be relieved of its obligation to reimburse [redacted] for paid

claims during this period. This obligation to continue treatment does not require that long-term, non-restorative therapies be completed if such non-completion would not constitute abandonment of the patient. [redacted] will provide Health Plan with information of all such Members receiving treatment and the applicable provider thereof. After termination of this Agreement, [redacted] shall provide evidence satisfactory to Health Plan that [redacted] has made payment of all claims for Covered Services rendered during the term hereof. [redacted] shall further be obligated to provide Health Plan with all reports and data required hereunder for services rendered during the term hereof. During this period, Health Plan shall not be relieved of its obligation to reimburse [redacted] for claims paid.

2. Following termination of this Agreement, at Member's request, [redacted] shall require its Participating Providers to copy all requested Member patient medical files in their possession and forward such files to another provider of Covered Services designated by Member.

3. Upon termination of this Agreement for any reason, [redacted] shall assist Health Plan in effecting an orderly transition of the processing of claims and other services provided by [redacted] under this Agreement so as to prevent disruption of Health Plan's operations. Such assistance shall be rendered in a manner consistent with usual and customary industry practice and with applicable vendor contracts between [redacted] and any third party. Without limiting the foregoing, [redacted] shall continue to process and pay all claims for services provided to Members prior to the termination, at no additional cost to Health Plan for a period of up to one hundred and eighty (180) days following termination provided that Health Plan continues to reimburse [redacted] for all paid claims as agreed upon throughout this period.

I. Notwithstanding any provisions of this Agreement, no termination of this Agreement shall be effective without prior written notice to LDH; and unless terminated immediately for-cause, the termination date shall be the last day of the month of termination.

V. INSURANCE AND INDEMNIFICATION

A. Health Plan and [redacted] each at its sole cost and expense, shall provide and maintain separate policies of general liability and professional liability insurance and other insurance as is necessary to insure each organization against any claim or claims for damages arising by reason of personal injury or death occasioned directly or indirectly in connection with the operation of each organization. [redacted] shall require its Participating Providers to maintain adequate and customary insurance coverages. All insurance required by this **Section V.A** shall, at a minimum, be in amounts no less than the amounts required by the LDH Contract or applicable law, whichever is greater. [redacted] shall provide Health Plan thirty (30) days written notice if the stated limit in the declarations page of an insurance policy required under this contract is reduced via endorsement or canceled prior to the expiration date shown on the certificate of insurance. [redacted] shall have the State of Louisiana named as an additional insured to the general liability insurance policy.

B. [redacted] shall indemnify and hold Health Plan harmless with respect to any claim against Health Plan, including but not limited to any fines, penalties, sanctions, liquidated damages or similar consequence imposed by LDH or other Government Agency, arising out of [redacted] negligence or failure to fulfill its obligations under this Agreement. Without limiting the foregoing, [redacted]

agrees that to the extent penalties are assessed against Health Plan by a Government Authority, as a result of [redacted] direct failure to comply with applicable rules, regulations, and LDH Contract requirements related to delegated responsibilities as set forth herein as it relates to the provision of services hereunder and , if available, [redacted] has been provided the opportunity to participate in any cure periods provided to Health Plan by LDH to correct such failure, [redacted] shall be responsible for the payment of such penalties in a mutually agreed upon timeframe. In the event such payment is not made in a timely manner to Health Plan, Health Plan shall have the right to offset any monies owed to [redacted] for Administrative Services Only (ASO) fees, by any penalties owed by [redacted] to Health Plan.

Health Plan shall indemnify and hold [redacted] harmless with respect to any claim against [redacted] including but not limited to any fines, penalties, sanctions, liquidated damages or similar consequence imposed by LDH or other Government Agency, arising out of Health Plan's negligence or failure to fulfill its obligations under this Agreement. Without limiting the foregoing, Health Plan agrees that to the extent penalties are assessed against [redacted] by a Government Authority, as a result of Health Plan's direct failure to comply with applicable rules, regulations, and LDH Contract requirements related to delegated responsibilities as set forth herein as it relates to the provision of services hereunder and Health Plan has been notified in a timely manner and has been provided the opportunity to participate in any cure periods provided to [redacted] by LDH to correct such failure, Health Plan shall be responsible for the payment of such penalties in a mutually agreed upon timeframe.

VI. CONFIDENTIALITY

A. The parties hereto mutually agree that, with respect to any and all Member records, files and other patient-related information (the "Member Information") and any other confidential or proprietary data, reports, or information maintained pursuant to this Agreement or plans, policies and procedures shared between the parties and the terms of this Agreement (the "Other Confidential Information"), the receiving party shall ensure the confidentiality of all such Member Information and Other Confidential Information and in doing so will take the same measures to ensure confidentiality as it would take to protect its own confidential or proprietary information. The receiving party shall ensure that Member Information and Other Confidential Information is not disclosed to any third party, except as required under this Agreement and except to such providers, employees and agents as require Member Information or Other Confidential Information in order to perform their duties. This paragraph and the restrictions contained herein shall not apply to any information which the receiving party can demonstrate by written record: (1) was already available to the public at the time of disclosure, or subsequently became available to the public, otherwise than by breach of this Agreement; (2) was in the possession of the receiving party prior to the commencement of the negotiations that resulted in the execution of this Agreement; (3) was obtained from any third party, provided that the receiving party did not know or have reason to know that such third party obtained the information from the providing party directly or indirectly under secrecy; or (4) was the subject of a court order to disclose. For the purposes of this paragraph, the compensation terms of this Agreement are confidential. Nothing in this paragraph shall preclude either party to this Agreement from disclosing information required or permitted to be disclosed pursuant to this Agreement or law, regulation or the LDH Contract or other contracts with a Government Authority(ies) governing the business of

either party. In the event that either party, or any of its partners or employees, becomes legally compelled (by deposition, interrogatory, request for documents, subpoena, civil or criminal investigative demand or similar process) to disclose any Member Information or Other Confidential Information of the other, the party being compelled to disclose shall provide the other party with prompt prior written notice so that the party having the right to keep such Confidential Information confidential may seek a protective order or other appropriate remedy.

B. [redacted] may be considered a "business associate" of Health Plan under the privacy and security regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") at 45 CFR §§160-164, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA). In providing services under this Agreement on behalf of Health Plan, [redacted] performs or assists in the performance of functions and activities involving the use and disclosure of Protected Health Information ("PHI," as defined in the HIPAA Privacy Rule). [redacted] provision of these services may involve the use/disclosure of Protected Health Information by Health Plan (or another business associate of Health Plan) to [redacted] Accordingly, the terms and conditions set forth in the Business Associate Addendum in **Exhibit E** shall govern the terms and conditions under which Health Plan may disclose or have disclosed to [redacted] and [redacted] may create, use or receive PHI on behalf of Health Plan.

VII. MISCELLANEOUS

A. This Agreement and the rights and obligations hereunder may not be assigned, subcontracted or delegated by either party without the prior written consent of the other party, which consent shall not be unreasonably withheld; provided, however, that either Party may assign this Agreement to an entity which controls, is under the control of or under common control with, that Party. For purposes of this provision, a change of corporate name by either party shall not be considered an assignment or delegation.

B. This Agreement shall be governed by and construed in accordance with the laws of the State of Louisiana.

C. Nothing in this Agreement shall be construed to establish any relationship between the parties other than as independent contractors. Neither [redacted] nor Participating Providers, nor any of their respective employees or agents are employees or agents of Health Plan; and neither Health Plan nor its employees or agents are Members, partners, employees or agents of [redacted] None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control of employment between the parties or any relationship other than that of independent parties contracting solely for the purpose of effectuating this Agreement. Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability or obligation of the other party or any third party unless such liability or responsibility is expressly assumed by the party sought to be charged therewith.

D. This Agreement may be amended at any time upon the mutual written agreement of the parties; provided, however, this Agreement shall be deemed to be automatically amended as necessary

to maintain compliance with State and federal law and any such amendment shall be binding upon the parties as of the effective date of such change in laws, rules or regulations.

E. In the event that changes in the Agreement as a result of revisions and/or applicable federal or state law or LDH Contract requirements materially affect the position of either party, Health Plan and [redacted] agree to negotiate in good faith such further amendments as may be necessary to correct any inequities.

F. Notice: All notices required or permitted by this Agreement shall be in writing and may be delivered in person or shall be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that provides proof of delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to [redacted]

If to Health Plan:

AmeriHealth Caritas Louisiana, Inc.

TBD

TBD

Attention: Market President

With a copy to:

AmeriHealth Caritas

200 Stevens Drive

Philadelphia, PA 19113

Attention: General Counsel

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or U.S. mail.

G. Upon request, [redacted] shall furnish to Health Plan financial statements (including a balance sheet, income statement and cash flow statement) for each fiscal year audited by a firm of

independent certified public accountants, within one hundred fifty (150) days of the end of such fiscal year. In association with the annual audit requirement specified herein, [redacted] shall also provide Health Plan with a SOC1 Type 2 report prepared at [redacted] sole expense by an independent external auditor.

H. [redacted], Participating Providers and Health Plan agree that all Member records shall be treated as confidential to comply with all State and federal laws regarding the confidentiality of patient records.

I. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision.

J. If any state laws, court cases or the regulations of any governmental agencies, or other circumstances beyond the control of either party prevents such party from meeting its obligations hereunder, the failure to meet such obligations shall not be considered a breach. Rather, the parties agree in such event to renegotiate the terms of this Agreement, in good faith, so that each party's obligations are in compliance with applicable laws or regulations. If this Agreement cannot be satisfactorily renegotiated, either party may terminate upon sixty (60) days' written notice to the other.

K. [redacted] hereby agrees that in no event, including but not limited to, non-payment by or insolvency of Health Plan, insolvency of [redacted] or non-payment by [redacted] to Participating Providers or breach of this Agreement, shall [redacted] or any Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member for covered services provided pursuant to this Agreement.

[redacted] further agrees that this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Health Plan Member, and that this provision supersedes any oral or written contrary agreement now existing or thereafter entered into between [redacted] and Member, or persons on their behalf.

L. [redacted]

M. Significant Administrative Changes. Should any changes required herein or in the Delegation Agreement attached hereto and made a part hereof result in significant increases in the administration of the program, the parties hereto shall negotiate in good faith a mutually agreed upon increase in the administrative fees paid to [redacted].

[REMAINDER OF PAGE INTENTIONALLY BLANK; SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and the year set forth below.

AMERIHEALTH CARITAS LOUISIANA, INC.		[redacted]	
By:		By:	
Print Name:	Kyle Viator	Print Name:	[redacted]
Title:	Market President	Title:	[redacted]
Date:		Date:	

EXHIBITS

Exhibit A-1	[redacted]
Exhibit A-2	[redacted]
Exhibit B	Administrative Services and Other [redacted] Responsibilities
Exhibit C	Performance Standards
Exhibit D	[redacted] Compensation
Exhibit E	Business Associate Addendum
Exhibit F	State of Louisiana - Required Subcontractor Provisions
Exhibit G	Agreement for Delegation of Responsibilities

[redacted]

[redacted] Confidential [redacted]. All claims submitted to [redacted] must be received on a CMS 1500 form from the Participating Provider. [redacted] does not accept UB claims forms.

[redacted]

Medical/Surgical Covered Procedure Codes

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

CPT	Description
[redacted]	[redacted]

Injectables

Code	Procedure Description
[redacted]	[redacted]

EXHIBIT A-2
BENEFIT SCHEDULE (DESCRIPTION OF COVERED [redacted] SERVICES)

[redacted] All claims submitted to [redacted] must be received on a CMS 1500 form from the Participating Provider. [redacted] does not accept UB claims forms.

The following services are covered by this Agreement and therefore, the responsibility of [redacted] and Participating Providers under the Agreement:

- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

EXHIBIT B
ADMINISTRATIVE SERVICES AND OTHER [redacted] RESPONSIBILITIES

This **Exhibit B** describes the administrative services to be provided by [redacted], and other related responsibilities of [redacted] in providing or arranging for the provision of Covered Services under the Agreement.

A. [redacted] shall be responsible for providing the following services to Health Plan:

1. [redacted]

[redacted] shall provide these services in accordance with requirements outlined in the Agreement for Delegation of Responsibilities, the relevant Health Plan policies and procedures, the applicable terms of the LDH Contract and other applicable State and federal laws, regulations and guidelines.

B. Health Plan reserves the right to rescind any of the activities performed by [redacted] under this **Exhibit B** (a) as a result of [redacted] material deviations from the requirements set forth herein for the functions and [redacted] failure to cure the deviations in the time and manner allocated by Health Plan and agreed to by [redacted] regulatory agency or accreditation organization to do so; (b) as a result of [redacted] failure to comply with Health Plan's specific recommendations regarding identified deficiencies in [redacted] performance of or [redacted] programs relating to functions performed by [redacted] herein and [redacted]' failure to comply with said recommendations in the required time period; (c) where such action is necessary to protect the health and welfare of Health Plan's Members and [redacted] cannot implement changes necessary to correct such action within the manner and time period imposed by LDH or any other regulatory agency; or (d) where such action is necessary to comply with State for federal regulatory requirements and/or obligations that have been communicated to

[redacted] by Health Plan and [redacted] is unable to comply with such regulatory requirements or obligations in the required manner and time period.

C. [redacted] acknowledges that pursuant to the LDH Contract, Health Plan is required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, Member appeal and grievance systems and other systems and programs meeting program standards and that Health Plan is directly accountable for compliance with such standards and for provision of access to quality, cost-effective care to Members. Nothing in this **Exhibit B** shall be construed to in any way limit Health Plan's authority or responsibility to meet standards or to take prompt corrective action to address a quality of care problem, resolve a Member appeal or grievance, or to comply with all regulatory requirements of LDH.

D. The parties understand and agree that, on an annual basis, Health Plan will conduct a comprehensive review, including but not limited to, random sample re-review and validation of [redacted] performance of [redacted] responsibilities under the Agreement, to determine whether [redacted] activities are being conducted in accordance with Health Plan's expectations, Demonstration program requirements, and applicable Accrediting Organization standards.

E. [redacted] shall designate an individual or individuals who will have day-to-day responsibility for the activities set forth in this **Exhibit B**, and identify such person(s) to Health Plan and make such person(s) reasonably available as requested by Health Plan.

F. [redacted] shall develop a process to supply Health Plan with a provider roster, including a first time full file and monthly updates consisting of additions, deletes, or edited providers in the format and timeframe agreed to by the parties at the start of the program. Changes to the format or required timeframes required by LDH or the regulatory agency are complied with as required; changes to format or timeframes required by Health Plan shall be mutually agreed to by the parties hereto.

EXHIBIT C
PERFORMANCE STANDARDS

[redacted] agrees that, to the extent penalties are assessed against Health Plan by LDH as a result of [redacted]' direct non-compliance with the performance standards set forth in this **Attachment C** and **Attachment C-1**, [redacted] shall be responsible for the payment of such penalties to Health Plan within a mutually agreed upon timeframe and, in the event such payment is not made in a timely manner to Health Plan, Health Plan shall have the right to offset any monies owed to [redacted] by any penalties owed by [redacted] to Health Plan.

[redacted] shall be responsible for providing encounter data as described in §42 CFR 438.242 and in the format specified by ACLA so as to continually meet timely, accurate and complete encounter results. [redacted] failure to meet the encounter performance standards may result in placement on a corrective action plan and/or imposition of financial penalties as referenced in the LDH contract.

Standard	Metric
[redacted]	
	≥99%
	≥98%
	≥90%
	≥99%
	100%
	≥99%
	≤ 5%
	≥ 95% in ≤ 30 seconds
	≤ 1%
	≤3 minutes
	100%
	100%
	≥98%
	100%
	≥99%
	≥95% by 10th of each month

Standard	Metric
[redacted]	≥98%
	≥90%
	≥90%

EXHIBIT D
[redacted] COMPENSATION

A. **General Compensation.** As compensation for [redacted] services, effective as of the Commencement Date, Health Plan shall pay [redacted] a capitation amount per member in paragraphs **B** and **C** of this **Exhibit D**. The capitation amount shall be inclusive of all administrative and management services provided by [redacted] The total monthly capitation payment shall be paid to [redacted] by the fifteenth (15th) day of each month in which services are to be provided, based upon membership as of the first (1st) day of the month. Such payments to [redacted] may be based on an estimated number of Members and adjusted retrospectively, unless otherwise noted in this **Exhibit D**, after each month's payment by Health Plan based on the actual number of Members for each month identified as eligible in the records of Health Plan as transmitted to [redacted]. In order to comply with applicable financial auditing requirements, the parties agree and acknowledge that the Member eligibility file(s) provided to [redacted] from which it will verify Member eligibility will be the same file(s) used by Health Plan to calculate the monthly capitation payment.

For any partial month of service, capitation payments to [redacted] will be based upon the number of days for which administrative services were furnished for such month. By way of example, if this Agreement terminates on the ninth (9th) day of a month that contains thirty (30) days, [redacted] administrative payment for that month will be calculated as the equivalent of nine-thirtieths (9/30th) of the total amount of the capitation payment for that month.

B. [redacted] Compensation

As compensation for [redacted] administration of the [redacted] benefits, effective as of the Commencement Date, Health Plan shall pay [redacted] capitation payment equal to [redacted] Retroactive eligibility calculations do not apply for Members receiving the adult materials allowance described in **Exhibit A-1.**

C. [redacted] Compensation

As compensation for [redacted] administration of the [redacted], effective as of the Commencement Date, Health Plan shall pay [redacted] capitation payment equal to [redacted]**)**. Retroactive eligibility calculations do not apply for Members receiving the [redacted] benefit.

EXHIBIT E
PRIVACY AND SECURITY/BUSINESS ASSOCIATE AGREEMENT ADDENDUM

I. INTRODUCTION

This Privacy and Security/Business Associate Agreement ("BAA") Addendum (the "Addendum") is made and entered into effective as of September 1, 2019 (the "Effective Date"), by and between **AmeriHealth Caritas Health Plan, on behalf of itself and its affiliates specified in Section III.A (collectively, "ACHP" or "Covered Entity")**, and [redacted] **"Supplier" or "Business Associate")**. This Addendum supplements, is incorporated into and made part of any and all agreements, contracts and understandings, whether written or verbal, between ACHP and Supplier (the "Services Agreement").

II. RECITALS

A. ACHP and Supplier intend to protect the privacy and security of certain Personally Identifiable Information" ("PII") (as defined below), including but not limited to Protected Health Information ("PHI") (as defined below) that Supplier may access, create, receive, maintain or transmit in order to provide goods and services to or on behalf of ACHP, in accordance with Applicable Law (as defined below), including but not limited to the HIPAA Requirements (as defined below).

B. In consideration of the mutual promises below, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows.

III. DEFINITIONS

A. "ACHP" or **"Covered Entity"** mean **AmeriHealth Caritas Health Plan and the following affiliates of AmeriHealth Caritas Health Plan (CHECK AS APPLICABLE):**

☒ **AmeriHealth Caritas District of Columbia, Inc.**	☐ **Blue Cross Complete of Michigan, LLC**
☒ **AmeriHealth Caritas Delaware, Inc.**	☐ **Florida True Health, Inc.**
☒ **AmeriHealth Caritas Louisiana, Inc.**	☐ **Keystone Family Health Plan**
☒ **AmeriHealth Michigan, Inc.**	☐ **Select Health of South Carolina, Inc.**
☐ **Community Behavioral Healthcare Network of Pennsylvania, Inc., dba PerformCare**	☐ **AmeriHealth Caritas Services, LLC**

☒ **AmeriHealth Caritas New Hampshire, Inc.** ☐ **AmeriHealth Caritas North Carolina, Inc.**

"ACHP" or **"Covered Entity"** also include any companies created, purchased or acquired by ACHP during the term of this Addendum. ACHP may from time to time provide written notice to Supplier of changes to the specification of the affiliated entities.

B. "Applicable Law" means all applicable federal, state and local laws, statutes, ordinances, rules, regulations, codes, orders, constitutions, treaties, common law or other legal requirement governing the confidentiality, privacy or security of PII, or notification regarding breaches of the same, including but not limited to requirements applicable to federal agencies, the HIPAA Requirements (as defined below), 42 C.F.R. Part 2 and 42 C.F.R. § 431.300 *et seq*., as any of the same may be amended or interpreted by a court of competent jurisdiction from time to time.

C. "HIPAA Requirements" means the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C § 1320d, the Health Information Technology for Economic and Clinical Health Act ("HITECH"), 42 U.S.C. §§ 17901 – 17953, and the regulations promulgated pursuant to such statutes, including but not limited to 45 C.F.R. Parts 160, 162 and 164), as the same may be amended or interpreted by a court of competent jurisdiction from time to time.

D. "Individual" means the person who is the subject of PII, and shall include a person who qualifies as a personal representative of the person under Applicable Law.

E. "Party" or "Parties" means Supplier and ACHP individually or collectively.

F. "Personally Identifiable Information" ("PII") means information, in any form, that identifies, relates to, describes, is capable of being associated with, or could reasonably be linked, directly or indirectly, with an individual, device or household, including but not limited to PHI.

G. "Privacy or Security Event" means any suspected or actual Security Incident or acquisition, access, loss, use or disclosure of PII that is not authorized by this Addendum or that violates Applicable Law, including any breach of the confidentiality or security of PII that is reportable under Applicable Law.

H. "Protected Health Information" and/or **"PHI"** has the meaning given such term under 45 C.F.R. §160.103.

I. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, or actual or potential violation of an explicit or implied security policy, including "computer security incident" as that term is defined in

Section 2 of NIST Publication 800-61 (Computer Security Incident Handling Guide) and "security incident" as that term is defined in 45 C.F.R. §164.304.

J. "Services" means the activities, functions, responsibilities, or obligations required to be performed or undertaken by Supplier under the Services Agreement.

K. "Services Agreement" means the underlying agreement(s) identified in **Exhibit E-1** to this Addendum that outlines the Services that Supplier agrees to provide to ACHP.

Any other capitalized terms used, but not otherwise defined in this Addendum, shall have the meaning given these terms in the HIPAA Requirements. Any inconsistency in the definition of a capitalized term shall be resolved in favor of a meaning that permits ACHP to comply with the HIPAA Requirements and other Applicable Law.

IV. PRIVACY AND SECURITY OF PII

A. Supplier agrees that it shall only access, use and disclose PII in accordance with the terms of this Addendum.

B. Supplier shall not access, use or disclose PII or data derived from PII except for the purpose of Supplier performing Services for ACHP under the Services Agreement, as such access, use or disclosure is limited by this Addendum, or as otherwise expressly permitted under this Addendum or as is Required By Law. Any other access, uses or disclosures of PII require prior express authorization by ACHP.

C. Supplier shall not access, use or disclose PII in any manner that would constitute a violation of Applicable Law, including but not limited to the HIPAA Requirements, or 42 C.F.R. Part 2 to the extent that Supplier receives, maintains or transmits information subject to 42 C.F.R. Part 2 ("Part 2 PII"). So long as such use or disclosure does not violate the HIPAA Requirements, other Applicable Law or this Addendum, Supplier may use or disclose PII: (i) as is necessary for the proper management and administration of Supplier's organization, to the extent such use or disclosure is necessary for Supplier to provide the Services; or (ii) carry out the legal responsibilities of Supplier, as provided in 45 C.F.R. §164.504(e)(4). Supplier shall not de-identify any PII created, received, used, disclosed or maintained under the Services Agreement or under this Addendum unless ACHP expressly agrees in writing to such de-identification. In the event that ACHP expressly agrees in writing to de-identification, Supplier shall not: (i) directly or indirectly receive remuneration in exchange for de-identified PII; (ii) utilize ACHP's de-identified PII for any other purposes; (iii) retain any identifiers that would enable re-identification of the de-identified PII; or (iv) attempt, or knowingly allow any third party to attempt, to re-identify the de-identified PII.

D. Supplier shall not disclose any PII to any third party pursuant to Section IV.C above unless Supplier first meets each requirement of this Section IV.D. Specifically, Supplier shall obtain in writing, prior to making any such permitted disclosure, reasonable

assurances from such third party (i) that such PII are held secure and confidential in accordance with the provisions of this Addendum, and (ii) that such PII shall be used and disclosed by the third party only as Required By Law or for the purposes for which it was disclosed to such third party. Supplier also must require that any breaches of confidentiality of the PII which become known to such third party be immediately reported by the third party to Supplier. Within three (3) business days of any disclosures of PII that are necessary for the proper management and administration of Supplier's organization or to carry out the legal responsibilities of Supplier, Supplier shall notify ACHP.

E. Supplier shall develop, implement, maintain, and use appropriate safeguards to prevent any access, acquisition, use or disclosure of PII or data derived from PII other than as provided by this Addendum, and shall implement administrative, physical, and technical safeguards as required by Applicable Law, including but not limited to 45 C.F.R §§164.308 - 164.316 and 164.530(c), the HITECH Act, and 42 C.F.R. § 2.16 to the extent that Supplier receives, maintains or transmits Part 2 PII, in order to protect the confidentiality, integrity, and availability of PII that Supplier or its agents or subcontractors create, receive, maintain or transmit. To the extent that Supplier Collects or Processes any Consumer's Personal Information (as such terms are defined in the California Consumer Privacy Act, Cal. Civil Code § 1798.100 *et seq*. (the "CCPA")) for or on behalf of ACHP, Supplier shall implement and maintain administrative, technical, and physical security measures to protect any non-encrypted or non-redacted personal information against unauthorized access, exfiltration, theft, or disclosure, as required by the CCPA). Supplier agrees to adopt the privacy and security standards provided in any policies, manuals or guidance issued by the Secretary or other federal and state agencies, including state departments of information technology, as the same may be amended from time to time. In addition to such standards, Supplier agrees to meet the security standards outlined in **Exhibit E-2** hereto.

F. Supplier shall ensure that any agents or subcontractors that create, receive, access, use, disclose, maintain or transmit PII or data derived from PII for or on behalf of Supplier agree in writing to all of the same restrictions, conditions and requirements that apply to Supplier under Applicable Law and this Addendum. With respect to each agent and subcontractor that may create, receive, access, maintain use, disclose or transmit PHI for or on behalf of Supplier, the agreements required by this Section IV.F shall include Business Associate Agreements ("BAAs"), as required by 45 C.F.R. §§164.308(b)(1), 164.314(a)(1) and (2) and 164.504(e)(5). Supplier shall terminate the provision of any data received from or on behalf of ACHP to an agent or subcontractor, if any, who fails to abide by such restrictions and obligations. Initially within ten (10) days of commencement of the Services Agreement, and within ten (10) days of a new or updated agreement with a subcontractor, Supplier shall provide ACHP with a list of all subcontractors who meet the definition of a business associate as defined under the HIPAA Requirements. Supplier shall notify ACHP of all agents and subcontractors to which PII are disclosed prior to such disclosures, and provide the company name, address and name of the contact person of such agents and subcontractors. Supplier shall supply copies of BAAs with its agents and subcontractors to ACHP upon request.

G. Supplier shall not directly or indirectly receive remuneration in exchange for PII, other than from or on behalf of ACHP in consideration of the Services rendered by Supplier under the Services Agreement. Supplier shall also not directly or indirectly receive remuneration for any use or disclosure of PII for marketing purposes, except as provided for under the Services Agreement.

H. Unless expressly authorized in writing in this Addendum or in the Services Agreement, Supplier shall not use any off shore entities to support technology or operations to provide the Services, and shall ensure that no PII is stored, transferred or processed outside of the forty-eight (48) contiguous United States, including but not limited to any cloud computing, cloud service or cloud storage capabilities and any backup data and disaster recovery locations.

I. In the event that Supplier receives a subpoena, court or administrative order, or other legal process seeking PII or otherwise relating to Supplier's services, duties or obligations under this Addendum or the Services Agreement, Supplier shall notify ACHP so that ACHP has an opportunity to object to the disclosure and to seek appropriate relief. Such notice shall be provided within forty-eight (48) hours of Supplier's receipt of such subpoena or other legal process. Supplier shall collaborate with ACHP with respect to Supplier's response to such request. If ACHP objects to such disclosure, Supplier shall refrain from disclosing the PII until ACHP has exhausted all available remedies. In the event that ACHP does not object to the disclosure or has exhausted all available remedies, Suppler may disclose PII, provided that Suppler only discloses the minimum amount of PII required to be disclosed under the applicable legal mandate and that, prior to such disclosure, Suppler obtains reliable assurance that confidential treatment are accorded the PII to be disclosed, in accordance with 45 C.F.R. § 164.512(e) and that Suppler otherwise complies with Applicable Law.

J. To the extent that Supplier Collects or Processes any Consumer's Personal Information (as such terms are defined in the CCPA) for or on behalf of ACHP, Supplier shall comply with the CCPA and Supplier shall not Collect or Sell (as such terms are defined in the CCPA) or retain, use or disclose the Personal Information for any purpose other than for the specific purpose of performing the Services. In the event that ACHP receives a valid request from a California resident to exercise any rights provided such person under the CCPA ("CCPA rights") and ACHP informs Supplier of such request, Supplier shall provide ACHP the information at its disposal that is necessary for ACHP to respond to such request within twenty (20) days of receipt of such request from ACHP, and otherwise comply with the CCPA with respect to any requests to exercise CCPA rights. If Supplier or its agents or subcontractors directly receives a request from an individual seeking to exercise the individual's CCPA rights, neither Supplier nor its agents or subcontractors shall respond directly to such a request. Instead, Supplier shall forward the request to ACHP the same day that it is received via a method that it is likely to ensure receipt by the next business day.

K. To the extent that the Services include an audit or evaluation of one or more Medicare or Medicaid plans operated by ACHP and Supplier receives, maintains or transmits any Part 2 PII pursuant to such audit or evaluation, Supplier shall do the following:

1. Maintain and destroy the Part 2 PII in a manner consistent with the policies and procedures required under 42 C.F.R. § 2.16;

2. Retain records in compliance with applicable federal, state, and local record retention laws; and

3. Only disclose the Part 2 PII back to ACHP or as permitted under 42 C.F.R. § 2.53(c) or (d), and only use the Part 2 PII to carry out the audit or evaluation for ACHP.

To the extent that the Services include an audit or evaluation of one or more Medicare or Medicaid plans operated by ACHP and Supplier will only review records containing Part 2 PII on the premises of ACHP pursuant to such audit or evaluation, Supplier shall comply with the limitations on use and disclosure set forth in Section IV.K.3 above.

V. PRIVACY AND SECURITY EVENT NOTIFICATION

A. Upon becoming aware of a Privacy or Security Event, Supplier agrees to: (i) investigate the Privacy or Security Event; (ii) notify ACHP in accordance with Section V.B and C below and as required under 45 C.F.R. §§ 164.314(a)(2)(i)(C), 164.410 and 164.504(e)(2)(ii)(C) and other Applicable Law; (iii) cooperate with ACHP in connection with any investigation conducted by or on behalf of ACHP; and (iv) mitigate any known harmful effect of the Privacy or Security Event.

B. During the term of this Addendum and thereafter for so long as PII is held by Supplier or its agent(s), subcontractor(s) or any third parties to whom Supplier has disclosed such data, Supplier shall immediately notify ACHP in writing of: (i) any Privacy or Security Event; and/or (ii) any legal action (including actions before an administrative tribunal) against Supplier arising from an alleged violation of Applicable Law. If Supplier maintains or has access to any Social Security numbers ("SSNs") and one or more SSNs have been compromised, Supplier shall notify ACHP within sixty (60) minutes of discovery. Supplier shall take: (i) prompt action to correct any deficiencies, and (ii) any action pertaining to any Privacy or Security Event, as required by Applicable Law. The notice required of Supplier under this Section V.B shall be provided by Supplier in all instances in which Supplier either suspects or knows of a potential Privacy or Security Event, or is party to a legal action for violation of Applicable Law. Supplier also shall meet the notice obligations in Section V.C immediately below.

C. In the case of a Privacy or Security Event during the term of this Addendum (and after such term if PII continues to be held by Supplier or its agent(s), subcontractor(s) or any third parties to whom Supplier has disclosed such data), Supplier shall immediately perform a breach risk assessment that considers, among other factors, the four (4) factors identified in 45 C.F.R. § 164.402. Supplier shall complete the risk assessment within forty-eight (48) hours of discovery of the Privacy or Security Event, and immediately report the findings of the risk assessment in writing to ACHP. At the same time, Supplier shall provide written notification to ACHP, including the following information: (i) the identification of each Individual, and the total number of Individuals, whose PII has been, or is reasonably believed by the Supplier to have been, accessed, acquired, used or disclosed during the breach (if applicable); (ii) a brief description of the Privacy or Security Event, including the cause, the date of the Privacy or Security Event, and the date of discovery; (iii) a description of the types of PII involved in the Privacy or Security Event; (iv) the identity of the person(s) or entity(ies), and the total number of unauthorized persons, which made the unauthorized access or use, or that received the unauthorized disclosure, of PII (if known); (v) a description of the actions Supplier is taking to investigate the Privacy or Security Event, mitigate losses and protect against further Privacy or Security Events; and (vi) such other information as ACHP may reasonably request. If necessary, Supplier shall provide ACHP with any additional information pertaining to the Privacy or Security Event as it becomes available.

D. The written notification required under Sections V.B and C above shall be provided via secure email (with a confirmation by overnight delivery service, or registered or certified mail placed in the mail no later than the following day) to the email address and postal address set forth in Section X.J below.

E. ACHP shall have the right to participate in any investigation relating to any Privacy or Security Event, and to instruct Supplier to delay the remediation of the cause of a Privacy or Security Event in order to increase the likelihood of success of the ongoing investigation, to the extent that such instructions to delay are reasonable and do not diminish or compromise Supplier's security or systems, and only to the extent directly related to the PII. Without limiting the foregoing, Supplier shall cooperate fully in ACHP's investigation and resolution of the Privacy or Security Event and provision of any necessary notifications to affected Individuals, law enforcement and state and federal agencies and regulatory authorities and their representatives or designees.

VI. HIPAA ADMINISTRATIVE REQUIREMENTS

A. Within two (2) business days of receipt of a request from ACHP for access to an Individual's PHI contained in a Designated Record Set maintained by Supplier, Supplier or its agents or subcontractors, if any, shall make such PHI available to ACHP for access to enable ACHP to fulfill its obligations under the HIPAA Requirements, including, but not limited to, 45 C.F.R. §164.524. If a request is made directly from an Individual to Supplier or its agents or subcontractors for access to PHI, Supplier must forward this request to ACHP the same day that it is received via a method that it is likely to ensure receipt by the next business day. Only ACHP shall be permitted to approve or deny a

request for access. Upon ACHP's request, Supplier shall appropriately provide the Individual access to such PHI.

B. Within two (2) business days of receipt of a request from ACHP for an amendment of PHI or a record about an Individual contained in a Designated Record Set maintained by Supplier, Supplier or its agents or subcontractors, if any, shall make such PHI available to ACHP for amendment and shall incorporate any such amendment to enable ACHP to fulfill its obligations under the HIPAA Requirements, including, but not limited to, 45 C.F.R. §164.526. If an Individual requests an amendment of PHI directly from Supplier or its agents or subcontractors, if any, Supplier must forward this request to ACHP the same day that it is received via a method that it is likely to ensure receipt by the next business day. Only ACHP shall be permitted to approve or deny a request for amendment. Upon ACHP's approval of a request to amend PHI in a Designated Record Set maintained by Supplier, Supplier shall appropriately amend the PHI maintained by it, or any agents or subcontractors.

C. Within two (2) business days of notice by ACHP of a request for an accounting of those disclosures of PHI required to be accounted for under the Privacy Rule ("accountable disclosures"), Supplier and any of its agents or subcontractors shall make available to ACHP the required information relating to accountable disclosures to enable ACHP to fulfill its obligations under the HIPAA Requirements, including, but not limited to, 45 C.F.R. §164.528. On a monthly basis, Supplier shall provide a report of accountable disclosures to ACHP, subject to the exceptions in 45 C.F.R. §164.528(a)(1). If an Individual requests an accounting of disclosures directly from Supplier or its agents or subcontractors, if any, Supplier must forward this request to ACHP the same day that it is received via a method that it is likely to ensure receipt by the next business day.

1. Supplier shall document all accountable disclosures and maintain such documentation for seven (7) years after the date of such accountable disclosures.

2. Upon termination of this Addendum, Supplier shall provide ACHP with a report of any accountable disclosures made during the prior six (6) years and not yet reported to ACHP, subject to the exceptions in 45 C.F.R. §164.528(a)(1). Notwithstanding any provision of this Addendum relating to termination, Supplier and any agents or subcontractors shall maintain documentation of all accountable disclosures occurring after the termination of this Addendum with respect to any PHI for which return or destruction was infeasible at the time of termination and related information required for purposes of complying with this Section VI.C. for a period of seven (7) years after the date of such accountable disclosures.

D. Supplier shall comply with any agreement that ACHP makes that either (i) restricts the use or disclosure of PHI pursuant to 45 C.F.R. §164.522(a), or (ii) requires confidential communication about PHI pursuant to 45 C.F.R. §164.522(b), provided that ACHP notifies Supplier of the restriction or confidential communication obligations. ACHP shall promptly notify Supplier in writing of the termination of any such agreed upon

restriction or confidential communication. If an Individual requests, directly from Supplier or its agents or subcontractors, a restriction on the use or disclosure of PHI or confidential communication about PHI, Supplier must forward this request to ACHP the same day that it is received by Supplier, via a method that it is likely to ensure receipt by the next business day.

E. Supplier and its agents or subcontractors, if any, shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. Supplier agrees to comply with the Secretary's guidance on what constitutes minimum necessary. Supplier represents and warrants that it has developed policies and procedures that limit the PHI to be used, disclosed or requested to the minimum necessary standard.

F. The HIPAA Requirements governing the access, use, disclosure, transmission and safeguarding of PHI shall apply to Supplier in the same manner as they apply to ACHP. To the extent Supplier is to carry out one or more of ACHP's obligations under the HIPAA Requirements, Supplier shall comply with such requirements that apply to ACHP in the performance of such obligation(s).

G. To the extent expressly permitted under the Services Agreement and as limited by this Addendum, Supplier may use or disclose PHI to perform Data Aggregation services for ACHP, subject to 45 C.F.R. §164.504(e)(2)(i)(B).

H. In the event that Supplier utilizes any files or reports that constitute a Designated Record Set comprised of PHI of members of a health plan operated by AmeriHealth Caritas District of Columbia, Inc., Supplier shall notify ACHP within thirty (30) days of the commencement of the file's or report's usage. The notification shall include the following: title of the report/file; confirmation that the report/file contains PHI; description of the basic content of the report/file; format of the report/file (electronic or paper); physical location of report/file; name and telephone number of current member(s) of the workforce of Supplier to whom such report/file is provided; and supporting documents.

VII. TRANSMITTING STANDARD TRANSACTIONS

A. If Supplier conducts, in whole or in part, Standard Transactions, as defined by the HIPAA Requirements, for or on behalf of ACHP, Supplier shall comply, and shall require any subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Part 162 and any standards mandated by applicable federal or state agencies. Supplier shall not enter into, or permit its subcontractors or agents to enter into, any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of ACHP that: (i) changes the definition, data condition, or use of a data element or segment in a Standard Transaction; (ii) adds any data element or segment to the maximum defined data set; (iii)

uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or (iv) changes the meaning or intent of the Standard Transaction's implementation specification.

B. If Supplier's Services use or require the use of Code Sets, as defined in the HIPAA Requirements, then Supplier shall utilize the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding for all Services for which Supplier is contractually obligated to provide for ACHP.

VIII. AMERIHEALTH CARITAS OBLIGATIONS

A. ACHP shall provide Supplier with the "Notice of Privacy Practices" that ACHP produces in accordance with 45 C.F.R. §164.520, as well as any changes to such notice, to the extent that such changes affect Supplier's permitted uses or disclosures.

B. ACHP shall provide Supplier with notice of any changes to, revocation of, or permission by an Individual to use or disclose PHI, if such changes affect Supplier's permitted uses or disclosures, within a reasonable period of time after ACHP becomes aware of such changes to or revocation of permission.

C. ACHP shall notify Supplier of any restriction to the use or disclosure of PHI that ACHP has agreed to or must comply with in accordance with 45 C.F.R. §164.522, to the extent that such restriction affects Supplier's permitted uses or disclosures.

D. ACHP shall not request Supplier to use or disclose PHI in any manner that would not be permissible under the HIPAA Requirements if done by ACHP.

IX. TERMINATION

A. The term of this Addendum shall be effective as of the Effective Date of this Addendum and continue until terminated by ACHP or any underlying Services Agreement expires or is terminated. The respective rights and obligations of ACHP and Supplier under this Addendum shall survive termination of this Addendum.

B. A breach by Supplier, or its agents or subcontractors, if any, of any provision of this Addendum, as determined by ACHP, shall constitute a material breach of the Addendum. If Supplier breaches this Addendum, ACHP may, in its discretion: (i) immediately terminate this Addendum; (ii) provide an opportunity for Supplier to cure the breach or end the violation and terminate this Addendum if Supplier does not promptly cure the breach or end the violation within a period specified by ACHP depending upon the

severity of the breach but not exceeding ten (10) days; or (iii) report the violation to the Secretary if neither termination nor cure is feasible.

C. ACHP may terminate this Addendum, effective immediately, if: (i) Supplier or its agent(s) or subcontractor(s) is named as a defendant in a criminal proceeding for a violation of Applicable Law; or (ii) there is a finding or stipulation made in any administrative or civil proceeding that Supplier or its agent(s) or subcontractor(s) has violated any standard or requirement of Applicable Law.

D. Upon request and following expiration or termination of this Addendum for any reason, Supplier shall return or, at ACHP's request, destroy via wiping pursuant to **Exhibit E-2** hereto (Required Minimum Security Standards), all PII and data and other material derived from PII that Supplier or its agents or subcontractors, if any, still maintain in any form within five (5) days of such request or expiration or termination of this Addendum, and shall retain no copies of any such data or material. If return or destruction is not feasible, Supplier shall provide a written explanation to ACHP, within five (5) days of such request or expiration or termination of this Addendum, identifying the data in question and the conditions that make the return or destruction of such data not feasible. If ACHP notifies Supplier in writing that ACHP agrees that the return or destruction of the data is not feasible, Supplier shall retain the data so long as return or destruction remains infeasible, subject to all of the protections of this Addendum, and shall make no further use or disclosure of such data. Should any conditions that make return or destruction of any data infeasible are no longer in effect at any point after termination, Supplier shall return or destroy the data in accordance with this Section IX.D. Supplier shall provide ACHP with a certification, within five (5) days of such request or expiration or termination of this Addendum, stating that neither Supplier nor its subcontractors or agents maintain any PII that was created or received from or on behalf of ACHP in any form, whether paper, electronic, film or other, or any data or other material derived from PII, except to the extent that ACHP has agreed that the return or destruction of specified data is not feasible.

E. If this Addendum is terminated for any reason, ACHP may also terminate the Services Agreement between the Parties. This provision shall supersede any termination provision to the contrary which may be set forth in the Services Agreement.

X. MISCELLANEOUS

A. A reference in this Addendum to a section in the HIPAA Requirements means the Privacy, Security, Standard Transactions, Breach Notification or Enforcement Rule section, as amended or interpreted by a court of competent jurisdiction from time to time. If any modification to this Addendum is Required By Law or required by Applicable Law affecting this Addendum, or if ACHP reasonably concludes that an amendment to this Addendum is needed because of any contractual obligations of ACHP, a change in federal or state law or guidance or changing industry standards, ACHP shall notify Supplier of such proposed modification(s) ("Legally-Required Modifications"). Such

Legally Required Modifications shall be deemed accepted by Supplier and this Addendum so amended, if Supplier does not, within thirty (30) days following the date of the notice (or within such other time period as may be mandated by Applicable Law), deliver to ACHP its written rejection of the same.

B. Unless greater coverage is required under the Services Agreement or any other agreement between ACHP and Supplier for the provision of Services related to this Addendum, Supplier shall maintain or cause to be maintained at all times the following insurance covering itself and each subcontractor or agent, if any, through whom Supplier provides Services to cover any claims for losses or damages that arise while this Addendum or the Services Agreement (whichever is longer) is in effect and/or was in effect and for so long as Supplier or its subcontractors or agents maintain any copies of the PII after termination of this Addendum: (i) a policy of electronic data processing, cybersecurity and privacy liability insurance, with limits of liability not less than ten million dollars ($10,000,000) per occurrence and ten million dollars ($10,000,000) annual aggregate, and (ii) such other insurance or self-insurance as shall be necessary to insure it against any claim(s) for losses or damages arising under this Addendum or from any violations of Supplier's obligations under Applicable Law, including but not limited to, any claims or the imposition of administrative penalties and fines arising from any Privacy or Security Events, or loss or theft of PII, that is caused by the negligent, intentional or willful act(s) or omission(s) of Supplier or its subcontractors or agents. Such insurance coverage shall apply to all site(s) of Supplier and to all Services provided by Supplier or by any subcontractors or agents under this Addendum and under the Services Agreement. If any of the aforementioned insurance is provided on a claims-made basis, Supplier agrees to maintain such coverage after the termination of this Addendum or the Services Agreement (whichever is longer) or shall purchase an extended reporting period or similar coverage for the longest period then available to ensure that insurance coverage is maintained.

C. Supplier and its agents and subcontractors (as applicable) shall make their books, records, agreements, facilities, personnel, systems, software, policies and procedures relating to the use, disclosure and safeguarding of PII available to the Secretary and any other applicable federal, state or local agencies and their designees and representatives upon request for purposes of determining Supplier's and ACHP's compliance with the HIPAA Requirements and other Applicable Law. Supplier shall notify ACHP regarding any PII that Supplier provides to the Secretary or other federal, state or local agencies or their designees and representatives concurrently with providing such PII to such parties, and upon request by ACHP, shall provide ACHP with a duplicate copy of such PII.

D. Within ten (10) days of receipt of a written request by ACHP, Supplier and its agents or subcontractors (as applicable), if any, shall allow ACHP to conduct a reasonable inspection of the books, records, agreements, facilities, systems, software, policies and procedures relating to the use, disclosure and safeguarding of PII pursuant to this Addendum, and shall make its personnel available for the same, for the purpose of determining whether Supplier has complied with this Addendum and Applicable Law;

provided, however, that (i) ACHP notifies Supplier in advance of the scope, location and timing of such an inspection; and (ii) ACHP agrees to protect the confidentiality of all confidential and proprietary information of Supplier to which ACHP has access during the course of such inspection.

E. In addition to any hold harmless and indemnification obligations under the Services Agreement, Supplier shall indemnify, hold harmless and defend ACHP, and its officers, directors, employees, representatives, agents, successors, permitted assigns and contractors and applicable state agencies from and against any and all claims, causes of action, liabilities, losses, damages, costs or expenses (including reasonable attorneys' fees and court or proceeding costs) arising out of or relating to: (i) any Privacy or Security Event that occurs while the PII is under the custody or control of Supplier or any of its agents or subcontractors; or (ii) any breach of this Addendum or violation of Applicable Law. This indemnity shall not be construed to limit ACHP's rights to common law indemnity.

1. For purposes of this **Section X.E**, "cost or expense" shall include, but not be limited to, all costs or expenses to ACHP resulting from a Privacy or Security Event, including ACHP's costs of: (i) investigating the Privacy or Security Event (including a risk assessment to review the impact of the Privacy or Security Event); (ii) preparing and distributing notices of breach to affected individuals, regulators (including where appropriate law enforcement officials) and/or the media if required; (iii) credit monitoring and identity theft and health care fraud monitoring not to exceed twenty-four (24) months, unless otherwise required by Applicable Law; (iv) fines or penalties assessed against ACHP by the Secretary or other regulatory authority having jurisdiction over ACHP; (v) any award that may be made pursuant to a state Attorney General action and levied against ACHP; (vi) ACHP's monitoring the effectiveness of Supplier's mitigation efforts/steps; and (vii) such other actions as may be required by a covered entity, customer, or by a governmental entity.

2. ACHP shall give Supplier notice of, and the Parties shall cooperate in, the defense of each such claim, suit or proceeding, including appeals, negotiations and any settlement or compromise thereof; provided that ACHP must approve the terms of any settlement or compromise that may impose any un-indemnified or nonmonetary liability on ACHP.

F. Supplier agrees that any of its personnel and agents who violate Applicable Law shall be subject to discipline or termination (as applicable) in accordance with Supplier's personnel policy. Supplier shall inform ACHP in the event that Supplier imposes any sanctions against any of its personnel or agents, or terminates any subcontractors, for violation of the provisions of Applicable Law.

G. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, any rights, remedies, obligations or liabilities whatsoever upon any person

other than ACHP, Supplier, the Michigan Department of Health and Human Services and the Louisiana Department of Health and Human Services (to the extent that the Services are provided to plans operated by ACHP in such states), or their respective successors or assigns.

H. The Parties are independent contractors and nothing herein shall be deemed to make them partners or joint venturers, or create an employment relationship between them.

I. Supplier will comply with all Applicable Law, to the extent that such laws apply to Supplier or are more protective of Individual privacy or are More Stringent than the HIPAA Requirements. This Addendum shall be construed and interpreted as broadly as necessary to implement and comply with the HIPAA Requirements and other Applicable Law.

J. Except as otherwise provided herein, all notices that are required or permitted to be given pursuant to this Addendum shall be in writing and shall be sufficient in all respects if delivered personally, by email or electronic facsimile (with a confirmation by registered or certified mail placed in the mail no later than the following day), or by registered or certified mail, postage prepaid, or by another delivery service that provides evidence of delivery, addressed to a Party as indicated below:

If to ACHP, to:

AmeriHealth Caritas Family of Companies
Privacy Office
200 Stevens Dr.
Philadelphia, PA 19113

If to Supplier, to:

[redacted]

With a copy to:
Privacy@amerihealthcaritas.com
Notice shall be deemed to have been given upon transmittal thereof as to communications which are personally delivered or transmitted by email or electronic facsimile; as to communications made by United States mail, on the third (3rd) day after mailing; and, as to communications made by other delivery service, on the date delivered. The above addresses may be changed by giving notice of such change in the manner provided above for giving notice.

K. If any provision of this Addendum is determined by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions hereof shall continue in full force and effect.

L. This Addendum together with the Services Agreement contains the entire understanding between the Parties hereto regarding the access, use, disclosure, transmission and safeguarding of PII and shall supersede any other oral or written agreements, discussions or understandings of any kind and nature with respect to such matters. In the event of any

conflict between the terms of this Addendum and the terms of the Services Agreement, the terms of this Addendum shall control unless the terms of such Services Agreement are stricter, as determined by ACHP or as the Parties otherwise agree in writing. No modification, addition to or waiver of any right, obligation or default shall be effective unless in writing and signed by the Party against whom the same is sought to be enforced. No delay or failure of either Party to exercise any right or remedy available hereunder, at law or in equity, shall act as a waiver of such right or remedy, and any waiver shall not waive any subsequent right, obligation, or default.

M. This Addendum shall be construed, interpreted and enforced in accordance with, and governed by, the laws of the Commonwealth of Pennsylvania and the United States of America.

N. Supplier shall make itself, its personnel, and any agents, affiliates, subsidiaries and subcontractors that are assisting the Supplier in the fulfillment of its obligations under this Addendum and Services Agreement, available to ACHP and the state agency, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against ACHP or the state agency, or their departments, agencies, divisions, directors, officers or employees, based upon a claimed violation of Applicable Law, except to the extent that Supplier, its personnel, agents, affiliates, subsidiaries or subcontractors are a named adverse party.

IN WITNESS WHEREOF, the Parties have caused this Addendum to be executed by their respective duly authorized representatives and to become effective as of the Effective Date.

AMERIHEALTH CARITAS		**Supplier**	
AmeriHealth Caritas Health Plan (on its behalf and on behalf of its affiliates)			
By:		By:	
Print Name:	Rebecca Gustafson	Print Name:	[redacted]
Title:	Privacy	Title:	[redacted]
Date:		Date:	

EXHIBIT E-1

Services Agreement(s)

As provided for in this Addendum, "Services Agreement" shall mean the following agreement(s) between the Parties:

[redacted]

EXHIBIT E-2
REQUIRED MINIMUM SECURITY STANDARDS

As required under **Section IV.E** of this Addendum, Supplier agrees to (and cause its agents and subcontractors to) develop, implement, maintain and use appropriate and effective privacy and security administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PII.

In addition to any other safeguards necessary to protect PII, Supplier shall implement and continue to enforce the following minimum security safeguards. ACHP makes no warranty or representation to Supplier that compliance by Supplier with the security provisions of the Addendum or of this **Exhibit E-2** are adequate or satisfactory for Supplier's own purposes, and Supplier is solely responsible for all decisions made by Supplier regarding the safeguarding, confidentiality and integrity of PII.

As used herein, the term "encryption" or "encrypted" refers to data that has been secured, consistent with Federal Information Processing Standards (FIPS) 140-2, the National Institute of Standards and Technology (NIST) publications regarding cryptographic standards and such other standards as may be prescribed, adopted, or endorsed under Applicable Law or regulatory guidance.

1. Policies. Supplier will develop and/or maintain privacy and information security policies related to the protection of PII, incident response and Privacy and Security Event management and notification, and shall ensure that all employees are aware of and will abide by these policies. Supplier shall update (as necessary) privacy and security policies and procedures in accordance with the Applicable Law and this Addendum. Supplier and its agents and subcontractors shall provide copies of such privacy and security policies and procedures to ACHP upon request. Among the policies that Supplier shall develop and implement are policies that address the following requirements:

   (a) That personal devices not be utilized in connection with the Services provided by Supplier under the Services Agreement or under this Addendum (as used herein "personal devices" shall mean devices not owned, provisioned or managed by the Supplier);

   (b) That Supplier not transmit or download any PII over the Internet or over any other insecure or open communication channel unless such information is encrypted using standards for encryption outlined in these Minimum Security Standards;

   (c) That if PII is stored on laptops or mobile handheld devices that such laptops and devices are encrypted and password-protected, and that such PII can be erased remotely; and

   (d) The other requirements set forth in this **Exhibit E-2** (Minimum Security Standards).

2. Confidentiality Training. All persons with access to PII must be trained on the requirements of Applicable Law and Supplier's privacy and security policies and

procedures, before being given access to PII, and must be (re)trained on a periodic basis thereafter. Supplier shall ensure that all persons who will handle or have access to any Social Security Numbers are advised of the confidentiality of the records; the safeguarding requirements to protect the records and prevent unauthorized access, handling, duplication and re-disclosure of the SSA records; and the civil and criminal sanctions for failure to safeguard the SSA records. Supplier shall enact and/or maintain safeguards necessary to protect these records and prevent the unauthorized or inadvertent access to, duplication of or disclosure of a Social Security Number.

3. Background Check. Prior to granting authorized access to PII to any employee working on behalf of Supplier or its agents or subcontractors, Supplier (and its agents and subcontractors) shall conduct a thorough criminal background check of such employee, and evaluate the results to assure there is no reasonable indication that such employee presents a risk for misuse or theft of PII or other confidential information.

4. Workstation/Laptop Encryption. All workstations, and laptops, personal devices, and portable devices (as applicable) that process and/or store PII must be encrypted at the operating system level and include pre-boot authentication. Any laptops, personal devices or portable devices that process and/or store PII must not be placed in suspend mode when unattended outside of the secured office location and are to be shut down completely when not in use or when unattended. Only the minimum necessary PII may be downloaded to a laptop or hard drive when absolutely necessary for business purposes, provided such laptop or hard drive is encrypted.

5. Database Encryption. PII stored within databases must be protected using either native or commercial database encryption technologies.

6. Transmission Encryption. All PII data transmissions shall be encrypted end-to-end when transmitted over public networks.

   (a) Transfers of electronic files containing PII shall be transmitted via Sterling File Gateway (SFG), or Secure File Transfer Protocol (SFTP) with express permission of ACHP. Supplier shall structure its SFP or SFTP (as applicable) folder and access privileges to prevent inappropriate disclosure of PII, and code the folders and sub-folders used for transmitting PII for a 24-hour auto-deletion cycle.

   (b) All mobile computing devices capable of using wireless encryption for network communication must do so when connected wirelessly to a Supplier network. Devices not capable of using wireless encryption are not to be connected wirelessly to the Supplier network or to any device attached to a Supplier network. All personnel shall use a virtual private network (VPN) and appropriate encryption technologies when connecting remotely for accessing PII. Wireless access points are to be configured to use AES-256 encryption, at a minimum.

   (c) When an application requires authentication using a web application protocol or is being used to transmit PII, it must use cryptographic protocols such as Transport Layer Security (TLS) 1.2 or higher or Secure Socket Layer (SSL).

7. Removable Media and Back-up Tapes. All electronic files that contain PII must be encrypted at the hardware level when stored on any removable media type device (i.e., USB thumb drives, floppies, CD/DVD, computer back-up tapes, etc.). No removable media may be used to store PII without prior written approval of ACHP.

8. Email Security. All e-mails to external parties that include PII must be sent via an encrypted method.

9. Anti-malware Software. All workstations, laptops, servers and other systems and devices that process and/or store PII must have a commercial third-party anti-malware software solution, including anti-virus, anti-spam, anti-hacker, anti-spyware capabilities, with a minimum daily automatic update.

10. Patch Management. All workstations, laptops and other systems that process and/or store PII must have all applicable security patches applied to the operating system and system software.

11. User Names and Password Controls. All authorized users must be issued a unique user name for accessing PII or data derived from PII. Passwords shall be at least eight characters in length and composed of characters from at least three of the following four groups from the standard keyboard: upper case letters (A-Z), lower case letters (a-z), Arabic numerals (0-9), and non-alphanumeric characters (punctuation symbols). Further, user names and passwords shall not be shared, or stored in readable format on a computer, and must be changed at least every 90 days or immediately if revealed or compromised.

12. Data Destruction. All PII must be wiped from systems and servers when the systems and servers are retired, and upon termination of this Addendum. The wipe method must conform to the U.S. Department of Defense standards for data destruction (DoD 5220.22-M). All PII on removable media must be destroyed or returned to ACHP when the data is no longer necessary or upon termination or expiration of the Services Agreement or this Addendum, as set forth in Section IX.D. Supplier shall retain written certification for any PII destroyed by Supplier or any subcontractors as a part of ongoing, emergency, and disaster recovery operations, and provide such certification upon request.

13. Remote Access. Any remote access to PII must be executed over an encrypted method using technology that does not allow data to be "cached," saved or copied onto unencrypted remote computers or those with insufficient security controls.

14. System Timeout. The system shall provide an automatic timeout after no more than five minutes of inactivity.

15. Warning Banners. All systems containing PII shall display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. Users who do not agree with such requirements shall be directed to log off the system.

16. System Logging. Any system that processes or stores PII shall log successes and failures of user authentication at all layers, system administrator/developer access and any changes. In addition, such system shall log all user transactions at the database layer. All login sessions and passwords stored within databases shall be encrypted.

17. Access Controls. The system shall use role-based access controls for all user authentications, enforcing the principle of least privilege.

18. Access Management Segregation. Role segregation of identity management purposes will maintain segregation between approvers and providers of access.

19. Intrusion Detection. All systems that are accessible via the Internet or store or transmit PII shall be protected by a suitable intrusion detection and prevention system.

20. Disaster Recovery. Disaster recovery processes shall be established to ensure the ongoing availability of business processes involving access to or use of PII.

21. System Security Review. All systems processing and/or storing PII shall have at least an annual system security review. Reviews shall include administrative and technical vulnerability scanning tools. If ACHP has delegated responsibilities to Supplier, then the annual system security review shall be a SOC 2 Type II audit, and Supplier shall promptly provide a copy of the SOC 2 Type II report and SOC 2 corrective action plan (as applicable) to ACHP.

22. Log Reviews. All systems processing and/or storing PII shall have a routine procedure in place to review system logs for unauthorized access. Application logs shall be maintained for at least six (6) years after the occurrence.

23. Change Control. All systems processing and/or storing PII shall have a documented change control procedure that ensures and documents separation of duties and protects the confidentiality, integrity and availability of PII.

24. Information Security Testing. Any systems, databases, websites and web-based portals that maintain or process PII shall undergo periodic security testing, conducted by either qualified internal personnel or a qualified and reputable third-party firm, to identify vulnerabilities.

    (a) Suppliers that are ACHP subcontractors shall ensure that annual certified penetration testing is conducted of any databases, websites, web-based portals and systems developed, implemented, managed, or supported as a deliverable delegated by ACHP. Certification of this testing shall be provided to ACHP.

    (b) Regardless of whether Supplier is a ACHP subcontractor, Suppler shall provide a report of any identified vulnerabilities within thirty (30) days after testing, and a plan to remediate any identified vulnerabilities within ninety (90) days of testing.

Remediation of any critical or high risk vulnerabilities shall be addressed in a timely manner.

25. Facility Security. Any Supplier facility that houses personnel or systems used in the viewing, processing, or storing of ACHP's PII shall have appropriate and reasonable perimeter controls including, but not limited to, the following: an electronic access control system, alarmed or monitored outer doors, identification badges for personnel, and a process for logging and escorting visitors.

26. Security Official. Supplier must have a designated security official who is responsible for the development and implementation of the policies and procedures required by this **Exhibit E-2**.

27. Cloud. If the Services include or involve any cloud or offsite hosting of PII, Supplier shall ensure that the PII is stored within a FedRAMP/HITECH compliant solution, and shall provide ACHP with an annual attestation to Supplier's compliance with the security standards set forth in this Addendum.

28. Facsimile Transmissions. Supplier shall ensure that it secures and protects any PII transmitted by facsimile, and shall ensure that appropriate notices relating to confidentiality and erroneous transmission are used with each facsimile transmission.

29. Website Security. To the extent that the Services include the operation of a website through which health care providers, members of ACHP, or federal or state agency personnel, agents or subcontractors can access member PII, Supplier shall ensure that any PII solicited on the website shall not be stored or captured on the website and shall not be further disclosed except as permitted under this Addendum.

30. File Hosting Services. Supplier may not use file hosting services, also known as file sharing sites (e.g., Dropbox, Google Cloud Storage), to transmit PII.

31. Ground Mail Service. When Supplier is transmitting PII via ground delivery service, Supplier may only do so via certified ground mail with return receipt, or other delivery service with document/parcel tracking and receipt signature systems, such as UPS or FedEx, within the continental U.S. and when sent to a named individual.

EXHIBIT E-3

NCQA Delegation Compliance Matrix

In those instances in which ACHP is contracting with Supplier for the purpose of Supplier providing an NCQA-delegated function, NCQA requires that the contract with the Supplier (i.e., the delegated entity) specify how the delegate is permitted to use and/or disclose data. Accordingly, this matrix is provided to permit easy understanding of how the BAA Addendum addresses each of the NCQA requirements.

NCQA Requirement	Provision In The BAA Addendum Addressing The Requirement
1. A list of the allowed uses of PHI.	See Addendum, Sections IV.A – IV.C
2. A description of delegate safeguards to protect the information from inappropriate use or further disclosure.	See Addendum, Section IV.E and **Exhibit E-2**
3. A stipulation that the delegate will ensure that sub-delegates have similar safeguards.	See Addendum, Section IV.F
4. A stipulation that the delegate will provide individuals with access to their PHI.	See Addendum, Section VI.A
5. A stipulation that the delegate will inform the organization if inappropriate uses of the information occur.	See Addendum, Section V.B and V.C
6. A stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.	See Addendum, Section IX.D

EXHIBIT F
LOUISIANA SUBCONTRACTOR PROVISIONS

INTRODUCTION

On February 25, 2019, the State of Louisiana ("State") Department of Health ("LDH") issued Request for Proposals #3000011953 (the "RFP") for the procurement of Managed Care Organizations (MCOs) to solicit proposals from qualified managed care organizations (MCOs) to provide high quality healthcare services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program known as Healthy Louisiana. AmeriHealth Caritas Louisiana, Inc. ("ACL") intends to submit a proposal in response to the RFP (the "ACL Response"), with the goal of being a successful proposer to which LDH will award a contract to ACL to serve as a MCO (the "State Contract"). Subcontractor is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's enrollees, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this Attachment, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). Subcontractor shall adhere to all requirements set forth for Subcontractors in the contract between LDH and ACL and the MCO Manual. ACL shall furnish these documents to Subcontractor upon request. No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Attachment. If any requirement in the Agreement, including this Attachment, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence.** Except as otherwise set forth in this Attachment**,** in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

   a) the body of the Agreement with exhibits and attachments;

   b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

   c) the RFP and any addenda and appendices;

   d) the MCO Systems Companion Guide;

   e) the MCO Quality Companion Guide; and

   f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, rules, regulations, guidelines and policies, including without limitation, any regulations or rules that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies as they exist at the time of the Agreement, or as subsequently amended, that are or may be applicable to the Agreement, whether or not specifically mentioned in this Exhibit and that such laws, rules, regulations, guidelines and policies are herein incorporated into this Agreement by reference and that any revisions thereto are automatically incorporated into this Agreement as they become effective. Any provision of the

Agreement that is in conflict with federal statutes, regulations or CMS policy guidance or rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies is deemed to be amended to conform to the provisions of those laws, regulations and policies. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.), the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro- Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and its implementing regulations at 45 CFR Part 80, in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (P.L 106-113);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as set forth in 45 CFR Part 182, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities;

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL 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 recipient (45 C.F.R. Part 3);

n) The Equal Opportunity Act of 1972:

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975;

t) The Americans with Disabilities Act of 1990;

u) Executive Order Number JBE 2018-15, relating to the Prohibition of Discriminatory Boycotts of Israel in State Procurement; and

v) 42 C.F.R. §438.100(a)(2), which requires Subcontractor to comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights; and

w) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan; and

x). Section 1557 of the Patient Protection and Affordable Care Act (ACA); and

y) Notwithstanding moral and religious objections in the Services section of the RFP, Subcontractor agrees not to discriminate in its employment practices, and will render services under the RFP without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Subcontractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Agreement.

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services including, but not limited to, the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for

reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract. The QAPI and UM requirements are included as part of the subcontract between ACL and the Subcontractor.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Reserved.

g) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

h) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the RFP.

i) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to enrollees through the last day that the Agreement is in effect.

j) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL enrollees pursuant to the Agreement including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract. ACL enrollees and their representatives shall be given access to and can request copies of the enrollee's medical records, to the extent and in the manner provided by LRS 40:1165.1, La. R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) as amended and subject to reasonable charges.

k) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse ("FWA") Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 C.F.R. Part 438, Subparts A and H; La. R.S. 46:437.1 through 437.14; 42 C.F.R. Part 455, Subpart A; LAC 50:I, Subpart 5; and 42 U.S.C. §1320a-7, §1320c-5, and §1396a(a)(68). Without limiting the foregoing:

a) Subcontractor shall report all known or suspected FWA to ACL in accordance with 42 CFR §438.608(a) and the State Contract and ACL requirements.

b) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by

ACL's enrollees, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

c) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA.

d) Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the Centers for Medicare and Medicaid Services ("CMS"), U.S. Department of Health and Human Services ("HHS"), the Office of Inspector General ("OIG"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide to CMS, HHS, OIG, the State Auditor's Office, the Office of the Attorney General, GAO, Comptroller General, LDH and/or their designees upon request with timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period set forth in Section 23 of this Exhibit, but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

e) Subcontractor and Subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, Subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding, to obtain the requested information, records or data. MFCU shall be allowed access to the Contractor's place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hours admission shall be allowed. The MCO contractor, Subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of noncompliance with an information, records or data request.

f) Subcontractor shall permit the State, CMS the HHS Inspector General, the Comptroller General, or their designees to audit, evaluate, and inspect any books,

records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed.

i. Subcontractor shall make available for purposes of an audit, evaluation or inspection under Section 5(f), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees.

ii. The right to audit under Section 5(f) will remain ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

iii. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees at any time.

g) Reserved.

h) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

j) In accordance with 42 C FR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or an individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.. Subcontractor is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8). Subcontractor shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Subcontractor shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 C.F.R. §455.436 To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)

http://exclusions.oig.hhs.gov/search.aspx

-

- System for Award Management
  http://www.sam.gov

- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

k) The Subcontractor shall conduct a screen, monthly as described in Section 5 (j) of this Exhibit, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

l) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

m) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR § 455.104 and 42 CFR §438.610) on ownership disclosure reporting and in accordance with RFP Section 2.9.6. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 C FR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

n) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA).

o) The Subcontractor shall have surveillance and utilization control programs and procedures pursuant to 42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification,

investigation and referral of suspected fraud cases.

p) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

q) Subcontractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly including coordinating with law enforcement agencies, with notice to ACL, if issues are suspected to be criminal in nature , to reduce the potential for reoccurrence, and conduct ongoing compliance with the requirements under this Agreement.

r) Subcontractor shall provide annual training to all employees, and shall train new hires within thirty (30) days of the date of employment, related to the following:

- Subcontractor's Code of Conduct;
- Privacy and Security – HIPAA;
- FWA identification and reporting procedures;
- Federal False Claims Act and employee whistleblower protections; and
- Procedures for timely consistent exchange of information; and collaboration with ACL and LDH; and
- Provisions that comply with 42 CFR §438. 608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

s) Subcontractor shall suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. ACL is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

.

6. <u>Employment of Personnel</u>.

a) <u>Non-Discrimination</u>. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) <u>Restriction on Certain Individuals</u>. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement

activity or from participating in –non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR § 1001.1901(b) and 42 CFR§ 1003.102(a)(2)}.

Additionally, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 USC §1320a-7) or Section 1156 (42 USC §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. This includes providers undergoing any of the following identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health services license;

ii. Exclusion from the Medicaid program;

iii. Exclusion form the Medicare program;

iv. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review ("SURS") Rule (LAC 50:1.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:1.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. Cooperation, Care Coordination and Continuity of Care.

a) Care Coordination. Subcontractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to ACL's Medicaid enrollees.

b) Continuity of Care. To the extent applicable to the services provided under the Agreement, Subcontractor shall develop and maintain a process of Continuity of Care

by which ACL's Medicaid enrollees and network and/or non-network provider interactions are effective to ensure that each enrollee has an ongoing source of preventative and primary care appropriate to their needs.

c) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid enrollees in accordance with professional standards. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

d) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this Exhibit, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this Exhibit and under the Agreement.

8. Provider Selection Requirements. To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR§438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and re-credentialing policies including, but not limited to: LDH, Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for specialized behavioral health providers.

c) Subcontractors that specialize in behavioral health are required to be accredited by rule, regulation, waiver or State Plan Amendment ("SPA") prior to contracting with ACL or prior to receiving Medicaid reimbursement, and shall comply with: all requirements of ACL,; CMS approved waivers; and/or the SPAs.

d) Subcontractors that specialize in behavioral health shall provide ACL with proof of accreditation from one of the following LDH approved national accrediting body:

- Council on Accreditation;
- Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- The Joint Commission ("TJC").

e) Subcontractor shall have a re-credentialing policy which includes, but is not limited

to, notifying ACL when Subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

f) Subcontractor shall notify ACL, regarding itself or any of its providers or subcontractors, and shall furnish documentation from the accreditation body within twenty-four (24) hours of the following: loss of accreditation, license or certification; suspension; or any action that could result in the loss of accreditation.

g) If Subcontractor or any provider of Subcontractor performs laboratory services under the Agreement, the Subcontractor or provider of Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

h) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

i) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this Exhibit, as may be modified by LDH from time to time.

j) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 2.20 of the State Contract.

k) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the RFP).

l) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

m) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the enrollee needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

n) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract that may materially impact Subcontractor's provider network

and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans**. Subcontractor's Physician Incentive Plans ("PIP") shall be incompliance with 42 CFR § 438.3(i).

a) Subcontractor shall disclose to ACL annually any PIP or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

b) Subcontractor shall provide written notification to ACL within thirty (30) days upon implementation of any new PIP or when an existing PIP is modified. The written notification must: (i) list the participating providers; and (ii) certify that the terms and conditions of the PIP are compliant with all applicable federal regulations.

c) Subcontractor shall furnish, upon request of ACL, additional information including, but not limited to, a copy of the PIP.

10. **Provider Preventable Conditions.** Subcontractor shall report to ACL, within seventy-two (72) hours, any provider preventable conditions ("PPCs") associated with claims for payment or enrollee treatment for which payment would otherwise be made. PPCs include: (i) Healthcare Acquired Conditions; and (ii) Other Provider Preventable Conditions, as defined by Section 2.11.10 of the State Contract..

11. **National Provider Identifier (NPI).** The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

12. **ACL Enrollee Hold Harmless.** Subcontractor shall accept the final payment made by ACL as payment-in-full for covered services provided under the Agreement. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from, or have recourse against LDH, ACL enrollees or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the enrollee), for health care services which are rendered to such enrollees by Subcontractor and its contractors, and which are covered services under the Louisiana Medicaid program. ACL enrollees shall not be held liable for payment for covered services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if the

Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that LDH or ACL enrollees shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 12 shall be construed to be for the benefit of ACL's enrollees. This Section 12 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's enrollees, or persons acting on their behalf.

13. **Enrollee Access.** Subcontractor and any providers providing services under the Agreement shall not restrict enrollee access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

14. **Enrollee Rights**. Subcontractor shall assist enrollees in understanding their rights to file grievances and appeals in accordance with ACL's Provider Manual.

    a) To the extent applicable, Subcontractor shall have a grievance system in place to address ACL enrollee grievances including, but not limited to the following:

        i. the referral of the enrollee to a designee of the Subcontractor authorized to review and respond to grievances and appeals that require corrective action; and

        ii. the provision of information explaining Enrollee Rights to file grievances, appeals and request a State Fair Hearing, in accordance with 42 CFR Part 438, Subpart F, both orally and in writing in a language that the Enrollee understands.

15. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL enrollee.

16. **ACL Enrollee Copayments**. Subcontractor shall not impose copayments for the following: (i) Family planning services and supplies; (ii) Emergency services; and (iii) Services provided to:

- Individuals younger than 21 years old;
- Pregnant women;
- Individuals who are impatient in long-term care facilities or other institutions;
- Native Americans; and
- Alaskan Eskimos.

To the extent that emergency services, as defined by the RFP, are provided by Subcontractor or any providers of Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

17. **ACL Enrollee Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's enrollees. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

18. **Marketing and Enrollee Education.** All Marketing (as such term is defined in the RFP) and enrollee education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the LDH requirements as set forth in

the RFP, including but not limited to the following:

a) All Marketing and enrollee education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and enrollee education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or enrollee education materials, or participate in any marketing and enrollee education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or enrollee education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 2.14.2 of the State Contract; but (ii) Subcontractor's Marketing and enrollee education activities may include those activities enumerated in Section 2.14.3 of the State Contract.

19. Misuse of Symbols, Emblems or Names in Reference to Medicaid. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

20. Confidentiality of Information.

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to enrollees or potential enrollees, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the enrollee/potential enrollee, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees/potential enrollees shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the

Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

21. **Safeguarding Information.** Subcontractor shall establish written safeguards, according to applicable state and federal laws and regulations and as described in the State Contract, which restrict the use and disclosure of information concerning enrollees or potential enrollees, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S.46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the enrollees or potential enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

22. **LDH Use of Data.** Notwithstanding any provision in this Exhibit or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

23. **Record Retention.**

a) Financial Records. Subcontractor shall retain all financial records, supporting documents, statistical records, and all other records for a period of at least ten (10) years from date of submission of the final expenditure report under the Agreement, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.. The only exceptions are the following:

i. If any litigation, claim, financial management review, or audit is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

ii. Records for real property and equipment acquired with federal funds shall be retained for ten (10) years after final disposition;

iii. When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the recipient; and

iv. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 C.F.R. §75.361(f).

Under no circumstances shall Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

b) Medical Records. All documentation and/or records maintained by Subcontractors, and its network providers related to covered services, charges, operations and agreements under this Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall the Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

24. **Independent Audits**. Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

25. **Information System Availability.** Subcontractor shall allow LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office or upon request of CMS, direct access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of the request. The data shall include the following or any additional data requested by LDH:

- Prior authorizations;
- Claims processing;
- Provider portal;
- Third-party Liability;
- FWA;
- Pharmacy benefits manager point of sale;

- Pharmacy benefits manager prior authorization; and
- Provider contracting and credentialing.

26. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

27. **Release of Records.** Subcontractor shall release medical records of enrollees upon request by enrollees or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

28. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit executed copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. Ten (10) calendar days' written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in Subcontractor's policy. In addition, Subcontractor is required to notify ACL of policy cancellations or reductions in limits. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. The insurance companies issuing the policies shall have no recourse against LDH for payment of premiums or for assessments under any form of the policies. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

a) Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of One Million Dollars ($1,000,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL, LDH any subcontractor during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of Two Million Dollars

($2,000,000) and a minimum general aggregate of Four Million Dollars ($4,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance which covers the professional acts or omissions of Subcontractor in the amount of at least Three Million Dollars ($3,000,000) per occurrence.

d) Automobile Liability. Automobile Liability Insurance shall have a minimum combined single limit per accident of $1,000,000. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

e) Cyber Liability Cyber liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of $3,000,000. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this Contract and shall have an expiration date no earlier than thirty (30) calendar days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium.

f) The policies are to contain, or be endorsed to contain, the following provisions:

i. Commercial General Liability, Automobile Liability, and Cyber Liability Coverages
LDH, its officers, agents, employees and volunteers shall be named as an additional insured as regards negligence by Subcontractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, are to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to LDH. Subcontractor's insurance shall be primary with respect to LDH, its officers, agents, employees and volunteers for any and all losses that occur under the Contract. Any insurance or self-insurance maintained by LDH shall be in excess and non-contributory of the Contractor's insurance.

2. Workers Compensation and Employers Liability Coverage
To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against LDH, its officers, agents, employees and volunteers for losses arising from work performed by the Subcontractor for LDH.

29. Hold Harmless. Subcontractor shall indemnify, defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) Any claims for damages or losses arising from services rendered by Subcontractor or any of its contractors, persons, or firms performing or supplying services, materials, or supplies to ACL in connection with the performance of this Agreement;

b) Any claims for damages or losses arising from sanctions on ACL network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the Fraud, Waste, and Abuse Prevention Section of the State Contract.

c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Subcontractor in the performance of this Agreement;

d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor, it's agents, officers, employees, or subcontractors by Subcontractor's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes;

e) Any claims for damages or losses arising from failure by Subcontractor, it's agents, officers, employees or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;

f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the Subcontractor by ACL;

g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against ACL or LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of the Subcontractor, its agents, officers, employees, or subcontractors.

i) If the Subcontractor performs services, or uses services, in violation of Section 38, the Subcontractor shall be in material breach of this Agreement and shall be liable to LDH and ACL for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Subcontractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

30. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL or reductions in payment to ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, which shall include, but may not be limited to Subcontractor's failure or refusal to respond to ACL's request for information and, as applicable, to provide medical records and/or credentialing information. Subcontractor's failure to comply with the provisions of the Agreement may also result in the termination of the State Contract in whole or in part, which shall result in termination of the

Agreement. At ACL's discretion or a directive by LDH, ACL shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall comply with any relevant corrective action plan imposed upon or developed by ACL and/or required by LDH in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

31. **Loss of Federal Financial Participation ("FFP").** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

32. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential or actual conflict(s). Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement and during the term of the Agreement.

33. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

34. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

35. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

36. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

37. **Termination for Threat to Health of ACL Enrollees.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of ACL's enrollees.

38. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes

the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

39. Independent Contractor/Subcontractors. It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

40. Licensing Requirements. Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

41. Entire Contract; Amendments. Subcontractor shall comply with, and agrees to be bound by, all provisions of theAgreement and shall act in good faith in the performance of the provisions of the Agreement.

The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing.

Except as provided in Section 3, any amendments, alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

42. Restrictions on Contracting. Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services contracted under the Agreement.

43. Antitrust. Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program.. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

44. Termination of LDH Contract. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make available to ACL and/or LDH or their respective designated representatives, in a u sable form at no

cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

45. **Law.** This Exhibit shall be governed by the laws of the State of Louisiana, without regard to its conflict of law provision, and Louisiana law will prevail if there is a conflict between the state law where the Subcontractor is based and Louisiana law.

EXHIBIT G

AGREEMENT FOR DELEGATION OF RESPONSIBILITIES

AMERIHEALTH CARITAS LOUISIANA, INC.

TO

[redacted]

This Delegation of Responsibilities Agreement (the "Agreement"), effective as of the 1ST day of September 2019, by and between AMERIHEALTH CARITAS LOUISIANA, INC. ("The Plan" or "ACLA") sets forth the terms and conditions under which The Plan, in accordance with the requirements of the NCQA, shall delegate to [redacted] (referred to herein as "Delegate") specific managed care activities. All capitalized terms herein shall have the meanings ascribed to them in the [redacted] Agreement between the parties (the "Services Agreement") dated January 1, 2020 as amended, by and among the parties.

WHEREAS, where applicable, The Plan has completed a review of Delegate's processes and documentation (including, where applicable, case files) for [redacted] meet or exceed The Plan's requirements and that The Plan can delegate to Delegate specific managed care activities as identified herein;

WHEREAS, the parties have determined that delegation of specific managed care activities, as authorized on the signature page of this Agreement, would be beneficial to both parties;

NOW THEREFORE, the parties agree as follows:

A. Pursuant to this Agreement, The Plan hereby delegates to Delegate that portion of the activities of credentialing and re-credentialing, network development and maintenance, utilization review and management, as applicable, and financial services and claims payment processes as mutually agreed upon by the parties and described herein.

B. Delegate hereby agrees to accept all responsibility associated with such delegation and specifically agrees to abide by the policies and procedures set forth in the Abstract of Delegated Oversight Activities Policy ("Policy") attached hereto as **Attachment G-1** and any and all procedures set forth herein, as may be amended, and supplemented at the discretion of The Plan and attached hereto, including all documentation, reporting and change in status notices as may be required by The Plan. Delegate's material deviations from Policy and/or procedures set forth herein may result in review and action by The Plan, including rescission of the specific Delegate activity affected thereby.

C. Delegate hereby agrees to notify The Plan immediately whenever Delegate has knowledge of or begins an investigation of the occurrence of any incident involving Delegate or any contracted Delegate professional provider which has or may (i) cause harm to any Member of The Plan; (ii) result in the involuntary termination of a contracted professional provider; or

(iii) otherwise have an adverse effect on the quality of services to Members; or other terms of the Agreement and/or Services Agreement such as those affecting service delivery, reporting accuracy and financial viability. Similarly, Delegate shall immediately notify The Plan upon receipt of any claim or threat of a claim or action against Delegate or any contracted professional provider, to the extent Delegate has notice or reasonably should have had notice, which involves any occurrences of the incidents described above or which may have a material adverse effect on the financial stability of Delegate. Delegate shall make a good faith effort to provide each such notice to The Plan immediately and in not more than five (5) business days from knowledge of the occurrence so that The Plan may take such actions as may be appropriate.

D. In accordance with Delegate's delegated credentialing and recredentialing ("CR") responsibilities, Delegate shall perform all functions as detailed in **Attachment G-2**, as approved by The Plan, including, but not limited to the following:

1. Delegate shall maintain and implement credentialing and recredentialing policies and procedures for providers within the scope of Delegate's authority, as approved by The Plan. Such policies and procedures shall be in compliance with The Plan's applicable policies, applicable NCQA standards, applicable State or federal law and regulations, and relevant requirements of applicable regulatory agencies, and shall include those utilized for reducing, suspending, or terminating a participating provider for reasons related to quality of care, competence, or professional conduct; procedures for reporting to appropriate authorities serious quality deficiencies which could result in suspension or termination of a participating provider; and procedures for provider appeals of credentialing/re-credentialing decisions.

2. Delegate shall be precluded from granting provisional credentialing status to any provider. For purposes hereof, "provisional credentialing status" means acceptance of the provider to provide services to Members without the provider having undergone the full credentialing process. All providers must fully complete the credentialing process before providing any services to Members. It is understood and agreed that in an emergency or when continuity of care is clinically necessary for a Member seeking treatment from Delegate for the first time, Delegate may arrange for the Member to receive services at an in-network benefit level from the Member's current provider or another provider for a limited period of time, in accordance with applicable law and regulation.

3. Upon The Plan's request on an annual basis, Delegate will provide to The Plan all credentialing policies and procedures for review and approval.

4. On a monthly basis or such other basis agreed to by the parties hereto, Delegate shall provide to The Plan credentialing reports which adhere to the content and format as required by The Plan including, but not limited to, a list of providers who are credentialed or recredentialed, the effective date of participation with the Delegate and evidence of recredentialing within a maximum of a thirty-six (36) month period following initial credentialing; provided, however, Delegate shall have the credentialing reports referenced herein readily available in electronic format and, upon The Plan's request, shall provide The Plan with the reports in either electronic or paper format;.

5. If Plan is assessed any penalties as the result of Delegate's direct apparent failure to comply with applicable delegated credentialing responsibilities, Plan must provide

Delegate with information sufficient for Delegate to investigate such assertion and Delegate shall have 30 days from date of receipt of such information to respond. The parties shall arrive at an agreement within 60 days of Delegate's response as to the extent penalties are assessed against the Plan by any third party, including a regulatory agency, as a result of Delegate's failure to comply with applicable delegated credentialing responsibilities. If no agreement is made, the parties shall abide by the dispute resolution process agreed upon in this agreement. If agreement is made, Delegate shall be responsible for the immediate payment of the penalties. Plan agrees to provide Delegate with notice that such a penalty has been assessed against Plan within as much time as reasonably practicable. It is at the sole discretion of the Plan whether to contest the penalty with the regulatory agency. To the extent Plan chooses to contest the penalty, Delegate agrees to comply with any requests for information needed to refute or negotiate the penalty or to validate the third party's determination.

6. The Plan reserves the right to immediately rescind this Agreement or any of the activities delegated to delegate as a result of failure to comply with the Plan's reasonable recommendations regarding identified credentialing deficiencies.
7. Delegate shall cooperate with The Plan's annual on-site review of Delegate's credentialing programs, including, but not limited to, random sampling of Delegate's practitioner credentialing and recredentialing files, a review of committee minutes, review and periodic validation of monitors, policies and procedures, and review of corrective action initiated by The Plan, if any.
8. The Plan retains the right to approve, suspend and terminate individual providers even if the organization delegates decision making. Delegate must promptly notify The Plan in the event a provider's participation in The Plan's program is terminated for cause by Delegate.
9. Delegate must obtain The Plan's written approval prior to making any material exceptions to Delegate's credentialing policies and procedures.

E. [redacted]

1. Delegated UM Activities as described in the matrix of Delegated Responsibilities attached hereto as **Attachment G-3** and incorporated herein to this Agreement.
2. On an annual basis, [redacted] shall develop, maintain and provide to The Plan for The Plan's review and approval the following:
   a. UM program description, including policies and procedures that are in compliance with the State of Louisiana's Medicaid program requirement, applicable NCQA Standards for Utilization Management, and applicable federal or State Department of Insurance and Financial Services, Health and/or Department of Community Health requirements.
   b. The criteria used for medical review.

c. A UM program evaluation containing analysis of the UM program effectiveness and recommendations and goals for the coming year.

3. On a monthly basis, Delegate shall provide The Plan with UM reports, which shall adhere to the content and format as required by The Plan and agreed upon by the parties.

4. [redacted] shall cooperate with The Plan's annual review of [redacted] UM program, including, but not limited to, a review of committee minutes applicable to services hereunder, review and periodic validation of monitoring studies, data collection and analysis pertaining to services hereunder, and review of authorization request files and reconsideration files. At The Plan's discretion, such review may occur on-site at the [redacted] office location(s).

5. [redacted] agrees to respond to The Plan's specific recommendations regarding deficiencies in [redacted] UM program identified by The Plan and assist with any re-review(s) of [redacted] programs. The Plan shall consult with [redacted] regarding formulation of any such recommendations and resolution time frames. In the event that [redacted]' policies, procedures and programs do not meet the standards set forth in this Agreement, the parties will attempt to mutually resolve any differences within thirty (30) calendar days. If the parties cannot agree, The Plan may request termination of the UM delegation pursuant to Paragraph 17.

F. In accordance with Delegate's delegated financial services responsibilities, Delegate shall perform all functions delegated by The Plan and detailed in the policies and procedures approved by The Plan, including, but not limited to:

1. Maintain general ledger and process journal entries as these relate to claims payments.

2. Adjudicate claims and process payments to providers (through electronic means or by check).

3. Process and mail checks to providers for approved claims.

4. Maintain cash disbursement journal ("CDJ") for all claims payments, and provide a copy to the Plan on a monthly basis.

5. Reconcile the CDJ to the encounter files (as defined in Exhibit C-1), and provide associated documentation to the Plan on a monthly basis.

6. Overall reconciliation of claims reports to cash disbursements.

7. Support external auditors in their annual examination of financial statements and for preparation and completion of the SOC1 report.

G. In accordance with Delegate's delegated claims management responsibilities, Delegate shall perform all functions required by The Plan and detailed in Delegate's Policies and Procedures as approved by The Plan regarding claims payment, including, but not limited to the following:

1. Perform all front end claims processing, including, but not limited to claims preparation, data entry, initial claims entry and return for services.

2. Adjudicate, adjust and/or settle all claims as appropriate for services.

3. Where appropriate determine whether claims are subject to Third Party Liability (TPL) or coordination of benefits policies and procedures. Provide to Plan savings reports resulting from this activity on a quarterly basis.

4. Maintain effective and reasonable system and procedural edits to identify duplicate claims.
5. Perform necessary quality assurance functions as agreed to by the Parties and report this information to the Plan on a monthly basis.
6. Maintain claims files for each reported claim throughout the life of a claim. Retain closed claim data as required pursuant to The Plan's policies.
7. Communicate to participating providers instructions for claim submission to Delegate.
8. Generate timely participating provider checks and provider remittance advices, as may be applicable, for services performed by participating providers, to the extent applicable.
9. Utilize logo specified and agreed to between the parties.
10. Establish and communicate to providers the claim appeal process.
11. Advise The Plan prior to any material change to methods, policy and/or procedure, desk level or system utilized in the claim adjudication process.
12. Generate a 1099 for professional paid claims processed by Delegate, as applicable.
13. Notify the Plan of any claim disputes involving litigation.
14. Provide reasonable support to The Plan's Member Services Team or other Plan personnel for resolution of Member inquiries.
15. Provide Health Plan (or its designee) with claims history files for all adjudicated claims as defined by The Plan. If the file format should be modified, Health Plan shall provide adequate notice to [redacted] and work with [redacted] to implement the modifications.
16. Provide designated claims inventory information and performance information according to defined schedule as mutually agreed upon by the Parties.
17. Maintain availability of systems in support of Member Services.
18. Permit The Plan, upon reasonable notice with the right to conduct performance audits of Delegate records, data, systems, and other relevant information on a periodic basis as appropriate to determine compliance with performance standards.
19. Comply with The Plan's claims performance standards in accordance with applicable requirements of law, regulation and applicable regulatory agencies.

H. In accordance with Delegate's delegated call center responsibilities, Delegate shall perform all functions required by The Plan and detailed in Delegate's Policies and Procedures as approved by The Plan regarding call center, including, but not limited to the following:

1. Conduct the required staff training and communication.
2. Adhere to service standards.
3. Handle inquiries.
4. Monitor calls for quality purposes.
5. Provide translation and TTY/TDD services or its equivalent.

I. The Plan does not delegate Quality Management activities to Delegate; however, Delegate shall maintain its own Quality Management ("QM") Program that includes the following:

1. On an annual basis, Delegate shall develop and maintain: (1) a current QM Program description that outlines the program structure, design, scope, and organizational responsibilities for quality improvement; (2) QM work plan that includes Delegate's annual objectives, scope, and projects or activities scheduled for the year; and (3) a written quality program evaluation that evaluates the overall effectiveness of the Delegate's QM program.

   All such QM Program documents shall be provided to The Plan for review on an annual basis and as otherwise requested by The Plan. The QM Program shall be in accordance with applicable NCQA standards and applicable federal requirements, and any work that Delegate performs on behalf of The Plan shall be in accordance with DHCF requirements and The Plan's requirements for quality improvement, as applicable.

2. Delegate shall provide written notice to The Plan of any and all material changes to Delegate's QM Program thirty (30) days in advance of such changes for the Plan's review of such changes.

J. Delegate's provider network shall meet all performance standards in accordance with applicable requirements of law, regulation, and applicable regulatory agencies, The Plan, and NCQA to the extent that as such are applicable to the Delegate delegated activities performed hereunder.

K. Delegate warrants and represents that all delegated activities it performs pursuant to this Agreement conform to all relevant federal and state laws and regulations, including but not limited to HIPAA and HITECH privacy and security laws and regulations; relevant requirements of applicable regulatory agencies; The Plan requirements; and all relevant accreditation standards, including specifically, applicable NCQA standards. Delegate further warrants and represents that all use of protected health information (PHI) are in accordance with the terms of the Business Associate Addendum executed between The Plan and Delegate. Protected health information includes, but is not limited to:

1. Names
2. Postal address
3. Dates -directly related to an individual
4. Telephone numbers
5. Fax numbers
6. Electronic mail address
7. Social security numbers
8. Medical record numbers
9. Health plan beneficiary number
10. Certification/license numbers
11. Device identifiers and serial numbers

12. Name of relative
13. Web Universal Resource Locator (URL)
14. Internet Protocol (IP) address number
15. Biometric identifiers, including fingers and voice prints
16. Photographic images
17. Any other unique identifying number, characteristic, or code

This information may be used for activities or functions that include, but are not limited to:

1. Claims Processing and Administration, includes past, present, or future payment for the provision of health care
2. Data Analysis, processing or administration
3. Health Care Payment and Remittance Advise
4. Medical Diagnosis: Relates to the past, present, or future physical or mental health or condition of an individual
5. Medical Records
6. Utilization Review
7. Quality Assurance
8. Billing
9. Benefit Management
10. Practice Management
11. Repricing
12. Enrollment Eligibility Data

L. Delegate shall provide written notice to The Plan of any and all material changes to Delegate's network development and maintenance, credentialing and recredentialing, utilization review and management, financial services, claims payment processes or encounter data transmission processes thirty (30) days in advance of such changes for The Plan's review and approval of such changes.

M. Delegate shall not assign any of its delegated responsibilities as enumerated in this Agreement, in whole or in part, to any third party without the express written consent of The Plan, which consent shall not be unreasonably withheld. Any such sub-delegation shall be (a) subject to the terms and conditions of this Agreement; and (b) set forth in a written document, signed by Delegate and the third party, which complies with the terms of this Agreement, The Plan's Policy, relevant requirements from applicable regulatory agencies, and applicable NCQA standards for delegation activities.

N. Plan Responsibilities:

1. Plan shall oversee Delegate's performance of the activities delegated under this Agreement through the review of periodic reports and annual evaluation to include file audits, as applicable. The parties understand and agree that, on an annual basis, the Plan will conduct a comprehensive

review, including but not limited to, review and validation of Delegate's performance of Delegate's delegated responsibilities, which will include random sampling of Delegate's credentialing and re-credentialing files and utilization management files, as applicable. The Plan has the right to review all information maintained by Delegate regarding the delegated activities set forth herein for The Plan's Members, including credentialing and UM files, in order to evaluate Delegate's compliance with this Agreement. Plan's oversight activities may be conducted directly by The Plan, or by Plan's corporate parent on behalf of The Plan.

2. Within thirty (30) days following The Plan's request to audit Delegate, Delegate shall provide the Plan representative either electronic access or paper copies of such information and documents as reasonably necessary for purposes of auditing compliance with this Agreement, including, but not limited to, applicable policies and procedures, committee minutes and other relevant information (as determined by The Plan) retained by the Delegate regarding the delegated activities. If Delegate is found by The Plan to be non-complaint with the delegated activities, the Delegate are required to develop an action plan, satisfactory to The Plan, to correct the deficiencies and shall submit the plan of action to The Plan within thirty (30) days from the date Delegate receives notice of said deficiencies from The Plan.

3. The Plan are responsible for activities related to ongoing assessment and improvement of medical record documentation as required by applicable provisions of NCQA, federal and state agencies.

4. The Plan allows the delegate to collect performance data necessary to assess member experience and clinical performance, as applicable. If the delegate is not permitted to collect data from members or practitioners directly, the Plan provides data for the delegate to use in assessing its performance.

O. It is understood and agreed that costs related to any routine audits performed in the normal course of auditing compliance with the terms and obligations hereunder shall be borne by The Plan. Repeat on-site audits or audits required to assess correction of deficiency or improvement of unsatisfactory performance or completion of a corrective action initiated by The Plan, shall be borne by Delegate. Such costs shall be reasonable and discussed and agreed to by the Parties in advance.

P. Delegate shall indemnify and hold The Plan harmless with respect to any claim against The Plan, including but not limited to any fines, penalties, sanctions, liquidated damages or similar consequence imposed by LDH or other Government Agency, arising out of Delegate's negligence or failure to fulfill its obligations under this Agreement. Without limiting the foregoing, Delegate agrees that to the extent penalties are assessed against The Plan by a Government Authority, as a result of Delegate's direct failure to comply with applicable rules, regulations, and LDH Contract requirements related to delegated responsibilities as set forth herein as it relates to the provision of services hereunder and , if available, Delegate has been provided the opportunity to participate in any cure periods provided to The Plan by LDH to correct such failure, Delegate shall be responsible for the payment of such penalties in a mutually agreed upon timeframe. In the event such payment is not made in a timely manner to The Plan, The Plan shall have the right to offset any monies owed to Delegate for Administrative Services Only (ASO) fees, by any penalties owed by Delegate to The Plan.

The Plan shall indemnify and hold Delegate harmless with respect to any claim against Delegate including but not limited to any fines, penalties, sanctions, liquidated damages or similar consequence imposed by LDH or other Government Agency, arising out of The

Plan's negligence or failure to fulfill its obligations under this Agreement. Without limiting the foregoing, The Plan agrees that to the extent penalties are assessed against Delegate by a Government Authority, as a result of The Plan's direct failure to comply with applicable rules, regulations, and LDH Contract requirements related to delegated responsibilities as set forth herein as it relates to the provision of services hereunder and The Plan has been notified in a timely manner and has been provided the opportunity to participate in any cure periods provided to Delegate by LDH to correct such failure, The Plan shall be responsible for the payment of such penalties in a mutually agreed upon timeframe.

Q. The Plan reserves the right to immediately rescind any of the activities delegated to Delegate herein (a) as a result of Delegate's material deviations from the functions delegated by this Agreement; or (b) as a result of Delegate's failure to comply with The Plan's specific recommendations regarding identified deficiencies in Delegate's performance of or Delegate's programs relating to functions delegated to Delegate herein, provided, however, that Delegate shall be provided a cure period during which identified deficiencies must be corrected to the satisfaction of The Plan; (c) where such action is necessary to protect the health and welfare of The Plan's Members; and (d) where such action is necessary in order to comply with State or federal laws, regulatory requirements and/or obligations. No activities delegated to Delegate herein shall be rescinded prior to the expiration of any cure periods provided by the regulatory agency, subject to Delegate's good faith effort to cure the deficiencies during the allotted cure period.

R. In the event of a conflict with the Services Agreement and this Agreement, the terms of this Agreement shall govern as to Delegate's delegated responsibilities.

S. This Agreement, including all attachments hereto, supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding. Amendments to this Agreement required because of legislative, regulatory, or legal requirements do not require the consent of Delegate or The Plan and are effective immediately on the effective date thereof.

T. Notwithstanding anything to the contrary contained herein, this Agreement shall terminate upon termination of the Services Agreement. Confidentiality of information and reporting obligations for services performed during the term of this Agreement shall survive termination of this Agreement.

U. Delegate acknowledges that The Plan is subject to State and federal regulatory requirements which require The Plan to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, Member appeal and grievance systems and other systems and programs meeting those regulatory requirements and that The Plan is directly accountable for compliance with such requirements and for provision of access to quality, cost-effective care to Members. Nothing in this Agreement shall be construed to in any way limit The Plan's authority or responsibility to meet standards or to take prompt corrective action to address a quality of care problem, resolve a Member appeal or grievance, or to comply with all applicable State and federal regulatory requirements.

V. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreement and shall become effective when one or more

counterparts have been signed by each of the parties hereto and delivered to each of the other parties hereto.

[REMAINDER OF PAGE INTENTIONALLY BLANK; SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives on the date written above.

AMERIHEALTH CARITAS LOUISIANA, INC.		[redacted]	
By:		By:	
Print Name:		Print Name:	[redacted]
Title:	Market President	Title:	[redacted]
Date:		Date:	

ATTACHMENT G-1
ABSTRACT OF DELEGATED OVERSIGHT ACTIVITIES POLICY

AmeriHealth Caritas Louisiana, Inc. ("ACLA") may enter into contractual arrangements that delegate the provision of Credentialing and Recredentialing, Utilization Review and Management, Financial Services and Claims Payment Processes, to outside organizations as permitted by the National Committee for Quality Assurance (NCQA). In these instances, ACLA maintains overall accountability for all delegated activities. In addition, ACLA assumes responsibility for conducting a pre-delegation evaluation and ongoing performance monitoring and oversight of the Delegate's performance.

All delegation arrangements are governed by agreements that outline the scope of activities, performance expectations, reporting responsibilities and consequences for failure to meet the contract requirements ("Delegation Agreement"). ACLA's Quality Assessment Performance Improvement ("QAPI") Committee reviews reports from delegated entities, as described hereinafter (see Committee Delegation Responsibility, below). At minimum, a formal annual audit of each Delegate's performance and capability is conducted. ACLA also reserves the right to investigate/audit Delegate performance at any time upon prior written notice which notice shall be a minimum of thirty (30) days.

Any deficiencies identified in the Delegate's performance are addressed collaboratively with the Delegate. Where performance deficiencies remain unresolved, ACLA may exercise its right to withdraw delegation, consistent with the terms of the Delegation Agreement. For delegated Credentialing/ Recredentialing, ACLA retains the right to approve or terminate a delegated practitioner who has been non-compliant with any standards set forth by ACLA, Federal or State entities or accrediting agencies. Delegates of ACLA are not permitted to sub-delegate any function(s) being delegated to them by ACLA, unless prior approved in writing by ACLA.

The ACLA QAPI Committee provides oversight of all delegated activity, including but not limited to:

- Review of routine performance reports and documents as outlined in the Delegation Agreement;
- Review of compliance with the terms of the Delegation Agreement
- Review of the annual Delegate evaluation
- Review of pre-delegation assessments and findings
- Review of completion of any subsequent corrective action deemed necessary by the respective committee
- Revocation of delegation should Delegate fail to make required corrections to delegated functions in a time and manner designated, as appropriate.

Results of the annual oversight audit and any additional investigations/audits are presented to the ACLA QAPI Committee, which approves the on-going delegation arrangements for these entities.

For potential Delegates, ACLA conducts a pre-delegation audit to ensure they have the capability to perform and are adequately performing the functions to be delegated. Candidates for Credentialing delegation are typically required to have one hundred (100) or more practitioners to be considered for delegation. Results of the pre-delegation audit are reported to the respective ACLA QAPI Committee and the ACLA Board. Achievement of a one hundred percent (100%) score or correction of deficiencies sufficient to attain a one hundred percent (100%) score is required for approval of delegation.

ATTACHMENT G-2
DELEGATED CREDENTIALING ACTIVITIES

In evaluating providers' ability to meet standards of participation with the Plan, Delegate shall accept applications, reapplications and attestations, collect all data elements from NCQA-approved sources and from State-approved sources, and verify, from primary sources where applicable, the following credentials of providers. Such verification process shall be completed within, but no later than, 45 days from the date of the provider's signed application page. For purposes of the previous sentence, "completed" shall mean to the date of the credentialing committee decision.

A. Credentialing Criteria

1. Current state licensure in all States where the provider may provide services to the Plan's members. Any limitations on scope of practice must be identified and considered in making credentialing and re-credentialing decisions.
2. Current copy of DEA or CDS certificate, as applicable
3. Evidence that provider maintains current malpractice insurance in amounts required by law.
4. If applicable, evidence of graduation from applicable professional school and completion of a residency or other postgraduate training as applicable. If applicable, written verification from a practitioner's applicant's medical school, residency program, and fellowship; or the acceptance of the American Medical Association (AMA) profile for verification of education and training. If the practitioner is board certified by either the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), verification by the appropriate board via Internet registry can serve as verification.
5. Professional claims liability history
6. Complete work history or curriculum vitae encompassing a five (5) year time span with no gap greater than six (6) months. Any gap in work history of more than six (6) months requires an explanation. Gap in work history and/or education training that are greater than one year (1) year are explained in writing.
7. If applicable, evidence of good standing regarding admitting privileges at a participating Plan hospital or admitting arrangements with a participating practitioner.
8. If applicable, history of loss of license and/or felony convictions.
9. If applicable, history of loss or limitation of privileges or disciplinary activity.
10. Lack of present illegal drug use.
11. Reasons of inability to perform essential functions of the position, with or without accommodations.
12. Verification that information was obtained from the National Practitioner Data Bank (NPDB). Actual documentation from NPDB must be obtained and maintained in practitioner file.

13. Verification of sanction activity by Medicare or Medicaid through NPDB and Medicare/Medicaid Sanction and Reinstatement Report and Department of Health and Human Service Office of Inspector General website
14. No evidence of disciplinary action by the applicable State Board/s.
15. Attestation to correctness/completeness of the information provided.
16. Signed and dated signature page.
17. If applicable, not opted out of Medicare participation – Absence from Medicare Opt Out lists for each state practitioner provides services to Plan members must be primary sourced verified.

B. Delegate shall verify the applicable providers' credentials at the time of initial credentialing and re-credentialing, at least every thirty-six (36) months to assure that all the information listed above is current and accurate.

C. Delegate shall utilize a system that monitors expiration dates of state license, DEA, CDS certificates, board certification, and malpractice insurance so that these certificates are current at the time of credentialing/re-credentialing. In addition, Delegate shall provide on-going monitoring of sanctions and complaints, so that any action, including Medicaid and Medicare sanctions, state sanctions or limitation on licensure, and complaints, is reviewed within thirty (30) days of its imposition.

D. Delegate shall establish and maintain a Credentialing Committee in accordance with applicable NCQA standards to review provider applications and make decisions regarding approval for credentialing/re-credentialing, denial or termination. Upon execution of this Agreement, and thereafter upon approval of a provider by the Delegate's Credentialing Committee, the Delegate shall provide the Plan with a list of providers that have been reviewed and approved by the Delegate's Credentialing Committee. The Delegate shall notify the Plan on at least a monthly basis of all terminated providers, including their date of termination, new providers and change of information, e.g. leave of absence, return from leave of absence, change in board certification status, address, telephone number, change of status of acceptance of new patients, and payment information.

E. Delegate shall electronically report to the Plan the following information at least semi-annually, and the Plan shall submit the information to the Credentialing Committee for review:

1. Roster of initially credentialed/re-credentialed providers to include all of the data elements required by the Plan.
2. Summary of performance improvement activities initiated or completed, if applicable.

F. Delegate shall provide to the Plan within a reasonable period of time any additional information or reports that may be requested by an accreditation or regulatory agency.

G. Delegate shall abide by additional credentialing standards as may be promulgated by NCQA.

H. Delegate shall report practitioner termination/s, suspension/s and disciplinary action/s to the appropriate authorities as required by law.

I. Delegate shall continue on-going monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and take appropriate action against providers when it identifies occurrence of poor quality.

J. Delegate shall provide an appeal process to providers terminated for quality reasons and to Medicaid participating providers terminated for quality or contractual reasons.

ATTACHMENT G-3
DELEGATED RESPONSIBILITIES

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
Utilization Program Structure		
Written Program Description. The Delegate's UM program description includes the following: 1. A written description of the program structure. 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated senior -level physician in UM program implementation. 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and process used to determine benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity.	X	
Physician Involvement. A senior level physician is actively involved in implementing the delegate's UM program.	X	
Annual Review of the UM program.	X	
Clinical Criteria for UM Decisions		
To make utilization decisions, the organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria. The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria 5. Annually reviews the UM criteria and the	X	

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
procedures for applying them, and updates the criteria when appropriate.		
Availability of Clinical Criteria The Organization: 1. States in writing how practitioners can obtain UM criteria 2. Makes the criteria available to its practitioners upon request.	X	
Consistency in Applying Criteria – At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	X	
Communication Services The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.		
1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues.	X	
Appropriate Professionals Qualified licensed health professionals assess the clinical information used to support UM decisions.		
Licensed Health Professionals - The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. 2. Specifying the type of personnel responsible for each level of UM decision making.	X	

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
Use of Practitioners for UM Decisions - - The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training or professional experience in medical or clinical practice. 2. A current clinical license to practice or an administrative license to review UM cases.	X	
Practitioner Review of Denials – The organization ensures that a physician or other healthcare professional, as appropriate, reviews any non-behavioral health denial based on medical necessity.	X	
Use of Board-Certified Consultants – The organization: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations. 2. Provides evidence that organization uses board-certified consultants for medical necessity determinations.	X	
Affirmative Statement About Incentives - The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.	X	
Timeliness of UM Decisions The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.		
The organization makes determination of medical necessity requests for non-urgent preservice decisions, urgent preservice decisions and post-service decisions within the timelines as described in State Contract (s), NCQA requirements (whichever is more stringent) or CMS guidelines if	X	

Functions	Entity Performing Functions	
	Delegate	Health Plan
applicable.		
The organization makes notification of UM decision making decisions for medical necessity requests for non-urgent preservice decisions, urgent preservice decisions and postservice decisions within the timelines as described in State Contract (s), NCQA requirements (whichever is more stringent) or CMS guidelines if applicable.	X	
Documentation of Relevant Information. Determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.	X	
Denial Notices The organization clearly documents and communicates the reason for a denial.		
Notification of Reviewer Availability: The organization notifies practitioners about: 1. The organization's policy for making an appropriate practitioner reviewer available to discuss any UM denial decision. 2. How to contact the reviewer.	X	
Discussing a Denial with a Reviewer: The organization provides practitioners with the opportunity to discuss any UM denial decision with a physician or other appropriate reviewer.	X	
Reason for Denial: The organization provides written (and verbal if required by State Contract or CMS) to members and their treating practitioners of the non-behavioral health denial that contains the following information: 1. The specific reasons for the denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request	X	

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
Notice of Appeal Rights/Process: The organization's written denial notification (and verbal if required by State Contract or CMS) to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.	X	
Appeals – Policies and Procedures		
Policies and Procedures - The organization has written policies and procedures in place for registering and responding to Medicaid appeals or Medicare reconsiderations (for CMS): 1. Preservice appeals. 2. Post-service appeals. 3. Expedited appeals. 4. External appeals.	X	
Satisfaction with the UM Process The organization evaluates member and practitioner satisfaction with its UM process.		
Assessing Satisfaction With UM Process - The organization's annual assessment of satisfaction with the UM process includes: 1. Collecting and analyzing data on member satisfaction to identify improvement opportunities. 2. Collecting and analyzing data on practitioner satisfaction to identify improvement opportunities. 3. Taking action designed to improve member satisfaction based on its assessment of member data. 4. Taking action designed to improve practitioner	Delegate not delegated to conduct member surveys.	X
Complaints and Grievances		

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
Organization has policies and procedures to support timely response to member grievances.	Delegate not delegated grievances, but has policies & procedures to support timely responses to Member grievances.	
Claims Administration		
Maintenance of Fee Schedule	X	
Claims Receipt	X	
Claims Processing	X	
Timely and Accurate Claims Adjudication	X	
Claims Auditing	X	
Claims Quality Monitoring	X	
Claims Edit	X	
Payment to Providers -- issuing checks to providers for eligible claims.	X	
EOP and EOB Production and delivery	X	
Claims Inquiries / Claims Customer Service	X	
Claim Appeals for Provider – appeals of a claim submitted to health plan for payment	X	
Call Center		
Incoming calls handling	X	
Provide an automated, telephonic response system for members and/or Providers	Delegate not delegated for member calls	
Call Documentation	X	
Required Staffing Training and Communication	X	
Service Standards	X	
Inquiry Handling	X	
Complaint Handling	X	
Call Quality Monitoring	X	
Translation Services	X	
TTY/TDD Services	X	
Provider Network		
Recruit and Contract Providers	X	
Maintain Provider Network adequacy	X	
Ensure provider compliance with Provider Network Requirements	X	
Ensure Provider Network Compliance with ADA requirements.	X	

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
Develop and maintain an appeal system to resolve claim and authorization disputes.	X	
Provider Communication	X	
Provider payments	X	
Credentialing and Recredentialing		
Oversight and Monitoring		X
Credentialing Program Structure	X	
Credentialing Policies and Procedures	X	
Accepts applications, reapplications and attestation	X	
Collects and reviews credentialing applications that include the following: 1. Reasons for inability to perform the essential functions of the position, with or without accommodation 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage 6. Current and signed attestation confirming the correctness and completeness of application	X	
Collects licensure information from NCQA-approved sources	X	
Collects DEA and CDS information from NCQA-approved sources	X	
Collects verify education and training information from NCQA-approved sources	X	
Collects work history information from NCQA-approved sources	X	
Collects history of liability claims information from NCQA-approved sources	X	
Collects and licensure sanction information from NCQA-approved sources	X	
Collects and primary source verify Medicare and Medicaid sanction from NCQA-approved sources	X	
Collects and Reviews Ownership Disclosure Forms	X	

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
Using NCQA approved sources and within prescribed time limits, organization conducts primary source verification of practitioner's: 1. A current and valid license to practice 2. A valid DEA or CDS certificate, if applicable 3. Education and training, as specified in the explanation 4. Board certification status, if applicable. 5. Work History 6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner Primary Source Verification for practitioners and providers- excluded providers through EPLS/SAM, OIG, GSA and DCH list of Excluded providers	X	
Verification of practitioners/providers from excluded participation in Medicare – Opt Out of Medicare	X	
Conducts site visits and ongoing monitoring	X	
Collects and evaluates ongoing monitoring information	X	
Implements Appropriate Interventions	X	
Reports to authorities practitioner and provider suspension or termination	X	
Notification of Provider Appeal Rights and Process	X	
Maintain policies and procedures that include the following practitioner's rights: 1. The right of practitioners to review information submitted to support their credentialing application. 2. The right of practitioners to correct erroneous information. 3. The right of practitioners to be informed of the status of their credentialing or recredentialing application upon request. 4. The process to notify practitioners of these rights.	X	
Designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.	X	

Functions	Entity Performing Functions	
	Delegate	**Health Plan**
Ensure that the Credentialing Committee reviews the credentials of all practitioners who do not meet established criteria.	X	
Implement a process for the Medical Director or designated physician's review and approval of clean files.	X	
Recredential practitioners at least every 36 months.	X	
Makes final credentialing decisions	X	
Quality Improvement		
Oversight and Monitoring		X
QAPI Policies	X	
Event Reporting- Harmful events to members receiving care have to be reported, tracked and investigated per CMS and MDCH standards	X	
Performance Improvement Projects for annual review or on a case by case basis	X	
Submission of Annual Program Description and Annual Program Evaluation	X	
Compliance		
Fraud, Waste, and Abuse Monitoring	X	X
Provider Fraud and Waste investigations	X	X
Compliance Program	X	X
Employee and Provider Training for Compliance, FWA and s. 6032 of the federal Deficit Reduction Act of 2005	X	X

This page is intentionally left blank.

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-2

[redacted]

Appendix F Material Subcontractor Response Template

This page is intentionally left blank.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
AmeriHealth Caritas Louisiana
Material subcontractor name:
[redacted]
Description of the Proposer's role and material subcontractor's role:
AmeriHealth Caritas Louisiana is responsible for the sourcing, vetting, selection, and oversight of [redacted], reporting on performance, providing ongoing support, and ensuring that they comply with the terms set out in the subcontractor agreement. [redacted] daily activities will be conducted in concert with our Operations team. [redacted]
Explanation of why the Proposer plans to subcontract this service and/or function:
[redacted]
A description of the material subcontractor's organizational experience:
[redacted]
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
Prior to approval as a material subcontractor, [redacted] will be evaluated, including screening for state and federal exclusions, review of ownership disclosures, review of trainings and policies, accreditation standards, and completion of all necessary documentation. [redacted] must demonstrate that they possess the infrastructure, organization, financial stability, and processes necessary to fulfill their roles. The local Vendor Management team, in collaboration with the Corporate Sourcing department will be responsible for onboarding, auditing and monitoring [redacted]. Monthly performance reports will be reviewed by Vendor Management and Corporate Sourcing for contract compliance. Areas of concern are flagged for remediation, including any complaints or grievances. If [redacted] consistently fails to meet agreed performance standards, they are issued a Corrective Action Plan (CAP) and required to determine the root cause of the deficiencies. They must meet the performance standard for three consecutive months before the CAP can be closed. If they continue to miss performance standards may be terminated for cause and may be subject to financial penalties. In order to ensure an appropriate return-on-investment (ROI), our Medical Economics department will collaborate with [redacted] and their team's extensive experience in program evaluation to determine opportunities for program growth or redirection to further address this key population health priority. Further, we constantly monitor for any reported or identified instances of fraud, waste and abuse, and third-party liability (TPL) to ensure that claims and payments are accurate, timely, and appropriate.

Instructions: The MCO should attach the executed contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Subcontract Provisions, Introductory Paragraph, pg. 1
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Contract
3	Specify the effective dates of the subcontract agreement.	Contract
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Subcontract Provisions, Par. 41, pg. 29
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Subcontract Provisions, Par. 41, pg. 29
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Subcontract Provisions, Par. 41, pg. 29
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Subcontract Provisions, Par. 44, pg. 30
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Subcontract Provisions, Par. 39, pgs. 29
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Subcontract Provisions, Introductory Paragraph, Pg. 1

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Subcontract Provisions, Introductory Paragraph, Pg. 1
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Subcontract Provisions, Par. 4(i), pg. 12
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Subcontract Provisions, Par. 40, pg. 29
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Contract
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Subcontract Provisions, Par 16, pg. 21
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Subcontract Provisions, Par. 8(g), pg. 19
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Subcontract Provisions, Par. 4(j), pg. 12
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Subcontract Provisions, Par. 23, pgs. 23-24

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Subcontract Provisions, Par. 5(d), pg. 13
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 2.9.6. The completed disclosure of ownership should be attached for executed contracts.	Subcontractor Provisions, Par. 5(m), pg. 15
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Subcontract Provisions, Par. 4(c), pg. 12
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Subcontract Provisions, Par. 4(e), pg. 12
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Subcontract Provisions , Par. 30(b), pg. 28
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Subcontract Provisions, Par. 30, pgs. 27-28

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Subcontract Provisions, Par. 4(b), pg. 11
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Subcontract Provisions, Par. 21, pg. 23
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Subcontract Provisions, Par. 4(g), pg. 12
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 12
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 12
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Subcontract Provisions, Par. 4(k), pg. 12
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Subcontract Provisions, Par. 12, pgs. 20-21
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Subcontract Provisions, Par. 29, pgs. 26-27

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Subcontract Provisions, Par. 28, pgs. 25-26
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Subcontract Provisions, Par. 3, pgs. 9-10 and Par. 45, pg. 30
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Subcontract Provisions, Par. 3, pgs. 9-10
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Subcontract Provisions, Par. 15, pg. 21
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Subcontract Provisions, Par. 32, pg. 28
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Subcontract Provisions, Par. 4(d), pg. 12
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Subcontract Provisions, Par. 26, pg. 25
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Subcontract Provisions, Par. 3(c), pg. 10
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Subcontract Provisions, Par. 42, pg. 29

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Subcontract Provisions, Par. 4(a), pg. 11
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Subcontract Provisions, Par. 38, pg. 29
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Subcontract Provisions, Par. 43, pg. 29

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Subcontract Provisions, Par. 5(e), pg. 13

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-2

[redacted]

Draft Agreement

This page is intentionally left blank.

AGREEMENT

THIS AGREEMENT, is made as of _____, 20[___] by and between AMERIHEALTH CARITAS LOUISIANA, INC., (herein "ACL") and [redacted] (herein [redacted]").

WHEREAS, [redacted] an organization engaged in the business of providing smoking cessation services; and

WHEREAS, ACL desires to utilize [redacted]s services in providing smoking cessation services to certain ACL Medicaid enrollees in the Louisiana Medicaid managed care program known as Healthy Louisiana; and

WHEREAS, [redacted] and ACL are entering into this Agreement to set forth their entire understanding and agreement with respect to the terms and conditions under which [redacted] shall provide such services;

NOW THEREFORE, in consideration of the mutual agreements hereinafter set forth, and intending to be legally bound hereby, the parties hereto agree as follows:

A. [redacted] During the term of this Agreement, [redacted] shall provide those services as set forth on the Statement of Work (herein "SOW"), which is attached hereto as Exhibit A and incorporated herein by reference.

B. **COMPENSATION**. [redacted] shall be paid for services rendered to ACL enrollees at the rates set forth in Exhibit A.

C. **TERM**. This Agreement is for a term of one (1) year commencing January 1, 2020. Either party may terminate this Agreement: (i) for cause at any time by giving the other party written termination notice specifying the cause for termination and providing the date such notice shall be effective; or (ii) for any or no reason by giving the other party ninety (90) days' prior written notice.

D. **REQUIRED SUBCONTRACTOR PROVISIONS.** [redacted] agrees to abide by the Louisiana Managed Care Organization Required Subcontractor Provisions as set forth as Exhibit B and incorporated herein by reference.

E. **INDEMNIFICATION**. [redacted] shall indemnify and hold harmless ACL and its officers, shareholders, agents, Directors, and employees, from and against any and all, liability, damages, losses and expenses, including attorneys' fees, arising out of or resulting from the rendering of [redacted]s Services hereunder, or from the acts or conduct of [redacted] or any agent, servant or employee of [redacted], or any [redacted] engaged by [redacted] [redacted] shall pay any judgment finally awarded, together with all expenses and fees, in any claim, suit or action which is brought against ACL and is within the indemnifications set forth herein, and shall pay any amounts payable in settlement or compromise of any such claim, suit or action. In the event [redacted] refuses or fails to pay any amount pursuant to this section, without thereby waiving any other rights or remedies available to it. ACL, shall have the right (but not the obligation) to pay such amounts and to thereafter deduct any equivalent amount from any amount which may be due under this Agreement.

F. **CONFIDENTIALITY**. ACL and [redacted] shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of ACL enrollees acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by LDH or the Louisiana Department of Insurance or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

G. **INSURANCE**. During the term of this Agreement, [redacted] shall maintain, at its sole expense,

professional liability insurance with a coverage amount of no less than one million ($1,000,000.00) dollars per occurrence and two million ($2,000,000.00) dollars in the aggregate. [redacted] shall also maintain general liability insurance with a coverage amount of no less than one-million ($1,000,000.00) dollars per occurrence and two million ($2,000,000.00) dollars in the aggregate. [redacted] shall provide ACL evidence of such insurance coverage via an insurance certificate and shall maintain such insurance for the term of the contract.

H. INDEPENDENT CONTRACTOR. This Agreement does not constitute [redacted] the employee or agent of ACL, or provide expressly or impliedly any power in [redacted] to contract for, or in the name of, ACL, or to hire persons as employees of ACL, or otherwise act on behalf of ACL. [redacted] agrees that in the performance of this Agreement, it shall act as an independent contractor for all purposes of any kind whatsoever, and all of its agents, [redacted] and employees, and agents and employees of its [redacted] shall be subject solely to the control, supervision and authority of [redacted] or its [redacted]

I. NON-ASSIGNABILITY. Neither party may assign this Agreement or any of its rights or obligations hereunder without the prior written consent of the other party, and any such attempted assignment shall be void, except that ACL may assign this Agreement, or any of its rights or obligations to any of its subsidiaries or affiliates without the consent of [redacted] Furthermore, no work to be performed by [redacted] shall be subcontracted to or performed on behalf of [redacted] by any third party without the prior written consent of ACL.

J. GOVERNING LAW. The Agreement shall be governed by and construed in accordance with the laws of the State of Louisiana, without regard to its conflicts of law provisions, and Louisiana law will prevail if there is a conflict between the state law where the Subcontractor is based and Louisiana law.

K. WAIVER. A failure of either party to exercise any right provided for herein, shall not be deemed to be a waiver of any right hereunder.

L. COMPLETE AGREEMENT AND MODIFICATIONS. This Agreement, including all exhibits, schedules or addenda, sets forth the entire understanding of the parties as to the subject matter and may not be modified, amended or waived except in a writing executed by both parties.

M. SEVERABILITY. In the event any one or more of the provisions of this Agreement is invalid or otherwise unenforceable, the enforceability of remaining provisions shall be unimpaired.

N. NON SOLICITATION. During the term of this Agreement and for one year period after the expiration of this Agreement, [redacted] shall not, on its behalf or on behalf of any other person, firm or corporation, recruit, solicit or induce, or attempt to recruit, solicit or induce, any employee of ACL or its affiliates to terminate their employment with ACL, or to become employed by any person, firm or corporation engaged in competition with ACL or its affiliates.

O. NOTICES. Any and all notices, requests, consents, demands or other communications required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been duly given (1) when delivered, if sent by United States registered or certified mail (return receipt requested), (2) when delivered, if delivered personally or by commercial courier, or (3) on the second following business day, if sent by United States Postal Service express mail or commercial overnight courier with applicable postage or delivery charges prepaid.

P. EXCLUDED PARTIES. Pursuant to section 1128A of the Social Security Act 42 CFR 1001.1901,and section 2455 of the Federal Acquisition Streamlining Act of 1994 and the Federal Acquisition Regulations (including but not limited to 48 CFR 9.405), ACL may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs or who has been debarred or suspended from participation in federal procurement or non-procurement activities. [redacted] represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under this Agreement, directors or officers, or any person with an ownership interest in [redacted] of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other federal health care

program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons").

In order to ensure that no payments from AmeriHealth Caritas are made to Sanctioned Persons, [redacted] shall screen all employees and contractors who will furnish goods or services under the Agreement to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, the [redacted] shall search the following websites upon initial employment or engagement of or contracting with a contractor or employee and shall also perform such searches on all directors and officers of [redacted], and on a monthly basis thereafter for employees, contractors, directors and officers:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  http://exclusions.oig.hhs.gov/search.aspx

- System for Award Management
  http://www.sam.gov

- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

Upon request of ACL, [redacted] will be required to furnish a written certification to ACL that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

[redacted] shall immediately notify ACL upon knowledge by [redacted] that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that [redacted] cannot provide reasonably satisfactory assurance to ACL that a Sanctioned Person will not receive payment from ACL under this Agreement, ACL may immediately terminate this Agreement. ACL reserves the right to recover all amounts paid by ACL for items or services furnished by a Sanctioned Person. Further, and without limiting [redacted] indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACL as a result of [redacted] having a relationship with a Sanctioned Person, [redacted] shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACL, ACL shall have the right

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

AMERIHEALTH CARITAS LOUISIANA, INC.	[redacted]
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Address: _____	Address: _____

EXHIBIT A

[redacted]

INTRODUCTION

[redacted]

PROJECT SCOPE

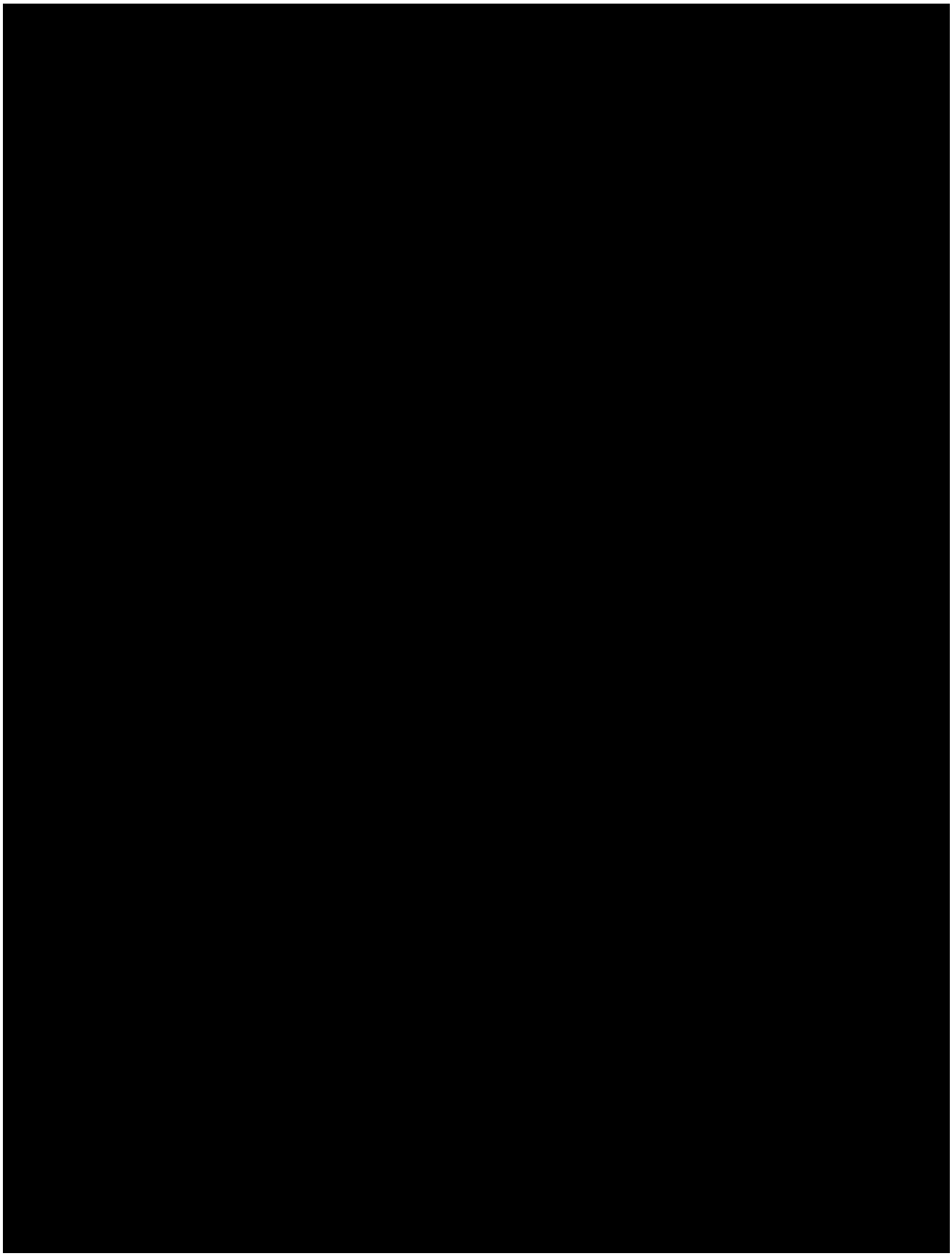
[redacted]

Fee Service Pricing:

Service Pricing	
Service	**Price of Service**
[redacted]	[redacted]
Service Pricing	

[redacted]

Provision of [redacted]		
[redacted]	[redacted]	[redacted]



[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

EXHIBIT B

Louisiana Managed Care Organization
Required Subcontractor Provisions

INTRODUCTION

On February 25, 2019, the State of Louisiana ("State") Department of Health ("LDH") issued Request for Proposals #3000011953 (the "RFP") for the procurement of Managed Care Organizations (MCOs) to solicit proposals from qualified managed care organizations (MCOs) to provide high quality healthcare services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program known as Healthy Louisiana. AmeriHealth Caritas Louisiana, Inc. ("ACL") intends to submit a proposal in response to the RFP (the "ACL Response"), with the goal of being a successful proposer to which LDH will award a contract to ACL to serve as a MCO (the "State Contract"). [Subcontractor] is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's enrollees, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this Attachment, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). Subcontractor shall adhere to all requirements set forth for Subcontractors in the contract between LDH and ACL and the MCO Manual. ACL shall furnish these documents to Subcontractor upon request. No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Attachment. If any requirement in the Agreement, including this Attachment, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence.** Except as otherwise set forth in this Attachment, in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

   a) the body of the Agreement with exhibits and attachments;

   b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

   c) the RFP and any addenda and appendices;

   d) the MCO Systems Companion Guide;

   e) the MCO Quality Companion Guide; and

   f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, rules, regulations, guidelines and policies, including without limitation, any regulations or rules that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies as they exist at the time of the Agreement, or as subsequently amended, that are or may be applicable to the Agreement, whether or not specifically mentioned in this Attachment and that such laws, rules, regulations, guidelines and policies are herein incorporated into this Agreement by reference and that any revisions thereto are automatically incorporated into this Agreement as they become effective. Any provision of the

Agreement that is in conflict with federal statutes, regulations or CMS policy guidance or rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies is deemed to be amended to conform to the provisions of those laws, regulations and policies. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.), the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro- Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and its implementing regulations at 45 CFR Part 80, in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (P.L 106-113);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as set forth in 45 CFR Part 182, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities;

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL 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 recipient (45 C.F.R. Part 3);

n) The Equal Opportunity Act of 1972:

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975;

t) The Americans with Disabilities Act of 1990;

u) Executive Order Number JBE 2018-15, **r**elating to the Prohibition of Discriminatory Boycotts of Israel in State Procurement; and

v) 42 C.F.R. §438.100(a)(2), which requires Subcontractor to comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights; and

w) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan; and

x). Section 1557 of the Patient Protection and Affordable Care Act (ACA); and

y) Notwithstanding moral and religious objections in the Services section of the RFP, Subcontractor agrees not to discriminate in its employment practices, and will render services under the RFP without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Subcontractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Agreement.

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services including, but not limited to, the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract. The QAPI and UM requirements are included as part of the subcontract between ACL and the Subcontractor.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Reserved.

g) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

h) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the RFP.

i) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to enrollees through the last day that the Agreement is in effect.

j) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL enrollees pursuant to the Agreement including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract. ACL enrollees and their representatives shall be given access to and can request copies of the enrollee's medical records, to the extent and in the manner provided by LRS 40:1165.1, La. R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) as amended and subject to reasonable charges.

k) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse ("FWA") Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 C.F.R. Part 438, Subparts A and H; La. R.S. 46:437.1 through 437.14; 42 C.F.R. Part 455, Subpart A; LAC 50:I, Subpart 5; and 42 U.S.C. §1320a-7, §1320c-5, and §1396a(a)(68). Without limiting the foregoing:

a) Subcontractor shall report all known or suspected FWA to ACL in accordance with 42 CFR §438.608(a) and the State Contract and ACL requirements.

b) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by

ACL's enrollees, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

c) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA.

d) Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the Centers for Medicare and Medicaid Services ("CMS"), U.S. Department of Health and Human Services ("HHS"), the Office of Inspector General ("OIG"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide to CMS, HHS, OIG, the State Auditor's Office, the Office of the Attorney General, GAO, Comptroller General, LDH and/or their designees upon request with timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period set forth in Section 23 of this Attachment, but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

e) Subcontractor and Subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, Subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding, to obtain the requested information, records or data. MFCU shall be allowed access to the Contractor's place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hours admission shall be allowed. The MCO contractor, Subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of noncompliance with an information, records or data request.

f) Subcontractor shall permit the State, CMS the HHS Inspector General, the

Comptroller General, or their designees to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed.

i. Subcontractor shall make available for purposes of an audit, evaluation or inspection under Section 5(f), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees.

ii. The right to audit under Section 5(f) will remain ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

iii. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees at any time.

g) Reserved.

h) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

j) In accordance with 42 C FR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or an individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.. Subcontractor is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8). Subcontractor shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Subcontractor shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 C.F.R. §455.436 To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)

http://exclusions.oig.hhs.gov/search.aspx

- System for Award Management
  http://www.sam.gov

- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

k) The Subcontractor shall conduct a screen, monthly as described in Section 5 (j) of this Attachment, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

l) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

m) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR § 455.104 and 42 CFR §438.610) on ownership disclosure reporting and in accordance with RFP Section 2.9.6. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 C FR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

n) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA).

o) The Subcontractor shall have surveillance and utilization control programs and procedures pursuant to 42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

p) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

q) Subcontractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly including coordinating with law enforcement agencies, with notice to ACL, if issues are suspected to be criminal in nature , to reduce the potential for reoccurrence, and conduct ongoing compliance with the requirements under this Agreement.

r) Subcontractor shall provide annual training to all employees, and shall train new hires within thirty (30) days of the date of employment, related to the following:

- Subcontractor's Code of Conduct;
- Privacy and Security – HIPAA;
- FWA identification and reporting procedures;
- Federal False Claims Act and employee whistleblower protections; and
- Procedures for timely consistent exchange of information; and collaboration with ACL and LDH; and
- Provisions that comply with 42 CFR §438. 608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

s) Subcontractor shall suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. ACL is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

6. Employment of Personnel.

a) Non-Discrimination. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) Restriction on Certain Individuals. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement

activity or from participating in –non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR § 1001.1901(b) and 42 CFR§ 1003.102(a)(2)}.

Additionally, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 USC §1320a-7) or Section 1156 (42 USC §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. This includes providers undergoing any of the following identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health services license;

ii. Exclusion from the Medicaid program;

iii. Exclusion form the Medicare program;

iv. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review ("SURS") Rule (LAC 50:1.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:1.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. Cooperation, Care Coordination and Continuity of Care.

a) Care Coordination. Subcontractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to ACL's Medicaid enrollees.

b) Continuity of Care. To the extent applicable to the services provided under the Agreement, Subcontractor shall develop and maintain a process of Continuity of Care

by which ACL's Medicaid enrollees and network and/or non-network provider interactions are effective to ensure that each enrollee has an ongoing source of preventative and primary care appropriate to their needs.

c) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid enrollees in accordance with professional standards. Such other service providers may include: [redacted] Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

d) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this Attachment, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this Attachment and under the Agreement.

8. Provider Selection Requirements. To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR§438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and re-credentialing policies including, but not limited to: LDH, Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for specialized behavioral health providers.

c) Subcontractors that specialize in behavioral health are required to be accredited by rule, regulation, waiver or State Plan Amendment ("SPA") prior to contracting with ACL or prior to receiving Medicaid reimbursement, and shall comply with: all requirements of ACL,; CMS approved waivers; and/or the SPAs.

d) Subcontractors that specialize in behavioral health shall provide ACL with proof of accreditation from one of the following LDH approved national accrediting body:

- Council on Accreditation;
- Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- The Joint Commission ("TJC").

e) Subcontractor shall have a re-credentialing policy which includes, but is not limited

to, notifying ACL when Subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

f) Subcontractor shall notify ACL, regarding itself or any of its providers or subcontractors, and shall furnish documentation from the accreditation body within twenty-four (24) hours of the following: loss of accreditation, license or certification; suspension; or any action that could result in the loss of accreditation.

g) If Subcontractor or any provider of Subcontractor performs laboratory services under the Agreement, the Subcontractor or provider of Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

h) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

i) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this Attachment, as may be modified by LDH from time to time.

j) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 2.20 of the State Contract.

k) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the RFP).

l) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

m) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the enrollee needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

n) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract that may materially impact Subcontractor's provider network

and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans**. Subcontractor's Physician Incentive Plans ("PIP") shall be incompliance with 42 CFR § 438.3(i).

a) Subcontractor shall disclose to ACL annually any PIP or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

b) Subcontractor shall provide written notification to ACL within thirty (30) days upon implementation of any new PIP or when an existing PIP is modified. The written notification must: (i) list the participating providers; and (ii) certify that the terms and conditions of the PIP are compliant with all applicable federal regulations.

c) Subcontractor shall furnish, upon request of ACL, additional information including, but not limited to, a copy of the PIP.

10. **Provider Preventable Conditions.** Subcontractor shall report to ACL, within seventy-two (72) hours, any provider preventable conditions ("PPCs") associated with claims for payment or enrollee treatment for which payment would otherwise be made. PPCs include: (i) Healthcare Acquired Conditions; and (ii) Other Provider Preventable Conditions, as defined by Section 2.11.10 of the State Contract..

11. **National Provider Identifier (NPI).** The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

12. **ACL Enrollee Hold Harmless.** Subcontractor shall accept the final payment made by ACL as payment-in-full for covered services provided under the Agreement. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from, or have recourse against LDH, ACL enrollees or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the enrollee), for health care services which are rendered to such enrollees by Subcontractor and its contractors, and which are covered services under the Louisiana Medicaid program. ACL enrollees shall not be held liable for payment for covered services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if the

Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that LDH or ACL enrollees shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 12 shall be construed to be for the benefit of ACL's enrollees. This Section 12 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's enrollees, or persons acting on their behalf.

13. **Enrollee Access.** Subcontractor and any providers providing services under the Agreement shall not restrict enrollee access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

14. **Enrollee Rights**. Subcontractor shall assist enrollees in understanding their rights to file grievances and appeals in accordance with ACL's Provider Manual.

    a) To the extent applicable, Subcontractor shall have a grievance system in place to address ACL enrollee grievances including, but not limited to the following:

        i. the referral of the enrollee to a designee of the Subcontractor authorized to review and respond to grievances and appeals that require corrective action; and

        ii. the provision of information explaining Enrollee Rights to file grievances, appeals and request a State Fair Hearing, in accordance with 42 CFR Part 438, Subpart F, both orally and in writing in a language that the Enrollee understands.

15. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL enrollee.

16. **ACL Enrollee Copayments**. Subcontractor shall not impose copayments for the following: (i) Family planning services and supplies; (ii) Emergency services; and (iii) Services provided to:

- Individuals younger than 21 years old;
- Pregnant women;
- Individuals who are impatient in long-term care facilities or other institutions;
- Native Americans; and
- Alaskan Eskimos.

To the extent that emergency services, as defined by the RFP, are provided by Subcontractor or any providers of Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

17. **ACL Enrollee Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's enrollees. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

18. **Marketing and Enrollee Education.** All Marketing (as such term is defined in the RFP) and enrollee education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the LDH requirements as set forth in

the RFP, including but not limited to the following:

a) All Marketing and enrollee education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and enrollee education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or enrollee education materials, or participate in any marketing and enrollee education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or enrollee education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 2.14.2 of the State Contract; but (ii) Subcontractor's Marketing and enrollee education activities may include those activities enumerated in Section 2.14.3 of the State Contract.

19. Misuse of Symbols, Emblems or Names in Reference to Medicaid. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

20. Confidentiality of Information.

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to enrollees or potential enrollees, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the enrollee/potential enrollee, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees/potential enrollees shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the

Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

21. **Safeguarding Information.** Subcontractor shall establish written safeguards, according to applicable state and federal laws and regulations and as described in the State Contract, which restrict the use and disclosure of information concerning enrollees or potential enrollees, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S.46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the enrollees or potential enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

22. **LDH Use of Data.** Notwithstanding any provision in this Attachment or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

23. **Record Retention.**

a) Financial Records. Subcontractor shall retain all financial records, supporting documents, statistical records, and all other records for a period of at least ten (10) years from date of submission of the final expenditure report under the Agreement, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.. The only exceptions are the following:

i. [redacted]

ii. Records for real property and equipment acquired with federal funds shall be retained for ten (10) years after final disposition;

iii. When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the recipient; and

iv. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 C.F.R. §75.361(f).

Under no circumstances shall Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

b) Medical Records. All documentation and/or records maintained by Subcontractors, and its network providers related to covered services, charges, operations and agreements under this Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall the Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

24. **Independent Audits**. Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

25. **Information System Availability.** Subcontractor shall allow LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office or upon request of CMS, direct access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of the request. The data shall include the following or any additional data requested by LDH:

- Prior authorizations;
- Claims processing;
- Provider portal;
- Third-party Liability;

- FWA;
- Pharmacy benefits manager point of sale;
- Pharmacy benefits manager prior authorization; and
- Provider contracting and credentialing.

26. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

27. **Release of Records.** Subcontractor shall release medical records of enrollees upon request by enrollees or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

28. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit executed copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. Ten (10) calendar days' written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in Subcontractor's policy. In addition, Subcontractor is required to notify ACL of policy cancellations or reductions in limits. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. The insurance companies issuing the policies shall have no recourse against LDH for payment of premiums or for assessments under any form of the policies. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

a) Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of One Million Dollars ($1,000,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL, LDH any subcontractor during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement.

Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of Two Million Dollars ($2,000,000) and a minimum general aggregate of Four Million Dollars ($4,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance which covers the professional acts or omissions of Subcontractor in the amount of at least Three Million Dollars ($3,000,000) per occurrence.

d) Automobile Liability. Automobile Liability Insurance shall have a minimum combined single limit per accident of $1,000,000. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

e) Cyber Liability Cyber liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of $3,000,000. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this Contract and shall have an expiration date no earlier than thirty (30) calendar days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium.

f) The policies are to contain, or be endorsed to contain, the following provisions:

1. Commercial General Liability, Automobile Liability, and Cyber Liability Coverages
LDH, its officers, agents, employees and volunteers shall be named as an additional insured as regards negligence by Subcontractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, are to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to LDH. Subcontractor's insurance shall be primary with respect to LDH, its officers, agents, employees and volunteers for any and all losses that occur under the Contract. Any insurance or self-insurance maintained by LDH shall be in excess and non-contributory of the Contractor's insurance.

2. Workers Compensation and Employers Liability Coverage
To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against LDH, its officers, agents, employees and volunteers for losses arising from work performed by the Subcontractor for LDH.

29. Hold Harmless. Subcontractor shall indemnify, defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) Any claims for damages or losses arising from services rendered by Subcontractor or any of its contractors, persons, or firms performing or supplying services, materials, or supplies to ACL in connection with the performance of this Agreement;

b) Any claims for damages or losses arising from sanctions on ACL network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the Fraud, Waste, and Abuse Prevention Section of the State Contract.

c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Subcontractor in the performance of this Agreement;

d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor, it's agents, officers, employees, or subcontractors by Subcontractor's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes;

e) Any claims for damages or losses arising from failure by Subcontractor, it's agents, officers, employees or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;

f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the Subcontractor by ACL;

g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against ACL or LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of the Subcontractor, its agents, officers, employees, or subcontractors.

i) If the Subcontractor performs services, or uses services, in violation of Section 38, the Subcontractor shall be in material breach of this Agreement and shall be liable to LDH and ACL for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Subcontractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

30. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL or reductions in payment to ACL, which ACL may in turn impose upon

Subcontractor to the extent arising from Subcontractor's acts or omissions, which shall include, but may not be limited to Subcontractor's failure or refusal to respond to ACL's request for information and, as applicable, to provide medical records and/or credentialing information. Subcontractor's failure to comply with the provisions of the Agreement may also result in the termination of the State Contract in whole or in part, which shall result in termination of the Agreement. At ACL's discretion or a directive by LDH, ACL shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall comply with any relevant corrective action plan imposed upon or developed by ACL and/or required by LDH in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

31. **Loss of Federal Financial Participation ("FFP").** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

32. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential or actual conflict(s). Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement and during the term of the Agreement.

33. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

34. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

35. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

36. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

37. **Termination for Threat to Health of ACL Enrollees.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of ACL's enrollees.

38. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

39. **Independent Contractor/Subcontractors.** It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

    Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

40. **Licensing Requirements.** Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

41. **Entire Contract; Amendments.** Subcontractor shall comply with, and agrees to be bound by, all provisions of theAgreement and shall act in good faith in the performance of the provisions of the Agreement.

    The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing.

    Except as provided in Section 3, any amendments, alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

42. **Restrictions on Contracting.** Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services contracted under the Agreement.

43. **Antitrust.** Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program.. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

44. **Termination of LDH Contract**. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make available to ACL and/or LDH or their respective designated representatives, in a usable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

45. **Law.** This Attachment shall be governed by the laws of the State of Louisiana, without regard to its conflict of law provision, and Louisiana law will prevail if there is a conflict between the state law where the Subcontractor is based and Louisiana law.

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-3

PerformRx℠ LLC

Appendix F Material Subcontractor Response Template

This page is intentionally left blank.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
AmeriHealth Caritas Louisiana
Material subcontractor name:
PerformRx LLC (PerformRx℠)
Description of the Proposer's role and material subcontractor's role:
AmeriHealth Caritas Louisiana will be responsible for the sourcing, vetting, selection, and oversight of PerformRx℠, reporting on performance, providing ongoing support, and ensuring that they comply with the terms set out in the subcontractor agreement. Their daily activities will be conducted under the purview of our Pharmacy Director. PerformRx℠ will provide comprehensive pharmacy benefit management (PBM), including development of detailed pharmacy benefit parameters; development of prior-authorization review protocols; establishment and maintenance of an appropriate UM program; formulary management; contracting management; development and maintenance of an adequate and accessible pharmacy network (recruitment, credentialing, contracting, directory, compliance monitoring, etc.); eligibility verification; call center services; provision of fraud and abuse prevention and detection services; processing and reconciliation of pharmacy claims; production and issuance of claims payments and remittance advice; transmission of encounter data; and production of standardized reports.
Explanation of why the Proposer plans to subcontract this service and/or function:
AmeriHealth Caritas Louisiana has determined that subcontracting PBM services is the most efficient, cost-effective way to provide these Medicaid covered services to our enrollees, while complying with service requirements/standards as set out by the Louisiana Department of Health.
A description of the material subcontractor's organizational experience:
Created as an operating division of AmeriHealth Caritas in 1999 to furnish PBM services to their Pennsylvania Medicaid managed care affiliate health plan, PerformRx℠ has grown to provide PBM to all Medicaid managed care health plans within AmeriHealth Caritas when pharmacy is not managed by the state/region, to Medicare Advantage D-SNP health plans and integrated dual eligible Medicare-Medicaid health plans, and to other non-affiliated government sponsored and commercial health plans across the country. They have supported AmeriHealth Caritas Louisiana since pharmacy services were integrated into the risk bearing model in 2012. PerformRx℠ was one of the first PBMs to achieve URAC accreditation for PBM and has maintained this designation since 2007. In 2012, they became one of a few PBMs in the country with URAC accreditation for their Drug Therapy Management program. PerformRx℠ received its NCQA UM accreditation in December 2017.
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
Although an affiliate of AmeriHealth Caritas, PerformRx℠ still has to demonstrate fitness to fulfill their role as a material subcontractor and is subject to evaluations for state and federal exclusions, review of ownership disclosures, review of trainings and policies, accreditation standards, and completion of all necessary documentation. PerformRX℠ is monitored by our local Vendor Management team, in collaboration with the Delegation Oversight department. They are responsible for onboarding, auditing and monitoring, guided and supported by an enterprise delegation oversight policy maintained by the Corporate Quality department. Dedicated staff monitor subcontractor performance against documented performance standards monthly. At a minimum, we require performance consistent with the requirements of the Medicaid contract and any applicable accreditation standards. Annually, PerformRx℠ is audited to ensure that their credentialing, UM, and other business processes and procedures continue to meet our requirements. The results of these audits are compiled and submitted to the appropriate Quality committees, along with any recommendations. In order to ensure an appropriate return-on-investment (ROI), our Medical Economics department works with Pharmacy, UM, and other relevant teams to assess patient outcomes and program ROI analyses, provider/plan goal alignment and pay-for performance initiatives, and pharmacy analytics. Further, we constantly monitor for any reported or identified instances of fraud, waste and abuse, and third-party liability (TPL) to ensure that claims and payments are accurate, timely, and appropriate.

Instructions: The MCO should attach the executed contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Subcontract Provisions, Introductory Paragraph, pg. 1
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Contract
3	Specify the effective dates of the subcontract agreement.	Contract
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Subcontract Provisions, Par. 41, pg. 19
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Subcontract Provisions, Par. 41, pg. 19
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Subcontract Provisions, Par. 41, pg. 19
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Subcontract Provisions, Par. 44, pg. 20
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Subcontract Provisions, Par. 39, pgs. 19
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Subcontract Provisions, Introductory Paragraph, Pg. 1

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Subcontract Provisions, Introductory Paragraph, Pg. 1
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Subcontract Provisions, Par. 4(i), pg. 4
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Subcontract Provisions, Par. 40, pg. 19
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Contract
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Subcontract Provisions, Par 16, pg. 12
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Subcontract Provisions, Par. 8(g), pg. 10
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Subcontract Provisions, Par. 4(j), pg. 4
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Subcontract Provisions, Par. 23, pgs. 14-15

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Subcontract Provisions, Par. 5(d), pgs. 4-5
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 2.9.6. The completed disclosure of ownership should be attached for executed contracts.	Subcontractor Provisions, Par. 5(m), pg. 7
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Subcontract Provisions, Par. 4(c), pg. 3
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Subcontract Provisions, Par. 4(e), pg. 4
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Subcontract Provisions , Par. 30(b), pg. 18
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Subcontract Provisions, Par. 30, pg. 18

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Subcontract Provisions, Par. 4(b), pg. 3
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Subcontract Provisions, Par. 21, pg. 14
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Subcontract Provisions, Par. 4(g), pg. 4
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 4
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 4
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Subcontract Provisions, Par. 4(k), pg. 4
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Subcontract Provisions, Par. 12, pgs. 11-12
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Subcontract Provisions, Par. 29, pgs. 17-18

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Subcontract Provisions, Par. 28, pgs. 15-17
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Subcontract Provisions, Par. 3, pg. 1 and Par. 45, pg. 20
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Subcontract Provisions, Par. 3, pg. 1
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Subcontract Provisions, Par. 15, pg. 12
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Subcontract Provisions, Par. 32, pg. 18
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Subcontract Provisions, Par. 4(d), pg. 3
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Subcontract Provisions, Par. 26, pg. 15
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Subcontract Provisions, Par. 3(c), pg. 2
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Subcontract Provisions, Par. 42, pg. 19

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Subcontract Provisions, Par. 4(a), pg. 3
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Subcontract Provisions, Par. 38, pg. 19
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Subcontract Provisions, Par. 43, pg. 20

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Subcontract Provisions, Par. 5(e), pg. 5

Attachment 2.10.2.3-3 PerformRx℠ LLC

(Signed Final Agreement and

Amendments)

This page is intentionally left blank.

PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

THIS PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT (the "Agreement"), dated as of October 22, 2012, is between PerformRx, LLC, a Pennsylvania limited liability company (hereinafter referred to as "PerformRx"), and AmeriHealth Mercy of Louisiana, Inc. (hereinafter referred to as the "Plan"). PerformRx and Plan are collectively referred to herein as the "Parties."

WHEREAS, PerformRx provides or arranges for the provision of comprehensive pharmacy benefit management services ("Pharmacy Services") for and on behalf of health benefit plans, including but not limited to managed care plans and Medicare Part D Plan Sponsors; and

WHEREAS, pursuant to a contract between the Louisiana Department of Health and Hospitals ("DHH") and the Plan (the "State Contract"), Plan operates a health benefit plan known as LaCare, and desires to engage PerformRx to provide certain Pharmacy Services for such health benefit plan; and

WHEREAS, PerformRx desires to provide such Pharmacy Services for Plan.

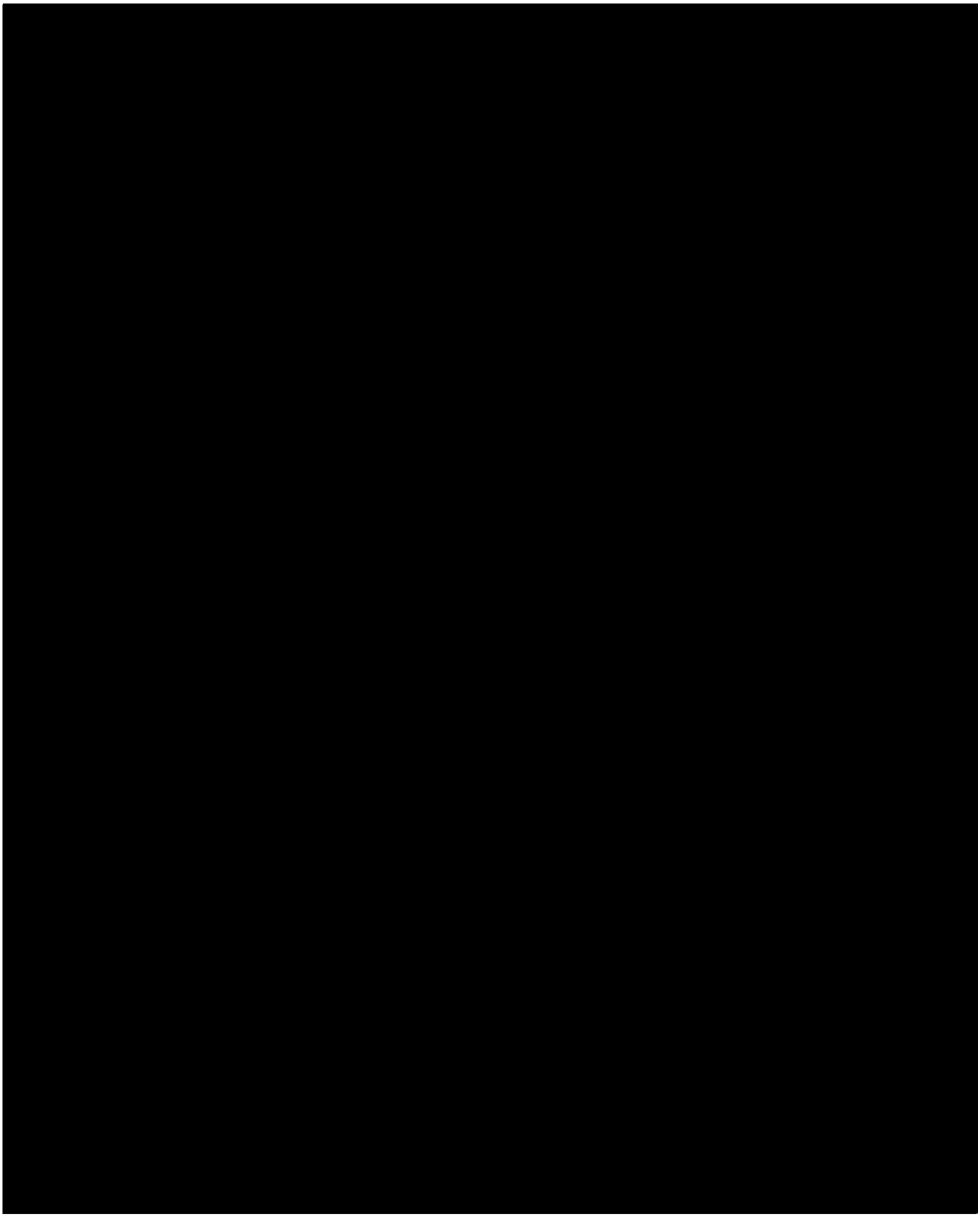
NOW, THEREFORE, in consideration of the foregoing, and of the mutual promises and agreements contained in this Agreement, and intending to be legally bound hereby, PerformRx and Plan agree as follows:

1. DEFINITIONS. Capitalized terms used in this Agreement, if not defined in context, shall have the meanings ascribed to them in **Exhibit A**, unless used and defined in another exhibit or addendum.

2. TERM. Subject to **Section 13**, this Agreement shall remain in full force and effect for a period of three (3) years commencing on the Effective Date. Thereafter, this Agreement shall be renewed for successive one-year periods unless either party provides written notice to the other of its intent not to renew at least ninety (90) days prior to the end of the then-current term.

3. EXCLUSIVITY. During the term of this Agreement (including all renewals), Plan shall exclusively utilize PerformRx for the Pharmacy Services that the Parties have agreed PerformRx is to provide hereunder. However, PerformRx shall not be limited in its ability to provide services similar to the Pharmacy Services to other customers. Notwithstanding the foregoing, Plan shall not be limited in its ability to contract with a successor PBM in the event of the termination of this Agreement for any reason, including but not limited to a termination resulting from the material default of PerformRx in the performance of its obligations under this Agreement. Plan's ability to contract with successor PBM begins during the pendency of such termination of this Agreement.

4. PERFORMRX'S SPECIFIC PERFORMANCE OBLIGATIONS. PerformRx shall provide to the Plan the services set forth in this **Section 4**, from the Effective Date and for the remainder of the initial and any renewal terms of this Agreement. PerformRx may subcontract



[redacted]

6. PA/Administrative Overrides. PerformRx will not charge Plan for any PA or administrative override placed at Plan offices by any of Plan's staff.

7. PerformRx will furnish standard prior authorization performance reports in accordance with Louisiana Department of Health and Hospitals ("DHH") requirements and as otherwise mutually agreed with Plan.

8. A Member, or a provider on the Member's behalf, may appeal PA denials in accordance with Plan's grievances and appeals policies. Plan shall conduct such appeals, and PerformRx will provide Plan with relevant information and otherwise provide reasonable assistance to Plan, at Plan's request, in support of such appeals.

B. Drug Utilization Review. PerformRx shall establish and maintain a utilization management program that promotes appropriate utilization of Covered Drugs, and that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act.. PerformRx shall routinely review and update its utilization management protocols. PerformRx will provide Plan with its existing quality-focused clinical protocols for review, modification and approval (including approval by DHH) before such protocols are implemented on behalf of Plan. PerformRx will analyze Plan's claims data and deliver an analysis to Plan on a quarterly basis that identifies potentially inappropriate prescription or utilization patterns.

1. Establishment of Drug Utilization Review ("DUR") Program. PerformRx will establish and maintain a DUR Program that includes mental health/substance abuse drugs, and that complies with guidelines and applicable laws and regulations governing Plan, including standards, policies, procedures and processes for prospective, concurrent and retrospective DUR. Without limiting the foregoing, prospective and retrospective DUR standards shall be consistent with the standards established by the fee-for-service Louisiana Medicaid program. A designated PerformRx clinical pharmacist will be responsible for daily oversight of the DUR program. At a minimum, PerformRx shall provide on-line, concurrent DUR messaging to Pharmacies and will take appropriate action based on Plan's benefit parameters and specifications.

2. Concurrent DUR System. PerformRx will use the claims processing system to evaluate each incoming drug claim with respect to the Member's drug history. The system alerts pharmacists to potential drug therapy problems through an online, NCPDP standard concurrent DUR message system transmitted in conjunction with adjudication of the claim. Concurrent DUR shall include, but is not limited to, the following standard edits as defined by First Data Bank parameters: (a) duplicate therapy; (b) early refills and frequency limitations; (c) duplicate drug; (d) potential drug interaction(s); (e) Formulary selection; and (f) minimum/maximum dose range. PerformRx's Concurrent DUR system will provide Plan with the ability to minimize the number of potentially dangerous conditions that result from improper drug utilization by Members by:

(a) Reviewing prescription drug claims for therapeutic appropriateness before drug dispensed;

(b) Applying criteria that may include the Members' medical history and available clinical information; and

(c) Focusing on Members with conditions that place them at the highest level of risk for potentially harmful outcomes.

3. Point-of-Sale Claims Processing System. When appropriate, the pharmacist receives advice through system messages and is directed to take additional steps to evaluate the order (e.g., call the prescribing physician). All therapeutic criteria will be rated using the following severity indicators:

(a) Will cause serious harm to relatively few people (high risk and low incidence);

(b) Will cause relatively minor harm to a large number of people (low risk and high incidence); and

(c) Will significantly increase the cost of healthcare by increasing hospitalizations or other treatment modalities.

PerformRx will provide electronic adjudication of secondary claims when Plan is a secondary payer at the Pharmacy point-of-service level.

4. Prospective DUR. PerformRx will undertake a prospective DUR analysis on a semi-annual basis to identify potentially inappropriate prescribing patterns. Prospective DUR interventions will only be undertaken by PerformRx at Plan's option, and will be priced separately.

5. Retrospective DUR. PerformRx will undertake a retrospective data analysis once a quarter to evaluate the benefits of its DUR programs that are targeted to reduce inappropriate medication usage. To provide a thorough analysis of the effectiveness of the program, PerformRx will evaluate Plan's existing drug usage review programs and make appropriate recommendations to Plan. Retrospective DUR interventions will only be undertaken by PerformRx at Plan's option, and will be priced separately.

6. Medication Therapy Management (MTM) Program. Within the first ninety (90) days following the Effective Date, PerformRx shall implement a medication therapy management (MTM) program for the identification and targeting of Members who would most benefit from the actions to be taken under the MTM program. The MTM program will include coordination among PerformRx, Plan, the Member, the pharmacist and the provider, using various means of communication and education. The MTM program shall include participation from community pharmacists, and both in-person and telephonic member interventions with training clinical pharmacists. Any reimbursement to community

pharmacists for participation in the MTM program will be separate and above dispensing and ingredient cost reimbursement from PerformRx.

C. Formulary Management

1. Establishment. The P&T Committee will be responsible for establishing and updating, by additions or deletions thereto, the Plan Formulary. Plan will make best efforts to align its Formulary with the PerformRx Formulary to ensure that the parties maximize pharmaceutical manufacturer Rebates. Plan will initiate the Formulary alignment process during implementation. PerformRx will be responsible for preparing the approved Formulary to Plan for print and publication by Plan. Plan will publish and make available its Formulary to all Members and Prescribers. The Formulary shall include a description of the process by which a provider may request an override of step-therapy/fail-first requirements. At a minimum, an override shall be granted when the Prescriber provides evidence that the preferred treatment method has been ineffective in the treatment of the Member's medical condition in the past or will cause or will likely cause an adverse reaction or other physical harm to the Member.

2. Revisions. PerformRx shall work with Plan to provide for the quarterly review of and possible revision to the Formulary, so as to address changes made desirable or mandated by any changes in the pharmaceutical industry, new or amended legislation and/or regulations, the experience of Plan and its providers with the Formulary, and new recommendations developed by PerformRx based upon its research and experience. A Member receiving a drug that was on the Formulary but that was subsequently removed or changed must be permitted to continue to receive that prescription drug if determined to be medically necessary, which determination shall be made in consultation with the Prescriber.

3. Communication. PerformRx will provide an electronic copy of the Formulary by drug, strength and dosage form in a format suitable for printing no less than monthly. Plan will be responsible to post the Formulary on its website. PerformRx shall also maintain and provide a functioning real-time "searchable" Formulary for website. A link to this application will be placed on the website by the Plan. Plan will be responsible to print and distribute the Formulary independently, upon request.

4. Continuity of Care (Transition Supply). PerformRx will ensure the provision of a supply of the medicines a Member takes on a regular basis for chronic conditions (maintenance medicines) that are not on the Formulary for at least sixty (60) days after the Effective Date of this Agreement, for Members who are Plan Members as of the Effective Date; and for at least sixty (60) days after the Member's enrollment to Plan, for Members who enroll with the Plan after the Effective Date of this Agreement. If the Member is taking antidepressants or antipsychotics, the Member will be able to continue treatment with such non-Formulary medicines for at least ninety (90) days after the applicable date. PerformRx will allow the Member to continue to receive a non-Formulary prescription drug after the 60- or 90-day time period, if PerformRx, in consultation with the prescriber, determines that it is medically necessary.

5. Outreach. At Plan's request, PerformRx will conduct a one-time outreach to the Prescribers in Plan's participating provider network prior to the Effective Date, in order to help transition Members to the Formulary.

D. Participating Pharmacy/Provider/Member Information Services

1. Pharmacy Call Center. PerformRx shall establish and maintain a Pharmacy Call Center with a dedicated, toll-free 800 telephone number to provide information to, and for communication with, participating Pharmacies and Prescribers from 7:00 a.m. until 7:00 p.m. (Central Time), Monday – Friday; provided, however, that PerformRx shall maintain after-hours coverage of the Pharmacy Call Center to address PA requests.

2. Status Reports. PerformRx will develop and provide monthly status reports of Pharmacy Call Center information to Plan and will also provide aggregate information for quarterly account meetings with Plan. Information in such reports shall at a minimum meet all requirements of DHH.

3. Member Information Services. PerformRx will provide toll-free access by Members to its Pharmacy Member Services Department on a 24/7 basis, in order to address Member questions regarding their prescription drug benefit. The scope of services provided by PerformRx includes the following, but in no event will the scope of services include Member mailings related to the following services:

(a) Co-pay/Deductible Issues. PerformRx Member Service Representatives will provide information regarding the status of medications on the Formulary lists and their co-pay status.

(b) Direct Member Reimbursements. PerformRx Member Service Representatives will provide information about direct member reimbursements and assist Members in filing for reimbursement.

(c) Early Refill. Based upon Plan's directions, PerformRx Member Services will assist Members in obtaining early refills in instances regarding, vacation supply, lost/stolen supply, leave of absence supply, national disaster supply, delayed mail-order supply and spilled medication supply.

(d) Eligibility. The PerformRx Member Service Representative will assist Members to contact the Plan regarding eligibility questions. Plan acknowledges that PerformRx has no responsibility for maintaining or updating Member eligibility, or for making eligibility determinations, and that therefore PerformRx may need to direct the caller to the Plan's Member Service department, depending on the nature of the eligibility issue.

(e) Formulary Information. PerformRx Member Service Representatives will assist members with Formulary questions.

(f) Prior Authorization Status. PerformRx Member Service Representatives will assist members regarding the status of a submitted prior authorization.

4. Member Identification Card. Plan is responsible for production and supply of Member identification cards. Unless otherwise permitted by DHH, the Plan membership card may not display the name or logo of PerformRx.

E. Account Management. PerformRx shall provide a designated team of associates to proactively administer services to Plan. The PerformRx team will work closely with Plan to implement clinical programs, Plan design, and other Pharmacy initiatives that support specific business goals identified by Plan. A PerformRx Account Manager will serve as Plan's primary contact. The Account Manager will be responsible for: (1) coordinating the activities of the Account Management team assigned to Plan; (2) providing quarterly on-site briefings to Plan to review Plan's performance and discuss strategic initiatives; and (3) maintenance of pharmaceutical information, Formulary management support and PA protocol development assistance, P&T Committee participation and meeting attendance, development of abbreviated drug monographs, Plan performance monitoring, and consulting with Plan staff.

Throughout the term of this Agreement, Plan shall provide PerformRx all information concerning its Plan Design and Beneficiary eligibility information needed by PerformRx to perform the Services described herein. This information must be complete and accurate, provided timely, and in a format and manner mutually agreed to by the parties. Member enrollment and eligibility information is collectively referred to as "Eligibility Information." PerformRx, its subcontractors and the Participating Pharmacies are entitled to rely on the accuracy and completeness of the Eligibility Information and updates thereto. Eligibility Information that is provided by Plan to PerformRx's claims processor, whether directly or indirectly, shall be the basis for determining the amount of fees payable to PerformRx under this Agreement, when such fees or portion(s) thereof are derived from Member counts, such as when fees are based on the number of members per month

F. Analysis and Reporting

1. Standard Reporting. Perform Rx will provide Plan with standard financial and management reports on utilization for the relevant time period, on a monthly, quarterly and annual basis, including the standard reports specified in **Exhibit E**. Upon request from Plan, PerformRx will provide such additional ad hoc reports as may be requested by Plan. Plan shall request such additional reports through the PerformRx Account Management Team described above in **Section 4.E**. PerformRx will invoice Plan for the programming and other charges associated with any such additional reports. Monthly reports will be provided by the twentieth (20^{th}) business day following the end of the month to which they apply; quarterly reports will be provided by the forty-fifth (45^{th}) business day following the end of the quarter to which they apply; and annual reports will be provided by the seventy-fifth (75^{th}) business day following the end of the year to which they apply. PerformRx shall also provide Plan with additional information necessary for Plan to perform State obligations, if any (including but not limited to compliance with all submitting all reports

and clinical information required by Plan for reporting purposes such as HEDIS, AHRQ and EPSDT; timely payment requirements; and quality assessment requirements) on a mutually agreed frequency.

2. Encounter Data. PerformRx shall provide Encounter Data relevant to the Pharmacy Services provided under this Agreement to Plan via electronic media within 20 business days after the close of Plan's encounter cycle, in a format that meets Plan's needs and complies with State regulatory requirements. Additional files will be billed separately. Original Encounter Data submitted with errors or data omission shall be corrected and re-submitted within fifteen (15) business days of the date the error file is made available to PerformRx.

3. Online Data Reporting/Editing. PerformRx shall make online computer software available to Plan, pursuant to which Plan shall have access to claims detail and eligibility information relating to its Members and the services provided to Members under this Agreement. Plan will have the capability of adding, updating and terminating Members and groups in the IPNS database via online connection. PerformRx shall provide computer training to Plan as reasonably requested by Plan. Fees for online reporting are outlined in **Exhibit B**.

G. Rebate Contracting and Management

1. Rebate Contracting. PerformRx shall directly contract with pharmaceutical manufacturers on Plan's behalf for rebates of a portion of the average wholesale price ("AWP"), wholesale acquisition cost ("WAC"), or other cost measures (as defined in each manufacturer agreement) of drugs, medical equipment or devices provided under this Agreement. Plan shall exclusively utilize PerformRx for the Rebate contracting services described in this **Section 4.G** and shall direct pharmaceutical manufacturers to PerformRx for contracting discussions.

2. Rebate Calculation; Payments to Plan. At the end of each calendar quarter, PerformRx will calculate the amount of Rebate due from each pharmaceutical manufacturer, by application of the contract-specific manufacturer's rebate formula. Rebates are available from a manufacturer for those manufacturer's products that included in Plan's Formulary. Plan shall allow PerformRx access to all supporting data, including a copy of Plan's formulary and any revisions or updates thereto, necessary for PerformRx to make Rebate calculations. Within 30 days after the end of each revenue cycle, PerformRx will invoice each pharmaceutical manufacturer for the amount of Rebate due from such manufacturer. PerformRx shall pay **one hundred percent (100%)** of such rebate payments to Plan (the "Plan Rebate"). PerformRx shall pay the Plan Rebate by separate check within 120 days after the end of the quarter to which each Plan Rebate payment applies.

3. Assumptions and Preconditions to Plan Rebate Payment Obligation. Notwithstanding the foregoing Paragraph (2), PerformRx's agreement to pay over the Plan Rebate to Plan is preconditioned on the following assumptions:

(a) That pharmaceutical manufacturers will continue to make Rebate payments;

(b) That pharmaceutical Rebate payments will continue to be legal and otherwise permissible under Federal and State statutes and regulations, and any other policy, procedure, contract provision of the like governing or controlling their payment;

(c) That the volume of product(s) included in the calculation of Rebate payments remains at least 98% constant;

(d) That the Formulary Management activities described in **Section 4.C** continue; and

(e) That the Member population does not significantly vary over the term of this Agreement so as to materially affect the overall scope of Pharmacy Services provided under this Agreement.

In the event of a material change to or in any of the foregoing conditions, or in any other condition affecting the amount of manufacturer Rebates, the parties shall negotiate, in good faith, an equitable adjustment to the Plan Rebate.

4. Rebate Assessment. PerformRx will assess Plan's current rebate arrangements and will make suggestions based upon (i) volume, (ii) exclusivity, and (iii) market share to optimize Rebate payments. Plan shall make good faith efforts to implement such recommendations.

H. Conversion. PerformRx will make good faith efforts to load Members' historical claim(s) data from DHH. Assuming receipt of valid data and file layout, PerformRx will load claim data history into its claims processing system. This conversion from DHH will enable PerformRx to complete DUR on new and refill claims and allow existing PAs to proceed uninterrupted. PerformRx will work cooperatively with Plan to develop detailed pharmacy benefit parameters. PerformRx will ensure that Plan's developed pharmacy benefit parameters will be implemented for Plan prior to the Effective Date. Plan agrees to undertake good faith efforts to report PerformRx's effort to obtain member claim data from existing PBM within timelines established during implementation.

I. Pharmacy Network Management

1. PerformRx agrees to provide and maintain a Pharmacy network comprised of independent and chain Pharmacies ("Network Pharmacies"). PerformRx will use its best efforts to build a Pharmacy network that complies with the network standards of the Louisiana Department of Health and Hospitals ("DHH"), including the requirement to make good faith efforts to contract with significant traditional providers. Only those pharmacies that have been licensed by and registered with the Louisiana Board of Pharmacy, and that otherwise conform to the Louisiana Board of Pharmacy's recordkeeping rules may be admitted as Network Pharmacies.

2. PerformRx shall maintain written agreements with Network Pharmacies ("Provider Agreements"). PerformRx may not deny a Provider Agreement to any pharmacy participating in the Louisiana Medicaid program. Any pharmacy or pharmacist participating in the Louisiana Medicaid program may participate as a Network Pharmacy, provided they are licensed and in good standing with the Louisiana State Board of Pharmacy and accept the terms and conditions of the Provider Agreement offered to them by PerformRx. Notwithstanding the foregoing, PerformRx may limit the distribution of Specialty Drugs from a network of specialty pharmacies that meet PerformRx's requirements to distribution of specialty drugs and that are willing to accept the terms of PerformRx's participating pharmacy contract.

3. PerformRx collects revenue from the network on generics, and/or brand drugs and/or Dispensing Fees. Such network-based reviews are subject to audit by Plan.

4. All Provider Agreements shall hold Plan harmless from and against any and all disputes between licensed providers and Plan, and any disputes between such licensed providers and PerformRx concerning the adjudication and the amount of the payment of the claims, to the extent that Plan relies on PerformRx's adjudication of such Claims submitted for Covered Drugs provided to Members.

5. PerformRx shall require Network Pharmacies to agree to accept the compensation as provided under the Provider Agreement as payment in full for all services rendered thereunder; and under no circumstances will Network Pharmacies make any charges or claims against any Member directly or indirectly for Covered Drugs. PerformRx shall require Network Pharmacies to agree that in no event, including but not limited to non-payment by Plan or PerformRx, Plan's or PerformRx's insolvency, or breach of this Agreement or the Provider Agreement, shall PerformRx and/or Network Pharmacies bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons acting on their behalf, other than the Plan, for pharmaceutical services provided pursuant to this Agreement.

6. PerformRx agrees, and shall require Network Pharmacies to agree, to cooperate and participate with Plan in its complaint and Appeal process to resolve disputes that may arise between Plan and Network Pharmacies and/or Plan and Members. PerformRx shall comply, and shall require Network Pharmacies to comply, with all final determinations made through said complaint and Appeal processes.

7. With respect to Network Pharmacies, PerformRx shall investigate quality of care complaints relative to Pharmacy benefits management and report quality of care complaints, and the subsequent action taken by PerformRx, to Plan within thirty (30) days of receipts of said complaints. PerformRx shall consider such complaints and their resolution during the contracting/re-contracting process.

8. PerformRx shall abide by, and shall require all Network Pharmacies to abide by, all quality assurance, quality improvement, accreditation, risk management,

utilization review, credentialing, re-credentialing and other administrative policies and procedures established and revised by Plan from time to time, current copies of which will be provided to PerformRx upon request. Plan shall notify PerformRx of any revision to the policies and procedures and they shall become binding upon PerformRx and Network Pharmacies thirty (30) days after notification.

9. PerformRx further agrees, and shall require all Network Pharmacies to agree, that PerformRx and Plan may share information including, but not limited to, quality management, utilization management, and DUR information. However, the Parties expressly understand that said information shall not be shared with anyone other than Plan and PerformRx, unless required by law.

10. PerformRx shall require Network Pharmacies to notify PerformRx within five business days, or such lesser period of time as required by law, of any Member claim alleging malpractice or the occurrence of any incident involving a Member.

11. PerformRx shall at all times comply with, and require its Network Pharmacies to comply with, any applicable rules, regulations, policies, and any quality improvement plans of Plan, as well as applicable Federal and State law, regulations and standards. Without limiting the foregoing, Network Pharmacies shall be required to comply with all policies and procedures as developed by PerformRx and/or the Plan, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of information of suspected or confirmed fraud or abuse to PerformRx regarding such suspected or confirmed fraud and abuse. .

12. PerformRx shall perform monthly desktop audits and periodic live audits of Network Pharmacies, through its subcontractor. PerformRx will be responsible for payment of its subcontractor, which shall not be on a contingency fee basis. Any funds recovered from an audited pharmacy on account of the conduct and findings of such an audit shall be returned to Plan net of PerformRx-incurred recovery fees.

13. PerformRx shall cooperate with Plan in setting electronic Coordination of Benefits/Third Party Liability ("COB/TPL") logic, and PerformRx shall properly code said COB/TPL logic into the system during the standard benefit design process. Plan shall use best efforts to ensure that its eligibility file, and the eligibility information contained therein, is accurate, includes accurate third party information, and is provided on a timely basis.

14. PerformRx shall add pharmacies that meet established criteria to the pharmacy network, but shall not delete network pharmacies without the prior consent of the Plan. PerformRx shall make available a monthly pharmacy provider directory file, in a format for printing and mailing to Members upon request, as well as a link to an on-line version updated in real time, but no less frequently than weekly. The pharmacy network directory will include such information as may be needed for Plan to meet the requirement to mail a hard-copy network directory to Members upon request and to post an up-to-date pharmacy provider directory on Plan's website, including but not limited to the following information on all Network Pharmacies: names, locations and telephone

numbers; any non-English languages spoken; identification of hours of operation, including identification of providers that are open 24 hours per day; identification of pharmacies that provide vaccine services; and identification of pharmacies that provide delivery services.

J. Mail Service Pharmacy. Mail service pharmacy shall be administered by a participating mail order vendor as a subcontractor to PerformRx. Mail service rates will apply to claims for a 90-day supply. Neither Plan nor PerformRx shall restrict Members' access to needed drugs and related pharmaceutical products by requiring that Members use mail-order pharmacy providers. Members shall not be charged anything above applicable co-pays (e.g., shipping and handling) for routinely processed mail order prescriptions.

K. Performance Standards and Penalties. PerformRx shall diligently attempt to maintain its performance at levels represented herein, in accordance with the standards set forth in **Exhibit D**. Such performance standards shall be measured daily, monthly, quarterly or annually (as set forth in **Exhibit D**) and reported to Plan on a quarterly basis. In the event that PerformRx fails to meet a performance standard, it shall pay to Plan the applicable penalty.

5. INFORMATION OBTAINED THROUGH PERFORMRX SERVICES.

Plan acknowledges and agrees that: (a) information in PerformRx databases is derived from third party sources and is not independently developed by PerformRx, and PerformRx utilizes industry materials and the advice and resources of outside vendors and healthcare professionals to provide PerformRx services; (b) the usefulness of the information provided by PerformRx is necessarily limited by the amount of information received by PerformRx from Plan and others, and the quality, completeness and accuracy of such information; (c) PerformRx's databases do not contain all currently available information on healthcare or pharmaceutical practices; (d) PerformRx is not responsible for failing to include information in databases that is not specifically requested by Plan or required by this Agreement, for the actions or omissions of contributors of information to PerformRx or for misstatements or inaccuracies in industry materials utilized by PerformRx; and (e) all warranty disclaimers and exclusions made by contributors of information or data to PerformRx shall apply to the PerformRx services provided hereunder.

6. SYSTEMS, DATA AND SECURITY.

A. Access to Systems. With respect to each service PerformRx is to provide to Plan involving Plan's access to a PerformRx system or database, PerformRx shall provide Plan with Access Information. Plan shall inform PerformRx of the identity of authorized users, of additions and deletions to the list of users, and of access rights of individual users, and shall further ensure that Access Information is not provided to unauthorized users. Passwords will expire periodically, which will require entry of a new password for each user on a regular interval defined by PerformRx. Plan shall provide, at its expense, the equipment, software and communications network transmission capabilities necessary to access PerformRx databases and systems.

B. Plan Data Provided for Input. If Plan is providing data to PerformRx, Plan shall keep the original source of all such data. If any media furnished by Plan are damaged due to PerformRx's equipment or performance of services, PerformRx will replace such media, but not the data on such media, at PerformRx's expense. PerformRx shall not be liable for the damage of any data on Plan media due to PerformRx's equipment or performance of services.

C. Internet Security. Plan acknowledges that the Internet is not a secure or reliable environment and that the ability of PerformRx to deliver Internet services is dependent upon the Internet and equipment, software, systems, data and services provided by various telecommunications carriers, equipment manufacturers, firewall providers and encryption system developers and other vendors and third-parties. Notwithstanding the above, PerformRx will make all reasonable efforts to maintain PerformRx's equipment, software, systems, data and services, and will take immediate steps to remedy any problems caused by failure or malfunction of any such equipment, software, systems, data and services. Plan acknowledges that use of the Internet in conjunction with PerformRx's services entails confidentiality and other risks that may be beyond PerformRx's reasonable control. PerformRx agrees to maintain and make available written and commercially reasonable encryption and other protocols to protect against unauthorized interception, corruption, use of or access to Proprietary Information that it receives and/or disseminates over the Internet ("Internet Protocol"). Plan acknowledges that it has reviewed and agrees with the adequacy of the Internet Protocol. PerformRx may, but shall not be required to, modify the Internet Protocol from time to time to the extent it believes in good faith that such modifications will not diminish the security of PerformRx's systems.

7. COMPENSATION.

A. Plan acknowledges and agrees that it has carefully reviewed **Exhibit B** hereto and shall pay: (1) all charges and fees set forth in **Exhibit B** for services that Plan has selected as of the Effective Date; and (2) PerformRx's expenses, including without limitation those expenses set forth in **Exhibit B**. For services not selected by Plan at the Effective Date but later selected by Plan ("Additional Services"), Plan shall pay PerformRx at PerformRx's then-current rates for such Additional Services or at such other rates as are reflected in a modified **Exhibit B** to which PerformRx and the Plan have agreed in writing prior to the rendering of the Additional Services.

B. Claims Payment. PerformRx will make available information reflecting the amount of payments that have become due from Plan for Claims approved for payment during the applicable period. Plan agrees to pay PerformRx's designated claims processor for Claims within five (5) days of the end of the Financial Cycle. Plan will not be liable for any individual prescription in an amount greater than what was actually paid to the dispensing Pharmacy for that prescription. Plan is entitled to receive a copy of the reconciliation of payments to pharmacies if they desire. Stale funds and funds associated with voided checks will be returned to Plan on a quarterly basis.

C. Plan shall pay PerformRx within fifteen (15) days of the date of receipt of a PerformRx invoice. In the event that any amounts due hereunder are not received by PerformRx by the due date, Plan shall pay to PerformRx a late charge at the lesser of one and one half percent (1.5%) per month or the maximum rate of interest allowed by law, until such invoice is

paid in full. Plan acknowledges that PerformRx may utilize a lockbox account to manage fees and expenses received by Plan, and that those financial institutions that provide lockbox services may refuse to review or to advise PerformRx of notations on payment instruments. Plan therefore agrees not to attempt to effect an accord or satisfaction through a payment instrument or accompanying written communication, and agrees further not to conditionally or restrictively endorse a payment instrument, and PerformRx shall not be bound by any such attempt or endorsement. Notwithstanding the above, Plan shall have the right to review and dispute any invoice submitted by PerformRx. Plan shall reimburse PerformRx for the expenses incurred by PerformRx, including attorneys' fees, in enforcing this **Section 7**.

D. Plan hereby acknowledges that certain of the fees set forth in **Exhibit B** are based on the fees that PerformRx pays to its claims processor for such services. In the event that PerformRx's claims processor increases its fees to PerformRx for services selected hereunder by Plan, PerformRx will provide written notice thereof to Plan, and **Exhibit B** shall thereafter be deemed to be modified accordingly, as of the effective date given by PerformRx in its written notice.

In addition, in the event that a government-imposed or industry-wide change alters the economics of this Agreement, then the financial terms of this Agreement shall be automatically adjusted at the time of such change to return the parties to their respective economic positions as they each existed under this Agreement immediately prior to such change. All such modifications will be made in good faith and PerformRx will timely provide Plan with the revised financial terms for implementation, which shall be subject to Plan review and verification prior to such implementation.

E. Payment Disputes. If a payment dispute arises between PerformRx and Plan, the disputing party will immediately notify the non-disputing party of any bona fide dispute of an invoiced amount, along with an explanation of the nature of the dispute. PerformRx and Plan will delay payments owed until the dispute is resolved and work together in good faith to research and resolve such disputes within a fifteen (15) business day timeframe. Both parties agree to pay, in accordance with the terms of this Agreement, any portion of an invoice that is not in dispute.

8. MUTUAL COOPERATION AND NOTICE OF ERRORS. Each party shall reasonably cooperate with the other party during implementation of Pharmacy Services and throughout the term of the Agreement as necessary for the performance of the Parties' respective obligations hereunder. As soon as necessary in order to permit PerformRx to fulfill its obligations under this Agreement, and otherwise within a reasonable period of time, Plan shall respond to any requests by PerformRx for information or determinations needed by PerformRx. Plan shall provide to PerformRx valid, correct, properly formatted and transmitted data and any other information necessary for PerformRx to fulfill its obligations to Plan. When Plan and PerformRx have agreed that Plan shall conduct testing of or review the testing results of a process or method, Plan shall have an obligation to promptly notify PerformRx of any error in the process or method that Plan discovers, and PerformRx shall have no responsibility to make adjustments with respect to and shall not be liable for errors about which Plan failed to give such notice to PerformRx upon testing, unless PerformRx discovered such error independent of Plan. Plan shall advise PerformRx of any PerformRx error, failure in performance, or inconsistency

promptly after discovery. Once either Plan or PerformRx discovers an error, failure in performance, or inconsistency, PerformRx shall promptly take the necessary steps to correct such error, failure in performance, or inconsistency.

9. PERFORMANCE WARRANTY.

A. Warranty. PerformRx shall at all times use commercially reasonable efforts to fulfill its obligations under this Agreement; provided, however, PerformRx's efforts shall not be deemed unreasonable to the extent PerformRx's ability to perform was affected by Plan's breach of its obligations hereunder or PerformRx was complying with the Plan's instructions.

[redacted]

C. DISCLAIMER. EXCEPT AS PROVIDED IN THIS SECTION 9, NOTWITHSTANDING ANY OTHER TERM OF THIS AGREEMENT, PERFORMRX'S SERVICES AND ALL SYSTEMS AND DATABASES DESCRIBED IN THIS AGREEMENT ARE PROVIDED "AS-IS" ON AN "AS AVAILABLE" BASIS, AND PERFORMRX SPECIFICALLY DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES, EXPRESS OR IMPLIED, REGARDING PHARMACY SERVICES PROVIDED HEREUNDER, INCLUDING WITHOUT LIMITATION THE IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR ANY PARTICULAR PURPOSE, AND NON-INFRINGEMENT AND IMPLIED WARRANTIES ARISING FROM COURSE OF DEALING OR COURSE OF PERFORMANCE.

10. LIMITATION OF LIABILITY. NOTWITHSTANDING ANY TERM OF THIS AGREEMENT, IN NO EVENT WILL EITHER PARTY TO THIS AGREEMENT BE LIABLE TO THE OTHER PARTY FOR SPECIAL, INDIRECT, INCIDENTAL, EXEMPLARY, CONSEQUENTIAL (INCLUDING BUT NOT LIMITED TO LOSS OF PROFITS) OR PUNITIVE DAMAGES ARISING FROM THE RELATIONSHIP OF THE PARTIES OR THE CONDUCT OF BUSINESS UNDER THIS AGREEMENT (EVEN IF THE RESPONSIBLE PARTY HAS BEEN ADVISED OF OR HAS FORESEEN THE POSSIBILITY OF SUCH DAMAGES).

PerformRx's Pharmacy Services are intended as an aid to, and not a substitute for, the knowledge, expertise, skill and judgment of Prescribers, Pharmacies or other healthcare professionals. Pharmacies, Prescribers, other healthcare professionals, and Plan are individually responsible for acting or not acting upon information generated and transmitted by PerformRx, and PerformRx does not control or intervene in the healthcare or Program decisions made or actions taken by Pharmacies, Prescribers, other healthcare professionals, Plan or Members, and PerformRx is not responsible therefor.

Notwithstanding any other provision of this Agreement, in no event will PerformRx have any liability to Plan if PerformRx has not directly caused such liability by breaching this Agreement, or for damages and expenses of any kind arising from any of the following: (a) Plan's negligence or failure to perform its obligations in this Agreement or abide by laws and regulations applicable to Plan's business; (b) Plan's making or directing changes or instructions, or use of data; (c) the provision of data or information to PerformRx by Plan or third parties or the lack by Plan or others of a right to forward data or information to PerformRx; (d) medical, scientific, or business judgments made by Plan as a result of Pharmacy Services provided by PerformRx or as a result of or after consultation with PerformRx staff; (e) the unauthorized interruption, corruption, use of or access through the Internet of Plan information except to the extent that Plan Proprietary Information was accessible as a direct result of PerformRx's failure to follow in all material respects its Internet Protocol; (f) the failure of healthcare providers to act in accordance with medical, pharmacy, or healthcare laws, regulations and standards; (g) exercising discretion on behalf of Plan at Plan's request, except to the extent PerformRx has failed to use reasonable care with respect to the exercise of such discretion.

11. INDEMNITY.

A. PerformRx's Indemnity to Plan. PerformRx shall indemnify and hold harmless Plan and its officers, directors, employees and agents, and the successors, representatives and assigns thereof, from and against any and all liability, loss, damage and expense, including reasonable attorneys' fees, arising directly or indirectly from third-party claims against Plan that are the direct result of PerformRx's failure to perform its responsibilities under this Agreement.

B. Plan's Indemnity to PerformRx. Plan shall indemnify and hold harmless PerformRx and its officers, directors, employees and agents, and the successors, representatives and assigns thereof, from and against any and all liability, loss, damage and expense, including reasonable attorneys' fees, arising directly or indirectly from third-party claims against PerformRx that are the direct result of Plan's failure to perform its responsibilities under this Agreement.

C. Indemnity Procedures. Each party's obligation to indemnify shall apply only if the party to be indemnified has given the party providing the indemnity ("Indemnifying Party") prompt written notice of the claim, provides all reasonable information and assistance to the Indemnifying Party for the Indemnifying Party to settle or defend the action, and grants the Indemnifying Party the sole authority to control the defense and settlement of the claim.

12. NO SURCHARGES OF MEMBERS. With the exception of co-payments (if applicable and allowed by State law) and charges for Pharmacy Services delivered on a fee-for-service basis to Members, PerformRx shall in no event, including, without limitation, non-payment by Plan, insolvency of Plan, or breach of this Agreement, bill, charge, collect any deposit, or attempt to bill, charge, collect or receive any form of payment from any Member for Pharmacy Services provided pursuant to this Agreement. Member shall not be liable to PerformRx for any sums owed to PerformRx by Plan. PerformRx may not deny services to any individual who is eligible for services because of the inability to pay a co-payment or other cost-sharing. Co-payments may not

be imposed for any of the following: family planning services and supplies; emergency services; or services provided to individuals younger than 21 years old, pregnant women, individuals who are inpatients in long-term care facilities or other institutions, Native Americans and Alaskan Eskimos.

13. TERMINATION.

A. Termination for Material Breach. If there is any material default by either party in the performance of the terms and conditions of this Agreement, the non-defaulting party shall provide written notice thereof to the defaulting party, in reasonably sufficient detail so as to permit the defaulting party to address the concern. In the event such default has not been cured to the satisfaction of the non-defaulting party within 45 days of receipt of such notice (or such longer period as the Parties may agree to), or if the defaulting party is not diligently pursuing a cure in the event cure cannot be completed within such 45-day period, then the non-defaulting party may terminate this Agreement by providing 15 days' written notice. Notwithstanding anything in this Agreement to the contrary, either party's default under this Agreement shall in no way reduce or otherwise affect the non-defaulting party's obligation to mitigate, to a commercially reasonable extent, its damages arising by such breach.

B. Termination for Insolvency/Bankruptcy. Either party may terminate this Agreement effective immediately without liability upon written notice to the other if any one of the following events occurs: (i) the other files a voluntary petition in bankruptcy or an involuntary petition is filed against it, (ii) the other is adjudged as bankrupt, (iii) a court assumes jurisdiction of the assets of the other under the Federal Reorganization Act; (iv) a trustee or receiver is appointed by a court for all or a substantial portion of the assets of the other; (v) the other becomes insolvent; or (vi) the other makes an assignment of its assets for the benefit of its creditors.

C. Termination Without Cause. Either party may terminate this Agreement at any time for "any reason" or "no reason" upon one hundred twenty (120) days' written notice to the other party.

D. Obligations Upon Termination. Upon expiration or termination of this Agreement: (a) Plan will pay contemporaneously with the expiration or termination date all amounts due PerformRx; (b) Plan will timely pay all subsequent invoices (1) for Pharmacy Services performed and expenses incurred on or prior to the expiration or termination date, and (2) for expenses associated with (i) the return to Plan of data transferred to electronic media at PerformRx's discretion, archived media stored by PerformRx or any other Plan Proprietary Information, or (ii) direct Member reimbursement and other paper Claim forms; (c) PerformRx will deliver to Plan within forty-five (45) business days of the expiration or termination date the balance of any funds delivered by Plan to PerformRx for the payment on Plan's behalf of Claims processed through IPNS, less all sums outstanding which are owed by Plan to PerformRx; (d) PerformRx shall either return or destroy any Plan Propriety Information, as instructed by Plan; and (e) PerformRx shall not be required to continue to perform Pharmacy Services hereunder, including without limitation making adjustments to Claims, or to continue providing ongoing storage and maintenance of records, unless the Plan and PerformRx otherwise agree, provided

that PerformRx shall cooperate in any event with Plan to ensure: (x) the orderly transfer of necessary data and history records; (y) the continuity of access and quality of care to Members; and (z) the completion of any and all remaining contractual obligations.

In addition, Plan and PerformRx recognize that in the event of termination of the State Contract, Plan is required to immediately make available to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Plan's and PerformRx's activities undertaken pursuant to this Agreement. The provision of such records will be at no expense to DHH.

14. PRIVACY COMPLIANCE. In rendering the Pharmacy Services described herein, PerformRx may create, maintain or receive from or transmit to Plan, Pharmacies, Prescribers or Members individually identifiable health information of Members which is "protected health information" ("PHI") within the meaning of the regulations promulgated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and codified at 45 CFR Parts 160 and 164 as amended from time to time (the "HIPAA Privacy Rules"). As required by the HIPAA Privacy Rules, PerformRx shall execute the Business Associate Agreement attached hereto as **Exhibit C**. PerformRx shall comply with the Business Associate obligations outlined in the Business Associate Agreement.

15. CONFIDENTIALITY. Proprietary Information shall include the terms of this Agreement (but not the existence thereof), its terms and all information disclosed by each party to the other pursuant to negotiations between the Parties. When used with respect to Plan, Proprietary Information shall mean all information pertaining to Plan's business and services, and Program Specifications and to PHI (as defined in **Section 14** hereof). When used with respect to PerformRx, Proprietary Information shall mean: (a) all information pertaining to PerformRx's business and services, including, but not limited to rebate contracts and MAC pricing tables; (b) PerformRx databases, software, layouts, designs, formats, procedures in any form of expression, processes, tags, applications, systems, interfaces, interface formats and protocols, and technology and all elements thereof; (c) files, compilations, analyses, publications, edits, protocols, documents and reports, both internal and available to Plan, providers, and others, including without limitation information, analyses, and recommendations provided by PerformRx; and (d) developments, changes, modifications, new features or functionality made at the request or expense or both of Plan.

The term "Proprietary Information" does not include information which: (1) has been or may in the future be published or is now or may in the future be otherwise in the public domain through no fault of the receiving party; (2) prior to disclosure pursuant to this Agreement, or during negotiations connected therewith, is property within the legitimate possession of the receiving party; (3) subsequent to disclosure pursuant to this Agreement is lawfully received from a third party having rights in the information without restriction of the third party's right to disseminate the information and without notice of any restriction against its further disclosure; or (4) is independently developed by the receiving party through its agents who have not had access to such Proprietary Information.

Each party represents and warrants that it has the right to disclose its Proprietary Information to the other party. Each party acknowledges and agrees that the other party's Proprietary Information constitutes confidential material and trade secrets of the other party. Each party agrees to hold the other party's Proprietary Information in confidence, to use and reproduce such Proprietary Information only to accomplish the intent of this Agreement or to comply with Federal or State statutes or regulations or with the order of a court of competent jurisdiction or a government agency requirement, and to use reasonable care to avoid unauthorized disclosure or use of the Proprietary Information. Notwithstanding anything in the foregoing to the contrary, Plan acknowledges that from time to time PerformRx may use Plan's Proprietary Information in the preparation of industry reports, and Plan hereby consents to such use by PerformRx, provided that under no circumstances may Plan or any Plan Member be identifiable through any such report.

All Proprietary Information, unless otherwise agreed in writing, remains the exclusive property of the disclosing party. For purposes of this Agreement, the existence of a copyright notice or claim will not cause or be construed to cause any part of the Proprietary Information to be published in the public domain. The Parties agree that immediately upon termination of this Agreement, without regard to the reason for termination, the Parties shall return to one another all written materials containing Proprietary Information that is the property of the other party.

If Plan is required to file this Agreement or any portion thereof with, or to provide any information pertaining to this Agreement to, any State or Federal agency or regulatory body, it shall notify PerformRx sufficiently in advance for PerformRx to work with Plan to redact such provisions and to keep confidential such information as PerformRx deems sensitive, to the extent allowed by the State or Federal agency or regulatory agency. Plan acknowledges that, at a minimum, PerformRx considers **Exhibit B** as confidential, as well as any PerformRx Network Pharmacy disbursement schedules and other monetary amounts contained in any addendum. Plan shall use its best efforts to advance PerformRx's position with the governmental agency or regulatory body that such provisions or information should not be provided or should not be made publicly available, and Plan shall keep PerformRx apprised of any decision by the agency or regulatory body in this regard. Plan shall provide PerformRx with copies of all written communications with the agency or regulatory body pertaining to the services to be provided hereunder or to this Agreement.

The Parties agree that monetary damages will be difficult to ascertain in the event of any breach of **Section 14** or **Section 15** and that monetary damages alone would not suffice to compensate a party for such breach. The Parties agree that in the event of violation of **Section 14** or **Section 15**, without limiting any other rights and remedies, an injunction may be brought against any party who has breached or threatened to breach **Section 14** or **Section 15**, without the requirement to post bond. In any proceeding upon a motion for equitable relief, a party's ability to answer as to damages shall not be interposed as a defense to the granting of such equitable relief.

16. COMPLAINTS AND GRIEVANCES.

A. Member Complaints and Grievances. In the event a Member files a complaint or grievance about PerformRx, PerformRx agrees to comply with and participate in Plan's Member complaint and grievance program and procedures, as outlined in Plan's policies and

procedures, as they pertain to complaints and grievances filed by Members. If PerformRx receives a complaint from a Member, it shall promptly forward that complaint to Plan so that Plan may take appropriate action.

B. Provider Claims Disputes. If a Network Pharmacy disputes any amount paid by PerformRx, PerformRx agrees to ensure that the Network Pharmacy is entitled to full and fair review of its claims dispute consistent with Federal and State laws. PerformRx will require that all Network Pharmacies comply with Plan requests for documentation or otherwise cooperate, in accordance with Plan policies and procedures, to resolve such claims disputes.

17. CULTURAL & LINGUISTIC APPROPRIATE SERVICES. PerformRx and its Network Pharmacies shall ensure access to care for limited/non-English speaking Members through PerformRx and/or Pharmacies' own multilingual staff or qualified interpreter service. PerformRx and its Network Pharmacies shall not: (a) require Members to provide their own interpreters or to use family members or friends as interpreters; (b) use minors as interpreters, except in only the most extraordinary circumstances; or (c) require Members pay for the services of an interpreter.

18. OWNERSHIP, USE OF NAME, PRESS RELEASES. Each party shall retain full and exclusive ownership and all rights over its respective Proprietary Information, and the programming, conception, development or enhancement thereof, and over its publications, trade secrets, copyrights, trademarks and patents, and the other party shall not purport to have ownership thereof. Plan solely owns Plan claims data. Plan shall not copy, reverse engineer, decompile or disassemble or otherwise attempt to create or derive the source code of any PerformRx software or system. Plan agrees not to take any action which would mask, delete or otherwise alter any PerformRx on-screen disclaimers or copyright, trademark and service notifications provided by PerformRx from time to time, or any "point and click" features relating to acknowledgement and acceptance of such disclaimers and notifications. Plan acknowledges that PerformRx's software, systems, products, services and related documentation may contain trade secrets of PerformRx or third parties and may be patented or copyrighted. Plan agrees not to make or distribute any copies of the foregoing without PerformRx's consent. Neither party shall release information to the press or, except as necessary to perform its obligations hereunder, over the Internet referring to the other party without the express written consent of the other party. Notwithstanding the above, Plan and PerformRx may use each other's name without written permission as necessary to provide the Pharmacy Services governed by this Agreement.

19. RIGHT TO AUDIT. During the term of this Agreement, and for up to two (2) years after its expiration or termination, Plan may, at its cost and expense, and upon reasonable advance notice, conduct audits during regular business hours of the PerformRx records and information pertaining to Pharmacy Services that PerformRx provides hereunder. Such audits may be conducted by Plan employees or by an independent third-party reasonably acceptable to PerformRx. Plan-designated auditors shall execute confidentiality agreements satisfactory to PerformRx. Unless a longer period is required for Plan to comply with Federal or State agency directives or requirements, the look-back period for audits by the Plan shall be limited to the calendar year preceding the year in which the audit is conducted. PerformRx shall allow Federal or State agencies, or Plan-designated auditors, to audit Pharmacy Services provided hereunder as

required by contracts or regulations applicable to Plan, and Plan shall give PerformRx prompt written notice during business hours upon learning that any such audit is to occur.

PerformRx shall cooperate fully with Plan and Plan-designated auditors during the course of any audit. Plan may initiate one full audit per contract year, and may initiate partial audits, during normal business hours, targeted at specific areas of concern to Plan at any time during the contract year, at Plan's sole expense with reasonable notice during normal business hours. In the event PerformRx is required to devote significant resources to any audit, Plan shall compensate PerformRx at the hourly rate of **One Hundred Fifty Dollars ($150.00)**.

Upon reasonable prior written notice, Plan may audit PerformRx for up to two (2) years after contract termination or expiration.

20. BOOKS AND RECORDS. All books and records relating to the performance of this Agreement and necessary for compliance with State and Federal law and regulations must be open to inspection, examination, or copying during normal business hours by Plan or duly authorized representatives of State or Federal agencies with jurisdiction over Plan. Such records shall include, without limitation, encounter data for a period of at least five years (or the length of time required under applicable State law), which obligation shall not terminate upon termination of this Agreement, and financial records pertaining to the cost of operations and income received for goods and services related to the performance of this Agreement. Such records shall be made available at all reasonable times at PerformRx's place of business or at such other mutually agreeable location. Books and records shall be maintained in accordance with general standards for book and record keeping.

21. SUBCONTRACTS. PerformRx shall maintain and make available to Plan, upon request, copies of all subcontracts.

A. PerformRx shall ensure that all subcontracts are in writing and require that the subcontractor: (i) make all books and records relating to the performance of this Agreement and necessary for compliance with State and Federal law and regulations available for inspection, examination, or copying during normal business hours by Plan or any other State or Federal agencies with jurisdiction over Plan; and ii) keep all such books and records for a term of at least five years from year in which the subcontract is in effect.

B. PerformRx shall require all subcontractors to maintain in force those insurance policies and bonds as recommended and/or required by industry standard.

C. PerformRx shall require all subcontractors to cooperate with PerformRx in order to meet its obligations under **Section 25**.

22. FORCE MAJEURE. Any party's delay in, or failure of, performance under this Agreement (other than Plan's failure to pay the fees and expenses due PerformRx for Pharmacy Services performed or to reimburse PerformRx for disbursements) shall be excused where such delay or failure is caused by an act of nature, fire, act of war or terrorist act, or other catastrophe; electrical, computer, software, transmission, power, communications or mechanical failure;

direction or effect of an order from a court or government agency or body; functions or malfunctions of the Internet, telecommunications services (including wireless), firewalls, encryption systems or security devices; or any other cause beyond a party's reasonable control.

23. INSURANCE. PerformRx shall carry general liability insurance and workers' compensation in accordance with applicable State and/or Federal requirements. Upon Plan's request, PerformRx will provide Plan with certificates evidencing such coverage.

24. COMPLIANCE WITH LAWS. PerformRx and Plan each represent and warrant, with respect to itself, that it will take reasonable steps to comply with the laws, regulations, and governmental policies, guidelines and instructions applicable to its provision of Pharmacy Services under this Agreement ("Governmental Obligations"), including but not limited to those Governmental Obligations set forth in **Exhibit F**, which are applicable with respect to the provision of Pharmacy Services by PerformRx in Customer's jurisdiction. Plan agrees to promptly notify PerformRx of any Governmental Obligations (regardless of whether they existed on the Effective Date) that impact or add to PerformRx's obligations hereunder ("Additional Obligations") as soon as practical after Plan has become aware of the same, including without limitation any changes to the Specific Performance Obligations required by any regulatory addendum the Parties may attach hereto.

If PerformRx is notified by Plan or otherwise that PerformRx's Specific Performance Obligations or this Agreement should be added to or altered as a result of Additional Obligations, PerformRx shall make such changes as mutually agreed to by Plan and PerformRx. If, in PerformRx's reasonable discretion: (a) Additional Obligations have a materially adverse financial effect on PerformRx's interest in this Agreement, (b) PerformRx and Plan cannot come to agreement on fees and implementation schedules for the Additional Obligations, and (c) Plan is not interested in having or cannot legally have PerformRx perform its obligations hereunder unless it also performs the Additional Obligations, then PerformRx may terminate this Agreement. Plan shall not assert any claim against PerformRx for monetary damages or equitable relief or otherwise for PerformRx's failure to perform the Additional Obligation from the date of notice to PerformRx of the Additional Obligation through the date agreed to by the Parties for implementation of such obligation, or, if PerformRx exercises a right to terminate the Agreement, through the termination date.

25. NONDISCRIMINATION. PerformRx shall not unlawfully discriminate, harass, or allow harassment, against any Member or against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, or on any other basis prohibited by law.

26. MISCELLANEOUS.

A. Notices. Notices under this Agreement shall be given in writing by personal delivery, prepaid certified or registered mail return receipt requested, independent overnight courier, or facsimile transmission with a copy sent by certified mail, registered mail, or independent overnight carrier to follow addressed to the following.

If to Plan: AmeriHealth Mercy of Louisiana
10000 Perkins Rowe
Building G, Suite 400
Baton Rouge, LA 70810

If to PerformRx: PerformRx
200 Stevens Drive
Philadelphia, PA 19113-1570
ATTN: President

With a Copy to: AmeriHealth Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113-1570
ATTN: General Counsel

B. Assignment. Neither party hereunder may assign this Agreement or its rights and obligations arising hereunder without the prior written consent of the other party. This Agreement shall be binding upon each party's successors and permitted assigns and shall inure to the benefit of and be enforceable by each party's successors and permitted assigns.

C. Amendment. This Agreement may be amended only pursuant to a written agreement between the Parties, executed by individuals authorized to bind the Parties thereto, subject to any necessary approvals by any applicable governmental agency Plan shall provide at least 45 days' prior written notice to PerformRx of any amendments or changes to any manual, policy or procedure document referenced in this Agreement. Notwithstanding the foregoing, Plan retains the right to unilaterally amend this Agreement, provided that such amendment incorporates only mandated changes as a result of statutes, regulations, accreditation requirements, or applicable contract(s) with a government agency.

D. Counterparts. This Agreement may be executed in counterparts, all of which together shall be deemed one and the same agreement.

E. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State without regard to its principles of conflicts of law.

F. Independent Contractor. Plan and PerformRx shall be considered independent of each other at all times. Nothing in this Agreement shall be construed to constitute the existence of any agency, joint venture, partnership or fiduciary relationship between the Parties. PerformRx shall choose the means to be employed and the manner of carrying out its obligations in this Agreement.

G. Entire Agreement. This Agreement, together with the exhibits, attachments, and addenda hereto, constitutes the entire understanding of the Parties with respect to the subject matter of this Agreement and supersedes and replaces all prior or contemporaneous agreements

between the parties, including but not limited to responses to requests for proposals or information, marketing literature, negotiations, understandings and representations, whether oral or written. No supplement, modification or amendment of this Agreement shall be binding unless contained in a writing signed by each of the Parties to this Agreement. No agent of any party hereto is authorized to make any representation, promise or warranty inconsistent with the terms hereof.

H. Validity. If an arbitrator, court or administrative agency determines any provision of this Agreement invalid, the provision shall be interpreted to the greatest extent permitted by law to give effect to the Parties' intentions, and the determination shall not affect the enforceability of any other provision.

I. Waiver. The waiver by any party of any breach of any provisions of this Agreement shall not operate, or be construed, as a waiver of any subsequent breach.

J. No Third-Party Beneficiaries. This Agreement is intended solely for the benefit of the Parties. In no event will any third party, including without limitation any Program Sponsor, Pharmacy, Prescriber, Member, bank, governmental entity, or contractor or client of Plan, have any rights under or right to enforce the terms of this Agreement.

K. Survival. Sections 7 (Compensation), 8 (Mutual Cooperation), 9 (Performance Warranty), 10 (Limitation of Liability), 11 (Indemnity), 12 (No Surcharges of Members), 13 (Termination), 14 (Privacy Compliance), 15 (Confidentiality), 18 (Ownership), 20 (Books and Records) and 26 (Miscellaneous) shall survive termination or expiration of this Agreement; provided, however, that PerformRx's obligation in **Section 9.B** to re-perform shall not survive for longer than six (6) months after termination or expiration of the Agreement.

L. Record Systems. PerformRx shall maintain adequate records systems for documenting Pharmacy Services provided to Members, including utilization data related to the dispensing of medications (e.g. date of service, fees charged, etc.) and shall contractually require Network Pharmacies to maintain adequate records reflecting their services under Provider Agreements with PerformRx.

M. Participation in Quality Assurance, Utilization Review, Peer Review and/or Grievance Procedures. Plan shall permit PerformRx to participate in internal/external quality assurance, utilization review, peer review and/or grievance procedures, as applicable. PerformRx represents that the Provider Agreements between PerformRx and Network Pharmacies document the same types of aforementioned rights for the Network Pharmacies. In addition, PerformRx represents that the Provider Agreements provide for the incorporation of any applicable managed care law into those agreements, including the right of providers to avail themselves of applicable dispute resolution procedures.

N. Headings. The headings in this Agreement are for convenience only and shall not be used to construe the meaning of the provisions in or to interpret this Agreement.

[REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK; SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement as of the day and year first above written.

AmeriHealth Mercy of Louisiana, Inc.

By: Kathleen Stone

Printed Name: Kathleen Stone

Title: Executive Director

Date: _____

PerformRx, LLC

By: _____

Printed Name: MESFIN TESENU

Title: President

Date: 10/26/2012

EXHIBIT A: DEFINITIONS

1.1 ACCESS INFORMATION. The unique identifier, password and related information necessary for Plan's on-line users to have the electronic capability to view and modify IPNS files or to use RxFocus®.

1.2 ADMINISTRATIVE PRIOR AUTHORIZATION (Standard). Includes, but are not limited to, quantity overrides, vacation supplies, "refill too soon" and dosage changes.

1.3 ADMINISTRATIVE PRIOR AUTHORIZATION (Specialty). Review for "Early Close" Prior Authorization Reviews. Early Close Prior Authorization Reviews are those reviews where, following initial review of the request for prior authorization, it is determined that additional follow-up or action is not required, including, by way of example, duplicate prior authorization requests and requests for Covered Medications that do not require Prior Authorization.

1.4 AGREEMENT. This Agreement and exhibits and addenda thereto.

1.5 APPEAL. A request for review of an action, including the following: (1) the denial or limited authorization of a requested service; (2) the reduction, suspension or termination of a previously authorized service; (3) the denial, in whole or part, of a payment for a service; (4) the failure to provide Pharmacy Services in a timely manner; or (5) the failure of a managed care organization ("MCO") or its subcontractor to act within the timeframes provided.

1.6 APPROVED CRITERIA. Clinically based drug utilization review criteria that have been approved by Plan.

1.7 AVERAGE WHOLESALE PRICE ("AWP"). The price for a given drug product as published in a nationally recognized compendia of wholesale drug prices used by PerformRx in calculating the payments for covered medications hereunder.

1.8 BASIC DRUG UTILIZATION REVIEW ("DUR"). Includes prospective, retrospective and concurrent DUR review at the point-of-service

1.9 CLAIM. The request of a Pharmacy or a Member for amounts due under a Program to the Pharmacy or Member subsequent to the Pharmacy's provision of prescription drugs or of certain other healthcare-related products or services to a Member. PerformRx will require each Pharmacy-submitted Claim to include, at a minimum, the prescriber's NPI, the drug manufacturer number, product number and package number for the drug dispensed.

1.10 CLINICAL PRIOR AUTHORIZATION (Standard). Includes Letter of Medical Necessity review involving a series of clinical pharmacists and/or physician interventions.

1.11 CLINICAL PRIOR AUTHORIZATION (Specialty). Includes Letter of Medical Necessity review involving a series of clinical pharmacists and/or physician interventions for Specialty Drugs.

1.12 COMPENDIA. Federally approved pharmacy references including the USPDI and the AHFS Drug Information.

1.13 CMS. Centers for Medicare and Medicaid Services.

1.14 COVERED DRUG. A drug product that is covered under the Plan's benefit design and coverage rules.

1.15 DISPENSING FEE The amount other than the ingredient component amount paid as compensation to pharmacies for providing pharmaceutical services. PerformRx's per-prescription Dispensing Fee to Network Pharmacies shall not be less than $2.50, unless otherwise permitted by DHH.

1.16 EFFECTIVE DATE. November 1, 2012 or such date upon which the Parties mutually agree as the date for the commencement of Pharmacy Services by PerformRx hereunder.

1.17 FINANCIAL CYCLE. A pre-determined period of time for which claim costs and administrative fees will be invoiced to the client and claim costs and Dispensing Fees will be paid to the network pharmacies.

1.18 FORMULARY. The list of prescription medications that are approved for use/or coverage by the Plan and which will be dispensed by Pharmacy to Members.

1.19 INTEGRATED PHARMACY NETWORK SYSTEM ("IPNS®"). A third-party proprietary system for the electronic Processing of prescription and certain other Claims submitted under Programs.

1.20 MEMBER. A person who is enrolled in the Program and has been assigned by Plan, who meets all of the eligibility requirements for membership in such Program, whose demographic information is loaded into the claims adjudication system using eligibility information provided by Plan, and who is entitled to the healthcare-related benefits of the Program.

1.21 NCPDP. The National Council for Prescription Drug Programs.

1.22 PAID CLAIM. A Claim that has been found to represent a covered healthcare-related benefit and requires reimbursement by Plan.

1.23 PHARMACY(IES). A pharmacy or other provider of healthcare-related products and services that participates in rendering to Members of a Program certain products and services covered under a Program.

1.24 PROGRAM SPONSOR. The entity that contracts for the provision of healthcare benefits to Members.

1.25 PRESCRIBER. A physician or other healthcare professional who legally prescribes a healthcare-related product or service to Members and such person's agents.

1.26 PROCESSING. The review of Claims to determine whether and to what extent they meet Program Specifications, and, if Plan requests, the determination of amounts due a Pharmacy or, if applicable, a Member under a Program.

1.27 PROGRAM. The contractual provision by an entity other than PerformRx of healthcare benefits to Members pursuant to which the Pharmacies and, if applicable, Members, receive funds for prescription drugs, durable medical equipment, and other healthcare-related goods and services as determined by a unique combination of factors including without limitation coverage specifications, reimbursement criteria and methods, and eligibility requirements.

1.28 PROGRAM SPECIFICATIONS. The IPNS specifications agreed to by Plan and PerformRx that reflect the combination of Program and healthcare industry factors that determine amount due to Pharmacies and, if applicable, Members, under a Program.

1.29 REBATES. Any and all upfront, concurrent or retrospective reimbursement or discount to PerformRx of any monetary amount from a pharmaceutical, medical equipment or device manufacturer that is directly or indirectly attributable to the purchase or utilization of any Covered Drug by any Members, including but not limited to, monetary amounts associated with formulary status, market share utilization, pharmacy pull-through programs, implementation allowances, clinical detailing allocations, and/or administration fees.

1.30 SPECIALTY DRUG. A drug that:

(1) is not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or

(2) includes at least two (2) of the following characteristics:

(a) requires inventory management controls including but not limited to unique storage specifications, short shelf life and special handling; or

(b) must be administered, infused or injected by a health care professional; or

(c) the drug is indicated primarily for the treatment or prevention of: (i) a complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid arthritis; or (ii) a rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States; or

(d) the total monthly cost is $3,000 or more.

1.31 SPECIFIC PERFORMANCE OBLIGATIONS. PerformRx's obligations set forth in **Section 4** of the Agreement.

1.32 STATE. The State of Louisiana.

EXHIBIT B

FEES

[redacted]

[redacted]

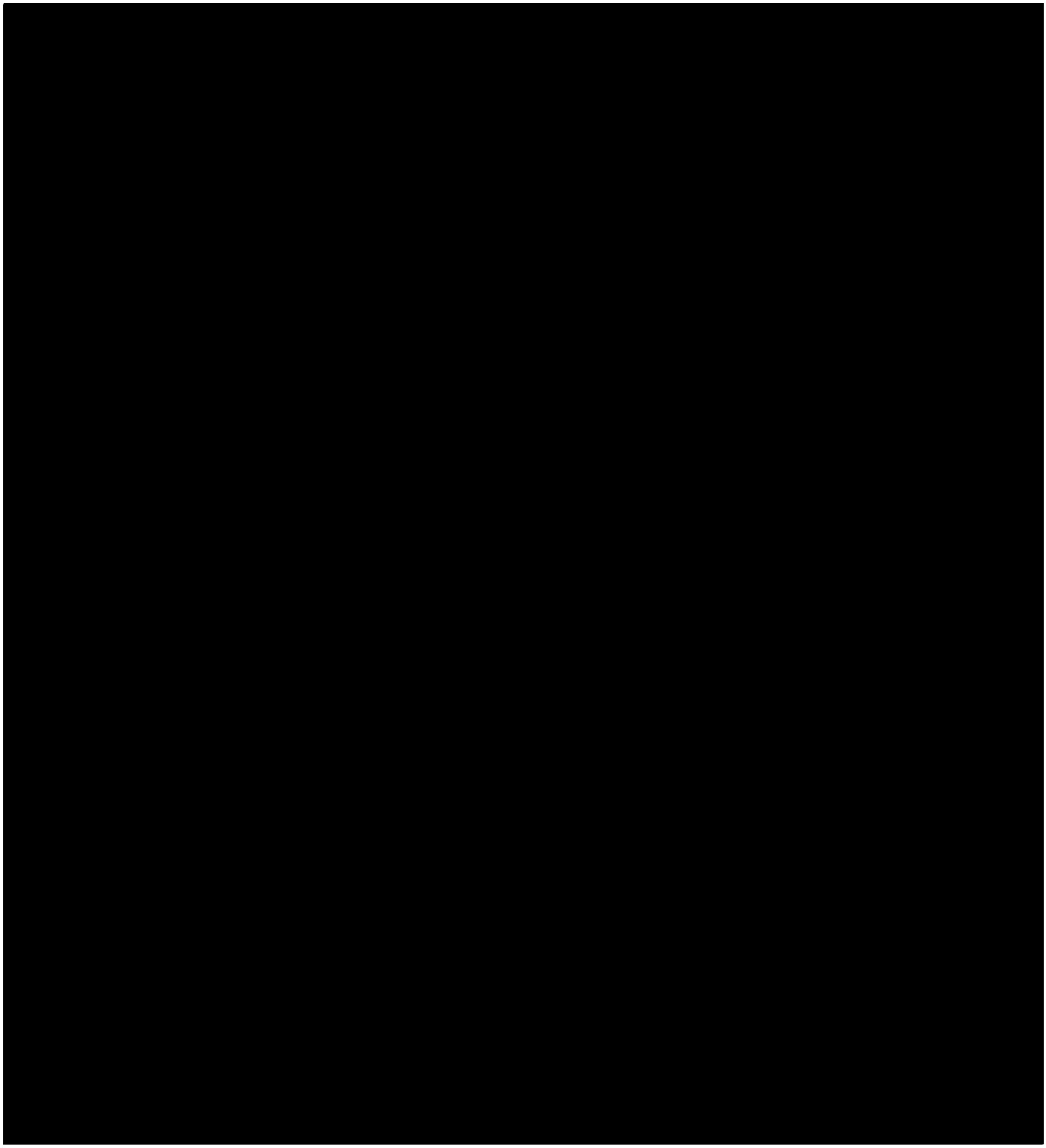


EXHIBIT C:

Business Associate Agreement Addendum

I. INTRODUCTION

This Business Associate Agreement Addendum (the "Addendum") is made and entered into effective as of __ [DATE]___ (the "Effective Date"), by and between AmeriHealth Mercy of Louisiana, Inc. (for purposes of this Addendum, the "Covered Entity"), and **PerformRx, LLC** ("Business Associate"). This Addendum supplements, is incorporated into and made part of any and all agreements, contracts and understandings, whether written or verbal, between Covered Entity and Business Associate (the "Services Agreement"). To the extent that any provision(s) of this Addendum conflict(s) with provision(s) contained in the Services Agreement, the provision(s) in this Addendum shall control with respect to the use and disclosure of Protected Health Information ("PHI"). This Addendum supersedes any previous business associate agreement between the parties.

II. RECITALS

A. Covered Entity and Business Associate intend to protect the privacy and security of certain PHI to which Business Associate may have access in order to provide goods and services to or on behalf of Covered Entity, in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-005 (February 17, 2009) and related regulations, the HIPAA Privacy Rule ("Privacy Rule"), 45 C.F.R. Parts 160 and 164, as amended, the HIPAA Security Rule ("Security Rule"), 45 C.F.R. Parts 160, 162 and 164, as amended, and other applicable federal and state laws regarding the use and disclosure of confidential information.

B. Business Associate may receive PHI from Covered Entity, or may create or obtain PHI from other parties for use on behalf of Covered Entity, which PHI may be used or disclosed only in accordance with this Addendum and the standards established by applicable laws.

C. Business Associate recognizes and agrees that it is obligated by law to comply with the applicable provisions of the HITECH Act.

D. In consideration of the mutual promises below, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

III. DEFINITIONS

A. "**Business Associate**" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR §160.103.

B. **"Covered Entity"** shall mean AmeriHealth Mercy of Louisiana, Inc..

C. **"Data Aggregation"** shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 CFR §164.501.

D. **"Designated Record Set"** shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 CFR §164.501.

E. **"Electronic Protected Health Information"** and/or **"EPHI"** shall have the same meaning as the term "electronic protected health information" in 45 CFR §160.103, and shall include, without limitation, any EPHI provided by Covered Entity or created or received by Business Associate on behalf of Covered

Entity. Unless otherwise stated in this Addendum, any provision, restriction, or obligation in this Addendum related to the use and disclosure of PHI shall apply equally to EPHI.

F. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended and related HIPAA regulations (45 CFR. Parts 160-164).

G. **"HITECH"** means the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

H. **"Individual"** shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 CFR §160.103. It shall also include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

I. **"More Stringent"** shall have the same meaning as the term "more stringent" in 45 CFR §160.202.

J. **"Privacy Rule"** shall mean the Standards for Privacy of Individually Identifiable Health Information, and Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule"), that are codified at 45 CFR parts 160 and 164, Subparts A, C, and E and any other applicable provision of HIPAA, and any amendments thereto, including HITECH.

K. **"Protected Health Information"** and/or **"PHI"** shall have the meaning given to the term under the Privacy Rule, including but not limited to, 45 CFR §164.103, and shall include, without limitation, any PHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity.

L. **"Required By Law"** shall have the meaning given to the term under the Privacy Rule, including but not limited to, 45 CFR §164.103, and any additional requirements created under HITECH.

M. **"Secretary"** shall mean the Secretary of the U.S. Department of Health and Human Services or his/her designee.

N. **"Security Incident"** shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 CFR §164.304.

O. **"Services Agreement"** shall mean the underlying agreement(s) that outline the terms of the services that Business Associate agrees to provide to Covered Entity ("Services") and that fall within the functions, activities or services described in the definition of "Business Associate" at 45 CFR §160.103.

P. **"State Law"** shall have the same meaning as the term "state law" in 45 CFR §160.202.

Q. **"Unsecured PHI"** shall have the same definition that the Secretary gives the term in guidance issued pursuant to §13402 of HITECH.

R. Any other capitalized terms used, but not otherwise defined in this Addendum shall have the same meaning as in the Privacy Rule and the Security Rule. Any inconsistency in the definition of a capitalized term shall be resolved in favor of a meaning that permits the Covered Entity to comply with the Privacy Rule and the Security Rule.

IV. BUSINESS ASSOCIATE OBLIGATIONS

A. Business Associate agrees that it shall only use and disclose PHI in accordance with the terms of this Addendum or as is Required By Law.

B. Business Associate shall not use or disclose PHI except for the purpose of performing Business Associate's obligations to Covered Entity in connection with Services provided under the Services Agreement; as such use or disclosure is limited by this Addendum.

C. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule. So long as such use or disclosure does not violate the Privacy Rule or this Addendum, Business Associate may use PHI: (i) as is necessary for the proper management and administration of Business Associate's organization, or (ii) to carry out the legal responsibilities of Business Associate, as provided in 45 CFR § 164.504(e)(4).

D. Business Associate will ensure that any agents, including subcontractors, to whom it provides PHI agree in writing to the same restrictions and conditions, including but not limited to those relating to termination of the contract for improper disclosure, that apply to Business Associate with respect to such information. Further, Business Associate shall implement and maintain sanctions against agents and subcontractors, if any, that violate such restrictions and conditions. Business Associate shall terminate any agreement with an agent or subcontractor, if any, who fails to abide by such restrictions and obligations. Business Associate shall not provide any PHI to any third party without Covered Entity's express written permission.

E. Business Associate shall develop, implement, maintain, and use appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other than as provided by this Addendum, and to implement administrative, physical, and technical safeguards as required by sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations and HITECH in order to protect the confidentiality, integrity, and availability of EPHI or PHI that Business Associate creates, receives, maintains, or transmits, to the same extent as if Business Associate were a Covered Entity. See HITECH § 13401.

F. The additional requirements of Title XIII of HITECH that relate to privacy and security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and shall be and by this reference hereby are incorporated into this Addendum.

G. Business Associate agrees to adopt the technology and methodology standards provided in any guidance issued by the Secretary pursuant to HITECH §§13401-13402.

H. Business Associate agrees to mitigate any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum and to notify Covered Entity of any breach of unsecured PHI, as required under HITECH § 13402.

I. Business Associate shall report, in writing, to Covered Entity any use or disclosure of PHI that is not authorized by this Addendum. Such written notice shall be provided to Covered Entity within three (3) business days of becoming aware of such use or disclosure.

J. In the case of a breach of Unsecured PHI, Business Associate shall, within three (3) business days of the discovery of a breach of such information, notify the Covered Entity of such breach. The notice shall include: (i) the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during the breach; (ii) a brief description of the breach, including the date of the breach and the date of discovery; (iii) a description of the types of Unsecured PHI involved in the breach; (iv) a description of the actions Business Associate is taking to investigate the breach, mitigate losses and protect against further breaches; and (v) such other information as Covered Entity may reasonably request.

K. Business Associate must obtain, prior to making any permitted disclosure as set forth in Section IV.D, reasonable assurances from such third party that such PHI will be held secure and confidential as provided pursuant to this Addendum and only disclosed as Required By Law or for the purposes for which it was disclosed to such third party, and that any breaches of confidentiality of the PHI which becomes known to such third party will be immediately reported to Business Associate. As part of obtaining this reasonable assurance, Business Associate agrees to enter into a Business Associate Agreement with each of its subcontractors pursuant to 45 CFR §164.308(b)(1) and HITECH §13401.

L. Business Associate shall make PHI in Designated Record Sets that are maintained by Business Associate or its agents or subcontractors, if any, available to Covered Entity for inspection and copying within ten (10) days of a request by Covered Entity to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524.

M. Within ten (10) days of receipt of a request from Covered Entity for an amendment of PHI or a record about an Individual contained in a Designated Record Set, Business Associate or its agents or subcontractors, if any, shall make such PHI available to Covered Entity for amendment and shall incorporate any such amendment to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524. If an Individual requests an amendment of PHI directly from Business Associate or its agents or subcontractors, if any, Business Associate must notify Covered Entity in writing within five (5) days of the request. Any denial of amendment of PHI maintained by Business Associate or its agents or subcontractors, if any, shall be the responsibility of Covered Entity. Upon the approval of Covered Entity, Business Associate shall appropriately amend the PHI maintained by it, or any agents or subcontractors.

N. Within ten (10) days of notice by Covered Entity of a request for an accounting of disclosures of PHI, Business Associate and any of its agents or subcontractors shall make available to Covered Entity the information required to provide an accounting of disclosures to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528. Except in the case of a direct request from an Individual for an accounting related to treatment, payment or operations disclosures through an electronic health record, if the request for an accounting is delivered directly to Business Associate or its agents or subcontractors, if any, Business Associate shall within five business (5) days of a request notify Covered Entity about such request. Covered Entity shall either inform Business Associate to provide such information directly to the Individual, or it shall request the information to be immediately forwarded to Covered Entity for compilation and distribution to such Individual. In the case of a direct request for an accounting from an Individual related to treatment, payment or operations disclosures through electronic health records, Business Associate shall provide such accounting to the Individual in accordance with HITECH §13405(c). Business Associate shall not disclose any PHI unless such disclosure is Required By Law or is in accordance with this Addendum. Business Associate shall document such disclosures. Notwithstanding Section VI. D., Business Associate and any agents or subcontractors shall continue to maintain the information required for purposes of complying with this Section IV. L. for a period of six (6) years after termination of the Addendum.

O. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary for purposes of determining Covered Entity's compliance with the Privacy Rule. Business Associate shall notify Covered Entity regarding any PHI that Business Associate provides to the Secretary concurrently with providing such PHI to the Secretary, and upon request by Covered Entity, shall provide Covered Entity with a duplicate copy of such PHI.

P. Business Associate and its agents or subcontractors, if any, shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure. Business Associate agrees to comply with the Secretary's guidance on what constitutes minimum necessary. *See* HITECH §13405. Business Associate represents and warrants that it has developed policies and procedures that limit the PHI to be used, disclosed or requested to the minimum necessary standard.

Q. Business Associate acknowledges that Business Associate has no ownership rights related to the PHI.

R. Unless greater coverage is required under the Services Agreement or any other agreement between Covered Entity and Business Associate for the provision of services related to this Addendum, Business Associate shall maintain or cause to be maintained the following insurance covering itself and each subcontractor or agent, if any, through whom Business Associate provides services; (i) a policy of commercial general liability and property damage insurance, and electronic data processing insurance, with limits of liability not less than two million dollars ($2,000,000) per occurrence and two million dollars ($2,000,000) annual aggregate and (ii) such other insurance or self insurance as shall be necessary to insure it against any claim or claims for damages arising under this Addendum or from violating Business Associate's own obligations under HIPAA and HITECH (*see* HITECH § 13404), including but not limited to, claims or the imposition of administrative penalties and fines on Business Associate or its subcontractors or agents, if any, arising from the loss, theft, or unauthorized use or disclosure of PHI. Such insurance coverage shall apply to all site(s) of Business Associate and to all services provided by Business Associate or any subcontractors or agents under this Addendum.

S. During the term of this Addendum, Business Associate shall notify Covered Entity within twenty-four (24) hours of any suspected or actual Security Incident or breach of security, intrusion or unauthorized use or disclosure of PHI or EPHI and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations, or any legal action against Business Associate arising from an alleged HIPAA violation. Business Associate shall take (i) prompt action to correct any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

T. Within ten (10) business days of a written request by Covered Entity, Business Associate and its agents or subcontractors, if any, shall allow Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI pursuant to this Addendum for the purpose of determining whether Business Associate has complied with this Addendum and HITECH; provided, however, that (i) Business Associate and Covered Entity mutually agree in advance upon the scope, location and timing of such an inspection; and (ii) Covered Entity shall protect the confidentiality of all confidential and proprietary information of Business Associate to which Covered Entity has access during the course of such inspection.

U. Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 CFR §164.504(e)(2)(I)(B).

V. If Business Associate knows of a pattern of activity or practice by the Covered Entity that constitutes a material breach or violation of the Covered Entity's obligations under this Addendum, Business Associate will take reasonable steps to cure the breach or end the violation. If such steps are unsuccessful within a period of 30 days, Business Associate will either: i) terminate the Agreement, if feasible; or ii) report the problem to the Secretary.

V. COVERED ENTITY OBLIGATIONS

A. Covered Entity shall provide Business Associate with the notice of any privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice.

B. Covered Entity shall provide Business Associate with notice of any changes to, revocation of, or permission by Individual to use or disclose PHI, if such changes affect Business Associate's permitted uses or disclosures, within a reasonable period of time after Covered Entity becomes aware of such changes to or revocation of permission.

C. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to or must comply with in accordance with 45 CFR § 164.522 and HITECH § 13405(a).

D. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

VI. TERMINATION

A. The term of this Addendum shall be effective as of the Effective Date of this Addendum and continue until terminated by Covered Entity or any underlying Services Agreement expires or is terminated. Any provision related to the use, disclosure, access, or protection of EPHI or PHI or that by its terms should survive termination of this Addendum shall survive termination.

B. A breach by Business Associate, or its agents or subcontractors, if any, of any provision of this Addendum, as determined by Covered Entity, shall constitute a material breach of the Addendum. If Business Associate breaches this Addendum, Covered Entity may, in its discretion: (i) immediately terminate this Addendum; (ii) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Addendum if Business Associate does not promptly cure the breach or end the violation within a period not to exceed 30 days; or (iii) report the violation to the Secretary if neither termination nor cure is feasible.

C. Covered Entity may terminate this Addendum effective immediately, if (i) Business Associate is named as a defendant in a criminal proceeding for a violation of HIPAA, HITECH, or other security or privacy laws; or (ii) there is a finding or stipulation that Business Associate has violated any standard or requirement of HIPAA, HITECH, or other security or privacy laws in any administrative or civil proceeding in which Business Associate is involved.

D. Upon termination of this Addendum for any reason, Business Associate shall return, or at Covered Entity's request, destroy all PHI that Business Associate or its agents or subcontractors, if any, still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall explain to Covered Entity why conditions make the return or destruction of such PHI not feasible. If Covered Entity agrees that the return or destruction of PHI is not feasible, Business Associate shall retain the PHI, subject to all of the protections of this Addendum, and shall make no further use of such PHI. If Business Associate elects to destroy the PHI, Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

E. If this Addendum is terminated for any reason, Covered Entity may also terminate the Services Agreement between the parties. This provision shall supersede any termination provision to the contrary which may be set forth in the Services Agreement.

VII. MISCELLANEOUS

A. A reference in this Addendum to a section in the Privacy Rule means the Privacy Rule section as in effect or as amended. If any modification to this Addendum is Required By Law or required by HITECH or any other federal or state law affecting this Addendum, or if Covered Entity reasonably concludes that an amendment to this Addendum is needed because of a change in federal or state law or changing industry standards, Covered Entity shall notify Business Associate of such proposed modification(s) ("Legally-Required Modifications"). Such Legally Required Modifications shall be deemed accepted by Business Associate and this Addendum so amended, if Business Associate does not, within thirty (30) calendar days following the date of the notice (or within such other time period as may be mandated by applicable state or federal law), deliver to Covered Entity its written rejection of such Legally-Required Modifications.

B. Business Associate and any of its subcontractors and agents shall indemnify, hold harmless and defend Covered Entity and its employees, officers, directors, agents, and contractors from and against any and all claims, losses, liabilities, costs, attorneys' fees, and other expenses incurred as a result of or arising directly or indirectly out of or in connection with Business Associate's or its subcontractors' or agents' breach of this Addendum, violation of HIPAA, HITECH or other applicable law, or otherwise related to the acts or omissions of Business Associate or its subcontractors or agents.

C. Business Associate may not subcontract any Services or assign any rights, nor may it delegate its duties, under this Addendum without the express written consent of Covered Entity.

D. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity, Business Associate, or their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

E. The parties are independent contractors and nothing in this Addendum shall be deemed to make them partners or joint venturers, or create an employment relationship between them.

F. Business Associate will comply with all appropriate federal and state security and privacy laws, to the extent that such laws apply to Business Associate or are more protective of Individual privacy or More Stringent than are the HIPAA laws.

G. All notices which are required or permitted to be given pursuant to this Addendum shall be in writing and shall be sufficient in all respects if delivered personally, by electronic facsimile (with a confirmation by registered or certified mail placed in the mail no later than the following day), by registered or certified mail, postage prepaid, or by another delivery service that provides evidence of delivery, addressed to a party as indicated below:

If to Covered Entity, to:	If to Business Associate, to:
AmeriHealth Mercy of Louisiana, Inc.	PerformRx
10000 Perkins Rowe Building G, Suite 400 Baton Rouge, LA 70810	Privacy Office 200 Stevens Dr. Philadelphia, PA 19113

Notice shall be deemed to have been given upon transmittal thereof as to communications which are personally delivered or transmitted by electronic facsimile; as to communications made by United States mail, on the third (3rd) day after mailing; and, as to communications made by other delivery service, on the date delivered. The above addresses may be changed by giving notice of such change in the manner provided above for giving notice.

H. If any provision of this Addendum is determined by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions hereof shall continue in full force and effect.

I. This Addendum contains the entire understanding between the parties hereto regarding the use and disclosure of PHI and shall supersede any other oral or written agreements, discussions and understandings of every kind and nature, including any provision in any Services Agreement. No modification, addition to or waiver of any right, obligation or default shall be effective unless in writing and signed by the party against whom the same is sought to be enforced. No delay or failure of either party to exercise any right or remedy available hereunder, at law or in equity, shall act as a waiver of such right or remedy, and any waiver shall not waive any subsequent right, obligation, or default.

J. This Addendum shall be construed, interpreted and enforced in accordance with, and governed by, the laws of the State of Louisiana and the United States of America.

IN WITNESS WHEREOF, the parties have caused this Addendum to be executed by their respective duly authorized representatives and to become effective as of the Effective Date.

COVERED ENTITY
AmeriHealth Mercy of Louisiana, Inc.

By: _____
Print Name: KATHLEEN STONE
Print Title: EXECUTIVE DIRECTOR

BUSINESS ASSOCIATE
PerformRx, LLC

By: _____
Print Name: Mesfin Tegenu
Print Title: President

EXHIBIT D:
PERFORMANCE STANDARDS

Relationship Management Onsite Meeting	4 Meetings per year with Health Plan or as requested by Health Plan, to include a minimum of one annual face to face meeting
Account Team Response Time	Will respond to requests within one (1) business day excluding holidays and vacation. Activity to be completed within thirty (30) days or a mutually agreed upon date.
PBM Vendor Management	Notification to Health Plan prior to contracting any subcontractors and/or affiliates
Accuracy in Plan Changes	Accuracy in plan changes rate will be at least 98% provided, however that if there are not sufficient changes that one (1) error would result in not meeting the standard, one (1) error will be allowed.
New Group Set-Up Procedures	New groups will be implemented within fifteen (15) business days of receiving the necessary information to program the new groups' parameters.
Programming/Set-Up of New or Changed Benefit Designs	Less complex changes, such as the addition of a new plan benefit (Basic) or a new benefit using an existing benefit, change in benefits copayments/days supply, or change in pharmacy network would be implemented by **PBM** within an average of five (5) business days. Moderately complex changes, such as benefit designs requiring research, adding copayments for specific drugs, adding multiple groups involving lower level demographic changes, adding maintenance benefit/maintenance list, or drug changes would be implemented by **PBM** within an average of ten (10) business days. Very complex changes, such as Prescription Drug Program revisions with major changes/research, administration of extensive, Sponsor-specific clinical programs would be implemented by **PBM** within agreed upon time frames, generally greater than ten (10) days.
Abandonment Call Rate	Five percent (5%) or less of all calls will be abandoned.
Availability of 24-hour Service	24 Hour service will be available 99% of the time.

Average Speed Answered	Average time to answer a Customer Call will be thirty (30) seconds or less.
Initial Call Resolution	Initial call resolution will occur at least 90% of the time.
Member Inquiries - Within forty-eight (48) hours on normal business days.	PerformRx will forward Member Inquiries to the client within forty-eight (48) hours and will respond to pharmacy-specific questions from Members within forty-eight (48) hours, both on normal business days.
Member Satisfaction	90% of members will respond as being satisfied or very satisfied with member call handling.
Occurrence of Busy Signal at Call Center/ Telephone Blockage Rate	Less than a 5% blockage rate.
Provider Complaints	PerformRx will contact pharmacy providers within forty-eight (48) hours on normal business days to address complaints.
Eligibility	Ninety-eight percent (98%) of daily eligibility loads posted to the PerformRx FTP site or received by [client] will be completed within one (1) business day of receipt.
NDC Updates	PerformRx will process all error-free drug data vendor files within three (3) business days of receipt at least ninety-nine percent (99%) of the time. PerformRx reserves the right to delay processing of the file, without penalty, when the file from the drug data vendor includes apparent data integrity issues.
Paper Claim Turnaround Time	**PBM** guarantees that member submitted claims requiring no development will be reimbursed or responded to within seventy-two (72) hours of receipt of the DMR, or as otherwise required by CMS.

Plan Administration Service Levels	Ninety-eight percent (98%) of the time PerformRx shall meet the Turnaround Times documented in the accompanying Standard Turnaround Time table for requests that pertain to a normal, not unusually large, volume of data. PerformRx and [client] will mutually agree in writing on requests that are to be deemed acceptable.
POS Claims Adjudication Accuracy	Ninety-nine percent (99%) of all claims received in PerformRx format will be processed accurately. Ninety-nine percent (99%) of manually-keyed claims received in PerformRx format will be processed with no errors.
Pricing Guarantee - Prescription Claim Reimbursement	Claims processing errors resulting from incorrect programming and totaling more than $100,000 in net adjustments will resulting assessment of a penalty.
Processing of Eligibility Changes or Updates	The electronic eligibility files will be installed and eligibility status will be effecting within one (1) business day of receipt of machine readable eligibility information.
System Availability	Claims processing system will be available no less than 99.5% of the time.
System Response	Point-of-Sale average daily processing time shall not be more than three (3) seconds ninety-nine percent (99%) of the time, excluding scheduled maintenance and telecommunications failure.
Universal Claim Forms (UCF) Processing	PerformRx shall process UCF claims within the following timeframes: - eighty percent (80%) within five (5) business days; - 98.5% within ten (10) business days; - 100% within fifteen (15) business days requiring no intervention
Formulary and Pricing File	Maintain CMS formulary submission and price files and submit timely to CMS per CMS requirements 3 Business Days Prior to CMS Delivery Date
Pharmacy access requirements	PerformRx shall adhere to following GeoAccess Requirements: -Urban areas: Travel distance for members living in urban parishes shall not exceed 10 miles; -Rural areas: Travel distance for members living in rural parishes shall not exceed 30 miles.
EOB Timelines of Release	PerformRx shall post a sample of EOBs to the Quality Validation ("QV") tool for [client]'s review by the 15th of each calendar month. PerformRx shall print and mail EOB's for each EOB file for [client]'s member within five (5) business days following the received notification from [client] approving the release of the EOB file.

Encounter Data	PerformRx shall submit ninety-nine percent (98%) of the Medicaid encounters in an Encounter Data file to [client] or the [client's] designee in the format required by the state in which the encounter is reported, within thirty (30) days from the end of the month in which the applicable encounter(s) occurred ("Reporting Month"), or within such a shorter [client]-specific time period as may be set out in a plan mutually agreed [client] Plan Addendum. The Encounter Data file will contain information provided to PerformRx by the [client]: (1) pharmacy's Medicaid ID from the Medicaid ID file for the Reporting Month and (2) the physician's state license loaded by PerformRx according to the Physician's Prescriber File (State License) load schedule. The Physician's Prescriber File received before 3:00 p.m. Central Standard Time will be loaded within one (1) business day of receipt. A Physician's Prescriber File received from [client] after 3:00 p.m. Central Standard Time will be deemed received on the next PerformRx business day.
Implementation	100% Timeliness of Project Delivery—Within Agreed Upon Delivery Time
Plan Implementation Procedures	Adherence to established deadlines mutually agreed upon by [client] and PerformRx.
Delivery Turnaround Time for All Mail Order Prescriptions	**PBM** guarantees that ninety-five percent (95%) of submitted prescriptions will be delivered within fourteen (14) calendar days or less.
Prescription Turnaround Time for All Prescriptions	Eight-five percent (85%) of all pharmacist-approved mail service prescriptions will be processed and shipped within five (5) business days.

Turnaround Time for Clean Prescriptions	Ninety Percent (90%) of pharmacist-approved "clean" mail service prescriptions will be processed and shipped within two (2) business days. Clean prescriptions shall mean those prescriptions that do not require member, prescriber or client intervention.
Medication Error Rates/Dispensing Accuracy	99.98% or higher of all prescriptions submitted to PerformRx shall be accurately dispensed to Members without discrepancies of, but not limited to, any of the following: (a) incorrect medication (exclusive of brand/generic substitution) (b) incorrect strength (c) incorrect member or (d) incorrect prescription instructions compared to prescribing physician's order.
Participating Pharmacy Disbursements Timelines	PerformRx shall release disbursements to Participating Pharmacies within three (3) PerformRx business days following the day on which PerformRx receives notification of adequate funding from the applicable banking institution.
Pharmacy Auditing	**PBM** guarantees that 100% of participating pharmacies will be subject to statistical audits and that 3% of pharmacies in the pharmacy network filling more than 250 claims during the previous year will be audited on-site based across our book of business. This standard will be measured and reported annually.
Pharmacy Network Access Guarantee	Network Pharmacy shall be available within 3 miles of a 98% of Member residences if a pharmacy is available. Network Pharmacy shall be available within 5 miles of a 99% of Member residences if a pharmacy is available. Network Pharmacy shall be available within 10 miles of a 99.5% of Member residences if a pharmacy is available.
Pharmacy Network Reimbursement	The pharmacy reimbursement setup and change processing accuracy rate will be at least ninety-eight percent (98%) provided, however that if there are not sufficient changes that one (1) error would result in not meeting the standard, one (1) error will be allowed.
Provider Contracting	100% of the time Provide a network provider contract to a requesting pharmacy within 2 business days of request

Expedited Coverage Determination Resolution	100% of cases within twenty-four (24) hours of receipt of the prescriber's supporting statement for exceptions
Prior Authorization Turnaround Time	100% of prior authorization have an average turnaround time within twenty-four (24) hours with no obligation to review by client excluding weekends and holidays.
Prior Authorization Turnaround Time	100% Member and physician notification within 48 hours of PA final determination (for Health Plan's Medicaid business)
Timeframe for Rebate Payments	Within one hundred and twenty (120) following the end of the quarter, PerformRx shall mail to customer a check for the total amount of rebate dollars owed to customer, based on payments received for the respective quarter.
Standard Management Report Accuracy	99% accurate
Standard Management Report Timelines	Standard reports to be delivered within fifteen (15) business days of end of the reporting period.

EXHIBIT E: STANDARD REPORTS

PerformRx will provide the Management Reports below at no additional cost:

Standard Management Reports	
Report	**Frequency**
Quarterly Review	Quarterly
Annual Review	Annual
Group Summary	Monthly
Utilization Summary – Current Period and Year-to-date	Monthly
Client Group Summary	Monthly
Utilization Report by Sex and Age	Monthly
13-Month Statistics with Trends	Monthly
Prescriber Ranking: Top XXX Prescribers - Summary	Monthly
Prescriber Specialty Summary: XXX or More Prescriptions	Monthly
Prescriber Ranking – Top XXX Prescribers - Detail	Monthly
Prescriber Profile – Top XXX Drugs – Prescribers with XXX or more Prescriptions	Monthly
Prescriber Summary by Specialty – Primary Care Physicians	Monthly
Prescriber Ranking by Specialty – Top XXX Non-Formulary Drugs	Monthly
Prescriber DAW Ranking: Top XXX Prescribers, Top XXX Drugs	Monthly
Summary of Prescribers – Brand/Generic	Monthly
Prescriber Profile Summary: Top XXX Drugs for Prescribers with XXX or More Prescriptions	Monthly
Specialty Profile: Top XXX Drugs	Monthly
Prescriber Utilization by Specialty	Monthly
Prescriber Detail: XXX or More Prescriptions/Dollars	Monthly
Therapeutic Class Ranking	Monthly
NDC Ranking: Top XXX Drugs	Monthly
GCN Ranking: Top XXX Drugs	Monthly
NDC Ranking: Top XXX Drugs – Retail vs. Mail-order	Monthly
Generic Drug Utilization Summary	Monthly
Therapeutic Class Detail	Monthly
Therapeutic Class Summary	Monthly

It is understood between both parties that any other customized reports may be provided with cost quoted upon request.

EXHIBIT F

GOVERNMENTAL OBLIGATIONS

Louisiana Coordinated Care Networks – Prepaid (CCN-P)
Required Subcontractor Provisions

PerformRx's obligations under this Agreement shall include the provisions set forth in this **Exhibit F**, which sets forth certain Customer-specific Governmental Obligations applicable to the provision of Pharmacy Services in Customer's jurisdiction. Such Governmental Obligations are hereby incorporated to the Agreement as if fully set forth therein. In the event of a conflict between the terms of the Agreement and the Customer-specific Governmental Obligations set forth in this **Exhibit F**, the relevant provision(s) in this **Exhibit F** shall control.

Introduction

On April 11, 2011, the State of Louisiana ("State") Department of Health and Hospitals ("DHH") issued Request for Proposals #305PUR-DHHRFP-CCN-P-MVA (the "RFP") for the procurement of Prepaid Coordinated Care Networks ("CCN-P") to solicit proposals from qualified entities to provide healthcare services to Medicaid enrollees participating in DHH's Medicaid Coordinated Care Network project. AmeriHealth Mercy of Louisiana, Inc. ("AML") submitted a proposal in response to the RFP (the "AML Response"), pursuant to which DHH awarded a contract to AML to serve as a CCN-P ("State Contract"). **PerformRx, LLC** ("Subcontractor") is a person, agency or organization with which AML will subcontract, or to which AML will delegate some of its management functions or other contractual responsibilities to provide covered services to AML's members, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this **Subcontractor Exhibit ("Exhibit")**, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between AML and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). No other terms and conditions agreed to by AML and Subcontractor shall negate or supersede the requirements of this Exhibit.

1. **Order of Precedence.** In the event of any inconsistency or conflict between of this Agreement and the State Contract, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

a. the body of the State Contract with its exhibits and attachments, excluding the RFP and the AML Response;

b. the RFP and any addenda and appendices;

c. the CCN-P Systems Companion Guide;

d. the CCN Quality Companion Guide; and

e. AML's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit AML to meet its reporting obligations to DHH, all reports submitted to AML by Subcontractor must be in a format accessible and modifiable by the

standard Microsoft Office suite of products, version 2003 or later, or in another format accepted and approved by AML.

3. Compliance with Laws and Regulations. Subcontractor agrees and warrants that it shall comply with all State and federal laws, regulations and policies as they exist at the time of this Agreement, or as subsequently amended that are or may be applicable to this Agreement, whether or not specifically mentioned in this **Exhibit**. Any provision of this Agreement that is in conflict with federal statutes, regulations or CMS policy guidance is deemed to be amended to conform to the provisions of those laws, regulations and federal policy. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws, including but not limited to:

a. Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b. All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.) and 20 U.S.C. §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);

c. Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d) and regulations issued pursuant thereto (45 CFR Part 80), in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement;

d. Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e. Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f. The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g. The Omnibus Reconciliation Act of 1981, as amended (P.L.E. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h. The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (H.R. 3426);

i. Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j. Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k. The Federal Drug Free Workplace Act of 1988, as set forth in 45 CFR Part 82, and any applicable State drug-free workplace law;

l. Title IX of the Education Amendments of 1972, regarding education programs and activities; and

m. Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to AML any lobbying with non-federal funds that takes place in connection with obtaining any federal award.

4. Fraud, Waste and Abuse (FWA) Detection and Prevention. Subcontractor shall cooperate with and abide by AML's FWA detection and prevention activities and shall adhere to AML's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations relating to FWA in the Medicaid and CHIP programs. Without limiting the foregoing:

a. Subcontractor shall report to AML any cases of suspected Medicaid fraud or abuse by AML's members, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit AML to meet its requirement to report to the Program Integrity Section within three (3) business days.

b. Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA. Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the U.S. Department of Health and Human Services ("HHS"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and DHH. Subcontractor shall provide timely and reasonable access to HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General and/or their designees, who shall have the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period (six (6) years following termination of the State Contract), but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

c. Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

d. Subcontractor shall immediately report to AML when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

e. In accordance with 42 CFR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Subcontractor shall comply with all applicable provisions of 2 CFR Part 376, pertaining to debarment and/or suspension. Subcontractor shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, the Subcontractor shall search the following websites on a monthly basis:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/search.aspx
- Health Care Integrity an Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp
- Excluded Parties List Serve (EPLS) www.EPLS.gov

Any and all exclusion information discovered by Subcontractor shall be immediately reported to AML.

f. In accordance with the requirements specified in 42 CFR §455, Subpart B, Subcontractor shall provide AML with full and complete information on the identity of each person or corporation with an ownership interest of five percent (5%) or greater in the Subcontractor, or any subcontractor of Subcontractor in which Subcontractor has five percent (5%) or more ownership interest. Subcontractor shall also provide such required information, including but not limited to financial statements, for each person or entity with ownership or controlling interest of five percent (5%) or more in Subcontractor and any of its subcontractors, including all entities owned or controlled by a parent organization. Reports shall be updated as necessary whenever changes in ownership occur. All information required to be reported under this paragraph shall be provided on CMS Form 1513.

g. If Subcontractor receives annual payments from AML of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA), which requires that Subcontractor, as a condition of receiving such payments, must establish written policies for all employees of Subcontractor (including management), and for any contractor or agent of Subcontractor, that provide detailed information about §§1932-71 of the False Claims Act established under sections 3729 through 3733 of Title 31 of the U.S. Code; administrative remedies for false claims and statements established under Chapter 38 of Title 31 of the U.S. Code; any state laws pertaining to civil or criminal penalties

for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA in Federal health care programs. Such policies shall include detailed provisions regarding Subcontractor's policies and procedures for detecting and preventing FWA. Subcontractor shall also include in any employee handbook a specific discussion of the foregoing laws, the rights of employees to be protected as whistleblowers, and Subcontractor's policies and procedures for detecting and preventing FWA.

5. Employment of Personnel.

a. Non-Discrimination. In the hiring or employment made possible or resulting from this Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex or national origin. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all State and federal laws applicable to employment of personnel.

b. Restriction on Certain Individuals. For the purposes of providing services under this Agreement, Subcontractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b) and 42 CFR §1003.102(a)(2)].

c. Screening of Personnel. Subcontractor shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of DHH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide AML with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under this Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d. Removal of Personnel. Subcontractor shall remove or reassign, upon written request from AML or DHH, any Subcontractor employee that AML or DHH, as applicable, deems to be unacceptable.

6. Cooperation.

a. Cooperation with Other Services Providers. To the extent applicable to the services provided under this Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs, Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

b. Cooperation with Other Contractors. In the event that AML has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Subcontractor's failure to cooperate and comply with this provision shall be sufficient grounds for AML to halt all payments due or owing to Subcontractor until it becomes compliant with this or any other contract provision.

7. Provider Selection Requirements. To the extent Subcontractor is responsible for the selection and retention of Providers:

a. Subcontractor shall have written policies and procedures in accordance with 42 CFR §438.214. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b. Subcontractor shall follow the State's credentialing and recredentialing policy.

c. Any laboratory testing site providing services under this Agreement must have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

d. All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under this Agreement.

e. Subcontractor's provider contract forms may be subject to review and approval by DHH; and DHH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under this Agreement. Provider contracts must include the CCN-P Provider Subcontract Requirements set forth in Appendix O to the RFP.

f. Subcontractor shall deny payments to Providers for Provider Preventable Conditions (as such term is defined in the RFP).

g. Subcontractor shall not execute provider contracts with Providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

h. Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the member needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the member's right to

participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

i. Subcontractor shall provide written notification to AML of its intent to terminate any provider contract that may materially impact Subcontractor's provider network and/or operations, as soon as possible but no later than ten (10) business days prior to the effective date of termination, so that AML may fulfill its reporting requirements to DHH.

8. Physician Incentive Plans. Subcontractor shall disclose to AML annually any Physician Incentive Plan (PIP) or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

9. National Provider Identifier (NPI). The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to AML upon request.

10. AML Member Hold Harmless. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against AML members, or persons acting on their behalf, for health care services which are rendered to such members by Subcontractor and its contractors, and which are core benefits and services under the Louisiana Medicaid program. AML members shall not be held liable for payment for core benefits and services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by AML or the insolvency of AML. This provision shall be construed to be for the benefit of AML's members. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and AML's members, or persons acting on their behalf.

11. AML Member Non-Discrimination. Subcontractor shall not discriminate in the provision of services to AML's members. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of AML's program or be otherwise subjected to discrimination in the performance of this Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

12. Marketing and Member Education. All Marketing (as such term is defined in the RFP) and member education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the DHH requirements as set forth in the RFP, including but not limited to the following:

a. All Marketing and member education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and member education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by DHH. AML, and not Subcontractor, is responsible for obtaining DHH approval, and Subcontractor shall provide all such materials to AML for submission to DHH. Subcontractor may not distribute any AML marketing or member education materials, or participate in any marketing and member education events and activities, without AML having received DHH consent.

b. In carrying out any Marketing or member education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 12.3 of the RFP; but (ii) Subcontractor's Marketing and member education activities may include those activities enumerated in Section 12.4 of the RFP.

13. Misuse of Symbols, Emblems or Names in Reference to Medicaid. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint or distribute any DHH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

14. Confidentiality of Information.

a. Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through Subcontractor's performance under this Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, DHH policies or this Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement.

b. All information as to personal facts and circumstances concerning members or potential members obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of AML, DHH or the member/potential member, unless otherwise permitted by HIPAA or required by applicable State and federal law or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Agreement.

c. Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of AML, the Subcontractor's use

and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to this Agreement as **Exhibit C**.

15. Safeguarding Information. Subcontractor shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members, to purposes directly connected with the performance of this Agreement. Subcontractor's written safeguards shall:

a. be comparable to those imposed upon DHH by 42 CFR Part 431, Subpart F and La. R.S. 45:56;

b. state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c. require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d. not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e. specify appropriate personnel actions to sanction violators.

16. DHH Use of Data. Notwithstanding any provision in this **Exhibit** or the Agreement to the contrary, DHH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from this Agreement.

17. Record Retention. All records originated or prepared by PerformRx or Network Pharmacies in connection with performance under this Agreement (with respect to PerformRx) and in connection with performance under Network Pharmacy contracts (with respect to Network Pharmacies) shall be retained and safeguarded in accordance with the terms and conditions of the State Contract. Without limiting the foregoing, financial records, supporting documents, statistical records, and all other records pertinent to this Agreement shall be retained for a period of at least six (6) years from the date of submission of AML's final expenditure report, with the following exceptions:

a. If any litigation, claim, financial management review or audit is started before the expiration of the 6-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

b. Records for real property and equipment acquired with federal funds shall be retained for six (6) years following its final disposition.

c. When records are transferred to or maintained by DHH, the 6-year retention period is not applicable to the Subcontractor.

d. Indirect cost rate proposals, cost allocation plans, etc., as specified in 45 CFR 74.53(g).

18. Release of Records. Subcontractor shall release medical records of members as may be authorized by the member, or as may be directed by authorized personnel of AML, DHH,

appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule).

19. Insurance. Subcontractor shall not commence work under this Agreement until it has obtained all insurance required herein; Subcontractor shall provide AML with certificates evidencing such coverage upon request. If so requested, Subcontractor shall submit copies of its insurance policies for inspection and approval by DHH before work under this Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. AML shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

a. Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of this Agreement, workers' compensation insurance, with at least the minimum levels of coverage required by law, for all of Subcontractor's employees that provide services under this Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b. Commercial Liability Insurance. During the life of this Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, AML and DHH during the Subcontractor's performance of work under this Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under this Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on DHH. Such Insurance shall name AML and DHH as additional insureds for claims arising from or resulting from the operations of Subcontractor under this Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a combined single limit of not less than One Million Dollars ($1,000,000). If so determined by DHH, and if applicable to Subcontractor, special hazards (as identified by DHH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c. Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of this Agreement, Errors & Omissions insurance in the amount of at least One Million Dollars ($1,000,000) per occurrence.

d. Licensed and Non-licensed Motor Vehicles. Subcontractor shall maintain, during the life of this Agreement, automobile liability insurance in an amount not less than combined single limits of One Million Dollars ($1,000,000) per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of this Agreement on the site of the work to be performed hereunder, unless such coverage is included in insurance that is elsewhere specified under this **paragraph 19**.

e. Fidelity Bond. Subcontractor shall secure and maintain during the term of this Agreement a blanket fidelity bond on all personnel in its employment. The bond shall include,

but not be limited to, coverage for losses sustained through any fraudulent or dishonest act or acts committed by any employees of Subcontractor.

20. Hold Harmless. Subcontractor shall defend, protect and hold harmless AML and DHH, and any of their respective officers, agents and employees, from and against:

a. any claims for damages or losses arising from services rendered by Subcontractor, or any of its contractors, employees, officers, agents or representatives performing or supplying services, materials or supplies in connection with this Agreement;

b. any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or statutes, by Subcontractor, its contractors, employees, officers, agents or representatives in the performance of this Agreement;

c. any claims for damages or losses resulting to any person or firm injured or damaged by the Subcontractor, its contractors, employees, officers, agents or representatives by Subcontractor's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under this Agreement in a manner not authorized hereunder or by Federal or State regulations or statutes;

d. any failure of Subcontractor, its contractors, employees, officers, agents or representatives to observe Federal or State laws, including but not limited to labor laws and minimum wage laws;

e. any claims for damages, losses or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of AML or DHH in connection with the defense of claims for such injuries, losses, claims or damages specified in the foregoing sub-paragraphs "a" through "d"; and

f. any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against AML or DHH or their respective agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor, its contractors, employees, officers, agents or representatives.

AML will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under this Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of AML, which shall not be unreasonably withheld.

21. Penalties and Sanctions; Corrective Actions. Subcontractor agrees that failure to comply with the provisions of this Agreement may result in the assessment of monetary penalties or sanctions against AML, which AML may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, and/or termination of the State Contract in whole or in part, which shall result in termination of this Agreement.

a. Subcontractor shall indemnify AML against any monetary penalties, administrative actions or sanctions that may be imposed on AML to the extent attributable to the

acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, AML may require Subcontractor to pay such penalties directly.

b. Subcontractor shall cooperate with any relevant corrective action plan imposed upon or developed by AML in response to identified deficiencies under the State Contract. AML may further require a corrective action plan of Subcontractor notwithstanding that DHH has not imposed the requirement on AML.

22. Loss of Federal Financial Participation (FFP). Subcontractor agrees to be liable of any loss of FFP suffered by DHH due to Subcontractor's, or any of its contractors', failure to perform the services as required under this Agreement.

23. Warranty of Removal of Conflict of Interest. Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under this Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform AML of any potential conflict. Subcontractor warrants that any conflict of interest will be removed prior to signing this Agreement.

24. Political Activity. None of the funds, materials, property or services provided directly or indirectly under this Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

25. Prohibited Payments. Payments under this Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

26. Emergency Management Plan. Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

27. Force Majeure. In the event of circumstances not reasonably within the control of Subcontractor or AML (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither AML nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under this Agreement. Notwithstanding, as long as this Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with this Agreement.

28. Termination for Threat to Health of AML Members. DHH or AML may terminate this Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of members enrolled in AML.

29. Homeland Security Considerations. Subcontractor shall perform the services to be provided under this Agreement within the boundaries of the United States. Subcontractor will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of this Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by AML or DHH, and shall be required to indemnify AML and DHH pursuant to the indemnification provisions of this Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under this Agreement.

30. Independent Contractor. It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of this Agreement, and not as officers, agents or employees, whether express or implied, of AML, DHH or the State of Louisiana. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either AML or DHH or the State of Louisiana.

31. Entire Contract. This Agreement, together with the RFP and addenda issued thereto by DHH, the AML Response, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect to the subject matter hereof. Subcontractor shall comply with, and agrees to be bound by, all provisions of this Agreement, including addenda, amendments and appendices, and shall act in good faith in the performance of the provisions of this Agreement.

The Subcontractor also agrees to comply with relevant provisions of the State Contract and any rules or regulations that may be promulgated by DHH pursuant to the State Contract, all DHH provider manuals, DHH issued guides, and all applicable DHH policies and procedures in effect throughout the duration of this Agreement.

This Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties hereto.

32. Amendments. This Agreement may be amended at any time as provided in this paragraph. The Agreement may be amended whenever appropriate to comply with State and federal requirements or State budget reductions; provided, however, subject to Section 3 of this **Exhibit**, no modification or change of any provision of this Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by AML and Subcontractor.

33. Governing Law. This Agreement shall be governed by the laws of the State of Louisiana, except its conflict of laws provisions both as to interpretation and performance.

34. Additional Regulatory Requirements.

a. Network Pharmacies may not refuse to provide covered medically necessary or covered preventive services to Members for non-medical reasons. However, Network Pharmacies shall not be required to continue treatment of a Member with whom the Network Pharmacy feels he/she cannot establish and/or maintain a professional relationship.

b. Neither PerformRx nor Network Pharmacies are permitted to encourage or suggest, in any way, that Members be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH.

c. PerformRx and Network Pharmacies shall adhere to medical record requirements as specified in the State Contract, to the extent applicable. Without limiting the foregoing, Member medical records must be released as may be authorized by the Member, as may be directed by authorized personnel of DHH, appropriate agencies of the State of Louisiana or the United States government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the State Contract. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to La.R.S. 40:1299.96, La.R.S. 13:3734 and La.C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule).

d. Whether announced or unannounced, PerformRx and Network Pharmacies are required to participate in and cooperate with any internal and external quality assessment review, utilization management and grievance procedures established by AML and/or DHH or its designee.

e. AML and PerformRx shall be responsible for resolving any disputes that may arise between them; and no dispute between them shall disrupt or interfere with the provision of services to Members.

f. PerformRx and Network Pharmacies shall adhere as applicable to the Quality Assessment and Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined in the State Contract, and such requirements (to the extent applicable to PerformRx) are hereby incorporated by reference to this Agreement.

g. PerformRx shall give AML immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on PerformRx's ability to perform the services included in this Agreement.

h. No provision of this Agreement shall, or shall be interpreted to, provide PerformRx with any incentives, monetary or otherwise, for the withholding of medically necessary care. In accordance with 42 CFR §438.210(e), compensation to PerformRx or individuals who conduct utilization review activities is not structured so as to provide incentives for the individual or PerformRx to deny, limit or discontinue medically necessary services to any Member.

i. PerformRx shall not have a contract arrangement with any Network Pharmacy in which the Network Pharmacy represents or agrees that it will not contract with another PBM or prepaid health plan, or in which PerformRx represents that it will

not contract with another pharmacy provider. PerformRx shall not hold itself out as having an exclusive relationship with any service provider.

j. Nothing in this Agreement shall allow, or be interpreted to allow, PerformRx, any Participating Pharmacy or AML to charge Members fees of any kind or any co-pay or cost-sharing amount above that which exists in the Louisiana State Medicaid Plan.

k. Nothing in this Agreement shall allow, or be interpreted to allow, PerformRx or AML to charge Participating Pharmacies fees of any kind.

AMENDMENT
TO
PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

This Amendment (the "Amendment") is made as of March 14, 2017 by and between AmeriHealth Caritas Louisiana, Inc. ("Plan" and f/k/a AmeriHealth Mercy of Louisiana, Inc.) and PerformRx, LLC ("PerformRx").

Background

Plan and PerformRx are parties to that certain Pharmacy Benefit Management Services Agreement dated as of October 22, 2012 (the "PBM Agreement"), pursuant to which PerformRx provides certain Pharmacy Services for Plan's health benefit plan under the Healthy Louisiana Program. Plan offers such health benefit plan pursuant to its contract with the Louisiana Department of Health ("LDH and f/k/a the Louisiana Department of Health and Hospitals), which was awarded to Plan through a competitive procurement under RFP #305PUR-DHHRFP-BH-MCO-2014-MVA (the "RFP"). The resultant contract between LDH and Plan (the "LDH Contract") became effective February 1, 2015, and includes certain requirements that are relevant to the provision of Pharmacy Services, and Plan and PerformRx mutually desire to amend the PBM Agreement in certain respects in order to reflect such requirements. Accordingly, Plan and PerformRx agree to the following:

1. **Payment of Provider Fee.** Effective January 1, 2016, for those pharmacies that are deemed a "local pharmacy," as defined in Section 7.17.2.1.2 of the LDH Contract, PerformRx will implement a process to ensure that the reimbursement is compliant with LDH and Myers and Stauffer to ensure reasonable reimbursement. Reasonable reimbursement is defined as no less than 97% of the calculated estimated fee schedule allowed amount. However, in no instance shall the difference between the calculated estimated Fee-for-Service allowed amount and the total amount reimbursed exceed $10.00. PerformRx shall add a $0.10 per prescription provider fee (the "Provider Prescription Fee") to the reimbursement of each pharmacy claim. The Provider Prescription Fee shall be included in the amount due from Plan for payment of Claims as set forth in **Section 7.B** of the PBM Agreement.

[redacted]

4. **Clarification of Performance Standards.** Effective July 1, 2016, certain performance standards set out in **Exhibit D** of the PBM Agreement shall be modified as follows:

   a. The **Average Speed Answered** performance standard set out in **Exhibit D** of the PBM Agreement is hereby modified to specify that 95% of calls must be answered with thirty (30) seconds or directed to an automatic call pick-up system with IVR options.

   b. The **Occurrence of Busy Signal at Call Center/Telephone Blockage Rate** standard set out in **Exhibit D** of the PBM Agreement is hereby modified to specify that no more than one percent (1%) of incoming calls receive a busy signal.

   c. The following performance standard is added to **Exhibit D**: **Average Hold Time** shall be maintained at three (3) minutes or less. Hold time, or wait time, for purposes of this standard, includes: (i) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and (ii) the measure of time when a customer service representative places a caller on hold.

   d. Plan shall provide PerformRx with sixty (60) days prior written notice of membership increases greater than 10% of Plan's total membership. To the extent Plan fails to provide sixty (60) days prior notice, PerformRx shall be given a grace period equal to the difference between the actual notice and the sixty (60) day notice required herein.

5. **Additional Conforming Modifications.** The following modifications are made in order to clarify certain of PerformRx's obligations under the PBM Agreement, and any conflict between these provisions and those set forth in the PBM Agreement shall be resolved so as to comply with the provisions set forth in this Amendment:

a. **Report Timeliness.** Notwithstanding anything in the Agreement to the contrary, to the extent Plan requires a due date prior to the timeframes set forth in the LDH contract, PerformRx and Plan will mutually agree on the date, which in no case shall be less than three days prior to LDH submission for regularly scheduled statutory reports, in which PerformRx shall furnish all LDH-required reports.

6. **Ratification of Agreement.** Except as set forth in this Amendment, the PBM Agreement remains in full force and effect. Capitalized terms used in this Amendment and not defined herein shall have the meaning ascribed to them in the PBM Agreement. This Amendment may be executed in counterparts, and a facsimile signature or signature transmitted by other electronic means such as scanning shall be valid as an original signature.

[REMAINDER OF PAGE INTENTIONALLY BLANK; SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, and intended to be legally bound, the parties have each executed this Amendment by their legally authorized representatives, as of the date set forth following their respective signatures.

AmeriHealth Caritas Louisiana, Inc.

By: _____

Kyle Viator
Executive Director

Date: 03/14/17

PerformRx, LLC

By: _____

Mesfin Tegenu
President

Date: 3/15/17

NOTICE AMENDMENT TO THE PHARMACY BENEFITS MANAGEMENT SERVICES AGREEMENT

This is an Notice Amendment to the Pharmacy Benefits Management Services Agreement, dated October 22, 2012, (hereinafter referred to as the "Agreement") between PerformRx, LLC, a Pennsylvania limited liability company (hereinafter referred to as "PerformRx"), and AmeriHealth Caritas Louisiana, Inc. (hereinafter referred to as "ACL"), as amended from time to time, and shall be effective upon notification to PerformRx.

WHEREAS, ACL desires to update Exhibit F of the Agreement to comply with mandated contract requirements related to required subcontractor provisions; and

WHEREAS, pursuant to Section 26.C of the Agreement, ACL has the right to unilaterally amend the Agreement for mandated changes as a result of statutes, regulations, accreditation requirements or applicable contract with a government agency; and

NOW THEREFORE, for good and valuable consideration, ACL amends the Agreement pursuant to Section 26.C of the Agreement as follows:

1. Exhibit F of the agreement shall be stricken in its entirety and shall be replaced by a new Exhibit F attached hereto as Attachment 1 and incorporated herein by reference.
2. This Amendment shall be effective upon receipt by PerformRx.
3. No additional changes to the Agreement, as amended or modified, are made by this Amendment and, in all other respects, the Agreement, as theretofore amended or modified, remains in full force and effect.

AMERIHEALTH CARITAS LOUISIANA, INC.

Kyle Viator
Market President

04/10/17
Date

Attachment 1

EXHIBIT F

Louisiana Managed Care Organization (MCOs)
Required Subcontractor Provisions

INTRODUCTION

On July 28, 2014, the State of Louisiana ("State") Department of Health ("LDH") issued Request for Proposals # 305PUR-DHHRFP-BH-MCO-2014-MVA (the "RFP") for the procurement of Managed Care Organizations (MCOs) to solicit proposals from qualified entities to provide healthcare services to Medicaid enrollees participating in LDH's Bayou Health Program. AmeriHealth Caritas Louisiana, Inc. ("ACL") submitted a proposal in response to the RFP (the "ACL Response"), pursuant to which LDH awarded a contract to ACL to serve as a MCO ("State Contract"). ("Subcontractor") is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's members, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this **Subcontractor Exhibit ("Exhibit F")**, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this **Exhibit F**. If any requirement in the Agreement, including this **Attachment F**, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence. Except as otherwise set forth in this Exhibit F,** in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

   a) the body of the Agreement with exhibits and attachments;

   b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

   c) the RFP and any addenda and appendices;

   d) the MCO Systems Companion Guide;

   e) the MCO Quality Companion Guide; and

   f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, regulations and policies as they exist at the time of the Agreement, or as subsequently amended that are or may be applicable to the Agreement, whether or not specifically mentioned in this **Exhibit F**. Any provision of the Agreement that is in conflict with federal statutes, regulations or CMS policy guidance is deemed to be amended to conform to the provisions of those laws, regulations and federal policy. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws, including but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.) and 20 U.S.C. §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and regulations issued pursuant thereto (45 CFR Part 80), in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L.E. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (H.R. 3426);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, as set forth in 45 CFR Part 82, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities; and

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL any lobbying with non-federal funds that takes place in connection with obtaining any federal award;

n) The Equal Opportunity Act of 1972;

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975; and

t) The Americans with Disabilities Act of 1990.

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services, including but not limited to the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

g) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the State Contract.

h) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to members through the last day that the Agreement is in effect.

i) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services

rendered to ACL members pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract). ACL members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.

j) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse (FWA) Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 CFR § 438.1-438.812 and La. R.S. 46:437.1-437.14; LAC 50:1.4101-4235. Without limiting the foregoing:

a) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by ACL's members, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

b) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA. Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the U.S. Department of Health and Human Services ("HHS"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide timely and reasonable access to HHS, LDH, GAO, the State Auditor's Office, the Office of the Attorney General and/or their designees, who shall have the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period (six (6) years following termination of the State Contract), but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

c) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted shall, upon request and as required by ACL, the State Contract or state or federal law, make available to the Medicaid Fraud Control Unit (MFCU) any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by ACL, the State Contract or State and/or Federal law, be allowed access to the place of business and to all Medicaid records of any of subcontractor's contractors, subcontractors or providers, whether contracted or non-

contracted, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.

d) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

e) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

f) In accordance with 42 CFR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Subcontractor shall comply with all applicable provisions of 2 CFR Part 376, pertaining to debarment and/or suspension. Subcontractor shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  http://exclusions.oig.hhs.gov/search.aspx
- Health Care Integrity an Protection Data Bank (HIPDB)
  http://www.npdb-hipdb.hrsa.gov/index.jsp
- System for Award Management
  http://www.sam.gov
- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

g) The Subcontractor shall conduct a screen, monthly as described in Section 5 (f) of this **Exhibit F**, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

h) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and

System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

i) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

j) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA), which requires that Subcontractor, as a condition of receiving such payments, must establish written policies for all employees of Subcontractor (including management), and for any contractor or agent of Subcontractor, that provide detailed information about §§1932-71 of the False Claims Act established under Sections 3729 through 3733 of Title 31 of the U.S. Code; administrative remedies for false claims and statements established under Chapter 38 of Title 31 of the U.S. Code; any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA in Federal health care programs. Such policies shall include detailed provisions regarding Subcontractor's policies and procedures for detecting and preventing FWA. Subcontractor shall also include in any employee handbook a specific discussion of the foregoing laws, the rights of employees to be protected as whistleblowers, and Subcontractor's policies and procedures for detecting and preventing FWA.

k) The Subcontractor shall have surveillance and utilization control programs and procedures (42 CFR § 456.3, § 456.4, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

l) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

6. <u>Employment of Personnel</u>.

a) <u>Non-Discrimination</u>. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of

personnel.

b) Restriction on Certain Individuals. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b) and 42 CFR §1003.102(a)(2)].

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. **Cooperation.**

a) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

b) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this **Exhibit F**, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this **Exhibit F** and under the Agreement.

8. **Provider Selection Requirements.** To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR §438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and

recredentialing policy, which includes but is not limited to notifying ACL when Subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

c) If Subcontractor performs laboratory services under the Agreement, the Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

d) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

e) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this **Exhibit F**, as may be modified by LDH from time to time.

f) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 15 of the State Contract.

g) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the RFP).

h) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

i) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the member needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

j) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract that may materially impact Subcontractor's provider network and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans.** Subcontractor shall disclose to ACL annually any Physician Incentive Plan (PIP) or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

10. **National Provider Identifier (NPI).** The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

11. **ACL Member Hold Harmless.** Subcontractor shall accept the final payment made by ACL as payment-in-full for core benefits and services provided under the Agreement. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from, or have recourse against ACL members or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the member), for health care services which are rendered to such members by Subcontractor and its contractors, and which are core benefits and services under the Louisiana Medicaid program. ACL members shall not be held liable for payment for core benefits and services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that ACL members shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 11 shall be construed to be for the benefit of ACL's members. This Section 11 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's members, or persons acting on their behalf.

12. **Member Access.** Subcontractor and any providers providing services under the Agreement shall not restrict member access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

13. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL member.

14. **ACL Member Copayments**. Subcontractor shall not impose copayments for the following:
    - Family planning services and supplies;
    - Emergency services;
    - Services provided to:
        - Individuals younger than 21 years old;
        - Pregnant women;
        - Individuals who are impatient in long-term care facilities or other institutions;
        - Native Americans; and
        - Alaskan Eskimos.

    To the extent that emergency services, as defined by the RFP, are provided by Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

15. **ACL Member Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to

ACL's members. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

16. **Marketing and Member Education.** All Marketing (as such term is defined in the RFP) and member education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the LDH requirements as set forth in the RFP, including but not limited to the following:

    a) All Marketing and member education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and member education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or member education materials, or participate in any marketing and member education events and activities, without ACL having received LDH consent.

    b) In carrying out any Marketing or member education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 12.3 of the RFP; but (ii) Subcontractor's Marketing and member education activities may include those activities enumerated in Section 12.4 of the RFP.

17. **Misuse of Symbols, Emblems or Names in Reference to Medicaid.** No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

18. **Confidentiality of Information.**

    a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

    b) All information as to personal facts and circumstances concerning members or potential members obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the member/potential member, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the

administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

19. **Safeguarding Information.** Subcontractor shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S. 46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

20. **LDH Use of Data.** Notwithstanding any provision in this **Exhibit F** or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

21. **Record Retention.** Financial records, supporting documents, statistical records, and all other records pertinent to the Agreement shall be retained for a period of at least six (6) years from the expiration date of the State Contract, including any extension thereof, with the following exceptions:

a) If any litigation, claim, financial management review or audit is started before the expiration of the 6-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

b) Records for real property and equipment acquired with federal funds shall be retained for six (6) years following its final disposition.

c) When records are transferred to or maintained by LDH, the 6-year retention period is not applicable to the Subcontractor.

d) Indirect cost rate proposals, cost allocation plans, etc., as specified in 45 CFR 74.53(g).

22. **Independent Audits**. Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

23. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

24. **Release of Records.** Subcontractor shall release medical records of members upon request by members or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

25. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

a) Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of Five Hundred Thousand Dollars ($500,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL and LDH during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the

Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of One Million Dollars ($1,000,000) and a minimum general aggregate of Two Million Dollars ($2,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance in the amount of at least One Million Dollars ($1,000,000) per occurrence.

d) Licensed and Non-licensed Motor Vehicles. Subcontractor shall maintain, during the life of the Agreement, automobile liability insurance in an amount not less than combined single limits of One Million Dollars ($1,000,000) per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the Agreement on the site of the work to be performed hereunder, unless such coverage is included in insurance that is elsewhere specified under this **Section 25.** Such insurance shall include third party bodily injury and property damage liability for owned, hired and non-owned automobiles.

26. **Hold Harmless.** Subcontractor shall defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) any claims for damages or losses arising from services rendered by Subcontractor, or any of its contractors, employees, officers, agents or representatives performing or supplying services, materials or supplies in connection with the Agreement;

b) any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or statutes, by Subcontractor, its contractors, employees, officers, agents or representatives in the performance of the Agreement;

c) any claims for damages or losses resulting to any person or firm injured or damaged by the Subcontractor, its contractors, employees, officers, agents or representatives by Subcontractor's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Agreement in a manner not authorized hereunder or by Federal or State regulations or statutes;

d) any failure of Subcontractor, its contractors, employees, officers, agents or representatives to observe Federal or State laws, including but not limited to labor laws and minimum wage laws;

e) any claims for damages, losses or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims or damages specified in the foregoing sub-paragraphs "a" through "d"; and

f) any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against ACL or LDH or their respective agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor, its contractors, employees, officers, agents or representatives.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

27. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, and/or termination of the State Contract in whole or in part, which shall result in termination of the Agreement.

    a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

    b) Subcontractor shall cooperate with any relevant corrective action plan imposed upon or developed by ACL in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

28. **Loss of Federal Financial Participation (FFP).** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

29. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential conflict. Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement.

30. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

31. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

32. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

33. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

34. **Termination for Threat to Health of ACL Members.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of members enrolled in ACL.

35. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

36. **Independent Contractor/Subcontractors.** It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

    Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

37. **Licensing Requirements.** Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

38. **Entire Contract.** Subcontractor shall comply with, and agrees to be bound by, all provisions of the Agreement and shall act in good faith in the performance of the provisions of the Agreement.

    The Subcontractor also agrees to comply with relevant provisions of the State Contract and any rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies and procedures in effect throughout the duration of the Agreement. Where the provisions of the Agreement differ from the requirements set forth in the LDH handbooks and/or manuals, the relevant LDH provision(s) shall control.

    The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties hereto.

    Any alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

39. **Restrictions on Contracting.** Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services contracted under the Agreement.

40. **Antitrust.** Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently

known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries

41. **Termination of LDH Contract**. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make available to ACL and/or LDH or their respective designated representatives, in a usable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

42. **Amendments**. The Agreement may be amended at any time as provided in this paragraph. The Agreement may be amended whenever necessary to comply with State and federal requirements or State budget reductions; provided, however, subject to Section 3 of this **Exhibit F**, no modification or change of any provision of the Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by ACL and Subcontractor.

43. **Law**. This **Exhibit F** shall be governed by the laws of the State of Louisiana, except its conflict of laws provisions both as to interpretation and performance.

Attachment 2.10.2.3-3

PerformRx℠ LLC

Executed Agreement

This page is intentionally left blank.

AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

April 9, 2019

Via Email and Overnight Mail

Mr. Mesfin Tegenu
President
PerformRx
200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Mr. Tegenu,

The purpose of this letter is to inform you that due to the requirements of the Louisiana Department of Health ("LDH"), AmeriHealth Caritas Louisiana ("ACL") must update the Louisiana Managed Care Organization Required Subcontractor Provisions of your subcontract agreement with ACL (the "Agreement") as follows:

1. Effective immediately the existing Louisiana Managed Care Organization Required Subcontractor Provisions of the Agreement are deleted in their entirety and replaced with the attached Louisiana Managed Care Organization Required Subcontractor Provisions, which are incorporated into the Agreement as if fully set forth therein.

2. Except as modified by this letter, the Agreement remains in full force and effect in accordance with it terms.

Thank you for your continuing relationship with ACL.

Very truly yours,

Kyle Viator

Market President
AmeriHealth Caritas Louisiana, Inc.

Attachment

Attachment

Louisiana Managed Care Organization
Required Subcontractor Provisions

INTRODUCTION

AmeriHealth Caritas Louisiana, Inc. ("ACL") submitted a proposal in response (the "ACL Response") to the State of Louisiana ("State") Department of Health's ("LDH") Request for Proposals #305PUR-DHHRFP-BH-MCO-2014-MVA (the "RFP"), pursuant to which LDH awarded a contract to ACL to serve as a Medicaid Managed Care Organization (MCO). Pursuant to the contract between LDH and ACL (the "State Contract"), ACL provides or arranges for the provision of specified health services under the Louisiana Medicaid managed care program known as Healthy Louisiana. PerformRx is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's members, and is therefore considered a "Subcontractor," as defined in the State Contract. Accordingly, the terms and conditions set forth in this Attachment, which are required of Subcontractors pursuant to the State Contract, are incorporated into the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). Subcontractor shall adhere to all requirements set forth for Subcontractors in the State Contract and any LDH issued guides. ACL shall furnish these documents to Subcontractor upon request. No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Attachment. If any requirement in the Agreement, including this **Attachment**, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence.** Except as otherwise set forth in this Attachment**,** in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

a) the body of the Agreement with exhibits and attachments;

b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

c) the RFP and any addenda and appendices;

d) the MCO Systems Companion Guide;

e) the MCO Quality Companion Guide; and

f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL and LDH.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, rules, regulations, guidelines and policies, including without limitation, any regulation or rules that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies as they exist at the time of the Agreement, or as subsequently amended, that are or may be applicable to the services provided under the Agreement, whether or not specifically mentioned in this Attachment and that such laws, rules, regulations, guidelines and policies are herein incorporated into this Agreement by reference and that any revisions thereto are automatically incorporated into this Agreement as they become effective. Any provision of the Agreement that is in conflict with federal statutes, regulations or

CMS policy guidance or rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies is deemed to be amended to conform to the provisions of those laws, regulations and policies. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.), the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro- Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and its implementing regulations at 45 CFR Part 80 (2001, as amended), in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (P.L. 106-113);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as implemented in 45CFR Part 82, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities;

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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.

Subcontractor shall disclose to ACL any lobbying with non-federal funds that takes place in connection with obtaining any federal award;

n) The Equal Opportunity Act of 1972:

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975;

t) The Americans with Disabilities Act of 1990; and

u) Executive Order Number JBE 2018-15, **r**elating to the Prohibition of Discriminatory Boycotts of Israel in State Procurement.

v) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

w) Section 1557 of the Patient Protection and Affordable Care Act (ACA).

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services including, but not limited to, the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract. The QAPI and UM requirements are included as part of the Agreement and herein incorporated by reference.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Subcontractor shall not portray core benefits or services, as defined in Section 6.1.4 of the State Contract, as value-added benefits or services.

g) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

h) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the RFP.

i) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to members through the last day that the Agreement is in effect.

j) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL members pursuant to the Agreement including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract. ACL members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by La.R.S. 40:1299.96, La.R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) as amended and subject to reasonable charges.

k) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse ("FWA") Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812; La.R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. Without limiting the foregoing:

a) Subcontractor shall report all known or suspected FWA to ACL in accordance with 42 CFR §438.608(a) and the State Contract and ACL requirements.

b) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by ACL's members, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

c) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA.

d) Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the U.S. Department of Health and Human Services ("HHS"), the Office of Inspector General ("OIG"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide upon request to HHS, OIG, the State Auditor's Office, the Office of the Attorney General, GAO, Comptroller General, LDH and/or their designees upon request with timely and reasonable access and the right to examine and make copies, excerpts or transcripts of all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions;

contact and conduct private interviews with Subcontractor and its employees and contractors; and do on -site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period set forth in Section 23 of this Attachment, but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

e) Subcontractor and Subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, Subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding, to obtain the requested information, records or data. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider of Subcontractor during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed. The MCO contractor, Subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of noncompliance with an information, records or data request.

f) Subcontractor shall permit the State, CMS the HHS Inspector General, the Comptroller General, or their designees to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed.

   i. Subcontractor shall make available for purposes of an audit, evaluation or inspection under Section 5(f), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid members.

   ii. The right to audit under Section 5(f) will remain ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

   iii. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid members at any time.

g) Reserved.

h) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

j) In accordance with 48 CFR §2.101 and 42 CFR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Subcontractor shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Subcontractor shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/search.aspx
- Health Care Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp
- System for Award Management http://www.sam.gov
- Louisiana Adverse Actions List Search (LAALS) http://adverseactions.LDH.la.gov

k) The Subcontractor shall conduct a screen, monthly as described in Section 5 (j) of this Attachment, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

l) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

m) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR § 455.104 and 42 CFR §438.610) on ownership disclosure reporting in accordance with Section 15.1.12 of the RFP. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 C FR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

n) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA), which requires that Subcontractor, as a condition of receiving such payments, must establish written policies for all employees of Subcontractor (including management), and for any contractor or agent of Subcontractor, that provide detailed information about §§1932-71 of the False Claims Act established under Sections 3729 through 3733 of Title 31 of the U.S. Code; administrative remedies for false claims and statements established under Chapter 38 of Title 31 of the U.S. Code; any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA in Federal health care programs. Such policies shall include detailed provisions regarding Subcontractor's policies and procedures for detecting and preventing FWA. Subcontractor shall also include in any employee handbook a specific discussion of the foregoing laws, the rights of employees to be protected as whistleblowers, and Subcontractor's policies and procedures for detecting and preventing FWA.

o) The Subcontractor shall have surveillance and utilization control programs and procedures pursuant to 42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

p) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

q) Subcontractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly including coordinating with law enforcement agencies, with notice to ACL, if issues are suspected to be criminal in nature , to reduce the potential for reoccurrence, and conduct ongoing compliance with the requirements under this Agreement.

r) Subcontractor shall provide annual training to all employees, and shall train new hires within thirty (30) days of the date of employment, related to the following:

- Subcontractor's Code of Conduct;
- Privacy and Security – HIPAA;
- FWA identification and reporting procedures;
- Federal False Claims Act and employee whistleblower protections;
- Procedures for timely consistent exchange of information and collaboration with ACL and LDH; and
- Compliance with 42 CFR §438. 608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

s) Subcontractor shall suspend payment to a network provider when the State determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. ACL is responsible for sending the network provider the required notice and appeal rights as required by the code

of federal regulation.

6. Employment of Personnel.

a) Non-Discrimination. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) Restriction on Certain Individuals. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in –non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR § 1001.1901(b) and 42 CFR§ 1003.102(a)(2)}.

Additionally, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 USC §1320a-7) or Section 1156 (42 USC §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. This includes providers undergoing any of the following identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health services license;

ii. Exclusion from the Medicaid program;

iii. Exclusion form the Medicare program;

iv. Withholding if Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review ("SURS") Rule (LAC 50:1.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:1.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from

ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. Cooperation, Care Coordination and Continuity of Care.

a) Care Coordination. Subcontractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to ACL's Medicaid members.

b) Continuity of Care. To the extent applicable to the services provided under the Agreement, Subcontractor shall develop and maintain a process of Continuity of Care by which ACL's Medicaid members and network and/or non-network provider interactions are effective to ensure that each member has an ongoing source of preventative and primary care appropriate to their needs.

c) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid members in accordance with professional standards. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

d) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this Attachment, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this Attachment and under the Agreement.

8. Provider Selection Requirements. To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR§438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and re-recredentialing policies including but not limited but not to: LDH, Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for specialized behavioral health providers.

c) Subcontractors that specialize in behavioral health are required to be accredited by rule, regulation, waiver or State Plan Amendment ("SPA") prior to contracting with ACL or prior to receiving Medicaid reimbursement, and shall comply with: all requirements of ACL,; CMS approved waivers; and/or the SPAs.

d) Subcontractors that specialize in behavioral health shall provide ACL with proof of

accreditation from one of the following LDH approved national accrediting body:

- Council on Accreditation;
- Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- The Joint Commission ("TJC").

e) Subcontractor shall have a re-credentialing policy which includes, but is not limited to, notifying ACL when Subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

f) Subcontractor shall notify ACL, regarding itself or any of its providers or subcontractors, and shall furnish documentation from the accreditation body within twenty-four (24) hours of the following: loss of accreditation, license or certification; suspension; or any action that could result in the loss of accreditation.

g) If Subcontractor or any provider of Subcontractor performs laboratory services under the Agreement, the Subcontractor or provider of Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

h) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

i) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this Attachment, as may be modified by LDH from time to time.

j) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 15 of the State Contract.

k) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the State Contract).

l) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

m) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the member needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

n) Subcontractor shall provide written notification to ACL of its intent to terminate any

provider contract that may materially impact Subcontractor's provider network and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans**. Subcontractor's Physician Incentive Plans ("PIP") shall be incompliance with 42 CFR § 438.3(i).

a) Subcontractor shall disclose to ACL annually any PIP or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

b) Subcontractor shall provide written notification to ACL within thirty (30) days upon implementation of any new PIP or when an existing PIP is modified. The written notification must: (i) list the participating providers; and (ii) certify that the terms and conditions of the PIP are compliant with all applicable federal regulations.

c) Subcontractor shall furnish, upon request of ACL, additional information including, but not limited to, a copy of the PIP.

10. Provider Preventable Conditions. Subcontractor shall report to ACL, within seventy-two (72) hours, any provider preventable conditions ("PPCs") associated with claims for payment or member treatment for which payment would otherwise be made. PPCs include: (i) Healthcare Acquired Conditions; and (ii) Other Provider Preventable Conditions, as defined by Section 25.8 of the Louisiana Medicaid Program Hospital Service Provider Manual.

11. National Provider Identifier (NPI). The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

12. ACL Member Hold Harmless. Subcontractor shall accept the final payment made by ACL as payment-in-full for core benefits and services provided under the Agreement. Notwithstanding State Plan approved cost sharing, Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from LDH or ACL, or have recourse against ACL members or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the member), for health care services which are rendered to such members by Subcontractor and its contractors, and which are core benefits and services under the Louisiana Medicaid program. A CL members shall not be held liable for payment for core benefits and services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that ACL members shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 11 shall be construed to be for the benefit of ACL's members. This Section 11 supersedes any oral or written contrary agreement now existing or

hereafter entered into between Subcontractor and ACL's members, or persons acting on their behalf.

13. **Member Access.** Subcontractor and any providers providing services under the Agreement shall not restrict member access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

14. **Member Rights**. Subcontractor shall assist members in understanding their rights to file grievances and appeals in accordance with ACL's Provider Manual.

a) To the extent applicable, Subcontractor shall have a grievance system in place to address ACL Member grievances including, but not limited to the following:

i. the referral of the Member to a designee of the Subcontractor authorized to review and respond to grievances and appeals that require corrective action; and

ii. the provision of information explaining Member Rights to file grievances, appeals and request a State Fair Hearing, in accordance with 42 CFR Part 438, Subpart F, both orally and in writing in a language that the Member understands.

15. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL member.

16. **ACL Member Copayments**. Subcontractor shall not impose copayments for the following: (i) Family planning services and supplies; (ii) Emergency services; and (iii) Services provided to:

- Individuals younger than 21 years old;
- Pregnant women;
- Individuals who are impatient in long-term care facilities or other institutions;
- Native Americans; and
- Alaskan Eskimos.

To the extent that emergency services, as defined by the State Contract, are provided by Subcontractor or any providers of Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

17. **ACL Member Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's members. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

18. **Marketing and Member Education.** All Marketing (as such term is defined in the State Contract) and member education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 C FR §438.10 and with the LDH requirements as set forth in the State Contract, including but not limited to the following:

a) All Marketing and member education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and member education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or member education materials, or participate in any marketing and member education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or member education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 12.3 of the State Contract; but (ii) Subcontractor's marketing and member education activities may include those activities enumerated in Section 12.4 of the State Contract.

19. Misuse of Symbols, Emblems or Names in Reference to Medicaid. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

20. Confidentiality of Information.

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning members or potential members obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the member/potential member, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the

media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

21. **Safeguarding Information.** Subcontractor shall establish written safeguards, according to applicable state and federal laws and regulations and as described in the State Contract, which restrict the use and disclosure of information concerning members or potential members, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S.46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

22. **LDH Use of Data.** Notwithstanding any provision in this Attachment or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

23. **Record Retention.**

a) Financial Records. Subcontractor shall retain all financial records, supporting documents, statistical records, and all other records for a period of at least ten (10) years from the date of submission of the final expenditure report under the Agreement, with the following exceptions:

i. If any litigation, claim, financial management review or audit is started before the expiration of the 10-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

ii. Records for real property and equipment acquired with federal funds shall be retained for ten (10) years following its final disposition.

iii. When records are transferred to or maintained by LDH, the 10-year retention period is not applicable to the Subcontractor.

iv. Indirect cost rate proposals, cost allocation plans, etc., as specified in 45 CFR 74.53(g).

b) Medical Records. Subcontractor shall retain all documents and medical records, related to services, charges, and operations under the Agreement for ten (10) calendar years after the last good, service or supply has been provided to an ACL Medicaid member or an authorized agent of the state or federal government or any of its authorized agents, unless those records are subject to review, audit, investigations of subject to administrative or judicial action brought by or on behalf of the state of federal government.

24. **Independent Audits.** Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced)

program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

25. **Information System Availability.** Subcontractor shall allow LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office or upon request of CMS, direct access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of the request. The data shall include the following or any additional data requested by LDH:

- Prior authorizations;
- Claims processing;
- Provider portal;
- Third-party Liability;
- FWA;
- Pharmacy benefits manager point of sale;
- Pharmacy benefits manager prior authorization; and
- Provider contracting and credentialing.

26. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

27. **Release of Records.** Subcontractor shall release medical records of members upon request by members or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

28. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit executed copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI. Subcontractor shall take and maintain insurance of the same nature and in the same amounts as required of the MCO, including but not limited to:

a) Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of Five Hundred Thousand Dollars ($500,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall

maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL and LDH during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of One Million Dollars ($1,000,000) and a minimum general aggregate of Two Million Dollars ($2,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance in the amount of at least One Million Dollars ($1,000,000) per occurrence.

d) Licensed and Non-licensed Motor Vehicles. Subcontractor shall maintain, during the life of the Agreement, automobile liability insurance in an amount not less than combined single limits of One Million Dollars ($1,000,000) per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the Agreement on the site of the work to be performed hereunder, unless such coverage is included in insurance that is elsewhere specified under this **Section 28.** Such insurance shall include third party bodily injury and property damage liability for owned, hired and non-owned automobiles.

29. Hold Harmless. Subcontractor shall indemnify, defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) any claims for damages or losses arising from services rendered by Subcontractor, or any of its contractors, employees, officers, agents or representatives performing or supplying services, materials or supplies in connection with the Agreement;

b) any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or statutes, by Subcontractor, its contractors, employees, officers, agents or representatives in the performance of the Agreement;

c) any claims for damages or losses resulting to any person or firm injured or damaged by the Subcontractor, its contractors, employees, officers, agents or representatives by Subcontractor's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Agreement in a manner not authorized hereunder or by Federal or State regulations or statutes;

d) claims for damages or losses arising from any failure by Subcontractor, its contractors, employees, officers, agents or representatives to comply with applicable Federal or State laws, including but not limited to State and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements or adverse judicial determinations;

e) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of LDH in connection with noncompliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to Subcontractor by MCO and/or LDH;

f) any claims for damages, losses or reasonable costs associated with legal expenses,

including, but not limited to those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims or damages specified in the foregoing sub-paragraphs "a" through "e"; and

g) any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against ACL or LDH or their respective agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor, its contractors, employees, officers, agents or representatives.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

30. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL or reduction in payments to ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, which shall include, but may not be limited to Subcontractor's failure or refusal to respond to ACL's request for information and, as applicable, to provide medical records and/or credentialing information, etc. Subcontractor's failure to comply with the provisions of the Agreement may also result in the termination of the State Contract in whole or in part, which shall result in termination of the Agreement. At ACL's discretion or a directive by LDH, ACL shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall comply with any relevant corrective action plan imposed upon or developed by ACL and/or required by LDH in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

31. **Loss of Federal Financial Participation ("FFP").** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

32. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential or actual conflict. Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement and during the term of the Agreement.

33. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

34. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

35. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

36. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

37. **Termination for Threat to Health of ACL Members.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of members enrolled in ACL.

38. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

39. **Independent Contractor/Subcontractors.** It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

40. **Licensing Requirements.** Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

41. **Entire Contract; Amendments.** Subcontractor shall comply with, and agrees to be bound by, all provisions of theAgreement and shall act in good faith in the performance of the provisions of the Agreement.

The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing.

Except as provided in Section 3, any amendments, alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

42. **Restrictions on Contracting.** Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services

contracted under the Agreement.

43. **Antitrust**. Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

44. **Termination of LDH Contract**. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make immediately available to ACL and/or LDH or their respective designated representatives, in a usable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

45. **Law.** This Attachment shall be governed by the laws of the State of Louisiana, except its conflict of laws provisions both as to interpretation and performance.

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-3

PerformRx℠ LLC

Draft Agreement

This page is intentionally left blank.

[Date]

Via Email and Overnight Mail

Mr. Mesfin Tegenu
President
PerformRx
200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Mr. Tegenu,

The purpose of this letter is to inform you that due to the requirements of the Louisiana Department of Health's (LDH) Request for Proposals (RFP), AmeriHealth Caritas Louisiana, Inc. (ACL) must revise the Louisiana Managed Care Organization Required Subcontractor Provisions of your subcontract agreement with ACL (the "Agreement") as follows:

1. Effective January 1, 2020 the existing Louisiana Managed Care Organization Required Subcontractor Provisions of the Agreement are deleted in their entirety and replaced with the attached Louisiana Managed Care Organization Required Subcontractor Provisions, which are incorporated into the Agreement as if fully set forth therein.

2. Except as modified by this letter, the Agreement remains in full force and effect in accordance with it terms.

Thank you for your continuing relationship with ACL.

Very truly yours,

Kyle Viator

Market President
AmeriHealth Caritas Louisiana, Inc.
Attachment

ATTACHMENT

Louisiana Managed Care Organization
Required Subcontractor Provisions

INTRODUCTION

On February 25, 2019, the State of Louisiana ("State") Department of Health ("LDH") issued Request for Proposals #3000011953 (the "RFP") for the procurement of Managed Care Organizations (MCOs) to solicit proposals from qualified managed care organizations (MCOs) to provide high quality healthcare services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program known as Healthy Louisiana. AmeriHealth Caritas Louisiana, Inc. ("ACL") intends to submit a proposal in response to the RFP (the "ACL Response"), with the goal of being a successful proposer to which LDH will award a contract to ACL to serve as a MCO (the "State Contract"). PerformRx is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's enrollees, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this Attachment, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). Subcontractor shall adhere to all requirements set forth for Subcontractors in the contract between LDH and ACL and the MCO Manual. ACL shall furnish these documents to Subcontractor upon request. No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Attachment. If any requirement in the Agreement, including this Attachment, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence.** Except as otherwise set forth in this Attachment, in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

   a) the body of the Agreement with exhibits and attachments;

   b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

   c) the RFP and any addenda and appendices;

   d) the MCO Systems Companion Guide;

   e) the MCO Quality Companion Guide; and

   f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, rules, regulations, guidelines and policies, including without limitation, any regulations or rules that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies as they exist at the time of the Agreement, or as subsequently amended, that are or may be applicable to the Agreement, whether or not specifically mentioned in this Attachment and that such laws, rules, regulations, guidelines and policies are herein incorporated into this Agreement by reference and that any revisions thereto are automatically incorporated into this Agreement as they become effective. Any provision of the Agreement that is in conflict with federal statutes, regulations or CMS policy guidance or rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH

provider manuals, LDH issued guides, and all applicable LDH policies is deemed to be amended to conform to the provisions of those laws, regulations and policies. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.), the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro- Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and its implementing regulations at 45 CFR Part 80, in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (P.L 106-113);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as set forth in 45 CFR Part 182, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities;

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL 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 recipient (45 C.F.R. Part 3);

n) The Equal Opportunity Act of 1972:

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975;

t) The Americans with Disabilities Act of 1990;

u) Executive Order Number JBE 2018-15, **r**elating to the Prohibition of Discriminatory Boycotts of Israel in State Procurement; and

v) 42 C.F.R. §438.100(a)(2), which requires Subcontractor to comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights; and

w) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan; and

x). Section 1557 of the Patient Protection and Affordable Care Act (ACA); and

y) Notwithstanding moral and religious objections in the Services section of the RFP, Subcontractor agrees not to discriminate in its employment practices, and will render services under the RFP without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Subcontractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Agreement.

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services including, but not limited to, the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract. The QAPI and UM requirements are included as part of the subcontract between ACL and the Subcontractor.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Reserved.

g) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

h) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the RFP.

i) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to enrollees through the last day that the Agreement is in effect.

j) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL enrollees pursuant to the Agreement including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract. ACL enrollees and their representatives shall be given access to and can request copies of the enrollee's medical records, to the extent and in the manner provided by LRS 40:1165.1, La. R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) as amended and subject to reasonable charges.

k) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse ("FWA") Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 C.F.R. Part 438, Subparts A and H; La. R.S. 46:437.1 through 437.14; 42 C.F.R. Part 455, Subpart A; LAC 50:I, Subpart 5; and 42 U.S.C. §1320a-7, §1320c-5, and §1396a(a)(68). Without limiting the foregoing:

a) Subcontractor shall report all known or suspected FWA to ACL in accordance with 42 CFR §438.608(a) and the State Contract and ACL requirements.

b) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by ACL's enrollees, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

c) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA.

d) Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the Centers for Medicare and Medicaid

Services ("CMS"), U.S. Department of Health and Human Services ("HHS"), the Office of Inspector General ("OIG"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide to CMS, HHS, OIG, the State Auditor's Office, the Office of the Attorney General, GAO, Comptroller General, LDH and/or their designees upon request with timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period set forth in Section 23 of this Attachment, but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

e) Subcontractor and Subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, Subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding, to obtain the requested information, records or data. MFCU shall be allowed access to the Contractor's place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hours admission shall be allowed. The MCO contractor, Subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of noncompliance with an information, records or data request.

f) Subcontractor shall permit the State, CMS the HHS Inspector General, the Comptroller General, or their designees to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed.

i. Subcontractor shall make available for purposes of an audit, evaluation or inspection under Section 5(f), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees.

ii. The right to audit under Section 5(f) will remain ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

iii. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees at any time.

g) Reserved.

h) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

j) In accordance with 42 C FR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or an individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.. Subcontractor is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8). Subcontractor shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Subcontractor shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 C.F.R. §455.436 To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  http://exclusions.oig.hhs.gov/search.aspx
-
- System for Award Management
  http://www.sam.gov
- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

k) The Subcontractor shall conduct a screen, monthly as described in Section 5 (j) of this Attachment, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

l) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and

System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

m) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR § 455.104 and 42 CFR §438.610) on ownership disclosure reporting and in accordance with RFP Section 2.9.6. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

n) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA).

o) The Subcontractor shall have surveillance and utilization control programs and procedures pursuant to 42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

p) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

q) Subcontractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly including coordinating with law enforcement agencies, with notice to ACL, if issues are suspected to be criminal in nature , to reduce the potential for reoccurrence, and conduct ongoing compliance with the requirements under this Agreement.

r) Subcontractor shall provide annual training to all employees, and shall train new hires within thirty (30) days of the date of employment, related to the following:

- Subcontractor's Code of Conduct;
- Privacy and Security – HIPAA;
- FWA identification and reporting procedures;
- Federal False Claims Act and employee whistleblower protections; and
- Procedures for timely consistent exchange of information; and collaboration with ACL and LDH; and
- Provisions that comply with 42 CFR §438. 608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

s) Subcontractor shall suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. ACL is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

6. Employment of Personnel.

a) Non-Discrimination. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) Restriction on Certain Individuals. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in –non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR § 1001.1901(b) and 42 CFR§ 1003.102(a)(2)}.

Additionally, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 USC §1320a-7) or Section 1156 (42 USC §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. This includes providers undergoing any of the following identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health services license;

ii. Exclusion from the Medicaid program;

iii. Exclusion form the Medicare program;

iv. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review ("SURS") Rule (LAC 50:1.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:1.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal

background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. Cooperation, Care Coordination and Continuity of Care.

a) Care Coordination. Subcontractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to ACL's Medicaid enrollees.

b) Continuity of Care. To the extent applicable to the services provided under the Agreement, Subcontractor shall develop and maintain a process of Continuity of Care by which ACL's Medicaid enrollees and network and/or non-network provider interactions are effective to ensure that each enrollee has an ongoing source of preventative and primary care appropriate to their needs.

c) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid enrollees in accordance with professional standards. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

d) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this Attachment, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this Attachment and under the Agreement.

8. Provider Selection Requirements. To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR§438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and re-credentialing policies including, but not limited to: LDH, Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for specialized behavioral health providers.

c) Subcontractors that specialize in behavioral health are required to be accredited by rule,

regulation, waiver or State Plan Amendment ("SPA") prior to contracting with ACL or prior to receiving Medicaid reimbursement, and shall comply with: all requirements of ACL,; CMS approved waivers; and/or the SPAs.

d) Subcontractors that specialize in behavioral health shall provide ACL with proof of accreditation from one of the following LDH approved national accrediting body:

- Council on Accreditation;
- Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- The Joint Commission ("TJC").

e) Subcontractor shall have a re-credentialing policy which includes, but is not limited to, notifying ACL when Subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

f) Subcontractor shall notify ACL, regarding itself or any of its providers or subcontractors, and shall furnish documentation from the accreditation body within twenty-four (24) hours of the following: loss of accreditation, license or certification; suspension; or any action that could result in the loss of accreditation.

g) If Subcontractor or any provider of Subcontractor performs laboratory services under the Agreement, the Subcontractor or provider of Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

h) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

i) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this Attachment, as may be modified by LDH from time to time.

j) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 2.20 of the State Contract.

k) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the RFP).

l) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

m) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the enrollee's health

status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the enrollee needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

n) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract that may materially impact Subcontractor's provider network and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans**. Subcontractor's Physician Incentive Plans ("PIP") shall be incompliance with 42 CFR § 438.3(i).

a) Subcontractor shall disclose to ACL annually any PIP or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

b) Subcontractor shall provide written notification to ACL within thirty (30) days upon implementation of any new PIP or when an existing PIP is modified. The written notification must: (i) list the participating providers; and (ii) certify that the terms and conditions of the PIP are compliant with all applicable federal regulations.

c) Subcontractor shall furnish, upon request of ACL, additional information including, but not limited to, a copy of the PIP.

10. Provider Preventable Conditions. Subcontractor shall report to ACL, within seventy-two (72) hours, any provider preventable conditions ("PPCs") associated with claims for payment or enrollee treatment for which payment would otherwise be made. PPCs include: (i) Healthcare Acquired Conditions; and (ii) Other Provider Preventable Conditions, as defined by Section 2.11.10 of the State Contract..

11. National Provider Identifier (NPI). The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

12. ACL Enrollee Hold Harmless. Subcontractor shall accept the final payment made by ACL as payment-in-full for covered services provided under the Agreement. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from, or have recourse against LDH, ACL enrollees or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the enrollee), for health care services which are rendered to such enrollees by Subcontractor and its contractors, and which are covered services under the Louisiana Medicaid program.

ACL enrollees shall not be held liable for payment for covered services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that LDH or ACL enrollees shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 12 shall be construed to be for the benefit of ACL's enrollees. This Section 12 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's enrollees, or persons acting on their behalf.

13. **Enrollee Access.** Subcontractor and any providers providing services under the Agreement shall not restrict enrollee access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

14. **Enrollee Rights**. Subcontractor shall assist enrollees in understanding their rights to file grievances and appeals in accordance with ACL's Provider Manual.

    a) To the extent applicable, Subcontractor shall have a grievance system in place to address ACL enrollee grievances including, but not limited to the following:

        i. the referral of the enrollee to a designee of the Subcontractor authorized to review and respond to grievances and appeals that require corrective action; and

        ii. the provision of information explaining Enrollee Rights to file grievances, appeals and request a State Fair Hearing, in accordance with 42 CFR Part 438, Subpart F, both orally and in writing in a language that the Enrollee understands.

15. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL enrollee.

16. **ACL Enrollee Copayments**. Subcontractor shall not impose copayments for the following: (i) Family planning services and supplies; (ii) Emergency services; and (iii) Services provided to:

    - Individuals younger than 21 years old;
    - Pregnant women;
    - Individuals who are impatient in long-term care facilities or other institutions;
    - Native Americans; and
    - Alaskan Eskimos.

    To the extent that emergency services, as defined by the RFP, are provided by Subcontractor or any providers of Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

17. **ACL Enrollee Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's enrollees. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

18. **Marketing and Enrollee Education.** All Marketing (as such term is defined in the RFP) and enrollee education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the LDH requirements as set forth in the RFP, including but not limited to the following:

a) All Marketing and enrollee education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and enrollee education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or enrollee education materials, or participate in any marketing and enrollee education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or enrollee education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 2.14.2 of the State Contract; but (ii) Subcontractor's Marketing and enrollee education activities may include those activities enumerated in Section 2.14.3 of the State Contract.

19. Misuse of Symbols, Emblems or Names in Reference to Medicaid. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

20. Confidentiality of Information.

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to enrollees or potential enrollees, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the enrollee/potential enrollee, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees/potential enrollees shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall

be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

21. Safeguarding Information. Subcontractor shall establish written safeguards, according to applicable state and federal laws and regulations and as described in the State Contract, which restrict the use and disclosure of information concerning enrollees or potential enrollees, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S.46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the enrollees or potential enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

22. LDH Use of Data. Notwithstanding any provision in this Attachment or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

23. Record Retention.

a) Financial Records. Subcontractor shall retain all financial records, supporting documents, statistical records, and all other records for a period of at least ten (10) years from date of submission of the final expenditure report under the Agreement, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.. The only exceptions are the following:

i. If any litigation, claim, financial management review, or audit is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

ii. Records for real property and equipment acquired with federal funds shall be retained for ten (10) years after final disposition;

iii. When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the recipient; and

iv. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 C.F.R. §75.361(f).

Under no circumstances shall Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

b) Medical Records. All documentation and/or records maintained by Subcontractors, and its network providers related to covered services, charges, operations and agreements under this Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall the Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

24. **Independent Audits**. Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

25. **Information System Availability.** Subcontractor shall allow LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office or upon request of CMS, direct access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of the request. The data shall include the following or any additional data requested by LDH:

- Prior authorizations;
- Claims processing;
- Provider portal;
- Third-party Liability;
- FWA;
- Pharmacy benefits manager point of sale;
- Pharmacy benefits manager prior authorization; and
- Provider contracting and credentialing.

26. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

27. **Release of Records.** Subcontractor shall release medical records of enrollees upon request by enrollees or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

28. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit executed copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. Ten (10) calendar days' written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in Subcontractor's policy. In addition, Subcontractor is required to notify ACL of policy cancellations or reductions in limits. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. The insurance companies issuing the policies shall have no recourse against LDH for payment of premiums or for assessments under any form of the policies. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

a) Workers' Compensation Insurance**.** Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of One Million Dollars ($1,000,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL, LDH any subcontractor during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of Two Million Dollars ($2,000,000) and a minimum general aggregate of Four Million Dollars ($4,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance which covers the professional acts or omissions of Subcontractor in the amount of at least Three Million Dollars ($3,000,000) per occurrence.

d) Automobile Liability. Automobile Liability Insurance shall have a minimum combined single limit per accident of $1,000,000. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

e) Cyber Liability Cyber liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of $3,000,000. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It

shall provide coverage for the duration of this Contract and shall have an expiration date no earlier than thirty (30) calendar days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium.

f) The policies are to contain, or be endorsed to contain, the following provisions:

1. Commercial General Liability, Automobile Liability, and Cyber Liability Coverages
LDH, its officers, agents, employees and volunteers shall be named as an additional insured as regards negligence by Subcontractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, are to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to LDH. Subcontractor's insurance shall be primary with respect to LDH, its officers, agents, employees and volunteers for any and all losses that occur under the Contract. Any insurance or self-insurance maintained by LDH shall be in excess and non-contributory of the Contractor's insurance.

2. Workers Compensation and Employers Liability Coverage
To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against LDH, its officers, agents, employees and volunteers for losses arising from work performed by the Subcontractor for LDH.

29. Hold Harmless. Subcontractor shall indemnify, defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) Any claims for damages or losses arising from services rendered by Subcontractor or any of its contractors, persons, or firms performing or supplying services, materials, or supplies to ACL in connection with the performance of this Agreement;

b) Any claims for damages or losses arising from sanctions on ACL network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the Fraud, Waste, and Abuse Prevention Section of the State Contract.

c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Subcontractor in the performance of this Agreement;

d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor, it's agents, officers, employees, or subcontractors by Subcontractor's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes;

e) Any claims for damages or losses arising from failure by Subcontractor, it's agents, officers, employees or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;

f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the Subcontractor by ACL;

g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses

which may in any manner accrue against ACL or LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of the Subcontractor, its agents, officers, employees, or subcontractors.

i) If the Subcontractor performs services, or uses services, in violation of Section 38, the Subcontractor shall be in material breach of this Agreement and shall be liable to LDH and ACL for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Subcontractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

30. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL or reductions in payment to ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, which shall include, but may not be limited to Subcontractor's failure or refusal to respond to ACL's request for information and, as applicable, to provide medical records and/or credentialing information. Subcontractor's failure to comply with the provisions of the Agreement may also result in the termination of the State Contract in whole or in part, which shall result in termination of the Agreement. At ACL's discretion or a directive by LDH, ACL shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall comply with any relevant corrective action plan imposed upon or developed by ACL and/or required by LDH in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

31. **Loss of Federal Financial Participation ("FFP").** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

32. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential or actual conflict(s). Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement and during the term of the Agreement.

33. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

34. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing

such services provides the appropriate surety bond.

35. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

36. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

37. **Termination for Threat to Health of ACL Enrollees.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of ACL's enrollees.

38. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

39. **Independent Contractor/Subcontractors.** It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

40. **Licensing Requirements.** Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

41. **Entire Contract; Amendments.** Subcontractor shall comply with, and agrees to be bound by, all provisions of theAgreement and shall act in good faith in the performance of the provisions of the Agreement.

The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing.

Except as provided in Section 3, any amendments, alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

42. **Restrictions on Contracting.** Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the

services contracted under the Agreement.

43. **Antitrust**. Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program.. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

44. **Termination of LDH Contract**. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make available to ACL and/or LDH or their respective designated representatives, in a usable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

45. **Law.** This Attachment shall be governed by the laws of the State of Louisiana, without regard to its conflict of law provision, and Louisiana law will prevail if there is a conflict between the state law where the Subcontractor is based and Louisiana law.

This page is intentionally left blank.

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-4

Southeastrans, Inc.

Appendix F Material Subcontractor Response Template

This page is intentionally left blank.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
AmeriHealth Caritas Louisiana
Material subcontractor name:
Southeastrans, Inc. (Southeastrans)
Description of the Proposer's role and material subcontractor's role:
AmeriHealth Caritas Louisiana is responsible for the sourcing, vetting, selection, and oversight of Southeastrans, reporting on performance, providing ongoing support, and ensuring that they comply with the terms set out in the subcontractor agreement. Southeastrans' daily activities will be conducted in concert with our Operations team. Southeastrans provides covered non-emergency medical transportation (NEMT) services, including development of the NEMT provider network (recruitment, credentialing, contracting, compliance, and safety monitoring, etc.); managing an enrollee call center for reservations, questions and issues; conducting enrollee eligibility and benefit verification; processing and reconciliation of provider claims; production and issuance of claims payments and remittance advice; transmission of encounter data; investigation of complaints, grievances, and appeals; surveying enrollee satisfaction; and production of standardized reports.
Explanation of why the Proposer plans to subcontract this service and/or function:
AmeriHealth Caritas Louisiana has determined that subcontracting NEMT services is the most efficient, cost-effective way to provide these Medicaid covered services to our enrollees, while complying with service requirements/standards as set out by the Louisiana Department of Health. Our key strategy in forging relationships for delegated NEMT services is to eliminate barriers including social determinants of health (SDoH) that prevent enrollees from accessing necessary services to achieve and maintain better health, and to integrate services that are timely and medically appropriate, and emphasize a "whole person" approach to care.
A description of the material subcontractor's organizational experience:
Southeastrans, Inc. was founded in 2000 as a transportation management company specializing in efficient and innovative delivery of human transportation services. Southeastrans manages a range of transportation programs including Medicaid NEMT, human service center transportation, and managed care organization transportation services. The company's management methodologies have demonstrated tremendous success in reducing program costs, improving transportation service quality, and in building comprehensive and reliable transportation provider networks. Southeastrans currently coordinates over 3.6 million non-emergency medical trips annually under contracts in Louisiana, Georgia, Tennessee, Arkansas, Virginia and the District of Columbia. The company has grown to over 700 employees across the United States and continues to pursue relationships that foster true healthcare, technology, datasmart tools and comprehensive reporting. Southeastrans has been our NEMT partner since April 2018.
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
Prior to approval as a material subcontractor, Southeastrans will be evaluated, including screening for state and federal exclusions, review of ownership disclosures, review of trainings and policies, accreditation standards, and completion of all necessary documentation. Southeastrans must demonstrate that they possess the infrastructure, organization, financial stability, and processes necessary to fulfill their roles. Southeastrans will be monitored by our local Vendor Management team, in collaboration with the Delegation Oversight department. They are responsible for onboarding, auditing and monitoring, guided and supported by an enterprise delegation oversight policy maintained by the Corporate Quality department. Dedicated staff will monitor Southeastrans' performance against documented performance standards monthly. At a minimum, we require performance consistent with the requirements of the Medicaid contract and any applicable accreditation standards. Annually, Southeastrans will be audited to ensure that their credentialing, UM, and other business processes and procedures continue to meet our requirements. The results of these audits are compiled and submitted to the appropriate Quality committees, along with any recommendations. In order to ensure an appropriate return on investment (ROI), our Medical Economics department works with UM, care management, and other relevant teams to assess patient outcomes and program ROI analyses, provider/plan goal alignment and pay-for-performance initiatives, and other analytics relevant to NEMT services. Further, we constantly monitor for any reported or identified instances of fraud, waste and abuse, and third-party liability (TPL) to ensure that claims and payments are accurate, timely, and appropriate for services rendered.

Instructions: The MCO should attach the executed contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Subcontract Provisions, Introductory Paragraph, pg. 1
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Contract
3	Specify the effective dates of the subcontract agreement.	Contract
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Subcontract Provisions, Par. 41, pg. 21
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Subcontract Provisions, Par. 41, pg. 21
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Subcontract Provisions, Par. 41, pg. 21
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Subcontract Provisions, Par. 44, pg. 22
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Subcontract Provisions, Par. 39, pgs. 21
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Subcontract Provisions, Introductory Paragraph, Pg. 1

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Subcontract Provisions, Introductory Paragraph, Pg. 1
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Subcontract Provisions, Par. 4(i), pg. 4
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Subcontract Provisions, Par. 40, pg. 21
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Contract
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Subcontract Provisions, Par 16, pg. 13
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Subcontract Provisions, Par. 8(g), pg. 11
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Subcontract Provisions, Par. 4(j), pg. 4
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Subcontract Provisions, Par. 23, pgs. 15-16

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Subcontract Provisions, Par. 5(d), pg. 5
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 2.9.6. The completed disclosure of ownership should be attached for executed contracts.	Subcontractor Provisions, Par. 5(m), pg. 7
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Subcontract Provisions, Par. 4(c), pg. 4
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Subcontract Provisions, Par. 4(e), pg. 4
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Subcontract Provisions , Par. 30(b), pg. 20
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Subcontract Provisions, Par. 30, pg. 20

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Subcontract Provisions, Par. 4(b), pg. 4
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Subcontract Provisions, Par. 21, pg. 15
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Subcontract Provisions, Par. 4(g), pg. 4
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 4
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 4
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Subcontract Provisions, Par. 4(k), pg. 4
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Subcontract Provisions, Par. 12, pgs. 12-13
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Subcontract Provisions, Par. 29, pgs. 18-20

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Subcontract Provisions, Par. 28, pgs. 17-18
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Subcontract Provisions, Par. 3, pgs. 1-2 and Par. 45, pg. 22
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Subcontract Provisions, Par. 3, pgs. 1-2
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Subcontract Provisions, Par. 15, pg. 13
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Subcontract Provisions, Par. 32, pg. 20
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Subcontract Provisions, Par. 4(d), pg. 4
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Subcontract Provisions, Par. 26, pg. 17
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Subcontract Provisions, Par. 3(c), pg. 2
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Subcontract Provisions, Par. 42, pg. 21

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Subcontract Provisions, Par. 4(a), pgs. 3-4
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Subcontract Provisions, Par. 38, pg. 21
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Subcontract Provisions, Par. 43, pg. 21-22

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Subcontract Provisions, Par. 5(e), pgs. 5-6

Attachment 2.10.2.3-4

Southeastrans, Inc.

Executed Agreement

- Amendment 1

- Amendment 2

This page is intentionally left blank.

NOTE: THIS AGREEMENT IS BINDING UPON EACH PARTY AT THE TIME THAT THE PARTY SIGNS THIS AGREEMENT, PROVIDED THAT THIS AGREEMENT REMAINS SUBJECT TO THE APPROVAL OF THE STATE OF LOUISIANA, AND MAY BE AMENDED BY THE PARTIES TO COMPLY WITH ANY REQUIREMENTS OF THE STATE OF LOUISIANA. SOUTHEASTRANS, INC. ACKNOWLEDGES THAT THE REQUIREMENTS OF THE STATE OF LOUISIANA, THE STATE CONTRACT, AND APPLICABLE LAWS AND REGULATIONS, AS AMENDED FROM TIME TO TIME, ARE INCORPORATED.

MEDICAL TRANSPORTATION SERVICES AGREEMENT

THIS AGREEMENT is made and entered into as of the 8th day of January, 2018, by and between AMERIHEALTH CARITAS LOUISIANA, INC. (hereinafter "Health Plan" or "ACLA"), a corporation organized under the laws of the State of Louisiana, and Southeastrans, Inc., a corporation organized under the laws of the State of Georgia ("Southeastrans").

WHEREAS, through a contract with the State of Louisiana's **Department of Health ("LDH" and the "Contract")**, Health Plan is engaged in the business of providing or arranging for the provision of prepaid health services, including without limitation, Non-emergency Medical Transportation ("NEMT") services to Members (as defined below); and

WHEREAS, Southeastrans is in the business of contracting with transportation providers in order to arrange for the provision of NEMT services for Health Plan Members in the State of Louisiana; and

WHEREAS, Health Plan desires to enter into an agreement with Southeastrans whereby Southeastrans will arrange for the delivery of NEMT services to Health Plan Members through a network of Participating Transportation Providers.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, Health Plan and Southeastrans, intending to be legally bound hereby, agree as follows:

I. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

A. "Accident" means (i) a vehicle in which a Member is being transported is involved in a collision, regardless of whether the Member is injured and whether or not another vehicle is involved; (ii) a Member falls or is dropped when moving to or from the vehicle, or when trying to enter or exit the vehicle; and (iii) a Member is otherwise injured while entering, in, or exiting the vehicle.

B. "Accreditation Organization" means the National Committee for Quality Assurance ("NCQA"), URAC or other organization that conducts independent review and accreditation of health plans.

C. "Action" means: (1) the denial or limited authorization of a requested services, including the type or level of service; (2) the reduction, suspension or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the LDH Contract; or (5) the failure of Health Plan to act within the timeframes required for the disposition of Appeals and Grievances under the LDH Contract.

D. "Commencement Date" means April 1, 2018, or any later date determined by Health Plan for the commencement of the delivery of transportation services to Members hereunder.

E. "Covered Services" means the services to which Southeastrans will transport Members as more particularly set forth in **Exhibit A** incorporated herein by reference.

F. "Emergency Medical Condition" means Transportation provided for an unforeseen combination of circumstances that apparently demand immediate attention at a medical facility to prevent serious impairment or loss of life.

G. "LDH" or the "LDH" means the Louisiana Department of Health or any successor agency of the State that administers the Medicaid program in the State.

H. "LDH Contract" means the applicable contract or contracts with the LDH as in effect from time to time pursuant to which Health Plan operates a managed care plan or plans in the Service Area (as defined below).

I. "Government Agency" means any local, State or federal government agency or entity with regulatory or other legal authority over Health Plan or this Agreement.

J. "Grievance" means an expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes Grievances and Appeals handled at the Health Plan level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights.)

K. "Member" means a Medicaid recipient residing within the Service Area enrolled in a health benefit plan operated by Health Plan and eligible to receive NEMT benefits under such benefit plan as determined by Health Plan.

L. "Non-Emergency Medical Transportation" (or "NEMT") shall mean a ride or reimbursement for a ride provided so that a Member with no other transportation resources can receive services covered by a ACLA under the LDH Contract. Non- Emergency Transportation does not include transportation provided on an emergency basis to a Member experiencing an Emergency Medical Condition, nor does the term include, for purposes of this Agreement, transportation to services that are not covered by Southeastrans under this Agreement as set forth in **Exhibit A**.

M. "Participating Transportation Provider" means a company or individual who has

entered into a contractual relationship with Southeastrans to transport Members to Covered Services.

N. "Service Area" means the State of Louisiana.

O. "State" means the State of Louisiana.

II. OBLIGATIONS OF SOUTHEASTRANS

A. NEMT Services.

1. Effective on the Commencement Date, Southeastrans shall arrange for the provision of NEMT services to eligible Members in accordance with the terms of this Agreement and the description of Covered Services, as set forth in **Exhibit A** hereto, and limited by the "Exclusions and Limitations to Coverage" (if any) also set forth in **Exhibit A**. Such Covered Services represent the services for which Health Plan is obligated to provide NEMT to Members in accordance with the LDH Contract, and may be modified from time to time by LDH and Health Plan, with timely notification provided to Southeastrans.

2. In providing or arranging for Covered Services hereunder, Southeastrans agrees to be bound by relevant Health Plan policies and procedures and/or rules and regulations of Health Plan which Health Plan has provided to Southeastrans, including, but not limited to, the Louisiana Medicaid Medical Transportation Provider Manual . Further, Southeastrans shall, at all times during the term of the Agreement, arrange for Covered Services in accordance with the applicable terms of the LDH Contract and with other applicable State and federal laws, regulations and guidelines. In the event that changes in Health Plan policies and procedures, rules and regulations, or any other Health Plan guidelines are required by operation of the terms of the LDH Contract, State or Federal law, or standards of applicable Accreditation Organizations, Southeastrans shall cooperate with Health Plan to timely comply with such new requirements.

3. Southeastrans shall obtain the prior approval of Health Plan of all general communications to Members or to Participating Transportation Providers regarding or naming Health Plan or the services provided pursuant to this Agreement, which approval shall not be unreasonably withheld, and shall use best efforts to obtain approvals from LDH in a timely fashion. Any communication materials created by Southeastrans which relate to the provision of Covered Services for Members must adhere to LDH requirements for Member communications. Such communication materials must be sent to Health Plan for review and approval prior to use and such approval shall not be unreasonably delayed or withheld. Health Plan's review of such materials shall be limited to approving the accuracy of the content and shall not encompass or constitute certification that Southeastrans's materials meet any applicable legal or regulatory requirements. All written Member materials are subject to review and approval by LDH.

All communication materials created by Health Plan which relate to Covered Services provided by Southeastrans under this Agreement must be sent to Southeastrans for review and approval prior to use. Southeastrans's review of such materials shall be

limited to approving the accuracy of the description of plan benefits, shall not encompass or constitute certification that Health Plan's materials meet any applicable legal or regulatory requirements, and shall not be unreasonably delayed or withheld. In the event of any dispute between the communication materials and this Agreement, the provisions of this Agreement shall prevail.

4. In the event that Southeastrans is unable to arrange for the provision of Covered Services by a Participating Transportation Provider with the appropriate training and experience to meet the particular health care needs of a Covered Member, Southeastrans shall, in consultation with ACLA, make a referral to an appropriately qualified non-participating NEMT provider.

B. NEMT Provider Network Management. Southeastrans shall recruit and contract with NEMT providers in such locations, in such number and with such specialties as shall be necessary to provide an adequate and accessible NEMT services delivery network to Members and which shall satisfy the requirements hereof, including the delegated activities set forth in **Exhibit G** and the applicable requirements of the LDH Contract, particularly any applicable statutes or regulations incorporated therein and, including but not limited to the provisions set forth in **Exhibit C**. Southeastrans shall have contracted with a network of Participating Transportation Providers such that said requirements have been met by the time of LDH's review of Health Plan's network adequacy but in no event later than the Commencement Date and shall adhere to the following:

1. Southeastrans will maintain its network of Participating Transportation Providers during the term of this Agreement such that any terminations of Participating Transportation Providers do not result in Southeastrans's failure to satisfy the requirements outlined herein.

2. Southeastrans shall at all times select and contract with Participating Transportation Providers in locations that will ensure reasonable access to NEMT services for Members as required pursuant to the LDH Contract. Southeastrans shall ensure that a sufficient number of Participating Transportation Providers and other personnel are available to provide necessary services to Members without limiting services or restricting services.

3. Southeastrans will achieve a provider network that adequately serves the needs of the Members and maintains a sufficient number, mix and geographic distribution of providers. As part of its credentialing process or otherwise, Southeastrans will ensure that sufficient numbers of Participating Transportation Providers have demonstrated the ability to serve Members with various special needs, including the ability to provide services to Members with chronic physical or mental disabilities, or developmental disabilities as applicable to the services provided hereunder.

4. Southeastrans shall provide the Health Plan with a complete provider registry file, including the data elements necessary to populate the LDH-required provider registry, thirty (30) days prior to the Commencement Date. Updates to the Participating Transportation Provider network shall be submitted in the agreed upon format no less than

monthly. Southeastrans agrees that, if required by LDH, Health Plan may list Participating Transportation Providers' names, addresses, telephone numbers, and specialty in Health Plan's Provider Directory.

5. Southeastrans's Provider Manual for Participating Transportation Providers (the "Southeastrans Provider Manual") shall be approved by Health Plan and, if required, by LDH. The Southeastrans Provider Manual shall adhere to all regulatory provisions as set forth by LDH and Health Plan.

6. Southeastrans shall require, in its Provider Agreement, notice from its Participating Transportation Providers of any adverse action or other event described below within five (5) business days of such Participating Transportation Providers' receiving any oral or written notice of any adverse action, including, without limitation, any malpractice suit or action, or other arbitration action naming or otherwise involving Southeastrans, any Participating Transportation Provider, or Health Plan, or any other event, occurrence or situation which might materially interfere with, modify or alter performance of any of Southeastrans's or its Participating Transportation Providers' duties or obligations under this Agreement.

7. Southeastrans may use its own template for purposes of establishing contractual relationships with Participating Transportation Providers; provided, however, that Southeastrans will include provisions in its Participating Transportation Provider agreements that are required to be so included by the LDH Contract. Upon request, Southeastrans will furnish to Health Plan a copy of its standard Participating Transportation Provider contract template (excluding rates) and the contract with any Participating Transportation Provider specifically identified by Health Plan. Southeastrans will not make any material modifications, excluding rate changes, to such contract template without Health Plan's prior written consent, which consent shall not be unreasonably or unduly withheld.

7. Southeastrans agrees that neither it nor any of its Providers shall participate in a restrictive or exclusive practice arrangement with other managed care organizations.

8. Participating Transportation Providers shall only transport Members to Covered Services set forth in **Exhibit A,** unless otherwise approved by Health Plan. Neither Southeastrans nor its Participating Transportation Providers shall seek payment from Members, Health Plan or LDH.

C. Quality Management Programs. Southeastrans shall follow its own quality assurance plan and guidelines, which shall be subject to approval of Health Plan, and such approval shall not be withheld unreasonably. Southeastrans agrees to cooperate and comply with Health Plan's quality management and oversight programs, including requiring Participating Transportation Providers to provide Health Plan access to Member NEMT records, if requested. In accordance with the scope of services defined in **Exhibits A, B and H**, Southeastrans will process requests for services within the time periods required by, and otherwise in accordance with, the standards of Health Plan, the LDH Contract, Accreditation Organizations and applicable law. Southeastrans will utilize the standards and criteria for the review of NEMT services adopted by LDH and Health Plan from time to time.

D. Member Grievances & Appeals. Notwithstanding that Health Plan does not delegate to Southeastrans the Member Appeal or Grievance processes, Southeastrans shall cooperate with Health Plan in the timely investigation of Member Appeals and Grievances.

E. Claims Processing & Payment; Encounter Reporting.

1. Southeastrans has established and maintains standards, policies and procedures for the timely and accurate processing and payment of claims for Covered Services provided to Members ("Claims Processing Guidelines"). The Claims Processing Guidelines shall be maintained in accordance with the requirements of State and federal law, the LDH Contract and the Health Plan. Southeastrans shall cause its Participating Transportation Providers to comply with Southeastrans's Claims Processing Guidelines. Claims processing shall be performed under this Agreement in accordance with **Exhibits D and G**.

2. Southeastrans shall meet all claims payment requirements as specified in the LDH Contract and applicable law, and as otherwise established by Health Plan. Southeastrans hereby agrees that it has the capacity and ability to comply with the standards for claim payment timeliness and accuracy set forth in the LDH Contract and otherwise by Health Plan. Southeastrans shall provide such periodic reports as may be requested by Health Plan to demonstrate Southeastrans's compliance with claims processing and payment standards. In the event that Health Plan incurs financial penalties as a result of Southeastrans's failure to meet claims payment standards, Health Plan may require Southeastrans to pay such penalties.

3. Encounter Data. No later than the eighth (8^{th}) calendar day of each month, or at such a frequency as may be required by ACLA to meet its obligations of the LDH Contract, Southeastrans shall maintain and provide to Health Plan the utilization data pertaining to Covered Services which are paid for by Southeastrans during the preceding month, including data not provided in the most recent submission (the "Encounter Data"). Southeastrans shall submit Encounter Data to Health Plan in a format designated by Health Plan and mutually agreed upon by the parties. Southeastrans shall reprocess claims and resubmit Encounter Data when necessary as a result of encounter errors or retroactive claims activity. If Health Plan reviews the Encounter Data file submitted by Southeastrans and is aware that the file does not meet required specifications, Health Plan will return the file to Southeastrans for corrections and Southeastrans shall correct and resubmit the Encounter Data file in a timely fashion.

4. Southeastrans will develop and implement a system for collecting, analyzing and reporting data to monitor utilization of NEMT services and to identify patterns of over- or under- utilization and claims fraud. Based upon the results of the analysis conducted, Southeastrans will perform targeted record audits to determine whether claims submitted are appropriate. If inappropriate claims by a Participating Transportation Provider are identified, Southeastrans will so notify Health Plan and will take corrective action with respect to the Participating Transportation Provider. Southeastrans will cooperate with Health Plan in reporting to governmental authorities any suspected fraudulent activity by Participating Transportation Providers.

F. Utilization Management. Utilization Management is not delegated to Southeastrans.

G. Licensure; Certification. Southeastrans and its Participating Transportation

Providers shall at all times, and at its sole expense, maintain such licensure and/or certification as required by LDH, the State of Louisiana Department of Insurance or other regulatory agency under applicable law, so as to allow Southeastrans to perform its responsibilities under this Agreement. Southeastrans shall provide evidence of such certification to Health Plan upon request. In the event that such licensure and/or certification lapses, is revoked, or otherwise ceases through circumstances within Southeastrans's control, then Southeastrans shall implement a corrective action plan designed to restore its certification status. Notwithstanding the foregoing, Health Plan may at its discretion consider such failure to maintain required certification to be a breach of this Agreement and exercise its rights under **Section IV.F** hereof. Health Plan acknowledges that Southeastrans is not licensed as an insurer, health maintenance organization or other type of licensed insurer. A regulatory determination that Southeastrans must obtain such licensure and Southeastrans's failure to obtain such licensure within the time period mandated by the regulatory agency constitutes grounds for termination of this Agreement in the discretion of Health Plan.

H. Recordkeeping; Auditing. Southeastrans and its Participating Transportation Providers shall maintain such records and provide such information to Health Plan, State or Federal regulatory agencies and Accreditation Organizations, including but not limited to LDH, the Attorney General's Office and the Louisiana Legislative Auditor as may be necessary for compliance by Health Plan with State and federal law, Accreditation Organization standards, or the LDH Contract or other applicable agreements with the State. The Health Plan and State or Federal agencies shall have the right upon request to inspect at all reasonable times any accounts, financial, administrative information and reports maintained by Southeastrans to the extent they pertain to Health Plan or its Members.

Southeastrans and its Participating Transportation Providers shall allow access during normal business hours to Health Plan, Accreditation Organizations and State or Federal regulatory agencies to periodically audit or inspect the facilities, offices, equipment, books, documents and records of Southeastrans and Participating Transportation Providers relating to the performance of this Agreement and Covered Services provided to Members, including, without limitation, financial records pertaining to Covered Services rendered to Members under this Agreement. Any costs associated with an audit by the Health Plan's Accreditation Organization shall be paid by Health Plan. Southeastrans and its Participating Transportation Providers shall comply with any requirements or directives issued by Health Plan, Accreditation Organizations and State or Federal agencies as a result of such evaluation, inspection or audit of Southeastrans and Participating Transportation Providers. Southeastrans and Participating Transportation Providers shall retain the books and records described in this **Section II.H.** for the longer of ten (10) full years from the date of final payment or until all audits are completed, whichever is longer. Southeastrans and Participating Transportation Providers acknowledge that certain Government Agencies may have the right to inspect and audit Southeastrans's and Participating Transportation Providers' books and records, as related to this Agreement, following the termination of this Agreement. The provisions of this **Section II.H.** shall survive termination of this Agreement, for the period of time required by State and federal Law.

I. Administrative Services. Southeastrans shall be responsible for all administrative services related to the delivery of transportation services hereunder, including but not limited to customer service support, a member call center, and a provider call center, in accordance with

Southeastrans's administrative procedures approved by Health Plan, which approval shall not be unreasonably withheld. Southeastrans shall set staff at a sufficient level to ensure the duties of the Agreement are performed adequately. Southeastrans shall ensure all staff dedicated to the provision of delegated functions under this Agreement have appropriate ongoing training (e.g., orientation, cultural sensitivity, program updates, policies and procedures compliance, computer, management information systems, fraud and abuse, False Claims Act, etc.), education and experience to fulfill the requirements of their position.

1. Provider Call Center. Southeastrans will provide customer service support to Participating Transportation Providers, and to Health Plan staff, for inquiries regarding issues including but not limited to Member eligibility and benefit information, provider services, and claims payment, by way of a toll-free telephone number to be provided by Health Plan, at least Monday through Friday, 8:00 am to 5:00 pm Central Time.

2. Member Call Center. Southeastrans shall provide a member call center for Members to use to arrange transportation services with Southeastrans. Southeastrans shall utilize the Health Plan's dedicated toll-free numbers. Primary and backup member call centers must be adequately staffed, as defined by compliance with call center metrics in Exhibit D, for routine reservation requests at least Monday through Friday, 7:00 AM to 7:00 PM Central Time, excluding State declared holidays. The call center must be staffed 24/7/365 for urgent and same-day requests, hospital discharges and *Where's My Ride?* inquiries.

Southeastrans shall provide Health Plan with access to recorded calls for purposes of monitoring compliance with timeliness of answering and completing calls, accuracy of information acquired during intake, call center staff professionalism, sensitivity, courtesy, and responsiveness to the Member's needs, and accuracy of trip scheduling. Health Plan representatives may also visit Southeastrans's call center and monitor live calls.

3. Account Management. Southeastrans shall provide full-time account management services to Health Plan, in the form of an individual employed by Southeastrans on a full-time basis, whose responsibility it shall be to manage the account of Health Plan. Such account management services shall be available and accessible to designated staff of Health Plan. Health Plan shall be entitled to require Southeastrans to remove, upon Health Plan's reasonable request and discussion, any Southeastrans personnel from providing services to Health Plan or its Members under this Agreement.

J. Performance Standards. In addition to the obligations and requirements otherwise set forth herein, Southeastrans shall satisfy, and perform its services hereunder in accordance with, the performance standards set forth in the LDH Contract and Exhibits A, D and D-1 hereto. Southeastrans shall furnish Health Plan with such standard reports as may be mutually agreed upon and so as to demonstrate Southeastrans's compliance with performance standards as outlined in Exhibits A, D and D-1 hereto. Further, Southeastrans agrees to work with Health Plan to modify

such standard reports in a mutually acceptable manner and time frame so that any such reports referenced in this Section or in any other Section of the Agreement are appropriate for Health Plan's Member population.

K. Ownership and Control. Southeastrans agrees to submit to LDH, within 35 days of request; within 35 days of any change in ownership; upon executing a contract with ACLA; and upon any renewal or extension of the contract, information as required pursuant to 42 C.F.R. §§ 455.104 -455.106 (related to ownership and control, business transactions and persons convicted of crimes), and as further clarified by the LDH Contract. Such information shall include, but is not necessarily limited to: (1) ownership or control of Southeastrans, or of any subcontractor of Southeastrans that is directly or indirectly owned by Southeastrans; (2) the ownership of any subcontractor of Southeastrans with whom Southeastrans has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; (3) any significant business transactions between Southeastrans and any wholly owned supplier of Southeastrans, or between Southeastrans and any subcontractor of Southeastrans, during the five-year period ending on the date of the request; and (4) the identity of any person who has ownership or control interest in Southeastrans, or is an agent or managing employee of Southeastrans, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services since the inception of those programs.

L. Notice of Events. Southeastrans shall give Health Plan written notice within three (3) business days after the occurrence or notice of the occurrence of any of the following events: (1) any merger, consolidation, sale of all or substantially all of its assets, or any other change in control of Southeastrans involving related or unrelated entities in a single transaction or a series of related transactions, if Southeastrans is a stock corporation; (2) any material reduction or discontinuance of services or material reduction in the capacity of Southeastrans as applicable; (3) any material adverse change in the financial condition, business or prospects of Southeastrans; (4) any action by Southeastrans seeking protection under any bankruptcy or insolvency law, or any appointment of a trustee or receiver for Southeastrans, or a substantial portion of its assets; (5) any transfer, by contract or otherwise, of the responsibility for the overall management or administration of Southeastrans to a third-party; (6) Southeastrans's receipt of any written or oral notice of any adverse action, occurrence or situation which might materially interfere with, modify or alter performance of any of Southeastrans's duties or obligations under this Agreement, including without limitation, any material malpractice suit, arbitration action, or other action naming or otherwise involving Southeastrans or Health Plan; and (7) any default by Southeastrans or Health Plan under a credit or loan facility or arrangement with a bank or other financial institution.

M. Reporting. Southeastrans shall submit timely, accurate and complete reports and/or data to Health Plan as required to meet all Health Plan, LDH and other regulatory reporting requirements and as set forth in **Exhibit G**. Southeastrans shall provide timely responses to requests arising from Health Plan or requests arising from LDH or other applicable regulatory agencies for reports and/or modifications thereto; and shall ensure that all such responses are timely, accurate and complete. Southeastrans shall certify all submitted data and reports. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data**.**

N. Notification of Accidents. Southeastrans shall notify ACLA of all Southeastrans and Participating Transportation Provider Accidents involving Members. This notification must be made on ACHP's NEMT Accident Report, which is hereby incorporated as Exhibit B-1 to Exhibit B (Transportation Protocols) of this Agreement. This notification shall be made within one (1) business day. Southeastrans shall supplement the initial NEMT Accident Report with additional information regarding the Accident and its outcomes as necessary and relevant.

III. OBLIGATIONS OF HEALTH PLAN

A. Compensation to Southeastrans.

1. Health Plan shall pay Southeastrans, and Southeastrans shall accept as payment in full for services rendered hereunder and to Members, the amounts set forth in **Exhibit E** hereto. Southeastrans shall be solely responsible for payments to Participating Transportation Providers for the provision of Covered Services to Members, and neither Health Plan, except as described herein, nor LDH shall be liable to providers for transportation services rendered to Members.

2. The total monthly payment shall be paid to Southeastrans by the fifteenth (15th) day of each month in which services are to be provided. Such payments to Southeastrans may be based on an estimated number of Members and adjusted retrospectively after each month's payment by Health Plan based on the actual number of Members for each month identified as eligible in the records of Health Plan as transmitted to Southeastrans.

B. Health Plan agrees to supply Southeastrans monthly full files on or before the first (1st) day of each month, with eligibility data reflecting additions, changes and deletions covering data at least up to and including the fifteenth (15th) day of the preceding month. Health Plan shall also provide Southeastrans with daily updates to eligibility data as made available by Health Plan. Such eligibility data shall be transmitted in a mutually agreed format and manner. Southeastrans will update its eligibility files with the updated Health Plan data within two (2) business days.

C. Southeastrans agrees that Health Plan may, in its discretion, use Southeastrans's name, address and telephone number in Health Plan's marketing and informational materials, including, without limitation, Health Plan's provider directory. Nothing in this Agreement shall be deemed to require Health Plan to conduct any specific marketing activities on behalf of Southeastrans or to identify Southeastrans in any specific marketing or informational materials.

D. Benefit Design and Interpretation: Coverage Decisions: Health Plan shall be solely responsible for informing Southeastrans of the benefit design of its managed care plan, as determined by LDH or other applicable Government Agency, including establishing benefits and any permitted copayments. In the event of an appeal of a service reduction or denial, Health Plan shall be solely responsible for interpreting the terms of and making final benefit determinations under its managed care plan.

E. Enrollment and Assignment of Members; Member Communications:

1. Member Communications. Health Plan shall be responsible for communicating with all Members upon enrollment to the Health Plan. Health Plan shall provide benefit information to Members concerning the type, scope and duration of benefits to which Members are entitled. Health Plan shall distribute to Members any disclosure forms, plan summaries or other material required by any Government Agency or other regulatory authority.

2. Member Rights and Responsibilities. Health Plan is responsible for informing Members of their rights and responsibilities, providing Members with Membership cards and Member handbooks, and distributing periodic communications to Members that may be required to be given to Members by any Government Agency. Health Plan shall also process Member Appeals and Grievances and respond to inquiries and requests from Members (collectively "Member Services"). Southeastrans shall partner with Health Plan in the timely investigation of Appeals and Grievances in accordance with **Exhibit D**.

IV. TERM AND TERMINATION

A. Term: The term of this Agreement shall commence on the Commencement Date for a one (1) year term ("Initial Term"), and shall automatically renew for additional one-year terms thereafter (each a "Renewal Term"), unless terminated as provided for herein.

B. If Health Plan materially breaches this Agreement by failure to satisfy its payment obligations set forth in **Section III.A** above and further described in **Exhibit E** hereto, and such material breach continues for a period of thirty (30) days after written notice is given to Health Plan of the claimed breach, then Southeastrans may, upon sixty (60) days' written notice to Health Plan, terminate this Agreement. Failure to pay amounts which are the subject of a good faith dispute regarding the amount of compensation to be paid to Southeastrans shall not be considered a material breach under this **Section IV.B**.

C. If either party materially breaches this Agreement in any manner other than a payment default specified in **Section IV.B** above, and such material breach continues for a period of forty-five (45) days after written notice is given to the breaching party, specifying the nature of the breach, the steps necessary to cure it and requesting that it be cured, the other party may upon written notice to the breaching party terminate this Agreement.

D. After the Initial Term of this Agreement, either party shall have the option to terminate this Agreement at any time, for any or no reason, upon no less than one hundred twenty (120) days prior written notice to the other party.

E. Either party may terminate this Agreement at any time in the event that the other party shall apply for, or consent to, appointment of a receiver, trustee or liquidator of the party to a substantial part of its assets, is the subject of a voluntary or involuntary petition in bankruptcy, or shall admit in writing its inability to pay its debts, file a petition or an answer seeking reorganization or arrangements with creditors or to take advantage of any insolvency law.

F. Termination by Health Plan. Should Southeastrans fail to perform the functions as set forth in this Agreement and any Exhibits thereto, Health Plan may terminate this Agreement or the applicable delegated function, as of the date written notice is given to Southeastrans, or such

later date as may be specified in the notice, provided, however, that Southeastrans shall be provided with the opportunity to cure any deficiencies identified by Health Plan in an agreed upon time period, which may be extended upon mutual agreement and good faith efforts of the parties. If the deficiencies are identified by LDH, any other regulatory agency or accreditation organization, Southeastrans shall abide by any official directive given by such regulatory agency or accreditation organization, be it the opportunity to cure said deficiency within the cure period provided by the regulatory agency or accreditation organization, if any or immediate revocation of the agreement.

G. Immediate Termination by Health Plan. Health Plan may immediately terminate this Agreement as of the date written notice is given to Southeastrans, or such later date as may be specified in the notice, without the need to provide for a cure period or advance notice, if:

1. Health Plan or LDH determine, in their sole discretion, that the health, safety or welfare of Members is or may be jeopardized by continuation of this Agreement;

2. Southeastrans commits fraud or a material misrepresentation in an application or report submitted to Health Plan or in any report filed with any person, corporation, partnership, association, Government Agency or any other entity relating to the provision of services or in any other manner related to this Agreement;

3. Upon the elimination by LDH of the transportation benefit to be provided by Health Plan, issuance of an order by the LDH to terminate this Agreement, or upon termination of the LDH Contract;

4. In the event of the cancellation, revocation, suspension or restriction of any insurance, license, certificate or other authorization required to be maintained by Southeastrans or Health Plan in order to perform the services required under this Agreement or upon Southeastrans's or Health Plan's failure to obtain such license, certificate or authority, including but not limited to either party's being expelled, disciplined, barred from participation in, or suspended from receiving payment under the Medicare Program or any state's Medicaid Program, or in the event that either party is convicted of any felony or of any crime related to the provision of health care services.

G. Effect of Termination.

1. After termination of this Agreement, Southeastrans shall provide evidence satisfactory to ACLA that Southeastrans has made payment of all claims for services rendered during the term hereof. Southeastrans shall further be obligated to provide ACLA with all reports and data required hereunder for services rendered during the term hereof.

2. Upon termination of this Agreement for any reason, Southeastrans shall assist Health Plan in effecting an orderly transition of the processing of claims and other services provided by Southeastrans under this Agreement so as to prevent disruption of Health Plan's operations. Such assistance shall be rendered in a manner consistent with usual and customary industry practice and with applicable vendor contracts between Southeastrans and any third party. Without limiting the foregoing, Southeastrans shall

continue to process and pay all claims for services provided to Members prior to the termination, at no additional cost to Health Plan for a period of up to three hundred sixty five (365) days following termination.

H. Notwithstanding any provisions of this Agreement and unless terminated immediately for-cause, the termination date shall be the last day of the month of termination.

V. INSURANCE AND INDEMNIFICATION

A. Health Plan and Southeastrans, each at its sole cost and expense, shall provide and maintain separate policies of general liability and professional liability insurance and other insurance as is necessary to insure each organization against any claim or claims for damages arising by reason of personal injury or death occasioned directly or indirectly in connection with the operation of each organization. All insurance required by this **Section V.A** shall, at a minimum, be in amounts no less than the amounts required by the LDH Contract or applicable law, whichever is greater. Southeastrans shall provide Health Plan thirty (30) days written notice if the stated limit in the declarations page of an insurance policy required under this contract is reduced via endorsement or canceled prior to the expiration date shown on the certificate of insurance, All insurance required under this contract, except for comprehensive automobile liability insurance (as applicable), shall include the State of Louisiana as an additional insured.

B. Southeastrans shall require its Participating Transportation Providers to have, at minimum, general liability coverage of $300,000 on the business entity, in addition to three months prepaid automobile liability coverage of $100,000 per person and $300,000 per accident or a combined single limit of $300,000. Any provider authorized to transport a recipient out of state must carry at minimum, automobile liability of $1,000,000. This liability policy shall include “owned” autos, hired autos, and nonowned leased autos.

C. Southeastrans shall indemnify and hold Health Plan harmless with respect to any claim against Health Plan, including but not limited to any fines, penalties, sanctions, liquidated damages or similar consequence imposed by LDH or other Government Agency, arising out of Southeastrans’s negligence or failure to fulfill its obligations under this Agreement. Without limiting the foregoing, Southeastrans agrees that to the extent penalties are assessed against Health Plan by a Government Authority, as a result of Southeastrans’s direct failure to comply with applicable rules, regulations, and LDH Contract requirements related to delegated responsibilities as set forth herein as it relates to the provision of services hereunder and , if available, Southeastrans has been provided the opportunity to participate in any cure periods provided to Health Plan by LDH to correct such failure, Southeastrans shall be responsible for the payment of such penalties in a mutually agreed upon timeframe. In the event such payment is not made in a timely manner to Health Plan, Health Plan shall have the right to offset any monies owed to Southeastrans for Administrative Services Only (ASO) fees, by any penalties owed by Southeastrans to Health Plan.

Health Plan shall indemnify and hold Southeastrans harmless with respect to any claim against Southeastrans including but not limited to any fines, penalties, sanctions, liquidated damages or similar consequence imposed by LDH or other Government Agency, arising out of

Health Plan's negligence or failure to fulfill its obligations under this Agreement. Without limiting the foregoing, Health Plan agrees that to the extent penalties are assessed against Southeastrans by a Government Authority, as a result of Health Plan's direct failure to comply with applicable rules, regulations, and LDH Contract requirements related to delegated responsibilities as set forth herein as it relates to the provision of services hereunder and Health Plan has been notified in a timely manner and has been provided the opportunity to participate in any cure periods provided to Southeastrans by LDH to correct such failure, Health Plan shall be responsible for the payment of such penalties in a mutually agreed upon timeframe.

VI. CONFIDENTIALITY

A. The parties hereto mutually agree that, with respect to any and all Member records, files and other patient-related information (the "Member Information") and any other confidential or proprietary data, reports, or information maintained pursuant to this Agreement or plans, policies and procedures shared between the parties and the terms of this Agreement (the "Other Confidential Information"), the receiving party shall ensure the confidentiality of all such Member Information and Other Confidential Information and in doing so will take the same measures to ensure confidentiality as it would take to protect its own confidential or proprietary information. The receiving party shall ensure that Member Information and Other Confidential Information is not disclosed to any third party, except as required under this Agreement and except to such providers, employees and agents as require Member Information or Other Confidential Information in order to perform their duties. This paragraph and the restrictions contained herein shall not apply to any information which the receiving party can demonstrate by written record: (1) was already available to the public at the time of disclosure, or subsequently became available to the public, otherwise than by breach of this Agreement; (2) was in the possession of the receiving party prior to the commencement of the negotiations that resulted in the execution of this Agreement; (3) was obtained from any third party, provided that the receiving party did not know or have reason to know that such third party obtained the information from the providing party directly or indirectly under secrecy; or (4) was the subject of a court order to disclose. For the purposes of this paragraph, the compensation terms of this Agreement are confidential. Nothing in this paragraph shall preclude either party to this Agreement from disclosing information required or permitted to be disclosed pursuant to this Agreement or law, regulation or the LDH Contract or other contracts with a Government Authority(ies) governing the business of either party. In the event that either party, or any of its partners or employees, becomes legally compelled (by deposition, interrogatory, request for documents, subpoena, civil or criminal investigative demand or similar process) to disclose any Member Information or Other Confidential Information of the other, the party being compelled to disclose shall provide the other party with prompt prior written notice so that the party having the right to keep such Confidential Information confidential may seek a protective order or other appropriate remedy.

B. Southeastrans may be considered a "business associate" of Health Plan under the privacy and security regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") at 45 CFR §§160-164, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA). In providing services under this Agreement on behalf of Health Plan, Southeastrans performs or

assists in the performance of functions and activities involving the use and disclosure of Protected Health Information ("PHI," as defined in the HIPAA Privacy Rule). Southeastrans's provision of these services may involve the use/disclosure of Protected Health Information by Health Plan (or another business associate of Health Plan) to Southeastrans. Accordingly, the terms and conditions set forth in the Business Associate Addendum in **Exhibit F** shall govern the terms and conditions under which Health Plan may disclose or have disclosed to Southeastrans, and Southeastrans may create, use or receive PHI on behalf of Health Plan.

VII. MISCELLANEOUS

A. This Agreement and the rights and obligations hereunder may not be assigned, subcontracted or delegated by either party without the prior written consent of the other party, which consent shall not be unreasonably withheld; provided, however, that Health Plan may assign this Agreement to an entity which controls, is under the control of or under common control with, Health Plan. For purposes of this provision, a change of corporate name by either party shall not be considered an assignment or delegation.

B. This Agreement shall be governed by and construed in accordance with the laws of the State of Louisiana.

C. Nothing in this Agreement shall be construed to establish any relationship between the parties other than as independent contractors. Neither Southeastrans nor Participating Transportation Providers, nor any of their respective employees or agents are employees or agents of Health Plan; and neither Health Plan nor its employees or agents are Members, partners, employees or agents of Southeastrans. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control of employment between the parties or any relationship other than that of independent parties contracting solely for the purpose of effectuating this Agreement. Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability or obligation of the other party or any third party unless such liability or responsibility is expressly assumed by the party sought to be charged therewith.

D. This Agreement may be amended at any time upon the mutual written agreement of the parties; provided, however, this Agreement shall be deemed to be automatically amended as necessary to maintain compliance with State and federal law and any such amendment shall be binding upon the parties as of the effective date of such change in laws, rules or regulations.

E. In the event that changes in the Agreement as a result of revisions and/or applicable federal or state law or LDH Contract requirements materially affect the position of either party, Health Plan and Southeastrans agree to negotiate in good faith such further amendments as may be necessary to correct any inequities.

F. Notice: All notices required or permitted by this Agreement shall be in writing and may be delivered in person or shall be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that provides proof of delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular

party's address for delivery or mailing of notice purposes:

If to Southeastrans:

Southeastrans, Inc.
Attn: Benjie Alexander
4751 Best Road,
Suite 300
Atlanta, GA 30337

If to Health Plan:

AmeriHealth Caritas Louisiana, Inc.
10000 Perkins Rowe
Block G, 4th Floor
Baton Rouge, LA 70810
Attention: Market President

With a copy to:

AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113
Attention: General Counsel

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or U.S. mail.

G. Upon request, Southeastrans shall furnish to Health Plan financial statements (including a balance sheet, income statement and cash flow statement) for each fiscal year audited by a firm of independent certified public accountants, within one hundred fifty (150) days of the end of such fiscal year. In association with the annual audit requirement specified herein, Southeastrans shall also provide Health Plan with a SOC 2 Type 2 report prepared at Southeastrans's sole expense by an independent external auditor.

H. Southeastrans, Participating Transportation Providers and Health Plan agree that all Member records shall be treated as confidential to comply with all State and federal laws regarding the confidentiality of patient records.

I. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision.

J. If any state laws, court cases or the regulations of any governmental agencies, or other circumstances beyond the control of either party prevents such party from meeting its obligations hereunder, the failure to meet such obligations shall not be considered a breach. Rather, the parties agree in such event to renegotiate the terms of this Agreement, in good faith, so that each party's obligations are in compliance with applicable laws or regulations. If this Agreement cannot be satisfactorily renegotiated, either party may terminate upon sixty (60) days' written notice to the other.

K. Southeastrans hereby agrees that in no event, including but not limited to, non-payment by or insolvency of Health Plan, insolvency of Southeastrans or non-payment by Southeastrans to Participating Transportation Providers or breach of this Agreement, shall Southeastrans or any Participating Transportation Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member for covered services provided pursuant to this Agreement.

Southeastrans further agrees that this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Health Plan Member, and that this provision supersedes any oral or written contrary agreement now existing or thereafter entered into between Southeastrans and Member, or persons on their behalf.

K. Regulatory Provisions. The provisions set forth in **Exhibit G** ("State of Louisiana - Required Subcontractor Provisions") set forth certain terms and conditions that shall apply to the provision of transportation services under this Agreement. In the event of any conflict with any term of this Agreement and any provision in **Exhibit G**, the provision in **Exhibit G** shall control with respect to the services provided under this Agreement.

L. Non-Solicitation of Employees. Both parties agree that during the term of this Agreement and for one (1) year thereafter, it will not directly or indirectly solicit or hire, or induce any employee or independent contractor of the other Party to terminate or breach an employment, contractual or other relationship with the other Party without the prior written consent of the other Party.

M. Significant Administrative Changes. Should any changes required herein or in the Delegation Agreement attached hereto and made a part hereof result in significant increases in the administration of the program, the parties hereto shall negotiate in good faith a mutually agreed upon increase in the administrative fees paid to Southeastrans.

[REMAINDER OF PAGE INTENTIONALLY BLANK; SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the day and the year set forth below.

AMERIHEALTH CARITAS LOUISIANA, INC.		**SOUTHEASTRANS , INC.**	
By:		By:	
Print Name:	Kyle Viator	Print Name:	Steve R. Adams
Title:	Market President	Title:	President/CEO
Date:	1/12/18	Date:	1/10/18

EXHIBITS

Exhibit A	Covered Services
Exhibit B	Transportation Protocols/Statement of Work
Exhibit B-1	NEMT Accident Report Form
Exhibit C	Participating Transportation Provider Contract Requirements
Exhibit D	Performance Standards
Exhibit D-1	Encounter Performance Standards
Exhibit E	Southeastrans Compensation
Exhibit F	Business Associate Addendum
Exhibit G	Agreement for Delegation of Responsibilities

EXHIBIT A
COVERED SERVICES

Description of Covered Services
Southeastrans shall be responsible for providing to ACLA the services set forth below. Southeastrans shall provide these services in accordance with the Transportation Protocols in **Exhibit B** hereto, the relevant ACLA policies and procedures, the applicable terms of the LDH Contract and other applicable State and federal laws, regulations and guidelines, and Accreditation Organization requirements.

The services to be provided by Southeastrans include the following:

- Assist ACLA with the development of transportation protocols that align with LDH and ACLA requirements
- Implement the Non-Emergency Transportation program outlined in the Agreement within agreed timeframes
- Manage and staff ACLA's toll-free NEMT member call center, including the reservation and Where's My Ride lines.
- Manage and staff ACLA's toll-free NEMT provider call center
- Develop, manage and maintain a State-wide Non-Emergency Medical Transportation provider network
  - Recruit, credential and contract with transportation providers
  - Maintain diverse, comprehensive, cost-effective coverage
  - Monitor transportation providers for compliance and safety with applicable Southeastrans, ACLA, and LDH requirements and applicable laws
  - Conduct on-site vehicle inspections of Participating Transportation Providers
- Conduct member eligibility and benefit verification
- Schedule one-way and round-trip Non-Emergency Medical Transportation for Members in accordance with the transportation protocols
- Manage and administer ACLA mileage reimbursement program
- Provide comprehensive fraud and abuse prevention and detection services
- Provide NEMT weekly claims processing and monthly reconciliation services
- Produce and send remittance advices and checks via First-Class mail or electronic means
- Transmit complete and accurate encounter data
- Timely respond to complaint, grievance and appeal investigations in accordance with the established process
- Produce standardized reports pursuant to the Agreement and LDH request; reports to include but not be limited to:

Report Title	**Frequency**	**Category**	**Due Date**
Claims Payment Accuracy	Monthly	Regulatory	8th of every month
Claims Processing Interest Payments - P183	Quarterly	Regulatory	10th of month following each calendar quarter - 4/10, 7/10, 10/10, 1/10
Claims Processing Summary Report - P169	Monthly	Regulatory	8th of every month
Claims Processing Approved - P169	Monthly	Regulatory	8th of every month

Report Title	Frequency	Category	Due Date
Claims Processing Denied - P169	Monthly	Regulatory	8th of every month
Denied Claims Summary Report - P173	Monthly	Regulatory	8th of every month
Member Call Center Report - PS107	Monthly	Regulatory	8th of every month
Provider Call Center Report - PI181	Monthly	Regulatory	8th of every month
Cash Disbursement Journal (CDJ) Report	Monthly	Regulatory	8th of every month
Encounters - 837P	Monthly		8th of every month
Premium Payment Report (aka Dead Head Report)	Monthly		8th of every month
Mileage Report	Weekly		Every Monday for the previous week
Provider Timeliness Report	Monthly		8th of every month

Service Area

The ACLA Service Area is the State of Louisiana.

Summary of Covered Services

The Parties agree that Transportation Services to the selected Covered Services are included in this Agreement. Southeastrans shall not be required to transport Members to any services marked "excluded" in this Attachment A. Health Plan warrants that is has reviewed this Attachment and verified the accuracy of the excluded and included services.

Service	Covered	Enhanced	Excluded
Abortion (with prior approval by Health Plan)	X		
ACLA Community Center Programs	X		
Adult Day Care			X
Alcohol Abuse Evaluation to Enter Treatment	X		
Alcohol Rehabilitation	X		
Alcoholics Anonymous Meetings	X		
Allergy (doctor visits, testing and injections)	X		
Alternative Health Care (e.g. acupuncture)			X
Behavioral Health	X		
Cardiac Rehab	X		
Chemotherapy	X		
Child Daycare			X
Chiropractor	X		
Community Psych Rehab	X		
Cosmetic Surgery			X
Counselor	X		
Court Ordered Exams or appointments (with prior approval by Health Plan)	X		
CSoC - Children's Choice Waiver	X		
CSoC - Community Choices Waiver (CCW)	X		
CSoC - EPSDT Targeted Populations	X		
CSoC - Infants and Toddlers	X		
CSoC – New Opportunities Waiver (NOW)	X		
CSoC - Residential Options Waiver	X		
CSoC - Supports Waiver	X		
Daily Mental Health (MR) Services	X		
Dental Exams	X		
Dental Services (other than exams)	X		
Dentures (≥ 21 YO)	X		
Diabetic Supplies and Education	X		
Dialysis	X		
Drug Abuse Evaluation to Enter Treatment	X		
Drug Rehabilitation	X		
Durable Medical Equipment	X		
EarlySteps (Infant & Toddler Early Intervention Services)	X		
Education/Outreach Programs (with prior approval by Health Plan)	X		
Employment			X
Experimental Medical Procedures/ Drugs			X
Extended Pediatric Center	X		

Service	Covered	Enhanced	Excluded
Family Planning Clinic Services	X		
Federally Qualified Health Centers (FQHC)	X		
Foot Care (Routine)	X		
General Education Diploma Courses, effective February 1, 2018		X	
Group Therapy	X		
Gym Membership & Swim Lessons (MECC Program)		X	
Hearing Aids (testing, fitting, repairs)	X		
Hospice Services	X		
Hospital - Admission	X		
Hospital - Discharge	X		
Hospital – Discharge to Behavioral Health Facility	X		
Hospital – Emergency Room, From	X		
Hospital – Inpatient Services, To	X		
Hospital - Outpatient services (O/P services must be covered services)	X		
Hospital to Hospital	X		
Hospital Visitation (i.e. mom to see newborn)	X		
Immunizations	X		
Infertility Services			X
Laboratory Services	X		
Lamaze Classes (or similar birthing class)	X		
Lead Screening/Testing	X		
Mammogram	X		
Nursing Facility – Travel to			X
Nutritional	X		
Occupational Therapy	X		
Ophthalmologist	X		
Optical – Exams		X	
Optical – Eyeglasses/contacts (pickup)		X	
Orthodontics (under age 21)	X		
Orthotic Services	X		
Other: Citizenship Verification			X
Pain Management (with prior approval by Health Plan)	X		
Pediatric Day Health Care (PDHC)			X
Pediatric Services	X		
Pharmacy Trips	X		
Physical Exam	X		
Physical Therapy (specify any limits)	X		
Physician Services	X		
Podiatry	X		
PPEC (Prescribed Pediatric Extended Care)	X		
Prenatal Services	X		
Program of All-Inclusive Care for the Elderly (PACE) ≥ 21 YO.			X
Prosthetic Services	X		
Psychiatric Facility	X		
Psychiatric Services	X		

Service	Covered	Enhanced	Excluded
Psychiatrist	X		
Radiation Treatments	X		
Radiology Services (X-rays, MRI)	X		
Rehabilitation Clinic Services	X		
Rehabilitation Services Outpatient Hospital	X		
Rural Health Clinic Services (RHC)	X		
Self Help Group Meetings	X		
Sexually Transmitted Disease Clinic†	X		
Shelter Workshop / Supportive employment			X
Smoking Cessation	X		
Social Security Office (SSI)			X
Social Worker	X		
Speech Therapy	X		
SSI Determination Medical Appointment	X		
Substance Abuse	X		
Support Groups (with prior approval by Health Plan)	X		
TBI Waiver			X
Transplant Services	X		
Transportation from Urgent Care Facility	X		
Transportation to Urgent Care Facility	X		
Tuberculosis Clinics†	X		
Vision/Hearing Screenings	X		
Vocational Rehabilitation	X		
Weight Control Programs – requires RROT/Care Coord prior auth	X		
WIC Appointments – After Pregnancy	X		
WIC Appointments – During Pregnancy	X		
Wound Care Services	X		

EXHIBIT B
TRANSPORTATION PROTOCOLS/STATEMENT OF WORK

	SERVICE ITEM	SERVICE REQUIREMENT
A. RESERVATIONS CALL-TAKING REQUIREMENTS		
A.1.	Standard Days and Hours of Customer Service Center Operation for Routine Reservation taking. Routine reservations are reservations for trips to doctor/treatment appointments that are not urgent and non-emergency, and the appointment is known in advance.	• Calls will be answered by a live person from at least 7:00 am to 7:00 pm Central Time. • Calls for routine reservations accepted Monday through Friday from 7:00 am to 7:00 pm CST • Calls for routine reservations are not accepted on Saturday and Sunday • Calls for routine reservations are not accepted on national holidays (New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving and Christmas)
A.2.	Hours of Operation for Urgent and Same Day Reservations. Urgent trips are same-day trips and trips for members who need same-day treatment, but not emergency treatment.	Calls for urgent and same day reservations accepted 24/7/365
A.3.	Hours of Operation for Ride Assistance (Where's my Ride) and Hospital Discharges	Calls for Ride Assistance (Where's My Ride?) and hospital discharges accepted 24/7/365
A.4.	Routine transportation appointments scheduled for Saturday and Sunday and Weekdays after 5pm	Allowed for regularly scheduled appointments (routine) to providers who routinely see patients during this time. Reservations for these trips will be scheduled during regular reservation hours.
A.5.	800 #'s	NEMT Reservations: 888-913-0364 [24/7/365] Ride Assist (Where's My Ride?): 877-659-6144 [24/7/365] NEMT Provider Line: 877-931-4748 NEMT Provider Fax Line: 877-931-4749 Hearing Impaired (TTY): 866-428-7588 ACLA Member Services at 1-888-756-0004 [24/7/365] ACLA Care Coordination/RROT at 1-888-643-0005 [M-F; 8:00 am to 5:00 pm CT] ACLA Care Coordination/RROT Fax at 1-866-428-7382
A.6.	Greeting	Greeting: "Thank you for calling AmeriHealth Caritas Louisiana's Non-Emergency Medical Transportation Services, this is XXXX may I have your ID #?"
A.7.	Interpreter Services	Southeastrans will provide the services of a certified language line for all interpreter needs for all reservation taking. Significant language population required (Louisiana specific: English, Spanish and Vietnamese)

SERVICE ITEM		SERVICE REQUIREMENT
B. SERVICE AREA		
B.1	Specific geography, as defined by whole state(s) or county(ies) within a state(s)	State of Louisiana. • **North –** Bienville, Bossier, Caddo**,** Caldwell, Claiborne, Franklin, Jackson, De Soto, East Carroll, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Red River, Richland, Sabine, Tensas, Union, Webster, West Carroll**.** • **South Central –** Allen, Avoyelles, Beauregard, Calcasieu, Concordia, Grant, Jefferson Davis, LaSalle, Rapides, Vernon, Winn, Cameron, Catahoula, Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, & Vermillion. • **Capital** – Livingston, St. Tammany, St. Helena, Tangipahoa, Washington, Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge,& West Feliciana. • **Gulf** – Jefferson, Orleans, Plaquemines, Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, St. John the Baptist, Terrebonne & St. Bernard
B.2	Limits to trip length, as measured in miles	All trip distances from the member's home to receive covered health services within the state are a covered benefit. Southeastrans will provide weekly mileage report to ACLA RROT. RROT will consult with Southeastrans upon review of the report to identify any issues. M-F; 8am to 5:00 pm CT FAX: 1-866-428-7382 Phone: 1-888-643-0005
B.3	Requests for transportation out of state	A trip out of State requires authorization. Transportation Request Form (Authorization forms) should be faxed to ACLA Care Coordination Team: M-F; 8am to 5:00 pm CT FAX: 1-866-428-7382 Phone: 1-888-643-0005
C. SCREENING CRITERIA		
C.1	Who can request transportation?	• Covered Members that are at least 17 years of age. Any eligible Member who is pregnant regardless of age. Covered Member's parent, legal guardian, or authorized representative. ACLA Case Manager or other plan representative. • Members under the age of 17 will require the presence of a parent/guardian. Transportation will not be provided for a child under the age of 17 who is unaccompanied unless they are an emancipated minor* or pregnant. If the Member is a single caregiver with more than one minor child in his/her care, ACLA approves transportation for the additional minor children. *Emancipated minor: Southeastrans should contact Member Services 1-888-756-0004 [24/7/365] to verify emancipation.
C.2	Hours of Notice for Routine (non-urgent) Medical Appointment	48 hours

	SERVICE ITEM	SERVICE REQUIREMENT
C.3	How far in advance can Members make routine reservations?	No more than 30 days
C.4	"Will Call" for return trips (when Members are not sure how long appointment will last)	Member should call the Ride Assistance (Where's my Ride) Line to schedule return trips. Provider has up to 60 minutes from the time of the call to pick up Member.
C.5	Instructions if Member calls less than required hours of notice in C. 2.	• If this is the Member's first time calling, educate Member, schedule trip and note in system. • All future attempts, educate Member of guidelines and verify urgency of appointment with facility or doctor. If verified as urgent, schedule transportation. • If non-urgent, note in system, and ask Member to reschedule their appointment to be within hours of notice requirements or offer mileage reimbursement.
C.6	Must Southeastrans Verify Appointments for same day and urgent trip requests?	Yes
C.7	Must Southeastrans Verify Member Eligibility?	Yes
C.8	Instructions if Member is not in Eligibility file	Southeastrans will call ACLA Member Services 24/7/365 at 1-888-756-0004 for final determination/confirmation of eligibility status.
C.9	Must Southeastrans verify Provider Participation status?	No
C.10	Must Southeastrans verify Closest Provider?	No
C.11	Modes of Transportation Covered	• Taxis, Uber & Lyft (written documentation of compliance with La. R.S. 40:1203.1 must be provided) • Public Transit: (may not be available in all parishes) • Mileage Reimbursement at **$.50** per mile • Volunteer Driver • Ambulatory: Sedan, Van (including Secure Patient Delivery) • Wheelchair vehicle • Ambulance – see C.17. • Air trips will be arranged by Southeastrans and approved by RROT/Care Coordination Team. M-F; 8am to 5:00pm CT Fax: 1-866-428-7382 Phone: 1-888-643-0005
C.12	Modes of transportation not covered unless written documentation of compliance with La. R.S. 40:1203.1 is provided	• Taxis • Uber • Lyft

	SERVICE ITEM	SERVICE REQUIREMENT
		• Other ride share programs that may become available from time to time
C.13	Public transit eligibility criteria	• Member resides less than ½ mile from transit stop • Member appointment is less than ½ mile from transit stop • Member is ambulatory • Member is ambulatory and physically and mentally capable of walking the distance before and after treatment unescorted.
C.14	Lodging covered	• Yes with approval from RROT/Care Coordination Team • Requests for overnight trips must be approved by RROT/Care Coordination Team • Hotel reimbursement = Up to $150 per day M-F; 8am to 5:00pm CST FAX: 1-866-428-7382 Phone: 1-888-643-0005
C.15	Meals covered	• Yes with approval from RROT/Care Coordination Team • Reimbursable up to $50 / day for member. • Reimbursable up to $50 / day for one attendant / caregiver • If the member cannot pay for the meal, refer the member to RROT/Care Coordination Team M-F; 8am to 5:00pm CST FAX: 1-866-428-7382 Phone: 1-888-643-0005
C.16	Transportation to/from ER	• Not allowed to ER • Not allowed between ERs • Allowed from ER/all medical discharges
C.17	Discharge from inpatient hospital stay	No authorization required for hospital discharge trips of non-ambulatory Member via ambulance to: • Member's home • Nursing home/SNF • Other hospital for inpatient admission
C.18	Non-Emergency Ambulance Transportation (NEAT)	**Members living in Nursing Home or Intermediate Care Facilities requiring NEAT trips**: Southeastrans completes the Transportation NEMT/NEAT Request Form. Southeastrans gives the NEAT provider the trip identification number. At the end of each day, Southeastrans will fax the forms to ACLA RROT at 866-428-7382. **All Other NEAT Requests:** **During normal business hours**: Hospitals or Ambulance providers should contact Southeastrans reservation line at 888-913-0364. Southeastrans will update their system with information and will

	SERVICE ITEM	SERVICE REQUIREMENT
		coordinate trip with ambulance provider and provide them with trip identification number. **After Hours, weekends, holidays**: Hospital must call ambulance provider directly. On following business day, ambulance provider will call Southeastrans reservation line at 888-913-0364 to provide the transfer information. Southeastrans updates their system and gives provider the trip identification number for claim billing.
C.19	Trips to the pharmacy	Yes, pharmacy is a covered benefit. Trip does not have to be in conjunction with an office visit.
C.20	Trips to nursing home	No
C.21	Trips for Covered Benefits	If there is a question concerning covered benefits, please call ACLA Member Services at 1-888-756-0004 [24/7/365]
C.22	Trips to ACLA-sponsored special events	Yes, with receipt of event letter from ACLA noting it is an approved event. Questions or uncertainties pertaining to these event transportation requests are to be directed to RROT/Care Coordination Team prior to arranging transportation. These trips are invoiced separately. 1-888-643-0005, M-F 8:00 a.m. – 5:00 p.m. Central Time
C.23	Additional Passengers	• Member and one additional passenger (escort) are allowed • Escort is allowed for a Member who is blind, deaf, handicapped, developmentally disabled or under the age of 17. Escort can be Members' parent, legal guardian or designee, but not a provider or employee of a provider rendering services. • Southeastrans shall allow children to accompany their parent on a space available basis, at no additional charge. Member must supply car seats, if required. (see C.24 below.)
C.24	Trip Limits	No trip limits
C.25	Member eligibility downloads	Health Plan shall provide a full member eligibility download on a monthly basis with updates on a daily basis.
C.26	Health Care Provider downloads	No
C.27	Car seats/ DME (wheelchairs)	Comply with State Law Member is required to provide all necessary child safety/booster seats and any other required durable medical equipment needed to safely make the trip. Contact the ACLA RROT/Care Coordination Team for support if member does not have required equipment: M-F; 8am to 5:00 pm CT Phone: 1-888-643-0005
[redacted]		
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

SERVICE ITEM		SERVICE REQUIREMENT
	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
E. MULTI-LOAD CRITERIA		
E.1.	Multi-loading standards	Permitted so long as no Member travels 45 minutes longer than if he/she had traveled directly.
E.2.	Cross-client multi-loading	Southeastrans may multi-load Members with Members of other Southeastrans clients.
F. REPORTING		
F.1.	Standard monthly reporting package	Yes – reports should be sent to DelegationOversight@amerihealthcaritas.com and nemt@amerihealthcaritas.com
F.2.	Ad hoc reports	Yes
F.3.	Encounter data provided?	Yes
G. GRIEVANCES, APPEALS & ACCIDENTS		
G.1.	All verbal member grievances and appeals received by Southeastrans	Members will be warm transferred to ACLA 24/7 Member Services at 1-888-756-0004 for grievance processing. (Key contact: ACLA NEMT Delegation Coordinator)
G.2.	All written member grievances and appeals received by Southeastrans	Correspondence will be forwarded via email to ACLA NEMT Delegation Coordinator within two (2) business days.
G.5.	Accident involving member	An initial NEMT Accident Report must be faxed to the Rapid Response Outreach Team (1-866-428-7382) and securely emailed to

	SERVICE ITEM	SERVICE REQUIREMENT
		nemt@amerihealthcaritas.com within 24 hours of notification that an Accident has occurred. All subsequent documentation (e.g., police report, drug screen results) must be attached to a follow up NEMT Accident Report and faxed to the Rapid Response Outreach Team.

ATTACHMENT B-1
NEMT ACCIDENT REPORT

To:	RROT	**From:**	Southeastrans
Fax:	1-866-428-7382	**Pages:**	2
Phone:	1-888-643-0005	**Date:**	
Re:	NEMT Accident Report	**Cc:**	nemt@amerihealthcaritas.com

☐ Initial report. Submit within 24 hours of occurrence of event. Complete all sections of this report and include any relevant documents					
☐ Follow up report. Complete member name and ID and include any relevant documents.					
1. Member Information					
Member Name:		Member ID:			
Is member a minor?	☐ Yes	☐ No			
If yes, who was traveling with the member?					
☐ Parent/guardian	☐ Care giver	☐ Other, describe			
Member destination at time of accident:		☐ Home	☐ Appointment		
2. Accident Information					
Date:		Time:			
Description:					
Were the police called?	☐ Yes	☐ No			
If yes, fax a copy of the police report when available to 1-866-428-7382.					
Was the member injured?	☐ Yes	☐ No			
Was anyone else injured?	☐ Yes	☐ No			
Was EMS called?	☐ Yes	☐ No			
Was member transported to an ED?		☐ Yes	☐ No		
Was anyone else transported to an ED?		☐ Yes	☐ No		
3. Participating Transportation Provider and Vehicle Information					
Name:		Phone:			
Address:		City & State:			
Vehicle Make & Model					
VIN:		License #			
4. Insurance Information					
Insurance Carrier:		Policy #:			
Address:		City & State:			
Phone:					
Effective Date:		Expiration Date:			
5. Driver Information					
Name:		Phone:			
Address:		City & State:			
6. Additional Information or Comments					

EXHIBIT C

Louisiana Managed Care Organization (MCOs)
Required Subcontractor Provisions

INTRODUCTION

On July 28, 2014, the State of Louisiana ("State") Department of Health ("LDH") issued Request for Proposals # 305PUR-DHHRFP-BH-MCO-2014-MVA (the "RFP") for the procurement of Managed Care Organizations (MCOs) to solicit proposals from qualified entities to provide healthcare services to Medicaid enrollees participating in LDH's Bayou Health Program. AmeriHealth Caritas Louisiana, Inc. ("ACL") submitted a proposal in response to the RFP (the "ACL Response"), pursuant to which LDH awarded a contract to ACL to serve as a MCO ("State Contract"). ("Subcontractor") is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's members, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this **Subcontractor Exhibit ("Exhibit C")**, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Exhibit C. If any requirement in the Agreement, including this **Exhibit C**, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence. Except as otherwise set forth in this Exhibit C,** in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

    a) the body of the Agreement with exhibits and attachments;

    b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

    c) the RFP and any addenda and appendices;

    d) the MCO Systems Companion Guide;

    e) the MCO Quality Companion Guide; and

    f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a

format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, regulations and policies as they exist at the time of the Agreement, or as subsequently amended that are or may be applicable to the Agreement, whether or not specifically mentioned in this **Exhibit C**. Any provision of the Agreement that is in conflict with federal statutes, regulations or CMS policy guidance is deemed to be amended to conform to the provisions of those laws, regulations and federal policy. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

   Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws, including but not limited to:

   a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

   b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.) and 20 U.S.C. §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);

   c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and regulations issued pursuant thereto (45 CFR Part 80), in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

   d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

   e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

   f) The Age Discrimination Act of 1975, as amended (42 U.S.C.

§6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L.E. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (H.R. 3426);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, as set forth in 45 CFR Part 82, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities; and

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL any lobbying with non-federal funds that takes place in connection with obtaining any federal award;

n) The Equal Opportunity Act of 1972;

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975; and

t) The Americans with Disabilities Act of 1990.

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services, including but not limited to the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

g) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the State Contract.

h) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to members through the last day that the Agreement is in effect.

i) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL members pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract). ACL members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.

j) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse (FWA) Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 CFR § 438.1-438.812 and La. R.S. 46:437.1-437.14; LAC 50:1.4101-4235. Without limiting the foregoing:

a) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by ACL's members, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

b) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA. Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the U.S. Department of Health and Human Services ("HHS"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide timely and reasonable access to HHS, LDH, GAO, the State Auditor's

Office, the Office of the Attorney General and/or their designees, who shall have the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period (six (6) years following termination of the State Contract), but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

c) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted shall, upon request and as required by ACL, the State Contract or state or federal law, make available to the Medicaid Fraud Control Unit (MFCU) any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by ACL, the State Contract or State and/or Federal law, be allowed access to the place of business and to all Medicaid records of any of subcontractor's contractors, subcontractors or providers, whether contracted or non-contracted, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.

d) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

e) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

f) In accordance with 42 CFR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations

issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Subcontractor shall comply with all applicable provisions of 2 CFR Part 376, pertaining to debarment and/or suspension. Subcontractor shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  http://exclusions.oig.hhs.gov/search.aspx

- Health Care Integrity an Protection Data Bank (HIPDB)
  http://www.npdb-hipdb.hrsa.gov/index.jsp

- System for Award Management
  http://www.sam.gov

- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

g) The Subcontractor shall conduct a screen, monthly as described in Section 5 (f) of this **Exhibit C**, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

h) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement

shall screen their owners and employees against the federal exclusion databases (such as LEIE and System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

i) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

j) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA), which requires that Subcontractor, as a condition of receiving such payments, must establish written policies for all employees of Subcontractor (including management), and for any contractor or agent of Subcontractor, that provide detailed information about §§1932-71 of the False Claims Act established under Sections 3729 through 3733 of Title 31 of the U.S. Code; administrative remedies for false claims and statements established under Chapter 38 of Title 31 of the U.S. Code; any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA in Federal health care programs. Such policies shall include detailed provisions regarding Subcontractor's policies and procedures for detecting and preventing FWA. Subcontractor shall also include in any employee handbook a specific discussion of the foregoing laws, the rights of employees to be protected as whistleblowers, and Subcontractor's policies and procedures for detecting and preventing FWA.

k) The Subcontractor shall have surveillance and utilization control programs and procedures (42 CFR § 456.3, § 456.4, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The

Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

l) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

6. <u>Employment of Personnel</u>.

a) <u>Non-Discrimination</u>. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) <u>Restriction on Certain Individuals</u>. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b) and 42 CFR §1003.102(a)(2)].

c) <u>Screening of Personnel</u>. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. **Cooperation.**

a) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

b) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this **Exhibit C**, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this **Exhibit C** and under the Agreement.

8. **Provider Selection Requirements.** To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR §438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and recredentialing policy, which includes but is not limited to
notifying ACL when Subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide

services under the Agreement for program integrity reasons.

c) If Subcontractor performs laboratory services under the Agreement, the Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

d) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

e) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this **Exhibit C**, as may be modified by LDH from time to time.

f) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 15 of the State Contract.

g) If applicable, Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the RFP).

h) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

i) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the member needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of

treatment or non-treatment; and (iv) the member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

j) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract, with or without cause, that may materially impact Subcontractor's provider network and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH.

9. **Physician Incentive Plans.** Subcontractor shall disclose to ACL annually any Physician Incentive Plan (PIP) or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

10. **National Provider Identifier (NPI).** The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

11. **ACL Member Hold Harmless.** Subcontractor shall accept the final payment made by ACL as payment-in-full for core benefits and services provided under the Agreement. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from, or have recourse against ACL members or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the member), for health care services which are rendered to such members by Subcontractor and its contractors, and which are core benefits and services under the Louisiana Medicaid program. ACL members shall not be held liable for payment for core benefits and services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of

ACL. Subcontractor further agrees that ACL members shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 11 shall be construed to be for the benefit of ACL's members. This Section 11 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's members, or persons acting on their behalf.

12. **Member Access.** Subcontractor and any providers providing services under the Agreement shall not restrict member access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

13. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL member.

14. **ACL Member Copayments**. Subcontractor shall not impose copayments for the following:
    - Family planning services and supplies;
    - Emergency services;
    - Services provided to:
        - Individuals younger than 21 years old;
        - Pregnant women;
        - Individuals who are inpatient in long-term care facilities or other institutions;
        - Native Americans; and
        - Alaskan Eskimos.

    To the extent that emergency services, as defined by the RFP, are provided by Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

15. **ACL Member Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's members. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

16. **Marketing and Member Education.** All Marketing (as such term is defined in the RFP) and member education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the LDH requirements as set forth in the RFP, including but not limited to the following:

    a) All Marketing and member education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid

eligibles or potential eligibles, and all marketing and member education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or member education materials, or participate in any marketing and member education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or member education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 12.3 of the RFP; but (ii) Subcontractor's Marketing and member education activities may include those activities enumerated in Section 12.4 of the RFP.

17. **Misuse of Symbols, Emblems or Names in Reference to Medicaid.** No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

18. **Confidentiality of Information.**

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning members or potential members obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the

member/potential member, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

19. **Safeguarding Information.** Subcontractor shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S. 46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

20. **LDH Use of Data.** Notwithstanding any provision in this **Exhibit C** or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

21. **Record Retention.** Financial records, supporting documents, statistical records, and all other records pertinent to the Agreement shall be retained for a period of at least ten (10) years from the expiration date of the State Contract, including any extension thereof, with the following exceptions:

a) If any litigation, claim, financial management review or audit is started before the expiration of the ten (10)-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

b) Records for real property and equipment acquired with federal funds shall be retained for ten (10) years following its final disposition.

c) When records are transferred to or maintained by LDH, the ten (10)-year retention period is not applicable to the Subcontractor.

d) Indirect cost rate proposals, cost allocation plans, etc., as specified in 45 CFR 74.53(g).

22. **Independent Audits**. If applicable, Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

23. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

24. **Release of Records.** Subcontractor shall release medical records of members upon request by members or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

25. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice (if applicable) and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

    a) Workers' Compensation Insurance**.** Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of Five Hundred Thousand Dollars ($500,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

    b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL and LDH during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by

Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of One Million Dollars ($1,000,000) and a minimum general aggregate of Two Million Dollars ($2,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance in the amount of at least One Million Dollars ($1,000,000) per occurrence.

d) Licensed and Non-licensed Motor Vehicles. Subcontractor shall maintain, during the life of the Agreement, automobile liability insurance in an amount not less than combined single limits of One Million Dollars ($1,000,000) per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the Agreement on the site of the work to be performed hereunder, unless such coverage is included in insurance that is elsewhere specified under this **Section 25.** Such insurance shall include third party bodily injury and property damage liability for owned, hired and non-owned automobiles.

26. Hold Harmless. Subcontractor shall defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) any claims for damages or losses arising from services rendered by Subcontractor, or any of its contractors, employees, officers, agents or representatives performing or supplying services, materials or supplies in connection with the Agreement;

b) any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or statutes, by Subcontractor, its contractors, employees, officers, agents or representatives in the performance of the Agreement;

c) any claims for damages or losses resulting to any person or firm injured or damaged by the Subcontractor, its contractors, employees, officers, agents or representatives by Subcontractor's publication, translation, reproduction, delivery, performance, use or disposition of

any data processed under the Agreement in a manner not authorized hereunder or by Federal or State regulations or statutes;

d) any failure of Subcontractor, its contractors, employees, officers, agents or representatives to observe Federal or State laws, including but not limited to labor laws and minimum wage laws;

e) any claims for damages, losses or reasonable costs associated with legal expenses, including but not limited to those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims or damages specified in the foregoing sub-paragraphs "a" through "d"; and

f) any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against ACL or LDH or their respective agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor, its contractors, employees, officers, agents or representatives.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

27. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, and/or termination of the State Contract in whole or in part, which shall result in termination of the Agreement.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall cooperate with any relevant corrective action plan imposed upon or developed by ACL in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

28. **Loss of Federal Financial Participation (FFP).** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

29. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential conflict. Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement.

30. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

31. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

32. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

33. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

34. **Termination for Threat to Health of ACL Members.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of members enrolled in ACL.

35. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The

term “United States” includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

36. **Independent Contractor/Subcontractors.** It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

    Excluding Participating Transportation Providers, Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

37. **Licensing Requirements.** Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

38. **Entire Contract.** Subcontractor shall comply with, and agrees to be bound by, all provisions of the Agreement and shall act in good faith in the performance of the provisions of the Agreement.

    The Subcontractor also agrees to comply with relevant provisions of the State Contract and any rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies and procedures in effect throughout the duration of the Agreement. Where the provisions of the Agreement differ from the requirements set forth in the LDH handbooks and/or manuals, the relevant LDH provision(s) shall control.

    The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion or other amendment hereto shall have any force or effect unless embodied in a written amendment

executed and approved by the parties hereto.

Any alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

39. **Restrictions on Contracting.** Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services contracted under the Agreement.

40. **Antitrust**. Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries

41. **Termination of LDH Contract**. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make available to ACL and/or LDH or their respective designated representatives, in a usable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

42. **Amendments.** The Agreement may be amended at any time as provided in this paragraph. The Agreement may be amended whenever necessary to comply with State and federal requirements or State budget reductions; provided, however, subject to Section 3 of this **Exhibit C**, no modification or change of any provision of the Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by ACL and Subcontractor.

43. **Law.** This **Exhibit C** shall be governed by the laws of the State of Louisiana, except its conflict of laws

44. **Record Requests for Governmental/Oversight Agency.** The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries

on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.

EXHIBIT D
PERFORMANCE STANDARDS

	Standards
Transportation Timeliness	
Provider arrives at least 15 minutes prior but no more than 1 hour before scheduled appointment, excluding trips that are late due to member action.	**≥95%**
Claims Processing	
Claims financial accuracy	**≥99%**
Claims processing accuracy	**≥98%**
Clean claims processed within fifteen (15) business days	**≥90%**
Process all other claims within thirty (30) calendar days	**99%**
Rejected claims returned to provider with reason code within fifteen (15) business days of receipt	**≥99%**
All pended claims fully adjudicated within sixty (60) calendar days of receipt	**100%**
Call Center Management	
Abandoned call rate	**≤ 5%**
Service Level based on average speed of answer via live person or IVR	**≥ 95% in ≤ 30 seconds**
Calls receiving busy signals	**≤ 1%**
Monthly average hold time for all reservation and where's my ride calls	**< 3 minutes**
Complaint resolution within ten (10) business days of receipt of all information	**100%**
Member complaint ratio per scheduled trip;	**≤ 0.75%**
Average response to Health Plan email inquiries within two (2) business days	**100%**
Credentialing	
Compliance with thirty-six (36) month recredentialing cycle	**100%**
Account Administration	
Monthly and daily member eligibility files loaded within twenty-four (24) hours of delivery	**≥98%**
Online reports available by eighth (8th) of month	**100%**
Web portal availability	**≥99%**
Encounters	
See Exhibit D-1, Encounter Performance Standards	

Southeastrans agrees that, to the extent penalties are assessed against Health Plan by LDH as a result of Southeastrans's direct non-compliance with the performance standards set forth in this **Exhibit D** and **Exhibit D-1**, Southeastrans shall be responsible for the payment of such penalties to Health Plan within a mutually agreed upon timeframe and, in the event such payment is not made in a timely manner to Health Plan, Health Plan shall have the right to offset any monies

owed to Southeastrans by any penalties owed by Southeastrans to Health Plan.

EXHIBIT D-1
ENCOUNTER PERFORMANCE STANDARDS

With respect to the performance standards set forth herein, Southeastrans shall adhere to the LDH Performance Standards and use best efforts to adhere to the Health Plan Performance Goal identified for each performance indicator. Southeastrans shall be responsible for providing encounter data consistent with ACFC requirements and the LDH System Companion Guide so as to continually meet timely, accurate and complete encounter results. Southeastrans's failure to meet these Encounter Performance Standards may result in placement on a corrective action plan and/or imposition of financial penalties as referenced in the LDH Contract.

PERFORMANCE INDICATOR	**DEFINITION**	**PERFORMANCE STANDARDS**
Encounter submission and accuracy	For encounter data submissions, Southeastrans shall submit complete and accurate encounter data, including encounters reflecting a zero dollar amount ($0.00).	100% of encounter data submitted by the 8th of the following month .
Encounter error correction timeliness	Southeastrans shall address any issues that prevent processing of an encounter.	90% of reported repairable errors corrected within thirty (30) days from the date the error report is received by the Health Plan. 99% of reported repairable errors corrected within sixty (60) days from the date the initial error report for the month was received by Southeastrans from Health Plan.
Encounter data change requests	Regulatory changes or special requests by either Health Plan or LDH.	90 days from receipt of LDH notice

EXHIBIT E

SOUTHEASTRANS COMPENSATION

1. Compensation.
    a. As compensation for Southeastrans's services, ACLA shall pay Southeastrans a [redacted]
    b. The capitation rate will be applied in accordance with the following formula:
        i. For each Member eligible to receive services hereunder who is enrolled in the Health Plan effective the first (1st) through the fourteenth (14th) day of the month, Health Plan shall pay to Southeastrans the full PMPM capitation rate for that Member's initial enrollment month.
        ii. For each Member eligible to receive services hereunder who is enrolled in the Health Plan effective on or after the fifteenth (15th) of the month, Health Plan shall not pay any capitation for the balance of the Member's initial enrollment month.
    c. Special events trips are invoiced monthly at the cost of the trip. Payment terms are Net30 days.

EXHIBIT F

BUSINESS ASSOCIATE ADDENDUM

I. INTRODUCTION

This Business Associate Agreement Addendum (the "Addendum") is made and entered into effective as of January 8, 2018 (the "Effective Date"), by and between **AmeriHealth Caritas Louisiana, Inc., referred to herein as the "Covered Entity")**, and Southeastrans ("Business Associate"). This Addendum supplements, is incorporated into and made part of any and all agreements, contracts and understandings, whether written or verbal, between Covered Entity and Business Associate (the "Services Agreement"). To the extent that any provision(s) of this Addendum conflict(s) with provision(s) contained in the Services Agreement, the provision(s) in this Addendum shall control with respect to the use and disclosure of Protected Health Information ("PHI"). This Addendum supersedes any previous Business Associate Agreement between the parties.

II. RECITALS

A. Covered Entity and Business Associate intend to protect the privacy and security of certain PHI to which Business Associate may have access in order to provide goods and services to or on behalf of Covered Entity, in accordance with (i) the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C § 1320d) ("HIPAA"); (ii) the Health Information Technology for Economic and Clinical Health Act ("the HITECH Act") (42 U.S.C. §§ 17901-17953); (iii) the requirements of the HIPAA Privacy Rule ("Privacy Rule"), Security Rule ("Security Rule"), Standard Transaction Rule, Enforcement Rule and Breach Notification Rule (45 C.F.R. Parts 160, 162 and 164, as amended) (collectively, the HIPAA Privacy, Security, Standard Transactions, Enforcement and Breach Rules are referred to herein as "the HIPAA Rules"); and (iv) other applicable federal and state laws regarding the privacy and security of individually identifiable health information.

B. HIPAA, the HITECH Act and the HIPAA Rules are collectively referred to in this Addendum as the "Global HIPAA Requirements."

C. Business Associate may create, receive, maintain or transmit PHI on behalf of Covered Entity, which PHI may be used or disclosed only in accordance with this Addendum and the standards established by applicable laws.

D. Business Associate recognizes and agrees that it is obligated by law to comply with the Global HIPAA Requirements.

E. In consideration of the mutual promises below, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

III. DEFINITIONS

A. "**Business Associate**" shall mean the entity whose name appears in Section I (and whose status has been determined in accordance with the Privacy Rule under 45 C.F.R. §160.103).

B. "Breach" shall have the meaning given to such term in 45 C.F.R. §164.402.

C. "Covered Entity" shall mean AmeriHealth Caritas Louisiana, Inc..

D. "Data Aggregation" shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 C.F.R. §164.501.

E. "Designated Record Set" shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 C.F.R. §164.501.

F. "Electronic Protected Health Information" and/or **"EPHI"** shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. §160.103, and shall include, without limitation, any EPHI provided by Covered Entity or created, received, maintained or transmitted by Business Associate on behalf of Covered Entity. Unless otherwise stated in this Addendum, any provision, restriction, or obligation in this Addendum related to the Use and/or Disclosure of PHI shall apply equally to EPHI.

G. "Global HIPAA Requirements" shall mean collectively HIPAA, the HITECH Act and the HIPAA Rules.

H. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C § 1320d, as amended and related HIPAA regulations (45 C.F.R. Parts 160, 162 and 164).

I. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification and Enforcement Rules, and, to the extent applicable, the Standard Transactions Rules, all at 45 C.F.R. Parts 160, 162 and 164.

J. "HITECH Act" shall mean the Health Information Technology for Economic and Clinical Health Act, 42 U.S.C. §§ 17901 - 17953.

K. "Individual" shall have the meaning given to the term under the Privacy Rule, including, but not limited to, 45 C.F.R. §160.103. It shall also include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).

L. "More Stringent" shall have the same meaning as the term "more stringent" in 45 C.F.R. §160.202.

M. "Protected Health Information" and/or **"PHI"** shall have the meaning given to the term under the Privacy Rule, including but not limited to, 45 C.F.R. §160.103, and shall include, without limitation, any PHI provided by Covered Entity or created, received, maintained or transmitted by Business Associate on behalf of Covered Entity. Unless otherwise stated in this Addendum, any provision, restriction, or obligation in this Addendum related to the Use and Disclosure of PHI shall apply equally to EPHI.

N. "Required By Law" shall have the meaning given this term under the Privacy Rule, including but not limited to, 45 C.F.R. §164.103, and any additional requirements created under the HITECH Act.

O. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his/her designee.

P. "Security Incident" shall mean the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 C.F.R. §164.304.

Q. "Services" shall mean the activities, functions, responsibilities, or obligations required to be perform or undertaken by Business Associate under the Services Agreement and this Addendum.

R. "Services Agreement" shall mean the underlying agreement(s) identified in Exhibit 1 to this Addendum that outlines the Services that Business Associate agrees to provide to Covered Entity and that fall within the functions, activities or services described in the definition of "Business Associate" at 45 C.F.R. §160.103.

S. "State Law" shall have the meaning given this term in 45 C.F.R. §160.202.

T. "**Subcontractor**" shall have the meaning given the term under 45 C.F.R. §160.103.

U. "Unsecured PHI" shall have the meaning given this term in 45 C.F.R §164.402.

V. Any other capitalized terms used, but not otherwise defined in this Addendum, shall have the meaning given these terms in the Global HIPAA Requirements. Any inconsistency in the definition of a capitalized term shall be resolved in favor of a meaning that permits the Covered Entity to comply with the Global HIPAA Requirements.

IV. BUSINESS ASSOCIATE OBLIGATIONS – MAINTAINING THE PRIVACY OF PHI

A. Business Associate agrees that it shall only Use and Disclose PHI in accordance with the terms of this Addendum or as is Required By Law.

B. Business Associate shall not Use or Disclose PHI except for the purpose of Business Associate performing Services to Covered Entity under the Services Agreement, as such Use or Disclosure is limited by this Addendum.

C. To the extent Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate shall comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligation(s).

D. Business Associate shall not Use or Disclose PHI in any manner that would constitute a violation of the HIPAA Rules. So long as such Use or Disclosure does not violate the HIPAA Rules or this Addendum, Business Associate may use PHI: (i) as is necessary for the proper management and administration of Business Associate's organization, or (ii) to carry out the legal responsibilities of Business Associate, as provided in 45 C.F.R. §164.504(e)(4). However, notwithstanding the fact that the HIPAA Rules permit the de-identification of PHI, Business Associate shall not be permitted to de-identify any PHI created, received, Use, Disclosed or maintained under the Services Agreement or under this Addendum unless Covered Entity expressly agrees in writing to such de-identification.

E. Business Associate shall not Disclose any PHI to any third party unless Business Associate first meets each requirement of this Section IV.E. Specifically, Business Associate shall obtain, prior to making any such permitted Disclosure, reasonable assurances from such third party (i) that such PHI will be held secure and confidential in accordance with the provisions of this Addendum, and (ii) that such PHI shall be Disclosed by the third party only as Required By Law or for the purposes for which it was Disclosed to such third party. Business Associate also must require that any breaches of confidentiality of the PHI which become known to such third party be immediately reported by the third party to Business Associate (which Business Associate then must report to Covered Entity as provided for in Section VI.C below).

F. Business Associate will ensure that any agents, including Subcontractors, that create, receive, maintain or transmit PHI on behalf of Business Associate agree in writing to the same restrictions, conditions and requirements, including but not limited to those relating to termination of the contract for improper Use or Disclosure of PHI, that apply to Business Associate with respect to such PHI. To obtain such written assurances, Business Associate agrees to enter into a Business Associate Agreement with each of its agents, including Subcontractors, as required by 45 C.F.R. §164.504(f)(1). Business Associate shall terminate the provision of any PHI received from or on behalf of Covered Entity to an agent or Subcontractor, if any, who fails to abide by such restrictions and obligations.

G. Except as otherwise limited in this Addendum, Business Associate may Use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B).

H. Unless expressly authorized in writing in this Addendum or in the Services Agreement, Business Associate shall not use offshore organizations or domestic organizations that intend to store or process PHI offshore.

V. BUSINESS ASSOCIATE OBLIGATIONS – MAINTAINING THE SECURITY OF PHI

A. Business Associate shall develop, implement, maintain, and use appropriate safeguards to prevent any Use or Disclosure of PHI or EPHI other than as provided by this Addendum, and shall implement administrative, physical, and technical safeguards as required by 45 C.F.R §§164.308, 164.310, 164.312 and 164.316 and by the HITECH Act in order to protect the confidentiality, integrity, and availability of EPHI or PHI that Business Associate creates, receives, maintains, or transmits, to the same extent as if Business Associate were a Covered Entity.

B. Business Associate will ensure that any agent, including a Subcontractor that creates, receives, maintains, or transmits EPHI on behalf of Business Associate agrees in writing to the same security restrictions, conditions and requirements that apply to Business Associate with respect to such EPHI. To obtain such written assurances, Business Associate agrees to enter into a Business Associate Agreement with each of its agents, including Subcontractors, as required by 45 C.F.R. §§164.308(b)(1) and 164.314(a)(1) and (2).

C. Business Associate agrees to adopt the technology and methodology standards provided in any guidance issued by the Secretary in connection with the HIPAA Requirements. In addition to such technology and methodology standards, Business Associate agrees to meet the security standards outlined in Exhibit 2.

VI. BUSINESS ASSOCIATE OBLIGATIONS – SECURITY INCIDENT AND BREACH NOTIFICATION OBLIGATIONS

A. Business Associate agrees to mitigate any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate in violation of the requirements of this Addendum and to notify Covered Entity (in accordance with Section IV.C below) of any Breach of Unsecured PHI, as required under 45 C.F.R. §164.314(a)(2)(i)(C).

B. Business Associate, consistent with the reporting obligations set forth in Section VI.C below, shall report, in writing, to Covered Entity any Use or Disclosure of PHI that is not authorized by this Addendum. Such written notice shall be provided to Covered Entity within three (3) business days of becoming aware of such unauthorized Use or Disclosure.

C. During the term of this Addendum and thereafter for so long as PHI is held by Business Associate, Business Associate shall notify Covered Entity within twenty-four (24) hours of: (i) any suspected or actual Security Incident, intrusion or unauthorized Use or

Disclosure of PHI or EPHI; (ii) any actual or suspected Use or Disclosure of data in violation of any applicable federal or state laws or regulations; and/or (iii) any legal action (including actions before an administrative tribunal) against Business Associate arising from an alleged HIPAA violation. Business Associate shall take: (i) prompt action to correct any such deficiencies, and (ii) any action pertaining to such unauthorized Use or Disclosure required by applicable federal and state laws and regulations. The notice required of Business Associate under this Section VI.C shall be provided by Business Associate in all instances in which Business Associate either suspects or knows of a potential Security Incident, use or disclosure in violation of laws/regulations, or is party to a legal action for HIPAA violations. If Business Associate learns that any one of these actions constitutes a Breach, then Business Associate also shall meet the notice obligations in Section VI.D immediately below.

D. In the case of a Breach of Unsecured PHI during the term of this Addendum (and after such term if PHI continues to be held by Business Associate), Business Associate shall, within three (3) business days of the discovery of the Breach, notify the Covered Entity of such Breach. The notice shall include: (i) the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or Disclosed during the Breach; (ii) a brief description of the Breach, including the date of the Breach and the date of discovery; (iii) a description of the types of Unsecured PHI involved in the Breach; (iv) a description of the actions Business Associate is taking to investigate the Breach, mitigate losses and protect against further Breaches; and (v) such other information as Covered Entity may reasonably request.

E. In addition to any indemnification and hold harmless obligations Business Associate has to Covered Entity under Section XI.B of this Addendum or under the Services Agreement, Business Associate shall indemnify and hold harmless Covered Entity from and against any claim, cause of action, liability, damage, cost or expense (including attorneys' fees and court or proceeding costs) arising out of or in connection with any unauthorized Use or Disclosure of PHI (whether a Breach or a Security Incident) which is caused by the negligent act(s) or omission(s) of Business Associate or by any agent or Subcontractor providing a service required under this Addendum or required under the Services Agreement.

a. For purposes of this Section VI.E, "cost or expense" shall include, but not be limited to, all costs or expenses to Covered Entity resulting from a Breach or Security Incident, including Covered Entity's costs of: (i) investigating the Breach or Security Incident (including a risk assessment to review the impact of the Breach/Security Incident); (ii) preparing and distributing notices of Breach to affected individuals, regulators (including where appropriate law enforcement officials) and/or the media if required; (iii) health care fraud and credit monitoring not to exceed one (1) year, unless otherwise required by applicable law or regulations; (iv) fines or penalties assessed against Covered Entity by the Secretary or other regulatory authority having jurisdiction over Covered Entity; (v) any award that may be made pursuant to a state Attorney General action and

levied against Covered Entity; (vi) Covered Entity's monitoring the effectiveness of Business Associate's mitigation efforts/steps; and (vii) such other actions as may be required by a Covered Entity, customer, or by a governmental entity.

b. Business Associate agrees to work cooperatively with Covered Entity to ensure that liability is properly determined and assigned by the Secretary or other regulatory authority having jurisdiction with regard to any such Breach/Security Incident.

VII. BUSINESS ASSOCIATE OBLIGATIONS – HIPAA ADMINISTRATIVE REQUIREMENTS

A. Within ten (10) days of receipt of a request from Covered Entity for access to an Individual's PHI contained in a Designated Record Set maintained by Business Associate, Business Associate or its agents or Subcontractors, if any, shall make such PHI available to Covered Entity for access to enable Covered Entity to fulfill its obligations under the HIPAA Rules, including, but not limited to, 45 C.F.R. §164.524. If a request is made directly from an Individual to Business Associate or its agents or Subcontractors for access to PHI, Business Associate must notify Covered Entity in writing within five (5) days of the request. Only Covered Entity shall be permitted to approve or deny a request for access. Upon Covered Entity's approval of a request to access PHI, Business Associate shall appropriately provide the Individual access to such PHI.

B. Within ten (10) days of receipt of a request from Covered Entity for an amendment of PHI or a record about an Individual contained in a Designated Record Set maintained by Business Associate, Business Associate or its agents or Subcontractors, if any, shall make such PHI available to Covered Entity for amendment and shall incorporate any such amendment to enable Covered Entity to fulfill its obligations under the HIPAA Rules, including, but not limited to, 45 C.F.R. §164.526. If an Individual requests an amendment of PHI directly from Business Associate or its agents or Subcontractors, if any, Business Associate must notify Covered Entity in writing within five (5) days of the request. Only Covered Entity shall be permitted to approve or deny a request for amendment. Upon Covered Entity's approval of a request to amend PHI in a Designated Record Set maintained by Business Associate, Business Associate shall appropriately amend the PHI maintained by it, or any agents or Subcontractors.

C. Within ten (10) days of notice by Covered Entity of a request for an accounting of those Disclosures of PHI required to be accounted for under the Privacy Rule ("accountable Disclosures"), Business Associate and any of its agents or Subcontractors shall make available to Covered Entity the required information relating to accountable Disclosures to enable Covered Entity to fulfill its obligations under the HIPAA Rules, including, but not limited to, 45 C.F.R. §164.528.

a. Business Associate shall not Disclose any PHI unless such Disclosure is Required By Law or is in accordance with this Addendum. Business Associate shall document such accountable Disclosures.

b. Notwithstanding any provision of this Addendum relating to termination (e.g., Sections IV.E and X), Business Associate and any agents or Subcontractors shall continue to maintain documentation of all accountable Disclosures and any other information required for purposes of complying with this Section VII.C. for a period of ten (10) years after termination of this Addendum.

D. Business Associate shall comply with any agreement that Covered Entity makes that either (i) restricts the Use or Disclosure of PHI pursuant to 45 C.F.R. §164.522(a), or (ii) requires confidential communication about PHI pursuant to 45 C.F.R. §164.522(b), provided that Covered Entity notifies Business Associate of the restriction or confidential communication obligations. Covered Entity shall promptly notify Business Associate in writing of the termination of any such agreed upon restriction or confidential communication.

E. Business Associate shall make its internal practices, books and records relating to the Use and Disclosure of PHI available to the Secretary for purposes of determining Covered Entity's compliance with the HIPAA Rules. Business Associate shall notify Covered Entity regarding any PHI that Business Associate provides to the Secretary concurrently with providing such PHI to the Secretary, and upon request by Covered Entity, shall provide Covered Entity with a duplicate copy of such PHI.

F. Business Associate and its agents or Subcontractors, if any, shall only request, Use and Disclose the minimum amount of PHI necessary to accomplish the purpose of the request, Use or Disclosure. Business Associate agrees to comply with the Secretary's guidance on what constitutes minimum necessary. Business Associate represents and warrants that it has developed policies and procedures that limit the PHI to be Used, Disclosed or requested to the minimum necessary standard.

G. Business Associate acknowledges that Business Associate has no ownership rights related to the PHI.

H. Unless greater coverage is required under the Services Agreement or any other agreement between Covered Entity and Business Associate for the provision of Services related to this Addendum, Business Associate shall maintain or cause to be maintained the following insurance covering itself and each Subcontractor or agent, if any, through whom Business Associate provides Services; (i) a policy of commercial general liability and property damage insurance, and electronic data processing or cyber liability insurance, with limits of liability not less than ten million dollars ($10,000,000) per occurrence and ten million dollars ($10,000,000) annual aggregate, and (ii) such other insurance or self-insurance as shall be necessary to insure it against any claim or claims for damages arising under this Addendum or from violating Business Associate's own obligations under the HIPAA Requirements, including but not limited to, claims or the

imposition of administrative penalties and fines on Business Associate or its Subcontractors or agents, if any, arising from the loss, theft, or unauthorized Use or Disclosure of PHI. Such insurance coverage shall apply to all site(s) of Business Associate and to all Services provided by Business Associate or by any Subcontractors or agents under this Addendum and under the Services Agreement.

I. Within ten (10) business days of a written request by Covered Entity, Business Associate and its agents or Subcontractors, if any, shall allow Covered Entity to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the Use or Disclosure of PHI pursuant to this Addendum for the purpose of determining whether Business Associate has complied with this Addendum and the HIPAA Rules; provided, however, that (i) Covered Entity notifies Business Associate in advance of the scope, location and timing of such an inspection; and (ii) Covered Entity agrees to protect the confidentiality of all confidential and proprietary information of Business Associate to which Covered Entity has access during the course of such inspection.

VIII. BUSINESS ASSOCIATE OBLIGATIONS – TRANSMITTING STANDARD TRANSACTIONS

A. If Business Associate conducts, in whole or in part, Standard Transactions, as defined by HIPAA, for or on behalf of Covered Entity, Business Associate shall comply, and shall require any Subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 42 C.F.R. Part 162. Business Associate shall not enter into, or permit its Subcontractors or agents to enter into, any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of Covered Entity that: (i) changes the definition, data condition, or use of a data element or segment in a Standard Transaction; (ii) adds any data element or segment to the maximum defined data set; (iii) uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or (iv) changes the meaning or intent of the Standard Transaction's implementation specification.

B. If Business Associate's Services use or require the use of Code Sets, as defined in HIPAA, then Business Associate shall on or before October 1, 2015 utilize the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding for all Services for which Business Associate is contractually obligated to provide for Covered Entity.

IX. COVERED ENTITY OBLIGATIONS

A. Covered Entity shall provide Business Associate with the "Notice of Privacy Practices" that Covered Entity produces in accordance with 45 C.F.R. §164.520, as well as any changes to such notice.

B. Covered Entity shall provide Business Associate with notice of any changes to, revocation of, or permission by an Individual to Use or Disclose PHI, if such changes affect Business Associate's permitted Uses or Disclosures, within a reasonable period of time after Covered Entity becomes aware of such changes to or revocation of permission.

C. Covered Entity shall notify Business Associate of any restriction to the Use or Disclosure of PHI that Covered Entity has agreed to or must comply with in accordance with 45 C.F.R. §164.522.

D. Covered Entity shall not request Business Associate to Use or Disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity.

X. TERMINATION

A. The term of this Addendum shall be effective as of the Effective Date of this Addendum and continue until terminated by Covered Entity or any underlying Services Agreement expires or is terminated. Any provision related to the Use, Disclosure, access, or protection of EPHI or PHI or that by its (their) terms should survive termination of this Addendum shall survive termination.

B. A breach by Business Associate, or its agents or Subcontractors, if any, of any provision of this Addendum, as determined by Covered Entity, shall constitute a material breach of the Addendum. If Business Associate breaches this Addendum, Covered Entity may, in its discretion: (i) immediately terminate this Addendum; (ii) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Addendum if Business Associate does not promptly cure the breach or end the violation within a period not to exceed thirty (30) days; or (iii) report the violation to the Secretary if neither termination nor cure is feasible.

C. If Business Associate knows of a pattern of activity or practice by the Covered Entity that constitutes a material breach or violation of the Covered Entity's obligations under this Addendum, Covered Entity will take reasonable steps to cure the breach or end the violation. If such steps are unsuccessful within a period of thirty (30) days, Business Associate either will: (i) terminate the Services Agreement, if feasible; or (ii) report the problem to the Secretary.

D. Covered Entity may terminate this Addendum effective immediately, if (i) Business Associate is named as a defendant in a criminal proceeding for a violation of the Global HIPAA Requirements or other security or privacy laws; or (ii) there is a finding or stipulation that Business Associate has violated any standard or requirement of the Global

HIPAA Requirements or other security or privacy laws in any administrative or civil proceeding in which Business Associate is involved.

E. Upon expiration or termination of this Addendum for any reason, Business Associate shall return or, at Covered Entity's request, destroy all PHI that Business Associate or its agents or Subcontractors, if any, still maintain in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall explain to Covered Entity why conditions make the return or destruction of such PHI not feasible. If Covered Entity agrees that the return or destruction of PHI is not feasible, Business Associate shall retain the PHI, subject to all of the protections of this Addendum, and shall make no further Use or Disclosure of such PHI. If Business Associate elects to destroy the PHI, Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed within thirty (30) days after this Addendum's expiration or termination.

F. If this Addendum is terminated for any reason, Covered Entity may also terminate the Services Agreement between the parties. This provision shall supersede any termination provision to the contrary which may be set forth in the Services Agreement.

XI. MISCELLANEOUS

A. A reference in this Addendum to a section in the HIPAA Rules means the Privacy, Security, Standard Transactions, Breach Notification or Enforcement Rule section as in effect or as amended. If any modification to this Addendum is Required By Law or required by the HITECH Act or any other federal or state law affecting this Addendum, or if Covered Entity reasonably concludes that an amendment to this Addendum is needed because of a change in federal or state law or changing industry standards, Covered Entity shall notify Business Associate of such proposed modification(s) ("Legally-Required Modifications"). Such Legally Required Modifications shall be deemed accepted by Business Associate and this Addendum so amended, if Business Associate does not, within thirty (30) days following the date of the notice (or within such other time period as may be mandated by applicable state or federal law), deliver to Covered Entity its written rejection of such Legally-Required Modifications.

B. In addition to the hold harmless and indemnification obligations under Section VI.E above and any such provisions under the Services Agreement, Business Associate and any of its Subcontractors and agents shall indemnify, hold harmless and defend Covered Entity and its employees, officers, directors, agents, and contractors from and against any and all claims, losses, liabilities, costs, attorneys' fees, and other expenses incurred as a result of or arising directly or indirectly out of or in connection with Business Associate's or its Subcontractors' or agents' breach of this Addendum, violation of the Global HIPAA Requirements or other applicable law, or otherwise related to the acts or omissions of Business Associate or its Subcontractors or agents.

C. Business Associate may not subcontract any Services or assign any rights, nor may it delegate its duties, under this Addendum without the express written consent of Covered Entity.

D. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, any rights, remedies, obligations or liabilities whatsoever upon any person other than Covered Entity, Business Associate, or their respective successors or assigns.

E. The parties are independent contractors and nothing in this Addendum shall be deemed to make them partners or joint venturers, or create an employment relationship between them.

F. Business Associate will comply with all appropriate federal and state security and privacy laws, to the extent that such laws apply to Business Associate or are more protective of Individual privacy or More Stringent than the HIPAA Rules.

G. All notices that are required or permitted to be given pursuant to this Addendum shall be in writing and shall be sufficient in all respects if delivered personally, by electronic facsimile (with a confirmation by registered or certified mail placed in the mail no later than the following day), by registered or certified mail, postage prepaid, or by another delivery service that provides evidence of delivery, addressed to a party as indicated below:

If to Covered Entity, to:	If to Business Associate, to:
AmeriHealth Caritas Louisiana, Inc.	Southeastrans, Inc.
Privacy Office	Attn: Benjie Alexander
PO Box 83580	4751 Best Road,
	Suite 300
Baton Rouge, LA 70884	Atlanta, GA 30337

With a copy to:

Privacy@amerihealthcaritas.com

Notice shall be deemed to have been given upon transmittal thereof as to communications which are personally delivered or transmitted by electronic facsimile; as to communications made by United States mail, on the third (3rd) day after mailing; and, as to communications made by other delivery service, on the date delivered. The above addresses may be changed by giving notice of such change in the manner provided above for giving notice.

H. If any provision of this Addendum is determined by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions hereof shall continue in full force and effect.

I. This Addendum contains the entire understanding between the parties hereto regarding the Use and Disclosure of PHI/EPHI and shall supersede any other oral or written agreements, discussions and understandings of every kind and nature, including provisions in any Services Agreement that are contrary to the provisions of this Addendum. No modification, addition to or waiver of any right, obligation or default shall be effective unless in writing and signed by the party against whom the same is sought to be enforced. No delay or failure of either party to exercise any right or remedy available hereunder, at law or in equity, shall act as a waiver of such right or remedy, and any waiver shall not waive any subsequent right, obligation, or default.

J. This Addendum shall be construed, interpreted and enforced in accordance with, and governed by, the laws of the State of Louisiana and the United States of America.

IN WITNESS WHEREOF, the parties have caused this Addendum to be executed by their respective duly authorized representatives and to become effective as of the Effective Date.

Covered Entity		**Business Associate**	
AmeriHealth Caritas Louisiana, Inc (on its behalf and on behalf of its affiliates)		**Southeastrans, Inc.**	
By:		By:	
Print Name:	Kyle Viator	Print Name:	Steve R. Adams
Title:	Market President	Title:	President/CEO

Attachment F-1

Services Agreement(s)

As provided for in this Exhibit F, "Services Agreement" shall mean the following agreement(s) between the parties:

AmeriHealth Caritas Lousiana Medical Transportation Services Agreement

Attachment F-2

Required Minimum Security Standards

As required under Section V.C of this Addendum, Business Associate agrees to (and cause its agents and Subcontractors to) develop, implement, maintain and use appropriate and effective privacy and security administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI.
In addition to any other safeguards necessary to protect PHI, Business Associate shall implement and continue to enforce the following minimum security safeguards. Covered Entity makes no warranty or representation to Business Associate that compliance by Business Associate with the security provisions of the Addendum or of this Exhibit 2 will be adequate or satisfactory for Business Associate's own purposes, and Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding, confidentiality and integrity of PHI.

1. Policies. Business Associate will develop and/or maintain privacy and information security policies related to the protection of PHI, and shall ensure that all employees are aware of and will abide by these policies. Business Associate shall update (as necessary) privacy and security policies and procedures in accordance with the Global HIPAA Requirements and this Addendum. Business Associate and its agents and Subcontractors shall provide copies of such privacy and security policies and procedures to Covered Entity upon request. Among the policies that Business Associate shall develop and implement are policies that address the following requirements:

    (a) That personal devices not be utilized in connection with the Services provided by Business Associate under the Services Agreement or under this Addendum (as used herein "personal devices" shall mean devices not owned, provisioned or managed by the Business Associate);

    (b) That Business Associate not transmit or download any PHI over the Internet or over any other insecure or open communication channel unless such information is encrypted using standards for encryption outlined in Sections (4), (5), (6), and (7) below; and

    (c) That if PHI is stored on laptops or mobile handheld devices that such laptops and devices are encrypted and that such PHI can be erased remotely.

2. Confidentiality Training. All persons with access to PHI must be trained on the HIPAA Rules and Business Associate's privacy and security policies and procedures, before being given access to PHI, and must be (re)trained on a periodic basis thereafter.

3. Background Check. Prior to granting authorized access to PHI to any employee working on behalf of Business Associate or its agents or Subcontractors, Business Associate (and its agents and Subcontractors) shall conduct a thorough criminal background check of such employee, and evaluate the results to assure there is no reasonable indication that

such employee presents a risk for misuse or theft of PHI or other confidential information.

4. Workstation/Laptop Encryption. All workstations, and laptops, personal devices, and portable devices (as applicable) that process and/or store PHI must be encrypted. As used herein, the term "encryption" or "encrypted" refers to data that has been secured consistent with Federal Information Processing Standards (FIPS) 140-2, and/or the National Institute of Standards and Technology (NIST) publications regarding cryptographic standards (or such other standards as may be prescribed, adopted, or endorsed under the HIPAA Rules). Only the minimum necessary PHI may be downloaded to a laptop or hard drive when absolutely necessary for business purposes, provided such laptop or hard drive is encrypted in accordance with the HIPAA Rules.

5. Database Encryption. PHI stored within databases must be protected using either native or commercial database encryption technologies.

6. Transmission Encryption. All PHI data transmissions shall be encrypted end-to-end when transiting over public networks.

7. Removable Media and Back-up Tapes. All electronic files that contain PHI must be encrypted when stored on any removable media type device (i.e., USB thumb drives, floppies, CD/DVD, computer back-up tapes, etc.).

8. Email Security. All e-mails to external parties that include PHI must be sent via an encrypted method.

9. Antivirus Software. All workstations, laptops and other systems that process and/or store PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.

10. Patch Management. All workstations, laptops and other systems that process and/or store PHI must have security patches applied.

11. User IDs and Password Controls. All authorized users must be issued a unique user name for accessing PHI. Passwords shall be at least eight characters in length and composed of characters from at least three of the following four groups from the standard keyboard: upper case letters (A-Z), lower case letters (a-z), Arabic numerals (0-9), and non-alphanumeric characters (punctuation symbols). Further, passwords shall not be shared or stored in readable format on a computer, and must be changed at least every 90 days, or immediately if revealed or compromised.

12. Data Destruction. All PHI must be wiped from systems/servers when the system is retired. The wipe method must conform to the U.S. Department of Defense standards for data destruction (DoD 5220.22-M). All PHI on removable media must be destroyed or returned to Covered Entity when the data is no longer necessary or upon termination or expiration of the Services Agreement or this Addendum, as set forth in Section X.E.

13. Remote Access. Any remote access to PHI must be executed over an encrypted method using technology that does not allow data to be "cached," saved or copied onto unencrypted remote computers or those with insufficient security controls.

14. System Timeout. The system shall provide an automatic timeout after no more than seven minutes of inactivity.

15. Warning Banners. All systems containing PHI shall display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. Users who do not agree with such requirements shall be directed to log off the system.

16. System Logging. Any system that processes or stores PHI shall log successes and failures of user authentication at all layers, system administrator/developer access and any changes. In addition, such system shall log all user transactions at the database layer. All login sessions and passwords stored within databases shall be encrypted.

17. Access Controls. The system shall use role-based access controls for all user authentications, enforcing the principle of least privilege.

18. Access Management Segregation. Role segregation of identity management purposes will maintain segregation between approvers and providers of access.

19. Intrusion Detection. All systems that are accessible via the Internet or store or transmit PHI shall be protected by a suitable intrusion detection and/or prevention system.

20. Disaster Recovery. Disaster recovery processes shall be established to ensure the ongoing availability of business processes involving access to or use of PHI.

21. System Security Review. All systems processing and/or storing PHI shall have at least an annual system security review. Reviews shall include administrative and technical vulnerability scanning tools.

22. Log Reviews. All systems processing and/or storing PHI shall have a routine procedure in place to review system logs for unauthorized access. Application logs shall be maintained for at least six (6) years after the occurrence.

23. Change Control. All systems processing and/or storing PHI shall have a documented change control procedure that ensures and documents separation of duties and protects the confidentiality, integrity and availability of PHI.

24. Information Security Testing. Systems that maintain or process PHI must undergo periodic internal and/or external security testing to identify vulnerabilities, and remediation of any critical or high risk vulnerabilities must be addressed in a timely manner.

25. Facility Security. Any Business Associate facility that houses personnel or systems used in the viewing, processing, or storing of Covered Entity's PHI shall have appropriate and reasonable perimeter controls including, but not limited to, the following: an electronic

access control system, alarmed or monitored outer doors, identification badges for personnel, and a process for logging and escorting visitors.

26. Security Official. Business Associate must have a designated security official who is responsible for the development and implementation of the policies and procedures required by this Exhibit 2.

Attachment F-3

NCQA Delegation Compliance Matrix

In those instances in which Covered Entity is contracting with Business Associate for the purpose of Business Associate providing an NCQA-delegated function, NCQA requires that the contract with the Business Associate (i.e., the delegated entity) specify how the delegate is permitted to use and/or disclose data. Accordingly, this matrix is provided to permit easy understanding of how the BAA Addendum addresses each of the NCQA requirements.

NCQA Requirement	Provision In The BAA Addendum Addressing The Requirement
1. A list of the allowed uses of PHI.	See Addendum, Sections IV.A and IV.B
2. A description of delegate safeguards to protect the information from inappropriate use or further disclosure.	See Addendum, Section V.A and Exhibit 3
3. A stipulation that the delegate will ensure that sub-delegates have similar safeguards.	See Addendum, Section V.B
4. A stipulation that the delegate will provide individuals with access to their PHI.	See Addendum, Section VII.A
5. A stipulation that the delegate will inform the organization if inappropriate uses of the information occur.	See Addendum, Section VI.B
6. A stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.	See Addendum, Section X.E

[END]

EXHIBIT G

AGREEMENT FOR DELEGATION OF RESPONSIBILITIES AMERIHEALTH CARITAS LOUISIANA, INC. TO SOUTHEASTRANS, INC.

This Delegation of Responsibilities Agreement (the "Agreement"), effective as of the 8th day of January, 2018, by and between AmeriHealth Caritas Louisiana Inc. ("The Plan" or "ACLA") sets forth the terms and conditions under which The Plan, in accordance with the requirements of the NCQA, shall delegate to Southeastrans, Inc. (referred to herein as "Delegate") specific managed care activities. All capitalized terms herein shall have the meanings ascribed to them in the Medical Transportation Services Agreement (the "Services Agreement") dated the 8th day of January, 2018, as amended, by and among the parties.

WHEREAS, where applicable, The Plan has completed a review of Delegate's processes and documentation (including, where applicable, case files) for utilization review and management, network development and maintenance, credentialing and recredentialing, financial services and claims payment processes, and has determined that such processes, documentation and Delegate's capability to perform encounter data transmissions meet or exceed The Plan's requirements and that The Plan can delegate to Delegate specific managed care activities as identified herein;

WHEREAS, the parties have determined that delegation of specific managed care activities, as authorized on the signature page of this Agreement, would be beneficial to both parties;

NOW THEREFORE, the parties agree as follows:

1. Pursuant to this Agreement, The Plan hereby delegates to Delegate that portion of the activities of credentialing and re-credentialing, network development and maintenance, as applicable, and financial services and claims payment processes as mutually agreed upon by the parties and described herein.

2. Delegate hereby agrees to accept all responsibility associated with such delegation and specifically agrees to abide by the policies and procedures set forth in the Abstract of Delegated Oversight Activities Policy ("Policy") attached hereto as **Attachment A** and any and all procedures set forth herein, as may be amended, and supplemented at the discretion of The Plan and attached hereto, including all documentation, reporting and change in status notices as may be required by The Plan. Delegate's material deviations from Policy and/or procedures set forth herein may result in review and action by The Plan, including rescission of the specific Delegate activity affected thereby.

3. Delegate hereby agrees to notify The Plan immediately whenever Delegate has knowledge of or begins an investigation of the occurrence of any incident involving Delegate or any contracted Delegate professional provider which has or may (i) cause harm to any Member of The Plan; (ii) result in the involuntary termination of a contracted professional provider; or (iii) otherwise have an adverse effect on the quality of services to Members; or other terms of the Agreement and/or Services Agreement such as those affecting service delivery, reporting accuracy and financial viability. Similarly, Delegate shall immediately notify The Plan upon receipt of any claim or threat of a claim or action against Delegate or any contracted professional provider, to the extent Delegate has notice or reasonably should have had notice, which involves any occurrences of the incidents described above or which may have a material adverse effect on

the financial stability of Delegate. Delegate shall make a good faith effort to provide each such notice to The Plan immediately and in not more than five (5) business days from knowledge of the occurrence so that The Plan may take such actions as may be appropriate.

4. In accordance with Delegate's delegated credentialing and recredentialing ("CR") responsibilities, Delegate shall perform all functions as detailed in **Attachment B**, as approved by The Plan, including, but not limited to the following:

A. Delegate shall maintain and implement credentialing and recredentialing policies and procedures for providers within the scope of Delegate's authority, as approved by The Plan. Such policies and procedures shall be in compliance with The Plan's applicable policies, applicable NCQA standards, applicable State or federal law and regulations, and relevant requirements of applicable regulatory agencies, and shall include those utilized for reducing, suspending, or terminating a Participating Transportation Provider for reasons related to quality of care, competence, or professional conduct; procedures for reporting to appropriate authorities serious quality deficiencies which could result in suspension or termination of a Participating Transportation Provider; and procedures for provider appeals of credentialing/ re-credentialing decisions.

B. Delegate shall be precluded from granting provisional credentialing status to any provider. For purposes hereof, "provisional credentialing status" means acceptance of the provider to provide services to Members without the provider having undergone the full credentialing process. All providers must fully complete the credentialing process before providing any services to Members. It is understood and agreed that in an emergency or when continuity of care is clinically necessary for a Member seeking treatment from Delegate for the first time, Delegate may arrange for the Member to receive services at an in-network benefit level from the Member's current provider or another provider for a limited period of time, in accordance with applicable law and regulation.

C. Upon The Plan's request on an annual basis, Delegate will provide to The Plan all CR policies and procedures for review and approval.

D. On a monthly basis or such other basis agreed to by the parties hereto, Delegate shall provide to The Plan credentialing reports which adhere to the content and format as required by The Plan including, but not limited to, a list of providers who are credentialed or recredentialed, the effective date of participation with the Delegate and evidence of recredentialing within a maximum of a thirty-six (36) month period following initial credentialing; provided, however, Delegate shall have the credentialing reports referenced herein readily available in electronic format and, upon The Plan's request, shall provide The Plan with the reports in either electronic or paper format;.

E. Delegate shall cooperate with The Plan's on-site review of Delegate's CR programs, including, but not limited to, a review of committee minutes, review and periodic validation of monitors, policies and procedures, and review of corrective action initiated by The Plan.

F. Delegate agrees to comply with The Plan's specific recommendations regarding deficiencies in Delegate's CR program identified by The Plan, time frames for resolution of any such deficiencies, and any re-reviews of Delegate's programs. The Plan shall consult with Delegate regarding formulation of any such recommendations and resolution time frames.

G. The Plan reserves the right to approve new providers credentialed by Delegate and to terminate or suspend any provider's participation in The Plan's programs. Delegate must promptly notify The Plan in the event a provider's participation in The Plan's program is terminated for cause by Delegate.

H. Delegate must obtain The Plan's written approval prior to making any material exceptions to Delegate's credentialing policies and procedures.

5. In accordance with Delegate's delegated financial services responsibilities, Delegate shall perform all functions delegated by The Plan and detailed in the policies and procedures approved by The Plan, including, but not limited to:

A. Maintain general ledger and process journal entries as these relate to claims payments.

B. Adjudicate claims and process payments to providers (through electronic means or by check).

C. Process and mail checks to providers for approved claims.

D. Maintain cash disbursement journal ("CDJ") for all claims payments.

E. Reconcile the CDJ to the encounter files

E. Overall reconciliation of claims reports to cash disbursements.

F. Support external auditors in their annual examination of financial statements and for preparation and completion of the SOC1 report.

6. In accordance with Delegate's delegated claims management responsibilities, Delegate shall perform all functions required by The Plan and detailed in Delegate's Policies and Procedures as approved by The Plan regarding claims payment, including, but not limited to the following:

A. Perform all front end claims processing, including, but not limited to claims preparation, data entry, initial claims entry and return for services.

B. Adjudicate, adjust and/or settle all claims as appropriate for services with a minimum of one (1) provider payment cycle per week, on the same day each week.

C. Where appropriate determine whether claims are subject to Third Party Liability (TPL) or coordination of benefits policies and procedures. Provide to Plan savings reports resulting from this activity on a quarterly basis.

D. Maintain effective and reasonable system and procedural edits to identify duplicate claims.

E. Perform necessary quality assurance functions as agreed to by the Parties and report this information to the Plan on a monthly basis.

F. Maintain claims files for each reported claim throughout the life of a claim. Retain closed claim data as required pursuant to The Plan's policies.

G. Communicate to Participating Transportation Providers instructions for claim submission to Delegate.

H. Generate timely Participating Transportation Provider checks and provider remittance advices, as may be applicable, for services performed by Participating Transportation Providers, to the extent applicable.

I. Utilize logo specified and agreed to between the parties.

J. Establish and communicate to providers the claim appeal process.

K. Advise The Plan prior to any material change to methods, policy and/or procedure, desk level or system utilized in the claim adjudication process.

L. Generate a 1099 for professional paid claims processed by Delegate, as applicable.

M. Notify the Plan of any claim disputes involving litigation.

N. Provide reasonable support to The Plan's Member Services Team or other Plan personnel for resolution of Member inquiries.

O. Provide Health Plan (or its designee) with claims history files for all adjudicated claims as defined by The Plan. If the file format should be modified, Health Plan shall provide adequate notice to Delegate and work with Delegate to implement the modifications.

P. Provide designated claims inventory information and performance information according to defined schedule as mutually agreed upon by the Parties.

Q. Maintain availability of systems in support of Member Services.

R. Permit The Plan, upon reasonable notice with the right to conduct performance audits of Delegate records, data, systems, and other relevant information on a periodic basis as appropriate to determine compliance with performance standards.

S. Comply with The Plan's claims performance standards in accordance with applicable requirements of law, regulation and applicable regulatory agencies.

7. In accordance with Delegate's delegated call center responsibilities, Delegate shall perform all functions required by The Plan and detailed in Delegate's Policies and Procedures as approved by The Plan regarding call center, including, but not limited to the following:

A. Conduct the required staff training and communication.

B. Adhere to service standards.

C. Handle inquiries.

D. Monitor calls for quality purposes.

E. Provide translation and TTY/TDD services or its equivalent.

8. The Plan does not delegate Quality Management activities to Delegate; however, Delegate shall maintain its own Quality Management ("QM") Program that includes the following:

A. On an annual basis, Delegate shall develop and maintain: (1) a current QM Program description that outlines the program structure, design, scope, and organizational responsibilities for quality improvement; (2) QM work plan that includes Delegate's annual objectives, scope, and projects or activities scheduled for the year; and (3) a written quality program evaluation that evaluates the overall effectiveness of the Delegate's QM program.

All such QM Program documents shall be provided to The Plan for review on an annual basis and as otherwise requested by The Plan. The QM Program shall be in accordance with applicable NCQA standards and applicable federal requirements, and any work that Delegate performs on behalf of The Plan shall be in accordance with DHCF requirements and The Plan's requirements for quality improvement, as applicable.

B. Delegate shall provide written notice to The Plan of any and all material changes to Delegate's QM Program thirty (30) days in advance of such changes for the Plan's review of such changes.

9. Delegate's provider network shall meet all performance standards in accordance with applicable requirements of law, regulation, and applicable regulatory agencies, The Plan, and NCQA to the extent that as such are applicable to the Delegate delegated activities performed hereunder.

10. Delegate warrants and represents that all delegated activities it performs pursuant to this Agreement conform to all relevant federal and state laws and regulations, including but not limited to HIPAA and HITECH privacy and security laws and regulations; relevant requirements of applicable regulatory agencies; The Plan requirements; and all relevant accreditation standards, including specifically, NCQA standards. Delegate further warrants and represents that all use of protected health information (PHI) will be in accordance with the terms of the Business Associate Addendum executed between The Plan and Delegate.

11. Delegate shall provide written notice to The Plan of any and all material changes to Delegate's network development and maintenance, credentialing and recredentialing, financial services, claims payment processes or encounter data transmission processes thirty (30) days in advance of such changes for The Plan's review and approval of such changes.

12. Delegate shall not assign any of its delegated responsibilities as enumerated in this Agreement, in whole or in part, to any third party without the express written consent of The Plan, which consent shall not be unreasonably withheld. Any such sub-delegation shall be (a) subject to the terms and conditions of this Agreement; and (b) set forth in a written document, signed by Delegate and the third party, which complies with the terms of this Agreement, The Plan's Policy, relevant requirements from applicable regulatory agencies, and applicable NCQA standards for delegation activities.

13. <u>Plan Responsibilities</u>:

A. Plan shall oversee Delegate's performance of the activities delegated under this Agreement through the review of periodic reports and annual evaluation to include file audits, as applicable. The parties understand and agree that, on an annual basis or as requested by the Plan with three (3) days' notice, the Plan will conduct a comprehensive review, including but not limited to, review and validation of Delegate's performance of Delegate's delegated

responsibilities, which will include random sampling of Delegate's credentialing and re-credentialing files, as applicable. The Plan has the right to review all information maintained by Delegate regarding the delegated activities set forth herein for The Plan's Members, including credentialing files, in order to evaluate Delegate's compliance with this Agreement. Plan's oversight activities may be conducted directly by The Plan, or by Plan's corporate parent on behalf of The Plan.

B. Within ten (10) days following The Plan's request to audit Delegate, Delegate shall provide the Plan representative either electronic access or paper copies of such information and documents as reasonably necessary for purposes of auditing compliance with this Agreement, including, but not limited to, applicable policies and procedures, committee minutes and other relevant information (as determined by The Plan) retained by the Delegate regarding the delegated activities. If Delegate is found by The Plan to be non-complaint with the delegated activities, the Delegate will be required to develop an action plan, satisfactory to The Plan, to correct the deficiencies and shall submit the plan of action to The Plan within ten (10) days from the date Delegate receives notice of said deficiencies from The Plan.

C. The Plan will be responsible for activities related to ongoing assessment and improvement of medical record documentation as required by applicable provisions of NCQA, federal and state agencies.

14. It is understood and agreed that costs related to any routine audits performed in the normal course of auditing compliance with the terms and obligations hereunder shall be borne by The Plan. Repeat on-site audits or audits required to assess correction of deficiency or improvement of unsatisfactory performance or completion of a corrective action initiated by The Plan, shall be borne by Delegate. Such costs shall be reasonable and discussed and agreed to by the Parties in advance.

15. Delegate agrees that to the extent penalties are assessed against The Plan by any regulatory agency as a result of Delegate's direct failure to comply with applicable delegated responsibilities set forth herein and as set forth in the Performance Standards set forth on of the Agreement, Delegate shall make arrangements to pay The Plan or the designated regulatory agency for such penalties. In the event that such payments are not made in a timely manner to the regulatory agency or The Plan as agreed upon, The Plan shall have the right to offset any monies owed to Delegate from the ASO fees by said penalties. However, should The Plan be notified by a regulatory agency of a failure on the part of Delegate to comply with any responsibilities set forth herein and a cure period is extended by the regulatory agency, then Delegate shall be permitted to cure the problem within such cure period provided by the regulatory agency and, if such cure is acceptable, no penalties shall be assessed or paid. The Plan further agrees to notify Delegate promptly upon notification by LDH or other regulatory agency of a problem or potential problem to allow Delegate an opportunity to correct the problem.

16. The Plan reserves the right to immediately rescind any of the activities delegated to Delegate herein (a) as a result of Delegate's material deviations from the functions delegated by this Agreement; or (b) as a result of Delegate's failure to comply with The Plan's specific recommendations regarding identified deficiencies in Delegate's performance of or Delegate's programs relating to functions delegated to Delegate herein, provided, however, that Delegate shall be provided a cure period during which identified deficiencies must be corrected to the satisfaction of The Plan; (c) where such action is necessary to protect the health and welfare of The Plan's Members; and (d) where such action is necessary in order to comply with State or federal laws, regulatory requirements and/or obligations. No activities delegated to Delegate herein shall be rescinded prior to the expiration of any cure periods provided by the regulatory agency, subject to Delegate's good faith effort to cure the deficiencies during the allotted cure period.

17. In the event of a conflict with the Services Agreement and this Agreement, the terms of this Agreement shall govern as to Delegate's delegated responsibilities.

18. This Agreement, including all attachments hereto, supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding. Amendments to this Agreement required because of legislative, regulatory, or legal requirements do not require the consent of Delegate or The Plan and will be effective immediately on the effective date thereof.

19. Notwithstanding anything to the contrary contained herein, this Agreement shall terminate upon termination of the Services Agreement. Confidentiality of information and reporting obligations for services performed during the term of this Agreement shall survive termination of this Agreement.

20. Delegate acknowledges that The Plan is subject to State and federal regulatory requirements which require The Plan to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, Member appeal and grievance systems and other systems and programs meeting those regulatory requirements and that The Plan is directly accountable for compliance with such requirements and for provision of access to quality, cost-effective care to Members. Nothing in this Agreement shall be construed to in any way limit The Plan's authority or responsibility to meet standards or to take prompt corrective action to address a quality of care problem, resolve a Member appeal or grievance, or to comply with all applicable State and federal regulatory requirements.

21. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreement and shall become effective when one or more counterparts have been signed by each of the parties hereto and delivered to each of the other parties hereto.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives on the date written above.

AMERIHEALTH CARITAS LOUISIANA, INC.		**SOUTHEASTRANS, INC.**	
By:		By:	Steve R. Adams
Print Name:	Kyle Viator	Print Name:	Steve R. Adams
Title:	Market President	Title:	President/CEO
Date:	01/12/18	Date:	1/10/18

ATTACHMENT A
ABSTRACT OF DELEGATED OVERSIGHT ACTIVITIES POLICY

AmeriHealth Caritas Louisiana, Inc. ("ACLA") may enter into contractual arrangements that delegate the provision of Credentialing and Recredentialing, Utilization Review and Management, Financial Services and Claims Payment Processes, to outside organizations as permitted by the National Committee for Quality Assurance (NCQA). In these instances, ACLA maintains overall accountability for all delegated activities. In addition, ACLA assumes responsibility for conducting a pre-delegation evaluation and ongoing performance monitoring and oversight of the Delegate's performance.

All delegation arrangements are governed by agreements that outline the scope of activities, performance expectations, reporting responsibilities and consequences for failure to meet the contract requirements ("Delegation Agreement"). The appropriate committees and subcommittees within ACLA's Quality Committee Structure review reports from delegated entities, as described hereinafter (see Committee Delegation Responsibility, below). At minimum, a formal annual audit of each Delegate's performance and capability is conducted. ACLA also reserves the right to investigate/audit Delegate performance at any time upon prior written notice which notice shall be a minimum of thirty (30) days.

Any deficiencies identified in the Delegate's performance are addressed collaboratively with the Delegate. Where performance deficiencies remain unresolved, ACLA may exercise its right to withdraw delegation, consistent with the terms of the Delegation Agreement. For delegated Credentialing/ Recredentialing, ACLA retains the right to approve or terminate a delegated practitioner who has been non-compliant with any standards set forth by ACLA, Federal or State entities or accrediting agencies. Delegates of ACLA are not permitted to sub-delegate any function(s) being delegated to them by ACLA, unless prior approved in writing by ACLA.

The ACLA Quality Assessment Performance Improvement Committee and related Subcommittees provide oversight of all delegated activity, including but not limited to:

- Review of routine performance reports and documents as outlined in the Delegation Agreement;
- Review of compliance with the terms of the Delegation Agreement
- Review of the annual Delegate evaluation
- Review of pre-delegation assessments and findings
- Review of completion of any subsequent corrective action deemed necessary by the respective committee
- Revocation of delegation should Delegate fail to make required corrections to delegated functions in a time and manner designated, as appropriate.

Results of the annual oversight audit and any additional investigations/audits are presented to the respective ACLA Committee, which approves the on-going delegation arrangements for these entities. The material reviewed by the Committee and the Committee's decision is presented to the ACLA Quality Assessment Performance Improvement Committee for final approval.

For potential Delegates, ACLA conducts a pre-delegation audit to ensure they have the capability to perform and are adequately performing the functions to be delegated. Candidates for Credentialing delegation are typically required to have one hundred (100) or more practitioners to be considered for delegation. Results of the pre-delegation audit are reported to the respective ACLA committee responsible for the delegated activity, the ACLA Quality Assessment Performance Improvement Committee and, the ACLA Board. Achievement of a ninety-five percent (95%) score or correction of deficiencies sufficient to attain a ninety-five percent (95%) score is required for approval of delegation.

Attachment B
Delegated Credentialing Activities

In evaluating providers' ability to meet standards of participation with the Plan, Delegate shall accept applications, reapplications and attestations, collect all data elements from NCQA-approved sources and from State-approved sources, and verify, from primary sources where applicable, the following credentials of providers. Such verification process shall be completed within, but no later than, 180 days from the date of the provider's signed application page. For purposes of the previous sentence, "completed" shall mean to the date of the credentialing committee decision.

Credentialing Criteria

a. Current state licensure in all States where the provider may provide services to the Plan's members. Any limitations on scope of practice must be identified and considered in making credentialing and re-credentialing decisions.
b. Current copy of DEA or CDS certificate, as applicable
c. Evidence that provider maintains current malpractice insurance in amounts required by law.
d. If applicable, evidence of graduation from applicable professional school and completion of a residency or other postgraduate training as applicable. If applicable, written verification from a practitioner's applicant's medical school, residency program, and fellowship; or the acceptance of the American Medical Association (AMA) profile for verification of education and training. If the practitioner is board certified by either the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), verification by the appropriate board via Internet registry can serve as verification.
e. Professional claims liability history
f. Complete work history or curriculum vitae encompassing a five (5) year time span with no gap greater than six (6) months. Any gap in work history of more than six (6) months requires an explanation. Gap in work history and/or education training that are greater than one year (1) year are explained in writing.
g. If applicable, evidence of good standing regarding admitting privileges at a participating Plan hospital or admitting arrangements with a participating practitioner.
h. If applicable, history of loss of license and/or felony convictions.
i. If applicable, history of loss or limitation of privileges or disciplinary activity.
j. Lack of present illegal drug use.
k. Reasons of inability to perform essential functions of the position, with or without accommodations.
l. Verification that information was obtained from the National Practitioner Data Bank (NPDB). Actual documentation from NPDB must be obtained and maintained in practitioner file.
m. Verification of sanction activity by Medicare or Medicaid through NPDB and Medicare/Medicaid Sanction and Reinstatement Report and Department of Health and Human Service Office of Inspector General website.
n. No evidence of disciplinary action by the applicable State Board/s.
o. Attestation to correctness/completeness of the information provided.
p. Signed and dated signature page.
q. If applicable, not opted out of Medicare participation – Absence from Medicare Opt Out lists for each state practitioner provides services to Plan members must be primary sourced verified.

Delegate shall verify the applicable providers' credentials at the time of initial credentialing and re-credentialing, at least every thirty-six (36) months to assure that all the information listed above is current and accurate.

Delegate shall utilize a system that monitors expiration dates of state license, DEA, CDS certificates, board certification, and malpractice insurance so that these certificates are current at the time of credentialing/re-credentialing. In addition, Delegate shall provide on-going monitoring of sanctions and complaints, so that any action, including Medicaid and Medicare sanctions, state sanctions or limitation on licensure, and complaints, is reviewed within thirty (30) days of its imposition.

Delegate shall establish and maintain a Credentialing Committee in accordance with applicable NCQA standards to review provider applications and make decisions regarding approval for credentialing/re-credentialing, denial or termination. Upon execution of this Agreement, and thereafter upon approval of a provider by the Delegate's Credentialing Committee, the Delegate shall provide the Plan with a list of providers that have been reviewed and approved by the Delegate's Credentialing Committee. The Delegate shall notify the Plan on at least a monthly basis of all terminated providers, including their date of termination, new providers and change of information, e.g. leave of absence, return from leave of absence, change in board certification status, address, telephone number, change of status of acceptance of new patients, and payment information.

Delegate shall report to the Plan the following information at least semi-annually:

a. Roster of initially credentialed/re-credentialed providers to include all of the data elements required by the Plan.
b. Summary of performance improvement activities initiated or completed, if applicable.

Delegate shall provide to the Plan within a reasonable period of time any additional information or reports that may be requested by an accreditation or regulatory agency.
Delegate shall abide by additional credentialing standards as may be promulgated by NCQA.

Delegate shall report practitioner termination/s, suspension/s and disciplinary action/s to the appropriate authorities as required by law.

Delegate shall continue on-going monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles and take appropriate action against providers when it identifies occurrence of poor quality.

Delegate shall provide an appeal process to providers terminated for quality reasons and to Medicaid participating providers terminated for quality or contractual reasons.

Attachment C
DELEGATED RESPONSIBILITIES

Function	Entity Performing Function	
	Delegate	Health Plan
Claims Administration		
Maintenance of Fee Schedule (which may include individually negotiated provider rates no lower than published LDH fee-for-service rates)	X	
Claims Receipt	X	
Claims Processing	X	
Timely and Accurate Claims Adjudication	X	
Claims Auditing	X	X
Claims Quality Monitoring	X	
Claims Edit	X	X
Payment to Providers -- issuing checks to providers for eligible claims.	X	
Remittance advice production and delivery	X	
Claims Inquiries / Claims Customer Service	X	
Provider Claim Disputes	X	
Call Center		
Required Staffing Training and Communication	X	
Service Standards	X	
Inquiry Handling	X	
Complaints and Grievances Handling	Delegate investigates complaints and grievances at the direction of Health Plan.	X
Quality Monitoring	X	X
Translation Services	X	
TTY/TDD or equivalent Services	X	
Provider Network		
Recruit and Contract Providers	X	
Maintain Provider Network adequacy	X	
Ensure provider compliance with Provider Network Requirements	X	
Ensure Provider Network Compliance with ADA requirements through provider applications and attestations.	X	
Credentialing and Recredentialing		
Oversight and Monitoring	X	
Credentialing Program Structure	X	
Credentialing Policies and Procedures	X	
Accepts applications, reapplications and attestation	X	
Collects and reviews Driver license information	X	
Collects and reviews Criminal Background Checks	X	

Function	Entity Performing Function	
	Delegate	Health Plan
Collects and reviews DMV Report	X	
Collects and reviews Defensive Driving Certificate	X	
Collects and reviews First Aid Training Certificate	X	
Collects and reviews Exclusions list Medicare and Medicaid	X	
Collects and reviews State Exclusions List	X	
Collects and reviews Drug Screening Test Results	X	
Collects and reviews Vehicle Capacity	X	
Collects and reviews Vehicle Model and Manufacturer	X	
Collects and reviews Vehicle Model Year	X	
Collects and reviews Vehicle Type	X	
Collects and reviews Vin Number	X	
Collects and reviews Vehicle License Number and Expiration Date	X	
Collects and reviews Vehicle Registration State	X	
Collects and reviews Vehicle Insurance Coverage and Expiration Date	X	
Conducts Vehicle Inspections	X	
Collects and Reviews Ownership Disclosure Forms	X	
Using applicable NCQA or CMS approved sources and within prescribed time limits, conduct primary source verification of excluded providers through EPLS/ SAM, OIG, GSA and DCH list of Excluded Providers	X	
Conducts ongoing monitoring	X	
Collects and evaluates ongoing monitoring information	X	
Implements Appropriate Interventions	X	
Notification of Provider Appeal Rights and Process	X	
Ongoing updates of required credentialing information.	X	
Makes final credentialing decisions	X	
Quality Improvement		
Oversight and Monitoring	X	X
QAPI Policies	X	X
Event Reporting- Harmful events to members receiving care have to be reported, tracked and investigated per CMS and state standards.	X	X
Performance Improvement Projects for annual review or on a case by case basis, when applicable	X	X
Submission of Annual Program Description and Annual Program Evaluation	X	X
Compliance		
Fraud, Waste, and Abuse Monitoring	X	X
Provider Fraud and Waste investigations	X	X
Compliance Program	X	X
Employee and Provider Training for Compliance, FWA and §6032 of the Federal Deficit Reduction Act of 2005	X	X

FIRST AMENDMENT TO
MEDICAL TRANSPORTATION SERVICES AGREEMENT

This First Amendment (the "***First Amendment***") is made and entered into by AmeriHealth Caritas Louisiana, Inc. (hereinafter "***Health Plan***"), and Southeastrans, Inc. (hereinafter "***Southeastrans***") as of this 17th day of August, 2018 with an effective date of September 1, 2018 (the "Effective Date"). Health Plan and Southeastrans shall be referred to hereinafter as "the Parties." Capitalized terms not defined herein shall have the meaning ascribed to them in the Agreement (defined below).

WHEREAS, the Parties entered into that certain Medical Transportation Services Agreement for the provision of non-emergency medical transportation dated January 8, 2018 (the "Agreement"); and

WHEREAS, the Parties desire to add reports to assist in the management of providers who fail to show up for a scheduled trip, and the monitoring of members who fail to show up for a scheduled trip; and

WHEREAS, the Parties desire to modify the Call Center Management Performance Standards to provide separate measures for average speed of answer by IVR and average speed of answer by live person, and revise the complaint ratio

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties intending to be legally bound, hereby agree as follows:

1. Capitalized Terms. Capitalized terms used herein shall have the same meanings ascribed to such terms in the Agreement.

2. Exhibits.

   2.1. Exhibit A. Exhibit A (Covered Services) of the Agreement is deleted in its entirety and replaced with Amended and Restated Exhibit A (Covered Services), attached hereto.

   2.2. Exhibit D. Exhibit D (Performance Standards) of the Agreement is deleted in its entirety and replaced with Amended and Restated Exhibit D (Performance Standards), attached hereto.

3. Ratification of Agreement. Except as modified by this this First Amendment, the terms and conditions of the Agreement are ratified and confirmed and remain in full force and effect. In the event of any inconsistency between the terms of this First Amendment and the Agreement, the terms of this First Amendment shall govern and control.

4. Authority. The individuals executing this First Amendment represent and warrant they have the requisite authority to sign this document on behalf of the Health Plan and Southeastrans, respectively, and to bind the Health Plan and Southeastrans to the terms herein.

[REMAINDER OF PAGE INTENTIONALLY BLANK; SIGNATURE PAGE FOLLOWS]

IN WITNESS THEREOF, the Parties hereto have executed this First Amendment as of the date written below.

AmeriHealth Caritas Louisiana, Inc.

By: _____
Print: Kyle Viator
Title: Market President

Date: 08/17/18

Southeastrans, Inc.

By: _____
Print: Steve R. Adams
Title: President/CEO

Date: 8/17/2018

Amended and Restated Exhibit A
Covered Services

Description of Covered Services
Southeastrans shall be responsible for providing to ACLA the services set forth below. Southeastrans shall provide these services in accordance with the Transportation Protocols in **Exhibit B** hereto, the relevant ACLA policies and procedures, the applicable terms of the LDH Contract and other applicable State and federal laws, regulations and guidelines, and Accreditation Organization requirements.

The services to be provided by Southeastrans include the following:

- Assist ACLA with the development of transportation protocols that align with LDH and ACLA requirements
- Implement the Non-Emergency Transportation program outlined in the Agreement within agreed timeframes
- Manage and staff ACLA's toll-free NEMT member call center, including the reservation and Where's My Ride lines.
- Manage and staff ACLA's toll-free NEMT provider call center
- Develop, manage and maintain a State-wide Non-Emergency Medical Transportation provider network
  - Recruit, credential and contract with transportation providers
  - Maintain diverse, comprehensive, cost-effective coverage
  - Monitor transportation providers for compliance and safety with applicable Southeastrans, ACLA, and LDH requirements and applicable laws
  - Conduct on-site vehicle inspections of Participating Transportation Providers
- Conduct member eligibility and benefit verification
- Schedule one-way and round-trip Non-Emergency Medical Transportation for Members in accordance with the transportation protocols
- Manage and administer ACLA mileage reimbursement program
- Provide comprehensive fraud and abuse prevention and detection services
- Provide NEMT weekly claims processing and monthly reconciliation services
- Produce and send remittance advices and checks via First-Class mail or electronic means
- Transmit complete and accurate encounter data
- Timely respond to complaint, grievance and appeal investigations in accordance with the established process
- Produce standardized reports pursuant to the Agreement and LDH request; reports to include but not be limited to:

Report Title	**Frequency**	**Category**	**Due Date**
Claims Payment Accuracy	Monthly	Regulatory	8th of every month
Claims Processing Interest Payments - P183	Quarterly	Regulatory	10th of month following each calendar quarter - 4/10, 7/10, 10/10, 1/10
Claims Processing Summary Report - P169	Monthly	Regulatory	8th of every month
Claims Processing Approved - P169	Monthly	Regulatory	8th of every month
Claims Processing Denied - P169	Monthly	Regulatory	8th of every month
Denied Claims Summary Report - P173	Monthly	Regulatory	8th of every month
Member Call Center Report - PS107	Monthly	Regulatory	8th of every month

Report Title	Frequency	Category	Due Date
Provider Call Center Report - PI181	Monthly	Regulatory	8th of every month
Cash Disbursement Journal (CDJ) Report	Monthly	Regulatory	8th of every month
Encounters - 837P	Monthly		8th of every month
Premium Payment Report (aka Dead Head Report)	Monthly		8th of every month
Mileage Report	Weekly		Every Monday for the previous week
Provider Timeliness Report	Monthly		8th of every month
Transportation Provider No-Show	Weekly		Every Monday for the previous week
Member No-Show	Monthly		8th of every month.

Service Area

The ACLA Service Area is the State of Louisiana.

Summary of Covered Services

The Parties agree that Transportation Services to the selected Covered Services are included in this Agreement. Southeastrans shall not be required to transport Members to any services marked "excluded" in this Attachment A. Health Plan warrants that is has reviewed this Attachment and verified the accuracy of the excluded and included services.

Service	Covered	Enhanced	Excluded
Abortion (with prior approval by Health Plan)	X		
ACLA Community Center Programs	X		
Adult Day Care			X
Alcohol Abuse Evaluation to Enter Treatment	X		
Alcohol Rehabilitation	X		
Alcoholics Anonymous Meetings	X		
Allergy (doctor visits, testing and injections)	X		
Alternative Health Care (e.g. acupuncture)			X
Behavioral Health	X		
Cardiac Rehab	X		
Chemotherapy	X		
Child Daycare			X
Chiropractor	X		
Community Psych Rehab	X		
Cosmetic Surgery			X
Counselor	X		
Court Ordered Exams or appointments (with prior approval by Health Plan)	X		
CSoC - Children's Choice Waiver	X		
CSoC - Community Choices Waiver (CCW)	X		
CSoC - EPSDT Targeted Populations	X		
CSoC - Infants and Toddlers	X		
CSoC – New Opportunities Waiver (NOW)	X		
CSoC - Residential Options Waiver	X		
CSoC - Supports Waiver	X		
Daily Mental Health (MR) Services	X		
Dental Exams	X		
Dental Services (other than exams)	X		
Dentures (≥ 21 YO)	X		
Diabetic Supplies and Education	X		
Dialysis	X		
Drug Abuse Evaluation to Enter Treatment	X		
Drug Rehabilitation	X		
Durable Medical Equipment	X		
EarlySteps (Infant & Toddler Early Intervention Services)	X		
Education/Outreach Programs (with prior approval by Health Plan)	X		
Employment			X
Experimental Medical Procedures/ Drugs			X
Extended Pediatric Center	X		

Service	Covered	Enhanced	Excluded
Family Planning Clinic Services	X		
Federally Qualified Health Centers (FQHC)	X		
Foot Care (Routine)	X		
General Education Diploma Courses, effective February 1, 2018		X	
Group Therapy	X		
Gym Membership & Swim Lessons (MECC Program)		X	
Hearing Aids (testing, fitting, repairs)	X		
Hospice Services	X		
Hospital - Admission	X		
Hospital - Discharge	X		
Hospital – Discharge to Behavioral Health Facility	X		
Hospital – Emergency Room, From	X		
Hospital – Inpatient Services, To	X		
Hospital - Outpatient services (O/P services must be covered services)	X		
Hospital to Hospital	X		
Hospital Visitation (i.e. mom to see newborn)	X		
Immunizations	X		
Infertility Services			X
Laboratory Services	X		
Lamaze Classes (or similar birthing class)	X		
Lead Screening/Testing	X		
Mammogram	X		
Nursing Facility – Travel to			X
Nutritional	X		
Occupational Therapy	X		
Ophthalmologist	X		
Optical – Exams		X	
Optical – Eyeglasses/contacts (pickup)		X	
Orthodontics (under age 21)	X		
Orthotic Services	X		
Other: Citizenship Verification			X
Pain Management (with prior approval by Health Plan)	X		
Pediatric Day Health Care (PDHC)			X
Pediatric Services	X		
Pharmacy Trips	X		
Physical Exam	X		
Physical Therapy (specify any limits)	X		
Physician Services	X		
Podiatry	X		
PPEC (Prescribed Pediatric Extended Care)	X		
Prenatal Services	X		
Program of All-Inclusive Care for the Elderly (PACE) ≥ 21 YO.			X
Prosthetic Services	X		
Psychiatric Facility	X		
Psychiatric Services	X		

Service	Covered	Enhanced	Excluded
Psychiatrist	X		
Radiation Treatments	X		
Radiology Services (X-rays, MRI)	X		
Rehabilitation Clinic Services	X		
Rehabilitation Services Outpatient Hospital	X		
Rural Health Clinic Services (RHC)	X		
Self Help Group Meetings	X		
Sexually Transmitted Disease Clinic†	X		
Shelter Workshop / Supportive employment			X
Smoking Cessation	X		
Social Security Office (SSI)			X
Social Worker	X		
Speech Therapy	X		
SSI Determination Medical Appointment	X		
Substance Abuse	X		
Support Groups (with prior approval by Health Plan)	X		
TBI Waiver			X
Transplant Services	X		
Transportation from Urgent Care Facility	X		
Transportation to Urgent Care Facility	X		
Tuberculosis Clinics†	X		
Vision/Hearing Screenings	X		
Vocational Rehabilitation	X		
Weight Control Programs – requires RROT/Care Coord prior auth	X		
WIC Appointments – After Pregnancy	X		
WIC Appointments – During Pregnancy	X		
Wound Care Services	X		

Amended and Restated Exhibit D

Performance Standards

	Standards
Transportation Timeliness	
Provider arrives at least 15 minutes prior but no more than 1 hour before scheduled appointment, excluding trips that are late due to member action.	**≥95%**
Claims Processing	
Claims financial accuracy	**≥99%**
Claims processing accuracy	**≥98%**
Clean claims processed within fifteen (15) business days	**≥90%**
Process all other claims within thirty (30) calendar days	**99%**
Rejected claims returned to provider with reason code within fifteen (15) business days of receipt	**≥99%**
All pended claims fully adjudicated within sixty (60) calendar days of receipt	**100%**
Call Center Management	
Abandoned call rate	**≤ 5%**
Service Level based on average speed of answer by IVR	**≥ 95% in ≤ 30 seconds**
Service Level based on average speed of answer by live person	**≥ 80% in ≤ 30 seconds**
Calls receiving busy signals	**≤ 1%**
Monthly average hold time for all reservation and where's my ride calls	**< 3 minutes**
Complaint resolution within ten (10) business days of receipt of all information	**100%**
Member complaint ratio per scheduled trip;	**≤ 0.50%**
Average response to Health Plan email inquiries within two (2) business days	**100%**
Credentialing	
Compliance with thirty-six (36) month recredentialing cycle	**100%**
Account Administration	
Monthly and daily member eligibility files loaded within twenty-four (24) hours of delivery	**≥98%**
Online reports available by eighth (8th) of month	**100%**
Web portal availability	**≥99%**
Encounters	
See Exhibit D-1, Encounter Performance Standards	

Southeastrans agrees that, to the extent penalties are assessed against Health Plan by LDH as a result of Southeastrans's direct non-compliance with the performance standards set forth in this **Exhibit D** and **Exhibit D-1**, Southeastrans shall be responsible for the payment of such penalties to Health Plan within a mutually agreed upon timeframe and, in the event such payment is not made in a timely manner to Health Plan, Health Plan shall have the right to offset any monies owed to Southeastrans by any penalties owed by Southeastrans to Health Plan.

EXHIBIT D-1
ENCOUNTER PERFORMANCE STANDARDS

With respect to the performance standards set forth herein, Southeastrans shall adhere to the LDH Performance Standards and use best efforts to adhere to the Health Plan Performance Goal identified for each performance indicator. Southeastrans shall be responsible for providing encounter data consistent with ACFC requirements and the LDH System Companion Guide so as to continually meet timely, accurate and complete encounter results. Southeastrans's failure to meet these Encounter Performance Standards may result in placement on a corrective action plan and/or imposition of financial penalties as referenced in the LDH Contract.

PERFORMANCE INDICATOR	DEFINITION	PERFORMANCE STANDARDS
Encounter submission and accuracy	For encounter data submissions, Southeastrans shall submit complete and accurate encounter data, including encounters reflecting a zero dollar amount ($0.00).	100% of encounter data submitted by the 8th of the following month.
Encounter error correction timeliness	Southeastrans shall address any issues that prevent processing of an encounter.	90% of reported repairable errors corrected within thirty (30) days from the date the error report is received by the Health Plan. 99% of reported repairable errors corrected within sixty (60) days from the date the initial error report for the month was received by Southeastrans from Health Plan.
Encounter data change requests	Regulatory changes or special requests by either Health Plan or LDH.	90 days from receipt of LDH notice

SECOND AMENDMENT TO AGREEMENT

This Second Amendment (the "Second Amendment") is made and entered into by AmeriHealth Caritas Louisiana Inc., (f/k/a AmeriHealth Mercy of Louisiana, Inc.) (hereinafter the "Health Plan"), and Southeastrans, Inc. (hereinafter "Southeastrans") as of this 18th day of April, 2019, effective immediately (the "Effective Date"). Health Plan and Southeastrans shall be referred to hereinafter as "the Parties."

WHEREAS, WHEREAS, the Parties entered into that certain Medical Transportation Services Agreement for the provision of non-emergency medical transportation dated January 8, 2018 (the "Agreement"); and;

WHEREAS, the Parties desire to amend and restate the Louisiana Managed Care Organization Required Subcontractor Provisions set forth in Exhibit C to reflect updated Louisiana Department of Health (***"LDH"***) subcontractor requirements.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties intending to be legally bound, hereby agree as follows:

1. Capitalized Terms. Capitalized terms used herein shall have the same meanings ascribed to such terms in the Agreement.

2. Exhibit C. Exhibit C (*Louisiana Managed Care Organization Required Subcontract Provisions*) is deleted in its entirety and replaced with Amended and Restated Exhibit C (*Louisiana Managed Care Organization Required Subcontract Provisions*), a copy of which is attached hereto and incorporated into the Agreement as if fully set forth therein.

3. Ratification of Agreement. Except as modified by this this Second Amendment, the terms and conditions of the Agreement are ratified and confirmed and remain in full force and effect. In the event of any inconsistency between the terms of this Second Amendment and the Agreement, the terms of this Second Amendment shall govern and control.

4. Authority. The individuals executing this Second Amendment represent and warrant they have the requisite authority to sign this document on behalf of the Health Plan and Southeastrans, respectively, and to bind the Health Plan and Southeastrans to the terms herein.

[REMAINDER OF PAGE INTENTIONALLY BLANK. SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, the Parties hereto have executed this Second Amendment as of the date written below.

AmeriHealth Caritas Louisiana, Inc.

By: _____
Name: Kyle Viator
Title: Market President
Date: 04/18/19

Southeastrans, Inc.

By: _____
Name: Steve R. Adams
Title: President/CEO
Date: April 18, 2019

Amended and Restated Exhibit C

Louisiana Managed Care Organization Required Subcontractor Provisions

INTRODUCTION

AmeriHealth Caritas Louisiana, Inc. ("ACL") submitted a proposal in response (the "ACL Response") to the State of Louisiana ("State") Department of Health's ("LDH") Request for Proposals #305PUR-DHHRFP-BH-MCO-2014-MVA (the "RFP"), pursuant to which LDH awarded a contract to ACL to serve as a Medicaid Managed Care Organization (MCO). Pursuant to the contract between LDH and ACL (the "State Contract"), ACL provides or arranges for the provision of specified health services under the Louisiana Medicaid managed care program known as Healthy Louisiana. Southeastrans, Inc. is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's members, and is therefore considered a "Subcontractor," as defined in the State Contract. Accordingly, the terms and conditions set forth in this Attachment, which are required of Subcontractors pursuant to the State Contract, are incorporated into the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). Subcontractor shall adhere to all requirements set forth for Subcontractors in the State Contract and any LDH issued guides. ACL shall furnish these documents to Subcontractor upon request. No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Attachment. If any requirement in the Agreement, including this **Attachment**, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence.** Except as otherwise set forth in this Attachment**,** in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

    a) the body of the Agreement with exhibits and attachments;

    b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

    c) the RFP and any addenda and appendices;

    d) the MCO Systems Companion Guide;

    e) the MCO Quality Companion Guide; and

    f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format

accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL and LDH.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, rules, regulations, guidelines and policies, including without limitation, any regulation or rules that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies as they exist at the time of the Agreement, or as subsequently amended, that are or may be applicable to the services provided under the Agreement, whether or not specifically mentioned in this Attachment and that such laws, rules, regulations, guidelines and policies are herein incorporated into this Agreement by reference and that any revisions thereto are automatically incorporated into this Agreement as they become effective. Any provision of the Agreement that is in conflict with federal statutes, regulations or CMS policy guidance or rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies is deemed to be amended to conform to the provisions of those laws, regulations and policies. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.), the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro- Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and its implementing regulations at 45 CFR Part 80 (2001, as amended), in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs

and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget
Refinement Act of 1999, as amended (P.L. 106-113);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as implemented in 45CFR Part 82, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities;

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL any lobbying with non-federal funds that takes place in connection with obtaining any federal award;

n) The Equal Opportunity Act of 1972:

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975;

t) The Americans with Disabilities Act of 1990; and

u) Executive Order Number JBE 2018-15, **r**elating to the Prohibition of Discriminatory Boycotts of Israel in State Procurement.

v) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

w) Section 1557 of the Patient Protection and Affordable Care Act (ACA).

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services including, but not limited to, the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract. The QAPI and UM requirements are included as part of the Agreement and herein incorporated by reference.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Subcontractor shall not portray core benefits or services, as defined in Section 6.1.4 of the State Contract, as value-added benefits or services.

g) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

h) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the RFP.

i) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to members through the last day that the Agreement is in effect.

j) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL members pursuant to the Agreement including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract. ACL members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by La.R.S. 40:1299.96, La.R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) as amended and subject to reasonable charges.

k) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse ("FWA") Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812; La.R.S. 46:437.1-437.14; 42 CFR §455.12 – 455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. Without limiting the foregoing:

a) Subcontractor shall report all known or suspected FWA to ACL in accordance with 42 CFR §438.608(a) and the State Contract and ACL requirements.

b) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by ACL's members, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no

more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

c) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA.

d) Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the U.S. Department of Health and Human Services ("HHS"), the Office of Inspector General ("OIG"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide upon request to HHS, OIG, the State Auditor's Office, the Office of the Attorney General, GAO, Comptroller General, LDH and/or their designees upon request with timely and reasonable access and the right to examine and make copies, excerpts or transcripts of all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on -site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period set forth in Section 23 of this Attachment, but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

e) Subcontractor and Subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, Subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding, to obtain the requested information, records or data. MFCU shall be allowed access to the place of business and to all Medicaid records

of any contractor, subcontractor, or provider of Subcontractor during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed. The MCO contractor, Subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of noncompliance with an information, records or data request.

f) Subcontractor shall permit the State, CMS the HHS Inspector General, the Comptroller General, or their designees to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed.

i. Subcontractor shall make available for purposes of an audit, evaluation or inspection under Section 5(f), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid members.

ii. The right to audit under Section 5(f) will remain ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

iii. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid members at any time.

g) Reserved.

h) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

j) In accordance with 48 CFR §2.101 and 42 CFR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under

Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Subcontractor shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Subcontractor shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  http://exclusions.oig.hhs.gov/search.aspx

- Health Care Integrity and Protection Data Bank (HIPDB)
  http://www.npdb-hipdb.hrsa.gov/index.jsp

- System for Award Management
  http://www.sam.gov

- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

k) The Subcontractor shall conduct a screen, monthly as described in Section 5 (j) of this Attachment, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

l) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and System of Award Management). Any unallowable funds made to

excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

m) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR § 455.104 and 42 CFR §438.610) on ownership disclosure reporting in accordance with Section 15.1.12 of the RFP. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 C FR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

n) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA), which requires that Subcontractor, as a condition of receiving such payments, must establish written policies for all employees of Subcontractor (including management), and for any contractor or agent of Subcontractor, that provide detailed information about §§1932-71 of the False Claims Act established under Sections 3729 through 3733 of Title 31 of the U.S. Code; administrative remedies for false claims and statements established under Chapter 38 of Title 31 of the U.S. Code; any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA in Federal health care programs. Such policies shall include detailed provisions regarding Subcontractor's policies and procedures for detecting and preventing FWA. Subcontractor shall also include in any employee handbook a specific discussion of the foregoing laws, the rights of employees to be protected as whistleblowers, and Subcontractor's policies and procedures for detecting and preventing FWA.

o) The Subcontractor shall have surveillance and utilization control programs and procedures pursuant to 42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

p) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

q) Subcontractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly including coordinating with law enforcement agencies, with notice to ACL, if issues are suspected to be criminal in nature , to reduce the potential for reoccurrence, and conduct ongoing compliance with the requirements under this Agreement.

r) Subcontractor shall provide annual training to all employees, and shall train new hires within thirty (30) days of the date of employment, related to the following:

- Subcontractor's Code of Conduct;
- Privacy and Security – HIPAA;
- FWA identification and reporting procedures;
- Federal False Claims Act and employee whistleblower protections;
- Procedures for timely consistent exchange of information and collaboration with ACL and LDH; and
- Compliance with 42 CFR §438. 608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

s) Subcontractor shall suspend payment to a network provider when the State determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. ACL is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

6. <u>Employment of Personnel</u>.

a) <u>Non-Discrimination</u>. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no

discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) Restriction on Certain Individuals. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in –non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR § 1001.1901(b) and 42 CFR§ 1003.102(a)(2)}.

Additionally, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 USC §1320a-7) or Section 1156 (42 USC §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. This includes providers undergoing any of the following identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health services license;

ii. Exclusion from the Medicaid program;

iii. Exclusion form the Medicare program;

iv. Withholding if Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review ("SURS") Rule (LAC 50:1.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:1.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. Cooperation, Care Coordination and Continuity of Care.

a) Care Coordination. Subcontractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to ACL's Medicaid members.

b) Continuity of Care. To the extent applicable to the services provided under the Agreement, Subcontractor shall develop and maintain a process of Continuity of Care by which ACL's Medicaid members and network and/or non-network provider interactions are effective to ensure that each member has an ongoing source of preventative and primary care appropriate to their needs.

c) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid members in accordance with professional standards. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

d) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this Attachment, the Agreement, or under

applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this Attachment and under the Agreement.

8. **Provider Selection Requirements.** To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR§438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and re-recredentialing policies including but not limited but not to: LDH, Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for specialized behavioral health providers.

c) Subcontractors that specialize in behavioral health are required to be accredited by rule, regulation, waiver or State Plan Amendment ("SPA") prior to contracting with ACL or prior to receiving Medicaid reimbursement, and shall comply with: all requirements of ACL,; CMS approved waivers; and/or the SPAs.

d) Subcontractors that specialize in behavioral health shall provide ACL with proof of accreditation from one of the following LDH approved national accrediting body:

- Council on Accreditation;
- Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- The Joint Commission ("TJC").

e) Subcontractor shall have a re-credentialing policy which includes, but is not limited to, notifying ACL when Subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

f) Subcontractor shall notify ACL, regarding itself or any of its providers or subcontractors, and shall furnish documentation from the accreditation body within twenty-four (24) hours of the following: loss of accreditation, license or certification; suspension; or any action that could result in the loss of

accreditation.

g) If Subcontractor or any provider of Subcontractor performs laboratory services under the Agreement, the Subcontractor or provider of Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

h) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

i) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this Attachment, as may be modified by LDH from time to time.

j) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 15 of the State Contract.

k) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the State Contract).

l) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

m) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the member needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42

U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

n) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract that may materially impact Subcontractor's provider network and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans**. Subcontractor's Physician Incentive Plans ("PIP") shall be incompliance with 42 CFR § 438.3(i).

a) Subcontractor shall disclose to ACL annually any PIP or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

b) Subcontractor shall provide written notification to ACL within thirty (30) days upon implementation of any new PIP or when an existing PIP is modified. The written notification must: (i) list the participating providers; and (ii) certify that the terms and conditions of the PIP are compliant with all applicable federal regulations.

c) Subcontractor shall furnish, upon request of ACL, additional information including, but not limited to, a copy of the PIP.

10. Provider Preventable Conditions. Subcontractor shall report to ACL, within seventy-two (72) hours, any provider preventable conditions ("PPCs") associated with claims for payment or member treatment for which payment would otherwise be made. PPCs include: (i) Healthcare Acquired Conditions; and (ii) Other Provider Preventable Conditions, as defined by Section 25.8 of the Louisiana Medicaid Program Hospital Service Provider Manual.

11. National Provider Identifier (NPI). The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall

submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

12. **ACL Member Hold Harmless.** Subcontractor shall accept the final payment made by ACL as payment-in-full for core benefits and services provided under the Agreement. Notwithstanding State Plan approved cost sharing, Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from LDH or ACL, or have recourse against ACL members or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the member), for health care services which are rendered to such members by Subcontractor and its contractors, and which are core benefits and services under the Louisiana Medicaid program. A CL members shall not be held liable for payment for core benefits and services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that ACL members shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 11 shall be construed to be for the benefit of ACL's members. This Section 11 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's members, or persons acting on their behalf.

13. **Member Access.** Subcontractor and any providers providing services under the Agreement shall not restrict member access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

14. **Member Rights**. Subcontractor shall assist members in understanding their rights to file grievances and appeals in accordance with ACL's Provider Manual.

a) To the extent applicable, Subcontractor shall have a grievance system in place to address ACL Member grievances including, but not limited to the following:

i. the referral of the Member to a designee of the Subcontractor authorized to review and respond to grievances and appeals that require corrective action; and

ii. the provision of information explaining Member Rights to file grievances, appeals and request a State Fair Hearing, in accordance with 42 CFR Part 438, Subpart F, both orally and in writing in a language that the Member understands.

15. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL member.

16. **ACL Member Copayments**. Subcontractor shall not impose copayments for the following: (i) Family planning services and supplies; (ii) Emergency services; and (iii) Services provided to:

- Individuals younger than 21 years old;
- Pregnant women;
- Individuals who are impatient in long-term care facilities or other institutions;
- Native Americans; and
- Alaskan Eskimos.

To the extent that emergency services, as defined by the State Contract, are provided by Subcontractor or any providers of Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

17. **ACL Member Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's members. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

18. **Marketing and Member Education.** All Marketing (as such term is defined in the State Contract) and member education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 C FR §438.10 and with the LDH requirements as set forth in the State Contract, including but not limited to the following:

a) All Marketing and member education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and member education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or member education materials, or participate in any marketing and member education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or member education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 12.3 of the State Contract; but (ii) Subcontractor's marketing and

member education activities may include those activities enumerated in Section 12.4 of the State Contract.

19. **Misuse of Symbols, Emblems or Names in Reference to Medicaid.** No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

20. **Confidentiality of Information.**

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning members or potential members obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the member/potential member, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated

confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

21. **Safeguarding Information.** Subcontractor shall establish written safeguards, according to applicable state and federal laws and regulations and as described in the State Contract, which restrict the use and disclosure of information concerning members or potential members, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S.46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

22. **LDH Use of Data.** Notwithstanding any provision in this Attachment or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

23. **Record Retention.**

a) Financial Records. Subcontractor shall retain all financial records, supporting documents, statistical records, and all other records for a period of at least ten (10) years from the date of submission of the final expenditure report under the Agreement, with the following exceptions:

i. If any litigation, claim, financial management review or audit is started before the expiration of the 10-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

ii. Records for real property and equipment acquired with federal funds shall be retained for ten (10) years following its final disposition.

iii. When records are transferred to or maintained by LDH, the 10-year retention period is not applicable to the Subcontractor.

iv. Indirect cost rate proposals, cost allocation plans, etc., as specified in 45 CFR 74.53(g).

b) Medical Records. Subcontractor shall retain all documents and medical records, related to services, charges, and operations under the Agreement for ten (10) calendar years after the last good, service or supply has been provided to an ACL Medicaid member or an authorized agent of the state or federal government or any of its authorized agents, unless those records are subject to review, audit, investigations of subject to administrative or judicial action brought by or on behalf of the state of federal government.

24. **Independent Audits**. Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

25. **Information System Availability.** Subcontractor shall allow LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office or upon request of CMS, direct access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of the request. The data shall include the following or any additional data requested by LDH:

- Prior authorizations;
- Claims processing;

- Provider portal;
- Second-party Liability;
- FWA;
- Pharmacy benefits manager point of sale;
- Pharmacy benefits manager prior authorization; and
- Provider contracting and credentialing.

26. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

27. **Release of Records.** Subcontractor shall release medical records of members upon request by members or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: La. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

28. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit executed copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI. Subcontractor shall take and maintain insurance of the same nature and in the same amounts as required of the MCO, including but not limited to:

a) Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of Five Hundred Thousand Dollars ($500,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL and LDH during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of One Million Dollars ($1,000,000) and a minimum general aggregate of Two Million Dollars ($2,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance in the amount of at least One Million Dollars ($1,000,000) per occurrence.

d) Licensed and Non-licensed Motor Vehicles. Subcontractor shall maintain, during the life of the Agreement, automobile liability insurance in an amount not less than combined single limits of One Million Dollars ($1,000,000) per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the Agreement on the site of the work to be performed hereunder, unless such coverage is included in insurance that is elsewhere specified under this **Section 28.** Such insurance shall include third party bodily injury and property damage liability for owned, hired and non-owned automobiles.

29. Hold Harmless. Subcontractor shall indemnify, defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) any claims for damages or losses arising from services rendered by Subcontractor, or any of its contractors, employees, officers, agents or representatives performing or supplying services, materials or supplies in connection with the Agreement;

b) any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or statutes, by Subcontractor, its contractors, employees, officers, agents or representatives in the performance of the Agreement;

c) any claims for damages or losses resulting to any person or firm injured or damaged by the Subcontractor, its contractors, employees, officers, agents or representatives by Subcontractor's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Agreement in a manner not authorized hereunder or by Federal or State regulations or statutes;

d) claims for damages or losses arising from any failure by Subcontractor, its contractors, employees, officers, agents or representatives to comply with applicable Federal or State laws, including but not limited to State and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements or adverse judicial determinations;

e) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of LDH in connection with noncompliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to Subcontractor by MCO and/or LDH;

f) any claims for damages, losses or reasonable costs associated with legal expenses, including, but not limited to those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims or damages specified in the foregoing sub-paragraphs "a" through "e"; and

g) any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against ACL or LDH or their respective agents, officers or employees, through the intentional conduct, negligence or omission of Subcontractor, its contractors, employees, officers, agents or representatives.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

30. Penalties and Sanctions; Corrective Actions. Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL or reduction in payments to ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, which shall include, but may not be limited to Subcontractor's failure or refusal to respond to ACL's request for information and, as applicable, to provide medical records and/or credentialing information, etc. Subcontractor's failure to comply with the provisions of the Agreement may also result in the termination of the State Contract in whole or in part, which shall result in

termination of the Agreement. At ACL's discretion or a directive by LDH, ACL shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall comply with any relevant corrective action plan imposed upon or developed by ACL and/or required by LDH in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

31. **Loss of Federal Financial Participation ("FFP").** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

32. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential or actual conflict. Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement and during the term of the Agreement.

33. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

34. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

35. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

36. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

37. **Termination for Threat to Health of ACL Members.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of members enrolled in ACL.

38. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

39. **Independent Contractor/Subcontractors.** It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

40. **Licensing Requirements.** Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

41. **Entire Contract; Amendments.** Subcontractor shall comply with, and agrees to be bound by, all provisions of theAgreement and shall act in good faith in the performance of the provisions of the Agreement.

The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing.

Except as provided in Section 3, any amendments, alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

42. **Restrictions on Contracting.** Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services contracted under the Agreement.

43. **Antitrust**. Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

44. **Termination of LDH Contract**. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make immediately available to ACL and/or LDH or their respective designated representatives, in a u sable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

45. **Law.** This Attachment shall be governed by the laws of the State of Louisiana, except its conflict of laws provisions both as to interpretation and performance.

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-4

Southeastrans, Inc.

Draft Agreement

This page is intentionally left blank.

THIRD AMENDMENT TO
MASTER SERVICES AGREEMENT

This Third Amendment (the "Third Amendment") is made and entered into by AmeriHealth Caritas Louisiana, Inc. (f/k/a AmeriHealth Mercy of Louisiana, Inc. and hereinafter referred to as "Health Plan") and Southeastrans, Inc.(hereinafter referred to as "Southeastrans") as of this _____ day of _____, 2019 with an effective date of January1, 2020 (the "Effective Date"). Health Plan and Southeastrans shall be referred to hereinafter as "the Parties."

WHEREAS, Health Plan and Southeastrans entered into a Master Services Agreement, with an effective date of April 1, 2018, as amended, whereby Southeastrans arranges for the delivery of non-emergency transportation services to Health Plan Members;

WHEREAS, effective January 1, 2020 the Parties desire to amend and restate the Louisiana Managed Care Organization Required Subcontractor Provisions set forth in Exhibit C to reflect future Louisiana Department of Health (***"LDH"***) subcontractor requirements.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties intending to be legally bound, hereby agree as follows:

1. Capitalized Terms. Capitalized terms used herein shall have the same meanings ascribed to such terms in the Agreement.

2. Exhibit C. Effective January 1, 2020, Exhibit C (*Louisiana Managed Care Organization Required Subcontract Provisions*) is deleted in its entirety and replaced with Amended and Restated Exhibit C (*Louisiana Managed Care Organization Required Subcontract Provisions*), a copy of which is attached hereto and incorporated into the Agreement as if fully set forth therein.

3. Ratification of Agreement. Except as modified by this this Seventh Amendment, the terms and conditions of the Agreement are ratified and confirmed and remain in full force and effect. In the event of any inconsistency between the terms of this Seventh Amendment and the Agreement, the terms of this Seventh Amendment shall govern and control.

4. Authority. The individuals executing this Seventh Amendment represent and warrant they have the requisite authority to sign this document on behalf of the Health Plan and Southeastrans, respectively, and to bind the Health Plan and Southeastrans to the terms herein.

[REMAINDER OF PAGE INTENTIONALLY BLANK. SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, the Parties hereto have executed this Seventh Amendment as of the date written below.

AmeriHealth Caritas Health Plan

By: _____
Name: Chad Goodwin
Title: Vice President, Corporate Sourcing
Date:

Southeastrans, Inc.

By: _____
Name:
Title:
Date:

Amended and Restated Exhibit C
Louisiana Managed Care Organization Required Subcontractor Provisions

INTRODUCTION

On February 25, 2019, the State of Louisiana ("State") Department of Health ("LDH") issued Request for Proposals #3000011953 (the "RFP") for the procurement of Managed Care Organizations (MCOs) to solicit proposals from qualified managed care organizations (MCOs) to provide high quality healthcare services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program known as Healthy Louisiana. AmeriHealth Caritas Louisiana, Inc. ("ACL") intends to submit a proposal in response to the RFP (the "ACL Response"), with the goal of being a successful proposer to which LDH will award a contract to ACL to serve as a MCO (the "State Contract"). Southeastrans is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's enrollees, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this Attachment, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). Subcontractor shall adhere to all requirements set forth for Subcontractors in the contract between LDH and ACL and the MCO Manual. ACL shall furnish these documents to Subcontractor upon request. No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Attachment. If any requirement in the Agreement, including this Attachment, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence.** Except as otherwise set forth in this Attachment, in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

    a) the body of the Agreement with exhibits and attachments;

    b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

    c) the RFP and any addenda and appendices;

    d) the MCO Systems Companion Guide;

    e) the MCO Quality Companion Guide; and

    f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, rules, regulations, guidelines and policies, including without limitation, any regulations or rules that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies as they exist at the time of the Agreement, or as subsequently amended, that are or may be applicable to the Agreement, whether or not specifically mentioned in this Attachment and that such laws, rules, regulations, guidelines and

policies are herein incorporated into this Agreement by reference and that any revisions thereto are automatically incorporated into this Agreement as they become effective. Any provision of the Agreement that is in conflict with federal statutes, regulations or CMS policy guidance or rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies is deemed to be amended to conform to the provisions of those laws, regulations and policies. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.), the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro- Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and its implementing regulations at 45 CFR Part 80, in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (P.L 106-113);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as set forth in 45 CFR Part 182, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and

activities;

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL 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 recipient (45 C.F.R. Part 3);

n) The Equal Opportunity Act of 1972:

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975;

t) The Americans with Disabilities Act of 1990;

u) Executive Order Number JBE 2018-15, relating to the Prohibition of Discriminatory Boycotts of Israel in State Procurement; and

v) 42 C.F.R. §438.100(a)(2), which requires Subcontractor to comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights; and

w) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan; and

x). Section 1557 of the Patient Protection and Affordable Care Act (ACA); and

y) Notwithstanding moral and religious objections in the Services section of the RFP, Subcontractor agrees not to discriminate in its employment practices, and will render services under the RFP without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Subcontractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Agreement.

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services including, but not limited to, the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract. The QAPI and UM requirements are included as part of the subcontract between ACL and the Subcontractor.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Reserved.

g) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

h) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the RFP.

i) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to enrollees through the last day that the Agreement is in effect.

j) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL enrollees pursuant to the Agreement including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract. ACL enrollees and their representatives shall be given access to and can request copies of the enrollee's medical records, to the extent and in the manner provided by LRS 40:1165.1, La. R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) as amended and subject to reasonable charges.

k) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **<u>Fraud, Waste and Abuse ("FWA") Detection and Prevention</u>.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 C.F.R. Part 438, Subparts A and H; La. R.S. 46:437.1 through 437.14; 42 C.F.R. Part 455, Subpart A; LAC 50:I, Subpart 5; and 42 U.S.C. §1320a-7, §1320c-5, and §1396a(a)(68). Without limiting the foregoing:

a) Subcontractor shall report all known or suspected FWA to ACL in accordance with 42 CFR §438.608(a) and the State Contract and ACL requirements.

b) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by ACL's enrollees, network providers, or by Subcontractor's providers, employees or subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

c) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA.

d) Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the Centers for Medicare and Medicaid Services ("CMS"), U.S. Department of Health and Human Services ("HHS"), the Office of Inspector General ("OIG"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide to CMS, HHS, OIG, the State Auditor's Office, the Office of the Attorney General, GAO, Comptroller General, LDH and/or their designees upon request with timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period set forth in Section 23 of this Attachment, but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

e) Subcontractor and Subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, Subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding, to obtain the requested information, records or data. MFCU shall be allowed access to the Contractor's place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hours admission shall be allowed. The MCO contractor, Subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of noncompliance with an information, records or data request.

f) Subcontractor shall permit the State, CMS the HHS Inspector General, the Comptroller General, or their designees to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed.

i. Subcontractor shall make available for purposes of an audit, evaluation or inspection under Section 5(f), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees.

ii. The right to audit under Section 5(f) will remain ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

iii. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees at any time.

g) Reserved.

h) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

j) In accordance with 42 C FR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or an individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.. Subcontractor is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8). Subcontractor shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Subcontractor shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 C.F.R. §455.436 To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  http://exclusions.oig.hhs.gov/search.aspx
-
- System for Award Management
  http://www.sam.gov
- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

k) The Subcontractor shall conduct a screen, monthly as described in Section 5 (j) of this Attachment, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

l) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

m) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) on ownership disclosure reporting and in accordance with RFP Section 2.9.6. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

n) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA).

o) The Subcontractor shall have surveillance and utilization control programs and procedures pursuant to 42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures

in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

p) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

q) Subcontractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly including coordinating with law enforcement agencies, with notice to ACL, if issues are suspected to be criminal in nature , to reduce the potential for reoccurrence, and conduct ongoing compliance with the requirements under this Agreement.

r) Subcontractor shall provide annual training to all employees, and shall train new hires within thirty (30) days of the date of employment, related to the following:

- Subcontractor's Code of Conduct;
- Privacy and Security – HIPAA;
- FWA identification and reporting procedures;
- Federal False Claims Act and employee whistleblower protections; and
- Procedures for timely consistent exchange of information; and collaboration with ACL and LDH; and
- Provisions that comply with 42 CFR §438. 608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

s) Subcontractor shall suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. ACL is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

6. <u>Employment of Personnel</u>.

a) <u>Non-Discrimination</u>. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) <u>Restriction on Certain Individuals</u>. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement

activity or from participating in –non-procurement activities under regulations issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR § 1001.1901(b) and 42 CFR§ 1003.102(a)(2)}.

Additionally, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 USC §1320a-7) or Section 1156 (42 USC §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. This includes providers undergoing any of the following identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health services license;

ii. Exclusion from the Medicaid program;

iii. Exclusion form the Medicare program;

iv. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review ("SURS") Rule (LAC 50:1.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:1.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. Cooperation, Care Coordination and Continuity of Care.

a) Care Coordination. Subcontractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to ACL's Medicaid enrollees.

b) Continuity of Care. To the extent applicable to the services provided under the Agreement, Subcontractor shall develop and maintain a process of Continuity of Care

by which ACL's Medicaid enrollees and network and/or non-network provider interactions are effective to ensure that each enrollee has an ongoing source of preventative and primary care appropriate to their needs.

c) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid enrollees in accordance with professional standards. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

d) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this Attachment, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this Attachment and under the Agreement.

8. Provider Selection Requirements. To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR§438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and re-credentialing policies including, but not limited to: LDH, Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for specialized behavioral health providers.

c) Subcontractors that specialize in behavioral health are required to be accredited by rule, regulation, waiver or State Plan Amendment ("SPA") prior to contracting with ACL or prior to receiving Medicaid reimbursement, and shall comply with: all requirements of ACL,; CMS approved waivers; and/or the SPAs.

d) Subcontractors that specialize in behavioral health shall provide ACL with proof of accreditation from one of the following LDH approved national accrediting body:

- Council on Accreditation;
- Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- The Joint Commission ("TJC").

e) Subcontractor shall have a re-credentialing policy which includes, but is not limited to, notifying ACL when Subcontractor denies a provider credentialing application or

disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

f) Subcontractor shall notify ACL, regarding itself or any of its providers or subcontractors, and shall furnish documentation from the accreditation body within twenty-four (24) hours of the following: loss of accreditation, license or certification; suspension; or any action that could result in the loss of accreditation.

g) If Subcontractor or any provider of Subcontractor performs laboratory services under the Agreement, the Subcontractor or provider of Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

h) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

i) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this Attachment, as may be modified by LDH from time to time.

j) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 2.20 of the State Contract.

k) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the RFP).

l) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

m) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the enrollee needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

n) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract that may materially impact Subcontractor's provider network and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting

requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans**. Subcontractor's Physician Incentive Plans ("PIP") shall be incompliance with 42 CFR § 438.3(i).

a) Subcontractor shall disclose to ACL annually any PIP or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

b) Subcontractor shall provide written notification to ACL within thirty (30) days upon implementation of any new PIP or when an existing PIP is modified. The written notification must: (i) list the participating providers; and (ii) certify that the terms and conditions of the PIP are compliant with all applicable federal regulations.

c) Subcontractor shall furnish, upon request of ACL, additional information including, but not limited to, a copy of the PIP.

10. Provider Preventable Conditions. Subcontractor shall report to ACL, within seventy-two (72) hours, any provider preventable conditions ("PPCs") associated with claims for payment or enrollee treatment for which payment would otherwise be made. PPCs include: (i) Healthcare Acquired Conditions; and (ii) Other Provider Preventable Conditions, as defined by Section 2.11.10 of the State Contract..

11. National Provider Identifier (NPI). The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

12. ACL Enrollee Hold Harmless. Subcontractor shall accept the final payment made by ACL as payment-in-full for covered services provided under the Agreement. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from, or have recourse against LDH, ACL enrollees or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the enrollee), for health care services which are rendered to such enrollees by Subcontractor and its contractors, and which are covered services under the Louisiana Medicaid program. ACL enrollees shall not be held liable for payment for covered services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that LDH or ACL enrollees shall not be held

liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 12 shall be construed to be for the benefit of ACL's enrollees. This Section 12 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's enrollees, or persons acting on their behalf.

13. **Enrollee Access.** Subcontractor and any providers providing services under the Agreement shall not restrict enrollee access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

14. **Enrollee Rights**. Subcontractor shall assist enrollees in understanding their rights to file grievances and appeals in accordance with ACL's Provider Manual.

    a) To the extent applicable, Subcontractor shall have a grievance system in place to address ACL enrollee grievances including, but not limited to the following:

        i. the referral of the enrollee to a designee of the Subcontractor authorized to review and respond to grievances and appeals that require corrective action; and

        ii. the provision of information explaining Enrollee Rights to file grievances, appeals and request a State Fair Hearing, in accordance with 42 CFR Part 438, Subpart F, both orally and in writing in a language that the Enrollee understands.

15. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL enrollee.

16. **ACL Enrollee Copayments**. Subcontractor shall not impose copayments for the following: (i) Family planning services and supplies; (ii) Emergency services; and (iii) Services provided to:

    - Individuals younger than 21 years old;
    - Pregnant women;
    - Individuals who are impatient in long-term care facilities or other institutions;
    - Native Americans; and
    - Alaskan Eskimos.

    To the extent that emergency services, as defined by the RFP, are provided by Subcontractor or any providers of Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

17. **ACL Enrollee Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's enrollees. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

18. **Marketing and Enrollee Education.** All Marketing (as such term is defined in the RFP) and enrollee education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the LDH requirements as set forth in the RFP, including but not limited to the following:

    a) All Marketing and enrollee education materials (print and multimedia) that

Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and enrollee education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or enrollee education materials, or participate in any marketing and enrollee education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or enrollee education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 2.14.2 of the State Contract; but (ii) Subcontractor's Marketing and enrollee education activities may include those activities enumerated in Section 2.14.3 of the State Contract.

19. Misuse of Symbols, Emblems or Names in Reference to Medicaid. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

20. Confidentiality of Information.

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to enrollees or potential enrollees, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the enrollee/potential enrollee, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees/potential enrollees shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

21. **Safeguarding Information.** Subcontractor shall establish written safeguards, according to applicable state and federal laws and regulations and as described in the State Contract, which restrict the use and disclosure of information concerning enrollees or potential enrollees, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S.46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the enrollees or potential enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

22. **LDH Use of Data.** Notwithstanding any provision in this Attachment or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

23. **Record Retention.**

a) Financial Records. Subcontractor shall retain all financial records, supporting documents, statistical records, and all other records for a period of at least ten (10) years from date of submission of the final expenditure report under the Agreement, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.. The only exceptions are the following:

i. If any litigation, claim, financial management review, or audit is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

ii. Records for real property and equipment acquired with federal funds shall be retained for ten (10) years after final disposition;

iii. When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the recipient; and

iv. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 C.F.R. §75.361(f).

Under no circumstances shall Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

b) Medical Records. All documentation and/or records maintained by Subcontractors, and its network providers related to covered services, charges, operations and agreements under this Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall the Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

24. **Independent Audits.** Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

25. **Information System Availability.** Subcontractor shall allow LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office or upon request of CMS, direct access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of the request. The data shall include the following or any additional data requested by LDH:

- Prior authorizations;
- Claims processing;
- Provider portal;
- Third-party Liability;
- FWA;
- Pharmacy benefits manager point of sale;
- Pharmacy benefits manager prior authorization; and
- Provider contracting and credentialing.

26. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

27. **Release of Records.** Subcontractor shall release medical records of enrollees upon request by enrollees or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: L a. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

28. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit executed copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. Ten (10) calendar days' written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in Subcontractor's policy. In addition, Subcontractor is required to notify ACL of policy cancellations or reductions in limits. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. The insurance companies issuing the policies shall have no recourse against LDH for payment of premiums or for assessments under any form of the policies. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

a) Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of One Million Dollars ($1,000,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL, LDH any subcontractor during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of Two Million Dollars ($2,000,000) and a minimum general aggregate of Four Million Dollars ($4,000,000) or the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be

covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance which covers the professional acts or omissions of Subcontractor in the amount of at least Three Million Dollars ($3,000,000) per occurrence.

d) Automobile Liability. Automobile Liability Insurance shall have a minimum combined single limit per accident of $1,000,000. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

e) Cyber Liability Cyber liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of $3,000,000. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this Contract and shall have an expiration date no earlier than thirty (30) calendar days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium.

f) The policies are to contain, or be endorsed to contain, the following provisions:

1. Commercial General Liability, Automobile Liability, and Cyber Liability Coverages
   LDH, its officers, agents, employees and volunteers shall be named as an additional insured as regards negligence by Subcontractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, are to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to LDH. Subcontractor's insurance shall be primary with respect to LDH, its officers, agents, employees and volunteers for any and all losses that occur under the Contract. Any insurance or self-insurance maintained by LDH shall be in excess and non-contributory of the Contractor's insurance.

2. Workers Compensation and Employers Liability Coverage
   To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against LDH, its officers, agents, employees and volunteers for losses arising from work performed by the Subcontractor for LDH.

29. Hold Harmless. Subcontractor shall indemnify, defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) Any claims for damages or losses arising from services rendered by Subcontractor or any of its contractors, persons, or firms performing or supplying services, materials, or supplies to ACL in connection with the performance of this Agreement;

b) Any claims for damages or losses arising from sanctions on ACL network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the Fraud, Waste, and Abuse Prevention Section of the State Contract.

c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Subcontractor in the performance of this Agreement;

d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor, it's agents, officers, employees, or subcontractors by Subcontractor's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes;

e) Any claims for damages or losses arising from failure by Subcontractor, it's agents, officers, employees or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;

f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the Subcontractor by ACL;

g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against ACL or LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of the Subcontractor, its agents, officers, employees, or subcontractors.

i) If the Subcontractor performs services, or uses services, in violation of Section 38, the Subcontractor shall be in material breach of this Agreement and shall be liable to LDH and ACL for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Subcontractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

30. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL or reductions in payment to ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, which shall include, but may not be limited to Subcontractor's failure or refusal to respond to ACL's request for information and, as applicable, to provide medical records and/or credentialing information. Subcontractor's failure to comply with the provisions of the Agreement may also result in the termination of the State Contract in whole or in part, which shall result in termination of the Agreement. At ACL's discretion or a directive by LDH, ACL shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall comply with any relevant corrective action plan imposed upon or developed by ACL and/or required by LDH in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

31. **Loss of Federal Financial Participation ("FFP").** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

32. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential or actual conflict(s). Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement and during the term of the Agreement.

33. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

34. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

35. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

36. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

37. **Termination for Threat to Health of ACL Enrollees.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of ACL's enrollees.

38. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services

under the Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

39. Independent Contractor/Subcontractors. It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

40. Licensing Requirements. Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

41. Entire Contract; Amendments. Subcontractor shall comply with, and agrees to be bound by, all provisions of theAgreement and shall act in good faith in the performance of the provisions of the Agreement.

The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing.

Except as provided in Section 3, any amendments, alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

42. Restrictions on Contracting. Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services contracted under the Agreement.

43. Antitrust. Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program.. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

44. Termination of LDH Contract. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make available to ACL and/or LDH or their respective designated representatives, in a u sable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

45. **Law.** This Attachment shall be governed by the laws of the State of Louisiana, without regard to its conflict of law provision, and Louisiana law will prevail if there is a conflict between the state law where the Subcontractor is based and Louisiana law.

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-5

[redacted]

Appendix F Material Subcontractor Response Template

This page is intentionally left blank.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
AmeriHealth Caritas Louisiana
Material subcontractor name:
[redacted]
Description of the Proposer's role and material subcontractor's role:
AmeriHealth Caritas Louisiana will be responsible for the sourcing, vetting, selection, and oversight of [redacted] reporting on performance, providing ongoing support, and ensuring that they comply with the terms set out in the subcontractor agreement. [redacted]
Explanation of why the Proposer plans to subcontract this service and/or function:
[redacted]
A description of the material subcontractor's organizational experience:
[redacted] persistent mental illness and substance abuse disorders, as well as people who are homeless, veterans, and families.
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
Prior to approval as a material subcontractor, [redacted] will be evaluated, including screening for state and federal exclusions, review of ownership disclosures, review of trainings and policies, accreditation standards, and completion of all necessary documentation. [redacted] must demonstrate that they possess the infrastructure, organization, financial stability, and processes necessary to fulfill their roles. The local Vendor Management team, in collaboration with the Corporate Sourcing department will be responsible for onboarding, auditing and monitoring [redacted] Monthly performance reports will be reviewed by Vendor Management and Corporate Sourcing for contract compliance, and areas of concern are flagged for remediation, including any complaints or grievances. If [redacted] consistently fails to meet agreed performance standards, they are issued a Corrective Action Plan (CAP) and required to determine the root cause of the deficiencies. They must meet the performance standard for three consecutive months before the CAP can be closed. If they continue to miss performance standards may be terminated for cause and may be subject to financial penalties. In order to ensure an appropriate return on investment (ROI), our Medical Economics department will work with UM, care management, and other stakeholders to assess patient outcomes and program ROI analyses, provider/plan goal alignment and pay-for-performance initiatives, and other analytics relevant to SDoH and [redacted] Corporation's services. Further, we constantly monitor for any reported or identified instances of fraud, waste and abuse, and third-party liability (TPL) to ensure that claims and payments are accurate, timely, and appropriate.

Instructions: The MCO should attach the executed contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between LDH and the MCO and the MCO Manual, and either physically incorporate these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Subcontract Provisions, Introductory Paragraph, pg. 1
2	Include a signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	Contract
3	Specify the effective dates of the subcontract agreement.	Contract
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Subcontract Provisions, Par. 41, pg. 27
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Subcontract Provisions, Par. 41, pg. 27
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Subcontract Provisions, Par. 41, pg. 27
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and LDH for any of the reasons described in the contract, the MCO shall immediately make available to LDH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to LDH.	Subcontract Provisions, Par. 44, pg. 27
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Subcontract Provisions, Par. 39, pgs. 27
9	Require that if any requirement in the subcontract is determined by LDH to conflict with the contract between LDH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Subcontract Provisions, Introductory Paragraph, Pg. 1

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Subcontract Provisions, Introductory Paragraph, Pg. 1
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to enrollees through the last day that the subcontract is in effect.	Subcontract Provisions, Par. 4(i), pg. 10
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Subcontract Provisions, Par. 40, pg. 27
13	Specify the amount, duration, and scope of benefits and services that are provided by the subcontractor.	Contract
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Subcontract Provisions, Par 16, pg. 19
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 C.F.R. § 493.1 and 493.3, and any other federal requirements.	Subcontract Provisions, Par. 8(g), pg. 17
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO enrollees pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between LDH and the MCO). MCO enrollees and their representatives shall be given access to and can request copies of the enrollees' medical records, to the extent and in the manner provided by La. R.S. 40:1165.1 and 45 C.F.R. §164.524 as amended and subject to reasonable charges.	Subcontract Provisions, Par. 4(j), pg. 10
17	Include record retention requirements as specified in the contract between LDH and the MCO.	Subcontract Provisions, Par. 23, pgs. 21-22

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to CMS, the U.S. Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, Government Accountability Office (GAO), LDH, and/or any of their designees upon request, and shall provide them with timely and reasonable access and the right to examine and make copies, excerpts, or transcripts of all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits and examinations, contact and conduct private interviews with the subcontractor's clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this provision are not limited to the required retention period, but shall last as long as records are retained. The subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Subcontract Provisions, Par. 5(d), pg. 11
19	Require the subcontractor to submit to the MCO a disclosure of ownership in accordance with RFP Section 2.9.6. The completed disclosure of ownership should be attached for executed contracts.	Subcontractor Provisions, Par. 5(m), pg. 13
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or LDH or its designee.	Subcontract Provisions, Par. 4(c), pg. 10
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by LDH or its designee.	Subcontract Provisions, Par. 4(e), pg. 10
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by LDH.	Subcontract Provisions , Par. 30(b), pg. 26
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontract and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by LDH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Subcontract Provisions, Par. 30, pg. 25

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by LDH.	Subcontract Provisions, Par. 4(b), pg. 9
25	Require safeguarding of information about MCO enrollees according to applicable state and federal laws and regulations and as described in contract between LDH and the MCO.	Subcontract Provisions, Par. 21, pg. 21
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Subcontract Provisions, Par. 4(g), pg. 10
27	Provide that the subcontractor comply with LDH's claims processing requirements as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 10
28	Provide that the subcontractor adhere to LDH's timely filing guidelines as outlined in the RFP.	Subcontract Provisions, Par. 4(h), pg. 10
29	Provide that, if LDH or its subcontractors discover an error or a conflict with a previously adjudicated encounter claim, the subcontractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by LDH or the MCO, or if circumstances exist that prevent the subcontractor from meeting this time frame, by a specified date approved by LDH.	Subcontract Provisions, Par. 4(k), pg. 10
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from LDH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Subcontract Provisions, Par. 12, pgs. 18-19
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold LDH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between LDH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between LDH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by LDH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by LDH.	Subcontract Provisions, Par. 29, pgs. 24-25

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's enrollees and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Subcontract Provisions, Par. 28, pgs. 23-24
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services, and stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the state law where the material subcontractor is based and Louisiana law.	Subcontract Provisions, Par. 3, pgs. 7-8 and Par. 45, pg. 28
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Subcontract Provisions, Par. 3, pg. 7-8
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Subcontract Provisions, Par. 15, pg. 19
36	Include a conflict of interest clause as stated in the contract between LDH and the MCO.	Subcontract Provisions, Par. 32, pg. 26
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between LDH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Subcontract Provisions, Par. 4(d), pg. 10
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Subcontract Provisions, Par. 26, pg. 23
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Subcontract Provisions, Par. 3(c), pg. 8
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Subcontract Provisions, Par. 42, pg. 27

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Subcontract Provisions, Par. 4(a), pg. 9
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Subcontract Provisions, Par. 38, pgs. 26-27
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Subcontract Provisions, Par. 43, pg. 27

	Checklist Item	Location (Include Name of Document, Page Number, and Section Number/Letter)
44	Contain the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Subcontract Provisions, Par. 5(e), pg. 11

AmeriHealth Caritas Louisiana

Attachment 2.10.2.3-5

[redacted]

Draft Agreement

This page is intentionally left blank.

AGREEMENT

THIS AGREEMENT, is made as of _____, 20[___] by and between AMERIHEALTH CARITAS LOUISIANA, INC., (herein "ACL") and [redacted]

WHEREAS, [redacted] is an organization engaged in the business of providing temporary respite care; and

WHEREAS, ACL desires to utilize [redacted] services in providing temporary respite care to certain ACL Medicaid enrollees in the Louisiana Medicaid managed care program known as Healthy Louisiana; and

WHEREAS, [redacted] and ACL are entering into this Agreement to set forth their entire understanding and agreement with respect to the terms and conditions under which [redacted] shall provide such services;

NOW THEREFORE, in consideration of the mutual agreements hereinafter set forth, and intending to be legally bound hereby, the parties hereto agree as follows:

A. **TEMPORARY RESPITE CARE SERVICES**. During the terms of this Agreement, [redacted] shall provide those services as set forth on the Statement of Work (herein "SOW"), which is attached hereto as Exhibit A and incorporated herein by reference.

B. **COMPENSATION**. [redacted] shall be paid for services rendered to ACL enrollees at the rates set forth in Exhibit A.

C. **TERM**. This Agreement is for a term of one (1) year commencing January 1, 2020. Either party may terminate this Agreement: (i) for cause at any time by giving the other party written termination notice specifying the cause for termination and providing the date such notice shall be effective; or (ii) for any or no reason by giving the other party ninety (90) days' prior written notice.

D. **REQUIRED SUBCONTRACTOR PROVISIONS.** [redacted] agrees to abide by the Louisiana Managed Care Organization Required Subcontractor Provisions as set forth as Exhibit B and incorporated herein by reference.

E. **INDEMNIFICATION**. [redacted] shall indemnify and hold harmless ACL and its officers, shareholders, agents, Directors, and employees, from and against any and all, liability, damages, losses and expenses, including attorneys' fees, arising out of or resulting from the rendering of [redacted] Services hereunder, or from the acts or conduct of [redacted] or any agent, servant or employee of [redacted] or any [redacted] engaged by [redacted] shall pay any judgment finally awarded, together with all expenses and fees, in any claim, suit or action which is brought against ACL and is within the indemnifications set forth herein, and shall pay any amounts payable in settlement or compromise of any such claim, suit or action. In the event [redacted] refuses or fails to pay any amount pursuant to this section, without thereby waiving any other rights or remedies available to it. ACL, shall have the right (but not the obligation) to pay such amounts and to thereafter deduct any equivalent amount from any amount which may be due under this Agreement.

F. **CONFIDENTIALITY**. ACL and [redacted] shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of ACL enrollees acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by LDH or the Louisiana Department of Insurance or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

G. **INSURANCE**. During the term of this Agreement, [redacted] shall maintain, at its sole expense, professional liability insurance with a coverage amount of no less than one million ($1,000,000.00) dollars per

occurrence and two million ($2,000,000.00) do[redacted] in the aggregate. [redacted] shall also maintain general liability insurance with a coverage amount of no less than one-million ($1,000,000.00) dollars per occurrence and two million ($2,000,000.00) dollars in the aggregate. [redacted] shall provide ACL evidence of such insurance coverage via an insurance certificate and shall maintain such insurance for the term of the contract.

H. **INDEPENDENT CONTRACTOR**. This Agreement does not constitute [redacted] the employee or agent of ACL, or provide expressly or impliedly any power in [redacted] to contract for, or in the name of, ACL, or to hire persons as employees of ACL, or otherwise act on behalf of ACL. [redacted] agrees that in the performance of this Agreement, it shall act as an independent contractor for all purposes of any kind whatsoever, and all of its agents, [redacted] and employees, and agents and employees of its [redacted] shall be subject solely to the control, supervision and authority of [redacted] or its [redacted]

I. **NON-ASSIGNABILITY**. Neither party may assign this Agreement or any of its rights or obligations hereunder without the prior written consent of the other party, and any such attempted assignment shall be void, except that ACL may assign this Agreement, or any of its rights or obligations to any of its subsidiaries or affiliates without the consent of [redacted] Furthermore, no work to be performed by [redacted] shall be subcontracted to or performed on behalf of [redacted] by any third party without the prior written consent of ACL.

J. **GOVERNING LAW**. The Agreement shall be governed by and construed in accordance with the laws of the State of Louisiana, without regard to its conflicts of law provisions, and Louisiana law will prevail if there is a conflict between the state law where the Subcontractor is based and Louisiana law.

K. **WAIVER**. A failure of either party to exercise any right provided for herein, shall not be deemed to be a waiver of any right hereunder.

L. **COMPLETE AGREEMENT AND MODIFICATIONS**. This Agreement, including all exhibits, schedules or addenda, sets forth the entire understanding of the parties as to the subject matter and may not be modified, amended or waived except in a writing executed by both parties.

M. **SEVERABILITY**. In the event any one or more of the provisions of this Agreement is invalid or otherwise unenforceable, the enforceability of remaining provisions shall be unimpaired.

N. **NON SOLICITATION**. During the term of this Agreement and for one year period after the expiration of this Agreement, [redacted] shall not, on its behalf or on behalf of any other person, firm or corporation, recruit, solicit or induce, or attempt to recruit, solicit or induce, any employee of ACL or its affiliates to terminate their employment with ACL, or to become employed by any person, firm or corporation engaged in competition with ACL or its affiliates.

O. **NOTICES**. Any and all notices, requests, consents, demands or other communications required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been duly given (1) when delivered, if sent by United States registered or certified mail (return receipt requested), (2) when delivered, if delivered personally or by commercial courier, or (3) on the second following business day, if sent by United States Postal Service express mail or commercial overnight courier with applicable postage or delivery charges prepaid.

P. **EXCLUDED PARTIES.** Pursuant to section 1128A of the Social Security Act 42 CFR 1001.1901,and section 2455 of the Federal Acquisition Streamlining Act of 1994 and the Federal Acquisition Regulations (including but not limited to 48 CFR 9.405), ACL may not make payment to any person or an affiliate of a person who is debarred, suspended or otherwise excluded from participating in the Medicare, Medicaid or other Federal health care programs or who has been debarred or suspended from participation in federal procurement or non-procurement activities. [redacted] represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under this Agreement, directors or officers, or any person with an ownership interest in [redacted] of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or

Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons").

In order to ensure that no payments from AmeriHealth Caritas are made to Sanctioned Persons, [redacted] shall screen all employees and contractors who will furnish goods or services under the Agreement to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs. To help make this determination, the [redacted] shall search the following websites upon initial employment or engagement of or contracting with a contractor or employee and shall also perform such searches on all directors and officers of [redacted] and on a monthly basis thereafter for employees, contractors, directors and officers:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
http://exclusions.oig.hhs.gov/search.aspx

- System for Award Management
http://www.sam.gov

- Louisiana Adverse Actions List Search (LAALS)
http://adverseactions.LDH.la.gov

Upon request of ACL, [redacted] will be required to furnish a written certification to ACL that it does not have a prohibited relationship with an individual or entity that is known or should be known to be a Sanctioned Person.

[redacted] shall immediately notify ACL upon knowledge by [redacted] that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that [redacted] cannot provide reasonably satisfactory assurance to ACL that a Sanctioned Person will not receive payment from ACL under this Agreement, ACL may immediately terminate this Agreement. ACL reserves the right to recover all amounts paid by ACL for items or services furnished by a Sanctioned Person. Further, and without limiting [redacted] indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACL as a result of [redacted] having a relationship with a Sanctioned Person, [redacted] shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACL, ACL shall have the right

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

AMERIHEALTH CARITAS LOUISIANA, INC.	[redacted]
By: _____	By: _____
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Address:	Address: _____ _____

EXHIBIT A

STATEMENT OF WORK: [redacted]

Purpose

[redacted] will provide [redacted] shall provide [redacted]

[redacted].

Project Scope

[redacted]

PROGRAM ENHANCEMENT/REFERRALS may include:

[redacted]:

1. [redacted]

[redacted]

2. [redacted]

3. [redacted]

4. [redacted]

5. [redacted]

[redacted]

FEE SERVICE PRICING:
AmeriHealth Caritas Louisiana shall reimburse [redacted]

[redacted]

IMPLEMENTATION TIMELINE:

Staff Experience & Timeline for Implementation

Once a contract is in place, [redacted] would immediately prepare staff for transition to this program within 30 days. [redacted] proposes to transition existing staff and hire new staff for the [redacted] for quick implementation. The complete [redacted] would coordinate service delivery and will generally work Monday-Friday with flexible hours to service members who do not follow conventional schedules, but would be available 24 hours a day, 7 days a week, with some nights and weekends based on outreach schedules and participants' scheduling needs.

EXHIBIT B

Louisiana Managed Care Organization
Required Subcontractor Provisions

INTRODUCTION

On February 25, 2019, the State of Louisiana ("State") Department of Health ("LDH") issued Request for Proposals #3000011953 (the "RFP") for the procurement of Managed Care Organizations (MCOs) to solicit proposals from qualified managed care organizations (MCOs) to provide high quality healthcare services statewide to Medicaid enrollees in the Louisiana Medicaid managed care program known as Healthy Louisiana. AmeriHealth Caritas Louisiana, Inc. ("ACL") intends to submit a proposal in response to the RFP (the "ACL Response"), with the goal of being a successful proposer to which LDH will award a contract to ACL to serve as a MCO (the "State Contract"). [Subcontractor] is a person, agency or organization with which ACL will subcontract, or to which ACL will delegate some of its management functions or other contractual responsibilities to provide covered services to ACL's enrollees, and is therefore considered a "Subcontractor," as defined in the RFP. Accordingly, the terms and conditions set forth in this Attachment, which are required of Subcontractors pursuant to the RFP, are incorporated to the agreement between ACL and Subcontractor defining the services to be provided by Subcontractor ("Agreement"). Subcontractor shall adhere to all requirements set forth for Subcontractors in the contract between LDH and ACL and the MCO Manual. ACL shall furnish these documents to Subcontractor upon request. No other terms and conditions agreed to by ACL and Subcontractor shall negate or supersede the requirements of this Attachment. If any requirement in the Agreement, including this Attachment, is determined by LDH to conflict with the State Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. **Order of Precedence.** Except as otherwise set forth in this Attachment, in the event of any inconsistency or conflict among the document elements of the Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

    a) the body of the Agreement with exhibits and attachments;

    b) the body of the State Contract with its exhibits and attachments, excluding the RFP and the ACL Response;

    c) the RFP and any addenda and appendices;

    d) the MCO Systems Companion Guide;

    e) the MCO Quality Companion Guide; and

    f) ACL's proposal submitted in response to the RFP.

2. **Software Reporting Requirement.** In order to permit ACL to meet its reporting obligations to LDH, all reports submitted to ACL by Subcontractor must be in a format accessible and modifiable by the standard Microsoft Office suite of products, version 2007 or later, or in another format accepted and approved by ACL.

3. **Compliance with Laws and Regulations.** Subcontractor agrees and warrants that it shall comply with all State and federal laws, rules, regulations, guidelines and policies, including without limitation, any regulations or rules that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies as they exist at the time of the Agreement, or as subsequently amended, that are or may be applicable to the Agreement, whether or not specifically mentioned in this Attachment and that such laws, rules, regulations, guidelines and policies are herein incorporated into this Agreement by reference and that any revisions thereto are automatically incorporated into this Agreement as they become effective. Any provision of the

Agreement that is in conflict with federal statutes, regulations or CMS policy guidance or rules or regulations that may be promulgated by LDH pursuant to the State Contract, all LDH provider manuals, LDH issued guides, and all applicable LDH policies is deemed to be amended to conform to the provisions of those laws, regulations and policies. Such amendment will be effective on the effective date of the statutes, regulations or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Without limiting the foregoing, Subcontractor agrees to comply with all applicable federal and State laws and regulations, including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

a) Title 42 of the Code of Federal Regulations (CFR) Chapter IV, Subchapter C (regarding Medical Assistance Programs);

b) All applicable standards, orders or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.), the Clean water Act (33 U.S.C. §1251 et seq.) and 20 U.S.C. §6082(2) of the Pro- Children Act of 1994, as amended (P.L. 103-227);

c) Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and its implementing regulations at 45 CFR Part 80, in accordance with which Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the Agreement;

d) Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;

e) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefitting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84);

f) The Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et seq.), which prohibits discrimination on the basis of age in programs or activities receiving or benefitting from federal financial assistance;

g) The Omnibus Reconciliation Act of 1981, as amended (P.L. 97-35), which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefitting from federal financial assistance;

h) The Balanced Budget Act of 1997, as amended (P.L. 105-33) and the Balanced Budget Refinement Act of 1999, as amended (P.L 106-113);

i) Americans with Disabilities Act, as amended (42 U.S.C. §12101 et seq.), and regulations issued pursuant thereto;

j) Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusions for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

k) The Federal Drug Free Workplace Act of 1988, P.L. 100-690, as set forth in 45 CFR Part 182, and any applicable State drug-free workplace law;

l) Title IX of the Education Amendments of 1972, regarding education programs and activities;

m) Byrd Anti-Lobbying Amendment, requiring Subcontractor to certify that it will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or any 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. Subcontractor shall disclose to ACL 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 recipient (45 C.F.R. Part 3);

n) The Equal Opportunity Act of 1972:

o) Federal Executive Order 11246;

p) The Federal Rehabilitation Act of 1973;

q) The Vietnam Era Veterans Readjustment Assistance Act of 1974;

r) Title IX of the Education Amendments of 1972;

s) The Age Act of 1975;

t) The Americans with Disabilities Act of 1990;

u) Executive Order Number JBE 2018-15, **r**elating to the Prohibition of Discriminatory Boycotts of Israel in State Procurement; and

v) 42 C.F.R. §438.100(a)(2), which requires Subcontractor to comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights; and

w) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR §146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan; and

x). Section 1557 of the Patient Protection and Affordable Care Act (ACA); and

y) Notwithstanding moral and religious objections in the Services section of the RFP, Subcontractor agrees not to discriminate in its employment practices, and will render services under the RFP without regard to race, color, religion, sex, national origin, veteran status, political affiliation, or disabilities. Any act of discrimination committed by Subcontractor, or failure to comply with these statutory obligations when applicable shall be grounds for termination of this Agreement.

4. **Claims, Reporting and Service Requirements.** Subcontractor agrees to comply with all record, reporting and applicable guidelines for the provision of services including, but not limited to, the following:

a) To the extent ACL has entered into an alternative reimbursement arrangement with Subcontractor, Subcontractor understands and agrees that all encounter data submitted by Subcontractor to ACL must comply with the same standards of completeness and accuracy as required for the proper adjudication of claims by ACL.

b) Subcontractor will submit any and all reports and clinical information to ACL for reporting purposes required by LDH.

c) Whether announced or unannounced, Subcontractor will participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by ACL and/or LDH or its designee.

d) Subcontractor is required to adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the State Contract. The QAPI and UM requirements are included as part of the subcontract between ACL and the Subcontractor.

e) Subcontractor shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which ACL/Subcontractor practices and/or the standards established by LDH or its designee.

f) Reserved.

g) Subcontractor shall make full disclosure of the method and amount of compensation or other consideration to be received from ACL pursuant to the Agreement.

h) Subcontractor will comply with LDH's claims processing requirements and timely filing guidelines as outlined in the RFP.

i) Services provided by Subcontractor under the Agreement must be in accordance with the Louisiana Medicaid State Plan and Subcontractor is required to provide these services to enrollees through the last day that the Agreement is in effect.

j) Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to ACL enrollees pursuant to the Agreement including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the State Contract. ACL enrollees and their representatives shall be given access to and can request copies of the enrollee's medical records, to the extent and in the manner provided by LRS 40:1165.1, La. R.S. 13:3734, and La. C.Ev. Art. 510; and 45 CFR Parts 160 and 164 (HIPAA Privacy Rule) as amended and subject to reasonable charges.

k) If LDH or ACL discovers errors or a conflict with a previously adjudicated encounter claim, Subcontractor shall be required to adjust or void the encounter within fourteen (14) calendar days of notification by ACL or LDH or if circumstances exist that prevent Subcontractor from meeting this time frame, a specified date shall be approved by LDH.

5. **Fraud, Waste and Abuse ("FWA") Detection and Prevention.** Subcontractor shall cooperate with and abide by ACL's FWA detection and prevention activities and shall adhere to ACL's relevant policies and procedures with respect thereto; and Subcontractor shall comply with all State and federal laws and regulations and State Contract requirements relating to FWA in the Medicaid and CHIP programs, including but not limited to 42 C.F.R. Part 438, Subparts A and H; La. R.S. 46:437.1 through 437.14; 42 C.F.R. Part 455, Subpart A; LAC 50:I, Subpart 5; and 42 U.S.C. §1320a-7, §1320c-5, and §1396a(a)(68). Without limiting the foregoing:

a) Subcontractor shall report all known or suspected FWA to ACL in accordance with 42 CFR §438.608(a) and the State Contract and ACL requirements.

b) Subcontractor shall report to ACL any cases of suspected Medicaid fraud or abuse by ACL's enrollees, network providers, or by Subcontractor's providers, employees or

subcontractors. Reports shall be made in writing, as soon as practical after discovering suspected incidents, but no more than two (2) business days, in order to permit ACL to meet its requirement to report to the Program Integrity Section within three (3) business days.

c) Subcontractor shall cooperate and assist the State and any state or federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA.

d) Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the Centers for Medicare and Medicaid Services ("CMS"), U.S. Department of Health and Human Services ("HHS"), the Office of Inspector General ("OIG"), the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General and LDH. Subcontractor shall provide to CMS, HHS, OIG, the State Auditor's Office, the Office of the Attorney General, GAO, Comptroller General, LDH and/or their designees upon request with timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions; contact and conduct private interviews with Subcontractor and its employees and contractors; and do on-site reviews of all matters relating to service delivery as specified by the State Contract. The rights of access in this subparagraph are not limited to the required retention period set forth in Section 23 of this Attachment, but shall last as long as records are retained. Subcontractor shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

e) Subcontractor and Subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, Subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding, to obtain the requested information, records or data. MFCU shall be allowed access to the Contractor's place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hours admission shall be allowed. The MCO contractor, Subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of noncompliance with an information, records or data request.

f) Subcontractor shall permit the State, CMS the HHS Inspector General, the Comptroller General, or their designees to audit, evaluate, and inspect any books,

records, contracts, computer or other electronic systems of the Subcontractor, or the Subcontractor's contractor, that pertain to any aspect of services and activities performed.

i. Subcontractor shall make available for purposes of an audit, evaluation or inspection under Section 5(f), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees.

ii. The right to audit under Section 5(f) will remain ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

iii. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to services provided to ACL's Medicaid enrollees at any time.

g) Reserved.

h) Subcontractor and its employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.

i) Subcontractor shall immediately report to ACL when it is discovered that any Subcontractor employee, provider or contractor has been excluded, suspended or debarred from any state or federal health care benefit program.

j) In accordance with 42 C FR §438.610, Subcontractor is prohibited from knowingly having a relationship with an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or an individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.. Subcontractor is prohibited from being controlled by a sanctioned individual under 42 U.S.C. §1320a-7(b)(8). Subcontractor shall comply with all applicable provisions of 42 CFR §438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation. Subcontractor shall screen all employees, contractors, and network providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 C.F.R. §455.436 To help make this determination, the Subcontractor shall search the following websites:

- Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
  http://exclusions.oig.hhs.gov/search.aspx

- System for Award Management
  http://www.sam.gov

- Louisiana Adverse Actions List Search (LAALS)
  http://adverseactions.LDH.la.gov

k) The Subcontractor shall conduct a screen, monthly as described in Section 5 (j) of this Attachment, to capture exclusions and reinstatements that have occurred since the last search. Any and all exclusion information discovered by Subcontractor shall be immediately reported to ACL. Any individual or entity that employs or subcontracts with an excluded individual or entity cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded individual or entity. This prohibition applies even when the Medicaid payment itself is made to another individual or entity who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against individuals or entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR§ 1003.102 (a) (2).

l) The Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply will all federal requirements (42 CFR §1002) on exclusion and debarment screening. All tax-reporting entities that bill and/or receive Louisiana Medicaid funds as the result of the Agreement shall screen their owners and employees against the federal exclusion databases (such as LEIE and System of Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or ACL dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

m) Subcontractor and any of its providers providing services under the Agreement, whether contracted or non-contracted, shall comply with all federal requirements (42 CFR § 455.104 and 42 CFR §438.610) on ownership disclosure reporting and in accordance with RFP Section 2.9.6. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as a result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 C FR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.

n) If Subcontractor receives annual payments from ACL of at least Five Million Dollars ($5,000,000), Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA).

o) The Subcontractor shall have surveillance and utilization control programs and procedures pursuant to 42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Subcontractor shall have internal controls and policies and procedures in place that are designed to prevent, detect and report known or suspected fraud, waste and abuse activities. The Subcontractor shall have methods for identification, investigation and referral of suspected fraud cases.

p) In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, Subcontractor shall report overpayments made by ACL to Subcontractor

and by Subcontractor to its subcontractors and/or providers providing services pursuant to the Agreement.

q) Subcontractor shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly including coordinating with law enforcement agencies, with notice to ACL, if issues are suspected to be criminal in nature , to reduce the potential for reoccurrence, and conduct ongoing compliance with the requirements under this Agreement.

r) Subcontractor shall provide annual training to all employees, and shall train new hires within thirty (30) days of the date of employment, related to the following:

- Subcontractor's Code of Conduct;
- Privacy and Security – HIPAA;
- FWA identification and reporting procedures;
- Federal False Claims Act and employee whistleblower protections; and
- Procedures for timely consistent exchange of information; and collaboration with ACL and LDH; and
- Provisions that comply with 42 CFR §438. 608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

s) Subcontractor shall suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. ACL is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.

6. <u>Employment of Personnel</u>.

a) <u>Non-Discrimination</u>. In the hiring or employment made possible or resulting from the Agreement, Subcontractor agrees that there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, national origin, or sexual orientation. Subcontractor shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts, as applicable to Subcontractor. Subcontractor further agrees that affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all applicable State and federal laws regarding employment of personnel.

b) <u>Restriction on Certain Individuals</u>. For the purposes of providing services under the Agreement, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in –non-procurement activities under regulations

issued under Executive Order 12549 or under its implementing guidelines [42 CFR §438.610(a) and (b), 42 CFR § 1001.1901(b) and 42 CFR§ 1003.102(a)(2)}.

Additionally, Subcontractor shall not employ or contract with any individual or shall terminate contracts with any individual excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 USC §1320a-7) or Section 1156 (42 USC §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. This includes providers undergoing any of the following identified through LDH proceedings:

i. Revocation of the provider's home and community-based services license or behavioral health services license;

ii. Exclusion from the Medicaid program;

iii. Exclusion form the Medicare program;

iv. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review ("SURS") Rule (LAC 50:1.Chapter 41);

v. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:1.Chapter 50); or

vi. The Louisiana Attorney General's Office has seized the assets of the service provider.

c) Screening of Personnel. Subcontractor shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH and its contractors who have access to electronic protected health information on Medicaid applicants and recipients. Subcontractor shall, upon request, provide ACL with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor staff assigned to or proposed to be assigned to any aspect of performance under the Agreement. Subcontractor must also screen all employees and contractors to determine whether any of them have been excluded from participation in federal health care programs.

d) Removal of Personnel. Subcontractor shall remove or reassign, upon written request from ACL or LDH, any Subcontractor employee that ACL or LDH, as applicable, deems to be unacceptable.

7. Cooperation, Care Coordination and Continuity of Care.

a) Care Coordination. Subcontractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to ACL's Medicaid enrollees.

b) Continuity of Care. To the extent applicable to the services provided under the Agreement, Subcontractor shall develop and maintain a process of Continuity of Care

by which ACL's Medicaid enrollees and network and/or non-network provider interactions are effective to ensure that each enrollee has an ongoing source of preventative and primary care appropriate to their needs.

c) Cooperation with Other Service Providers. To the extent applicable to the services provided under the Agreement, Subcontractor shall cooperate and communicate with other service providers who serve Medicaid enrollees in accordance with professional standards. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

d) Cooperation with Other Contractors. In the event that ACL has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, Subcontractor agrees to cooperate fully with such other contractors. Subcontractor shall not commit any act that will interfere with the performance of work by any other contractor. Notwithstanding the foregoing, this provision does not require Subcontractor to relinquish or otherwise surrender any protections, rights or remedies available to it under this Attachment, the Agreement, or under applicable law. Subcontractor's failure to reasonably cooperate and comply with this provision shall be sufficient grounds for ACL to invoke contract remedies for breach arising under this Attachment and under the Agreement.

8. Provider Selection Requirements. To the extent Subcontractor is responsible for the selection and retention of providers:

a) Subcontractor shall have written policies and procedures in accordance with 42 CFR§438.214 to the extent applicable. Subcontractor's selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

b) Subcontractor shall follow the applicable requirements of the State's credentialing and re-credentialing policies including, but not limited to: LDH, Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for specialized behavioral health providers.

c) Subcontractors that specialize in behavioral health are required to be accredited by rule, regulation, waiver or State Plan Amendment ("SPA") prior to contracting with ACL or prior to receiving Medicaid reimbursement, and shall comply with: all requirements of ACL,; CMS approved waivers; and/or the SPAs.

d) Subcontractors that specialize in behavioral health shall provide ACL with proof of accreditation from one of the following LDH approved national accrediting body:

- Council on Accreditation;
- Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- The Joint Commission ("TJC").

e) Subcontractor shall have a re-credentialing policy which includes, but is not limited to, notifying ACL when Subcontractor denies a provider credentialing application or

disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to provide services under the Agreement for program integrity reasons.

f) Subcontractor shall notify ACL, regarding itself or any of its providers or subcontractors, and shall furnish documentation from the accreditation body within twenty-four (24) hours of the following: loss of accreditation, license or certification; suspension; or any action that could result in the loss of accreditation.

g) If Subcontractor or any provider of Subcontractor performs laboratory services under the Agreement, the Subcontractor or provider of Subcontractor must meet all applicable State requirements and 42 CFR §§ 493.1 and 493.3, and any other Federal requirements.

h) All provider contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated to Subcontractor under the Agreement.

i) Subcontractor's provider contract forms may be subject to review and approval by LDH; and LDH shall have the right to review and approve or disapprove any and all provider contracts entered into by Subcontractor for the provision of any services under the Agreement. Provider contracts must include the Bayou Health Provider Subcontract Requirements set forth in this Attachment, as may be modified by LDH from time to time.

j) Provider contracts must contain a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with Section 2.20 of the State Contract.

k) Subcontractor shall deny payments to providers for Provider Preventable Conditions (as such term is defined in the RFP).

l) Subcontractor shall not execute provider contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§1128 or 1156 of the Social Security Act (42 U.S.C. §1320a-7, 42 U.S.C. §1320c-5), or who are otherwise barred from participation in the Medicaid and/or Medicare program. Subcontractor shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from non-procurement activities under regulations issued under Executive Orders.

m) Subcontractor shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the provider contract, for the following: (i) the enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (ii) any information the enrollee needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions. Violation by Subcontractor of the anti-gag provisions of 42 U.S.C. §1932(b)(3)(D) may subject the Subcontractor to intermediate sanctions.

n) Subcontractor shall provide written notification to ACL of its intent to terminate any provider contract that may materially impact Subcontractor's provider network

and/or operations, as soon as possible but no later than five (5) business days prior to the effective date of termination, so that ACL may fulfill its reporting requirements to LDH. In the event Subcontractor terminates a provider contract for cause, the Subcontractor shall provide immediate written notice to ACL of the termination.

9. **Physician Incentive Plans**. Subcontractor's Physician Incentive Plans ("PIP") shall be incompliance with 42 CFR § 438.3(i).

a) Subcontractor shall disclose to ACL annually any PIP or risk arrangements Subcontractor may have with physicians, either through a group practice arrangement or with individual physicians, even if there is no substantial financial risk between Subcontractor and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low.

b) Subcontractor shall provide written notification to ACL within thirty (30) days upon implementation of any new PIP or when an existing PIP is modified. The written notification must: (i) list the participating providers; and (ii) certify that the terms and conditions of the PIP are compliant with all applicable federal regulations.

c) Subcontractor shall furnish, upon request of ACL, additional information including, but not limited to, a copy of the PIP.

10. **Provider Preventable Conditions.** Subcontractor shall report to ACL, within seventy-two (72) hours, any provider preventable conditions ("PPCs") associated with claims for payment or enrollee treatment for which payment would otherwise be made. PPCs include: (i) Healthcare Acquired Conditions; and (ii) Other Provider Preventable Conditions, as defined by Section 2.11.10 of the State Contract..

11. **National Provider Identifier (NPI).** The HIPAA Standard Unique Health Identifier regulations (45 CFR §162, Subparts A and D) require that all covered entities (health care clearinghouses and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from that National Plan and Provider Enumeration System (NPPES). To the extent applicable, Subcontractor shall obtain such NPI, and shall submit its NPI, and those of any of Subcontractor's providers, as applicable, to ACL upon request.

12. **ACL Enrollee Hold Harmless.** Subcontractor shall accept the final payment made by ACL as payment-in-full for covered services provided under the Agreement. Subcontractor hereby agrees not to bill, charge, collect a deposit from, seek cost-sharing or other forms of compensation, remuneration or reimbursement from, or solicit or accept any surety or guarantee of payment from, or have recourse against LDH, ACL enrollees or persons acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the enrollee), for health care services which are rendered to such enrollees by Subcontractor and its contractors, and which are covered services under the Louisiana Medicaid program. ACL enrollees shall not be held liable for payment for covered services furnished under a provider contract, referral or other arrangement, to the extent that those payments would be in excess of the amount that the enrollee would owe if the Subcontractor provided the services directly. Subcontractor agrees that this provision is

applicable in all circumstances including, but not limited to, non-payment by ACL or the insolvency of ACL. Subcontractor further agrees that LDH or ACL enrollees shall not be held liable for the costs of any and all services provided by Subcontractor and its contractors whose service is not covered by ACL or does not obtain timely approval or authorization. This Section 12 shall be construed to be for the benefit of ACL's enrollees. This Section 12 supersedes any oral or written contrary agreement now existing or hereafter entered into between Subcontractor and ACL's enrollees, or persons acting on their behalf.

13. **Enrollee Access.** Subcontractor and any providers providing services under the Agreement shall not restrict enrollee access to needed drugs and pharmaceutical products by requiring members to use mail order pharmacy providers.

14. **Enrollee Rights**. Subcontractor shall assist enrollees in understanding their rights to file grievances and appeals in accordance with ACL's Provider Manual.

    a) To the extent applicable, Subcontractor shall have a grievance system in place to address ACL enrollee grievances including, but not limited to the following:

        i. the referral of the enrollee to a designee of the Subcontractor authorized to review and respond to grievances and appeals that require corrective action; and

        ii. the provision of information explaining Enrollee Rights to file grievances, appeals and request a State Fair Hearing, in accordance with 42 CFR Part 438, Subpart F, both orally and in writing in a language that the Enrollee understands.

15. **Disputes.** Subcontractor and ACL shall be responsible for resolving any disputes that may arise between the parties, and no dispute between the parties shall disrupt or interfere with the provisions of services to ACL enrollee.

16. **ACL Enrollee Copayments**. Subcontractor shall not impose copayments for the following: (i) Family planning services and supplies; (ii) Emergency services; and (iii) Services provided to:

- Individuals younger than 21 years old;
- Pregnant women;
- Individuals who are impatient in long-term care facilities or other institutions;
- Native Americans; and
- Alaskan Eskimos.

To the extent that emergency services, as defined by the RFP, are provided by Subcontractor or any providers of Subcontractor, the emergency services shall be coordinated without the requirement of ACL prior authorization of any kind.

17. **ACL Enrollee Non-Discrimination.** Subcontractor shall not discriminate in the provision of services to ACL's enrollees. Subcontractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin or basis of health status or need for health care services, shall be excluded from participation in, or be denied benefits of ACL's program or be otherwise subjected to discrimination in the performance of the Agreement. This provision shall be included in all provider contracts, as applicable to Subcontractor.

18. **Marketing and Enrollee Education.** All Marketing (as such term is defined in the RFP) and enrollee education materials and activities conducted and/or furnished by Subcontractor shall comply with the requirements of 42 CFR §438.10 and with the LDH requirements as set forth in the RFP, including but not limited to the following:

a) All Marketing and enrollee education materials (print and multimedia) that Subcontractor plans to distribute that are directed at Medicaid eligibles or potential eligibles, and all marketing and enrollee education events and activities for potential or current enrollees, as well as any community/health education activities that are focused on health care benefits (such as health fairs or other health education and promotion activities) are subject to prior review and approval by LDH. ACL, and not Subcontractor, is responsible for obtaining LDH approval, and Subcontractor shall provide all such materials to ACL for submission to LDH. Subcontractor may not distribute any ACL marketing or enrollee education materials, or participate in any marketing and enrollee education events and activities, without ACL having received LDH consent.

b) In carrying out any Marketing or enrollee education activities: (i) Subcontractor is prohibited from engaging in the activities enumerated in Section 2.14.2 of the State Contract; but (ii) Subcontractor's Marketing and enrollee education activities may include those activities enumerated in Section 2.14.3 of the State Contract.

19. Misuse of Symbols, Emblems or Names in Reference to Medicaid. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast or other production, alone or with other words, letters, symbols or emblems, the words "Louisiana Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing," unless prior written approval is obtained from LDH. Specific written authorization from LDH is required to reproduce, reprint or distribute any LDH form, application or publication for a fee. Each piece of mail or information issued in violation of the foregoing constitutes a violation.

20. Confidentiality of Information.

a) Subcontractor shall ensure that medical records and any and all other health and enrollment information relating to enrollees or potential enrollees, which is provided to or obtained by or through Subcontractor's performance under the Agreement, whether verbal, written, electronic file or otherwise, shall be protected as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164, and other applicable State and Federal laws, LDH policies or the Agreement. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under the Agreement.

b) All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of ACL, LDH or the enrollee/potential enrollee, unless otherwise permitted by HIPAA or required by applicable state or federal laws or regulations; provided, that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollees/potential enrollees shall be limited to purposes directly connected with the administration of the Agreement.

c) Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To the extent that Subcontractor is a business associate (as defined in HIPAA) of ACL, the Subcontractor's use and disclosure of protected health information (PHI, as defined in HIPAA) shall be governed by the terms and conditions set forth in the Business

Associate Agreement Addendum attached to the Agreement.

d) All financial, statistical, personal, technical and other data and information relating to ACL's and/or LDH's operation which are designated confidential by ACL and/ or LDH and made available to Subcontractor in carrying out Subcontractor responsibilities shall be protected by the Subcontractor from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to ACL. The identification of all such confidential data and information as well as ACL's procedural requirements for protection of such data and information from unauthorized use and disclosure shall be provided by ACL in writing to Subcontractor. The Subcontractor shall not be required under provisions of this paragraph to keep confidential any data or information which is or becomes publicly available, is already rightfully in the Subcontractor's possession, is independently developed by the Subcontractor outside the scope of the Agreement, or is rightfully obtained from third parties.

e) Under no circumstance shall the Subcontractor discuss and/or release information to the media concerning the Agreement, State Contract or the Bayou Health Program without prior express written approval of ACL and, to the extent required, LDH.

21. **Safeguarding Information.** Subcontractor shall establish written safeguards, according to applicable state and federal laws and regulations and as described in the State Contract, which restrict the use and disclosure of information concerning enrollees or potential enrollees, to purposes directly connected with the performance of the Agreement. Subcontractor's written safeguards shall:

a) be comparable to those imposed upon LDH by 42 CFR Part 431, Subpart F and La. R.S.46:56;

b) state that the Subcontractor will identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

c) require a written authorization from the enrollees or potential enrollee before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR 164.508;

d) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

e) specify appropriate personnel actions to sanction violators.

22. **LDH Use of Data.** Notwithstanding any provision in this Attachment or the Agreement to the contrary, LDH shall have unlimited rights to use, disclose or duplicate, for any purpose, all information and data developed, derived, documented or furnished by Subcontractor resulting from the Agreement.

23. **Record Retention.**

a) Financial Records. Subcontractor shall retain all financial records, supporting documents, statistical records, and all other records for a period of at least ten (10) years from date of submission of the final expenditure report under the Agreement, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.. The only exceptions are the following:

i. If any litigation, claim, financial management review, or audit is started before the expiration of the ten (10) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

ii. Records for real property and equipment acquired with federal funds shall be retained for ten (10) years after final disposition;

iii. When records are transferred to or maintained by LDH, the ten (10) year retention requirement is not applicable to the recipient; and

iv. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 C.F.R. §75.361(f).

Under no circumstances shall Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

b) Medical Records. All documentation and/or records maintained by Subcontractors, and its network providers related to covered services, charges, operations and agreements under this Agreement shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Under no circumstances shall the Subcontractor destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of LDH.

24. **Independent Audits.** Subcontractor, if performing a key internal control, shall, at its own expense, submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm must conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by ACL or LDH, the subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

25. **Information System Availability.** Subcontractor shall allow LDH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by LDH or the Louisiana Attorney General's Office or upon request of CMS, direct access to its data for the purpose of data mining and review. Access shall be granted within thirty (30) calendar days of the request. The data shall include the following or any additional data requested by LDH:

- Prior authorizations;
- Claims processing;
- Provider portal;
- Third-party Liability;
- FWA;
- Pharmacy benefits manager point of sale;
- Pharmacy benefits manager prior authorization; and

- Provider contracting and credentialing.

26. **Notice of Adverse Results.** Subcontractors shall immediately notify ACL in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform services under the Agreement.

27. **Release of Records.** Subcontractor shall release medical records of enrollees upon request by enrollees or authorized representative, as may be directed by authorized personnel of ACL, LDH, appropriate agencies of the State of Louisiana or the U.S. Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in the Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to: L a. R.S. 40:1299.96, La. R.S. 13:3734 and La.C.Ev. Art. 510, and 45 CFR Parts 160 and 164 (the HIPAA Privacy Rule) and subject to reasonable charges. Subcontractor shall not charge ACL, LDH or the Bureau of Health Services Financing or their designated agent for any copies requested.

28. **Insurance.** Subcontractor shall not commence work under the Agreement until it has obtained all required insurance, including but not limited to the necessary liability, malpractice, and workers' compensation insurance as is necessary to adequately protect ACL's members and ACL; Subcontractor shall provide ACL with certificates evidencing such coverage upon execution of the Agreement and thereafter, upon request. If so requested, Subcontractor shall submit executed copies of its insurance policies for inspection and approval by LDH before work under the Agreement is commenced. Subcontractor's insurance policies shall not be canceled, permitted to expire or be changed without thirty (30) days' advance notice. Ten (10) calendar days' written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in Subcontractor's policy. In addition, Subcontractor is required to notify ACL of policy cancellations or reductions in limits. ACL shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy of Subcontractor; and the payment of such a deductible shall be the sole responsibility of the Subcontractor. The insurance companies issuing the policies shall have no recourse against LDH for payment of premiums or for assessments under any form of the policies. Except for workers' compensation, all insurance shall be placed with insurers with an A.M. Best rating of not less an A-VI.

a) Workers' Compensation Insurance. Subcontractor shall obtain and maintain during the life of the Agreement, workers' compensation insurance, with a limit of One Million Dollars ($1,000,000) per accident/per disease/per employee or the minimum levels of coverage required by law, whichever is greater, for all of Subcontractor's employees that provide services under the Agreement. Subcontractor shall furnish proof of adequate coverage upon request.

b) Commercial Liability Insurance. During the life of the Agreement, Subcontractor shall maintain commercial general liability ("CGL") insurance which shall protect the Subcontractor, ACL, LDH any subcontractor during the Subcontractor's performance of work under the Agreement from claims or damages for personal injury, including accidental death, as well as for claims for property damages that may arise from operations under the Agreement, whether such operations be by the Subcontractor or by anyone directly or indirectly employed by Subcontractor, or that may otherwise impose liability on LDH. Such Insurance shall name ACL and LDH as additional insureds for claims arising from or resulting from the operations of Subcontractor under the Agreement. Subcontractor's CGL coverage shall include bodily injury, property damage and contractual liability, with a minimum limit per occurrence of Two Million Dollars ($2,000,000) and a minimum general aggregate of Four Million Dollars ($4,000,000) or

the minimum level of coverage required by law, whichever is greater. If so determined by LDH, and if applicable to Subcontractor, special hazards (as identified by LDH) may be covered by a rider or riders to the CGL policy, or by separate policies of insurance.

c) Errors & Omissions Insurance. Subcontractor shall obtain and maintain in force for the duration of the Agreement, Errors & Omissions insurance which covers the professional acts or omissions of Subcontractor in the amount of at least Three Million Dollars ($3,000,000) per occurrence.

d) Automobile Liability. Automobile Liability Insurance shall have a minimum combined single limit per accident of $1,000,000. ISO form number CA 00 01 (current form approved for use in Louisiana), or equivalent, is to be used in the policy. This insurance shall include third-party bodily injury and property damage liability for owned, hired and non-owned automobiles.

e) Cyber Liability Cyber liability insurance, including first-party costs, due to an electronic breach that compromises the State's confidential data shall have a minimum limit per occurrence of $3,000,000. Claims-made coverage is acceptable. The date of the inception of the policy shall be no later than the first date of the anticipated work under this Contract. It shall provide coverage for the duration of this Contract and shall have an expiration date no earlier than thirty (30) calendar days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premium.

f) The policies are to contain, or be endorsed to contain, the following provisions:

1. Commercial General Liability, Automobile Liability, and Cyber Liability Coverages
   LDH, its officers, agents, employees and volunteers shall be named as an additional insured as regards negligence by Subcontractor. ISO Forms CG 20 10 (for ongoing work) AND CG 20 37 (for completed work) (current forms approved for use in Louisiana), or equivalents, are to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to LDH. Subcontractor's insurance shall be primary with respect to LDH, its officers, agents, employees and volunteers for any and all losses that occur under the Contract. Any insurance or self-insurance maintained by LDH shall be in excess and non-contributory of the Contractor's insurance.

2. Workers Compensation and Employers Liability Coverage
   To the fullest extent allowed by law, the insurer shall agree to waive all rights of subrogation against LDH, its officers, agents, employees and volunteers for losses arising from work performed by the Subcontractor for LDH.

29. Hold Harmless. Subcontractor shall indemnify, defend, protect and hold harmless LDH, and any of its officers, agents and employees, from and against:

a) Any claims for damages or losses arising from services rendered by Subcontractor or any of its contractors, persons, or firms performing or supplying services, materials, or supplies to ACL in connection with the performance of this Agreement;

b) Any claims for damages or losses arising from sanctions on ACL network providers and enrollees, including, but not limited to, termination or exclusion from the network, in accordance with provisions in the Fraud, Waste, and Abuse Prevention Section of the State Contract.

c) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Subcontractor in the performance of this Agreement;

d) Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor, it's agents, officers, employees, or subcontractors by Subcontractor's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes;

e) Any claims for damages or losses arising from failure by Subcontractor, it's agents, officers, employees or subcontractors to comply with applicable federal or state laws, including, but not limited to, state and federal Medicaid laws and regulations, labor laws and minimum wage laws, or to comply with any applicable consent decrees, settlements, or adverse judicial determinations;

f) Any claims for damages, losses, reasonable costs, or attorney fees, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with non-compliance with any judgment, settlement, court order, or consent decree, for which the responsibility for compliance has been delegated to the Subcontractor by ACL;

g) Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of ACL or LDH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

h) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against ACL or LDH or their agents, officers, or employees, through the intentional conduct, negligence, or omission of the Subcontractor, its agents, officers, employees, or subcontractors.

i) If the Subcontractor performs services, or uses services, in violation of Section 38, the Subcontractor shall be in material breach of this Agreement and shall be liable to LDH and ACL for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Subcontractor shall be required to hold harmless and indemnify LDH pursuant to the indemnification provisions of this Contract.

ACL will provide prompt notice of any claim against it that is subject to indemnification by Subcontractor under the Agreement. Subcontractor, at its sole option and at its sole expense, may assume the defense of any such claim; provided, however, that Subcontractor may not settle or compromise any claim subject to indemnification hereunder without the advance written consent of ACL, which shall not be unreasonably withheld.

30. **Penalties and Sanctions; Corrective Actions.** Subcontractor agrees that failure to comply with the provisions of the Agreement may result in the assessment of monetary penalties or sanctions against ACL or reductions in payment to ACL, which ACL may in turn impose upon Subcontractor to the extent arising from Subcontractor's acts or omissions, which shall include, but may not be limited to Subcontractor's failure or refusal to respond to ACL's request for information and, as applicable, to provide medical records and/or credentialing information. Subcontractor's failure to comply with the provisions of the Agreement may also result in the termination of the State Contract in whole or in part, which shall result in termination of the Agreement. At ACL's discretion or a directive by LDH, ACL shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

a) Subcontractor shall indemnify ACL against any monetary penalties, administrative actions or sanctions that may be imposed on ACL to the extent attributable to the acts and/or omissions of Subcontractor. In lieu of reimbursement of monetary penalties, ACL may require Subcontractor to pay such penalties directly.

b) Subcontractor shall comply with any relevant corrective action plan imposed upon or developed by ACL and/or required by LDH in response to identified deficiencies under the State Contract. ACL may further require a corrective action plan of Subcontractor for deficiencies in Subcontractor's performance notwithstanding that LDH has not imposed the requirement on ACL.

31. **Loss of Federal Financial Participation ("FFP").** Subcontractor agrees to be liable of any loss of FFP suffered by LDH due to Subcontractor's, or any of its contractors', failure to perform the services as required under the Agreement.

32. **Warranty of Removal of Conflict of Interest.** Subcontractor hereby warrants that it, its officers and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Agreement. Subcontractor shall periodically inquire of its officers and employees concerning such conflicts, and shall promptly inform ACL of any potential or actual conflict(s). Subcontractor warrants that any conflict of interest will be removed prior to signing the Agreement and during the term of the Agreement.

33. **Political Activity.** None of the funds, materials, property or services provided directly or indirectly under the Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the Hatch Act.

34. **Prohibited Payments.** Payments under the Agreement may not be made for: (a) organ transplants, unless the State Plan has written standards meeting coverage guidelines specified; (b) non-emergency services provided by or under the direction of an excluded individual; (c) any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (d) any amount expended for roads, bridges, stadiums or any other item or service not covered under a state plan; and (e) any amount expended for home health care services unless the organization furnishing such services provides the appropriate surety bond.

35. **Emergency Management Plan.** Subcontractor shall have in place an emergency management plan, specifying the actions that Subcontractor will conduct to ensure the ongoing provision of health services in an epidemic, disaster or man-made emergency, including but not limited to localized acts of nature, accidents and technological and/or attack-related emergencies.

36. **Force Majeure.** In the event of circumstances not reasonably within the control of Subcontractor or ACL (e.g., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither ACL nor Subcontractor will have any liability or obligation on account of reasonable delay in the provision or arrangement of services under the Agreement. Notwithstanding, as long as the Agreement remains in full force and effect, Subcontractor shall be responsible for the services required to be provided or arranged for in accordance with the Agreement.

37. **Termination for Threat to Health of ACL Enrollees.** LDH or ACL may terminate the Agreement immediately if it is determined that actions by Subcontractor pose a serious threat to the health of ACL's enrollees.

38. **Homeland Security Considerations.** Subcontractor shall perform the services to be provided under the Agreement entirely within the boundaries of the United States. The term "United States" includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Subcontractor will not hire any individual to perform any services under the Agreement if that individual is required to have a work visa approved by the U.S.

Department of Homeland Security and such individual has not met this requirement. If Subcontractor performs or uses services in violation of this restriction, Subcontractor shall be in material breach of the Agreement and shall be liable for any costs, fees, damages, claims or expenses incurred by ACL or LDH, and shall be required to indemnify ACL and LDH pursuant to the indemnification provisions of the Agreement. The provisions of this paragraph shall apply to any and all agents and contractors used by Subcontractor to perform any services under the Agreement.

39. Independent Contractor/Subcontractors. It is expressly agreed that Subcontractor and any of its contractors, agents, officers, employees and representatives are acting in an independent capacity in the performance of the Agreement, and not as officers, agents or employees, whether express or implied, of ACL, LDH or the State of Louisiana. It is further expressly agreed that the Agreement shall not be construed as a partnership or joint venture between Subcontractor or any of its contractors and either ACL or LDH or the State of Louisiana.

Subcontractor shall not, without prior approval of ACL, enter into any subcontract or other agreement for any of the work contemplated under the Agreement without approval of ACL.

40. Licensing Requirements. Subcontractor is required to be currently licensed and/or certified under applicable State and Federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the services and/or other related activities delegated by ACL under the Agreement.

41. Entire Contract; Amendments. Subcontractor shall comply with, and agrees to be bound by, all provisions of theAgreement and shall act in good faith in the performance of the provisions of the Agreement.

The Agreement and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing.

Except as provided in Section 3, any amendments, alterations, variations, modifications, waivers or extensions of the termination date, or early termination of the Agreement shall only be valid when reduced to writing, duly signed and attached to the Agreement.

42. Restrictions on Contracting. Nothing in the Agreement shall be construed to restrict Subcontractor from contracting with another Managed Care Organization or other managed care entity for the services contracted under the Agreement.

43. Antitrust. Subcontractor and Subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or program mechanism, including but not limited to product units purchased or reimbursed under the Louisiana Medicaid managed care program.. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

44. Termination of LDH Contract. Subcontractor recognizes that, in the event of termination of the State Contract for any of the reason described in the State Contract, ACL shall immediately make available to LDH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to ACL's and Subcontractor's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to LDH. Accordingly, in furtherance of such ACL obligations, and upon request by ACL, Subcontractor agrees to make available to ACL and/or LDH or their respective designated representatives, in a u sable form at no cost, any and all records, whether medical or financial, related to Subcontractor's activities undertaken pursuant to the Agreement.

45. **Law.** This Attachment shall be governed by the laws of the State of Louisiana, without regard to its conflict of law provision, and Louisiana law will prevail if there is a conflict between the state law where the Subcontractor is based and Louisiana law.

Attachment 2.10.2.5-1 NCQA Certificate of Accreditation

This page is intentionally left blank.

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

AmeriHealth Caritas Louisiana

Medicaid HMO

an accreditation status of

Commendable

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

05/17/2018	05/17/2021
DATE GRANTED	EXPIRATION DATE

This page is intentionally left blank.

Attachments to 2.10.7 Provider Network

Delivering the Next **Generation** of Health Care

Transforming Louisiana health with innovation & leadership

Walking the path with our enrollees every day

Collaboratively delivering integrated person-centered care

Investing & scaling community-based care efforts to expand access

Simplifying provider & LDH relationships to focus on quality care

AmeriHealth Caritas™
Louisiana

Attachment 2.10.7.1-1 Provider Network Listing

Attachment submitted electronically per Addendum 2 Question #8.

This page is intentionally left blank.

Attachment 2.10.7.2-1 Provider Network Capacity

Attachment submitted electronically per Addendum 2 Question #8.

This page is intentionally left blank.

Attachments to 2.10.11 Quality

Delivering the Next
Generation
of Health Care

Transforming Louisiana health with innovation & leadership

Walking the path with our enrollees every day

Collaboratively delivering integrated person-centered care

Investing & scaling community-based care efforts to expand access

Simplifying provider & LDH relationships to focus on quality care

AmeriHealth Caritas™
Louisiana

Attachment 2.10.11.5-1 Sample Clinical Practice Guideline — Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents.

This page is intentionally left blank.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Guidance for the Clinician in Rendering Pediatric Care

CLINICAL PRACTICE GUIDELINE

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

KEY WORDS

attention-deficit/hyperactivity disorder, children, adolescents, preschool, behavioral therapy, medication

ABBREVIATIONS

AAP—American Academy of Pediatrics
ADHD—attention-deficit/hyperactivity disorder
DSM-PC—*Diagnostic and Statistical Manual for Primary Care*
CDC—Centers for Disease Control and Prevention
FDA—Food and Drug Administration
DSM-IV—*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*
MTA—Multimodal Therapy of ADHD

The recommendations in this report do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

www.pediatrics.org/cgi/doi/10.1542/peds.2011-2654

doi:10.1542/peds.2011-2654

All clinical practice guidelines from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

abstract

FREE

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and can profoundly affect the academic achievement, well-being, and social interactions of children; the American Academy of Pediatrics first published clinical recommendations for the diagnosis and evaluation of ADHD in children in 2000; recommendations for treatment followed in 2001. *Pediatrics* 2011;128:000

Summary of key action statements:

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).
2. To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria have been met (including documentation of impairment in more than 1 major setting); information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).
3. In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).
4. The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

5. Recommendations for treatment of children and youth with ADHD vary depending on the patient's age:
   a. For *preschool-aged children (4–5 years of age)*, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).
   b. For *elementary school–aged children (6–11 years of age)*, the primary care clinician should prescribe US Food and Drug Administration–approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.
   c. For *adolescents (12–18 years of age)*, the primary care clinician should prescribe Food and Drug Administration–approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.
6. The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

INTRODUCTION

This document updates and replaces 2 previously published clinical guidelines from the American Academy of Pediatrics (AAP) on the diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) in children: "Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder" (2000)[1] and "Clinical Practice Guideline: Treatment of the School-aged Child With Attention-Deficit/Hyperactivity Disorder" (2001).[2] Since these guidelines were published, new information and evidence regarding the diagnosis and treatment of ADHD has become available. Surveys conducted before and after the publication of the previous guidelines have also provided insight into pediatricians' attitudes and practices regarding ADHD. On the basis of an increased understanding regarding ADHD and the challenges it raises for children and families and as a source for clinicians seeking to diagnose and treat children, this guideline pays particular attention to a number of areas.

Expanded Age Range

The previous guidelines addressed diagnosis and treatment of ADHD in children 6 through 12 years of age. There is now emerging evidence to expand the age range of the recommendations to include preschool-aged children and adolescents. This guideline addresses the diagnosis and treatment of ADHD in children 4 through 18 years of age, and attention is brought to special circumstances or concerns in particular age groups when appropriate.

Expanded Scope

Behavioral interventions might help families of children with hyperactive/impulsive behaviors that do not meet full diagnostic criteria for ADHD. Guidance regarding the diagnosis of problem-level concerns in children based on the *Diagnostic and Statistical Manual for Primary Care* (DSM-PC), *Child and Adolescent Version*,[3] as well as suggestions for treatment and care of children and families with problem-level concerns, are provided here. The current DSM-PC was published in 1996 and, therefore, is not consistent with intervening changes to *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). Although this version of the DSM-PC should not be used as a definitive source for diagnostic codes related to ADHD and comorbid conditions, it certainly may continue to be used as a resource for enriching the understanding of ADHD manifestations. The DSM-PC will be revised when both the DSM-V and ICD-10 are available for use.

A Process of Care for Diagnosis and Treatment

This guideline and process-of-care algorithm (see Supplemental Fig 2 and Supplemental Appendix) recognizes evaluation, diagnosis, and treatment as a continuous process and provides recommendations for both the guideline and the algorithm in this single publication. In addition to the formal recommendations for assessment, diagnosis, and treatment, this guideline

provides a single algorithm to guide the clinical process.

Integration With the Task Force on Mental Health

This guideline fits into the broader mission of the AAP Task Force on Mental Health and its efforts to provide a base from which primary care providers can develop alliances with families, work to prevent mental health conditions and identify them early, and collaborate with mental health clinicians.

The diagnosis and management of ADHD in children and youth has been particularly challenging for primary care clinicians because of the limited payment provided for what requires more time than most of the other conditions they typically address. The procedures recommended in this guideline necessitate spending more time with patients and families, developing a system of contacts with school and other personnel, and providing continuous, coordinated care, all of which is time demanding. In addition, relegating mental health conditions exclusively to mental health clinicians also is not a viable solution for many clinicians, because in many areas access to mental health clinicians to whom they can refer patients is limited. Access in many areas is also limited to psychologists when further assessment of cognitive issues is required and not available through the education system because of restrictions from third-party payers in paying for the evaluations on the basis of them being educational and not health related.

Cultural differences in the diagnosis and treatment of ADHD are an important issue, as they are for all pediatric conditions. Because the diagnosis and treatment of ADHD depends to a great extent on family and teacher perceptions, these issues might be even more prominent an issue for ADHD. Specific cultural issues are beyond the scope of this guideline but are important to consider.

METHODOLOGY

As with the 2 previously published clinical guidelines, the AAP collaborated with several organizations to develop a working subcommittee that represented a wide range of primary care and subspecialty groups. The subcommittee included primary care pediatricians, developmental-behavioral pediatricians, and representatives from the American Academy of Child and Adolescent Psychiatry, the Child Neurology Society, the Society for Pediatric Psychology, the National Association of School Psychologists, the Society for Developmental and Behavioral Pediatrics, the American Academy of Family Physicians, and Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD), as well as an epidemiologist from the Centers for Disease Control and Prevention (CDC).

This group met over a 2-year period, during which it reviewed the changes in practice that have occurred and issues that have been identified since the previous guidelines were published. Delay in completing the process led to further conference calls and extended the years of literature reviewed in order to remain as current as possible. The AAP funded the development of this guideline; potential financial conflicts of the participants were identified and taken into consideration in the deliberations. The guideline will be reviewed and/or revised in 5 years unless new evidence emerges that warrants revision sooner.

The subcommittee developed a series of research questions to direct an extensive evidence-based review in partnership with the CDC and the University of Oklahoma Health Sciences Center. The diagnostic review was conducted by the CDC, and the evidence was evaluated in a combined effort of the AAP, CDC, and University of Oklahoma Health Sciences Center staff. The treatment-related evidence relied on a recent evidence review by the Agency for Healthcare Research and Quality and was supplemented by evidence identified through the CDC review.

The diagnostic issues were focused on 5 areas:

1. ADHD prevalence—specifically: (*a*) What percentage of the general US population aged 21 years or younger has ADHD? (*b*) What percentage of patients presenting at pediatricians' or family physicians' offices in the United States meet diagnostic criteria for ADHD?
2. Co-occurring mental disorders—of people with ADHD, what percentage has 1 or more of the following co-occurring conditions: sleep disorders, learning disabilities, depression, anxiety, conduct disorder, and oppositional defiant disorder?
3. What are the functional impairments of children and youth diagnosed with ADHD? Specifically, in what domains and to what degree do youth with ADHD demonstrate impairments in functional domains, including peer relations, academic performance, adaptive skills, and family functioning?
4. Do behavior rating scales remain the standard of care in assessing the diagnostic criteria for ADHD?
5. What is the prevalence of abnormal findings on selected medical screening tests commonly recommended as standard components of an evaluation of a child with suspected ADHD? How accurate are these tests in the diagnosis of ADHD compared with a reference standard (ie, what are the psychometric properties of these tests)?

The treatment issues were focused on 3 areas:

1. What new information is available

regarding the long-term efficacy and safety of medications approved by the US Food and Drug Administration (FDA) for the treatment of ADHD (stimulants and nonstimulants), and specifically, what information is available about the efficacy and safety of these medications in preschool-aged and adolescent patients?

2. What evidence is available about the long-term efficacy and safety of psychosocial interventions (behavioral modification) for the treatment of ADHD for children, and specifically, what information is available about the efficacy and safety of these interventions in preschool-aged and adolescent patients?
3. Are there any additional therapies that reach the level of consideration as evidence based?

Evidence-Review Process for Diagnosis

A multilevel, systematic approach was taken to identify the literature that built the evidence base for both diagnosis and treatment. To increase the likelihood that relevant articles were included in the final evidence base, the reviewers first conducted a scoping review of the literature by systematically searching literature using relevant key words and then summarized the primary findings of articles that met standard inclusion criteria. The reviewers then created evidence tables that were reviewed by content-area experts who were best able to identify articles that might have been missed through the scoping review. Articles that were missed were reviewed carefully to determine where the abstraction methodology failed, and adjustments to the search strategy were made as required (see technical report to be published). Finally, although published literature reviews did not contribute directly to the evidence base, the articles included in review articles were cross-referenced with the final evidence tables to ensure that all relevant articles were included in the final evidence tables.

For the scoping review, articles were abstracted in a stratified fashion from 3 article-retrieval systems that provided access to articles in the domains of medicine, psychology, and education: PubMed (www.ncbi.nlm.nih.gov/sites/entrez), PsycINFO (www.apa.org/pubs/databases/psycinfo/index.aspx), and ERIC (www.eric.ed.gov). English-language, peer-reviewed articles published between 1998 and 2009 were queried in the 3 search engines. Key words were selected with the intent of including all possible articles that might have been relevant to 1 or more of the questions of interest (see the technical report to be published). The primary abstraction included the following terms: "attention deficit hyperactivity disorder" or "attention deficit disorder" or "hyperkinesis" and "child." A second, independent abstraction was conducted to identify articles related to medical screening tests for ADHD. For this abstraction, the same search terms were used as in the previous procedure along with the additional condition term "behavioral problems" to allow for the inclusion of studies of youth that sought to diagnose ADHD by using medical screening tests. Abstractions were conducted in parallel fashion across each of the 3 databases; the results from each abstraction (complete reference, abstract, and key words) were exported and compiled into a common reference database using EndNote 10.0.[4] References were subsequently and systematically deduplicated by using the software's deduplication procedure. References for books, chapters, and theses were also deleted from the library. Once a deduplicated library was developed, the semifinal database of 8267 references was reviewed for inclusion on the basis of inclusion criteria listed in the technical report. Included articles were then pulled in their entirety, the inclusion criteria were reconfirmed, and then the study findings were summarized in evidence tables. The articles included in relevant review articles were revisited to ensure their inclusion in the final evidence base. The evidence tables were then presented to the committee for expert review.

Evidence-Review Process for Treatment

In addition to this systematic review, for treatment we used the review from the Agency for Healthcare Research and Quality (AHRQ) Effective Healthcare Program "Attention Deficit Hyperactivity Disorder: Effectiveness of Treatment in At-Risk Preschoolers; Long-term Effectiveness in All Ages; and Variability in Prevalence, Diagnosis, and Treatment."[5] This review addressed a number of key questions for the committee, including the efficacy of medications and behavioral interventions for preschoolers, children, and adolescents. Evidence identified through the systematic evidence review for diagnosis was also used as a secondary data source to supplement the evidence presented in the AHRQ report. The draft practice guidelines were developed by consensus of the committee regarding the evidence. It was decided to create 2 separate components. The guideline recommendations were based on clear characterization of the evidence. The second component is a practice-of-care algorithm (see Supplemental Fig 2) that provides considerably more detail about how to implement the guidelines but is, necessarily, based less on available evidence and more on consensus of the committee members. When data were lacking, particularly in the

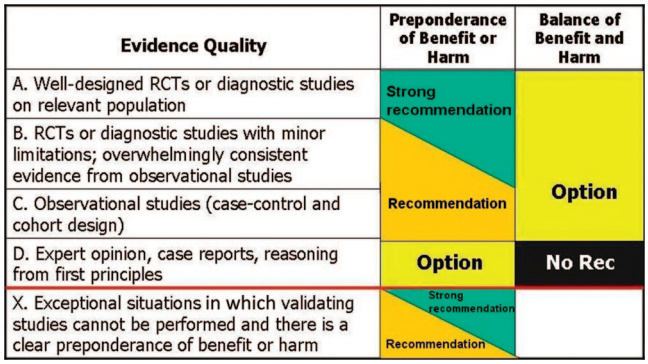


FIGURE 1

Integrating evidence-quality appraisal with an assessment of the anticipated balance between benefits and harms if a policy is conducted leads to designation of a policy as a strong recommendation, recommendation, option, or no recommendation. The evidence is discussed in more detail in a technical report that will follow in a later publication. RCT indicates randomized controlled trial; Rec, recommendation.

process-of-care algorithmic portion of the guidelines, a combination of evidence and expert consensus was used. Action statements labeled "strong recommendation" or "recommendation" were based on high- to moderate-quality scientific evidence and a preponderance of benefit over harm.[6] Option-level action statements were based on lesser-quality or limited data and expert consensus or high-quality evidence with a balance between benefits and harms. These clinical options are interventions that a reasonable health care provider might or might not wish to implement in his or her practice. The quality of evidence supporting each recommendation and the strength of each recommendation were assessed by the committee member most experienced in epidemiology and graded according to AAP policy (Fig 1).[6]

The guidelines and process-of-care algorithm underwent extensive peer review by committees, sections, councils, and task forces within the AAP; numerous outside organizations; and other individuals identified by the subcommittee. Liaisons to the subcommittee also were invited to distribute the draft to entities within their organizations. The resulting comments were compiled and reviewed by the chairperson, and relevant changes were incorporated into the draft, which was then reviewed by the full committee.

ABOUT THIS GUIDELINE

Key Action Statements

In light of the concerns highlighted previously and informed by the available evidence, the AAP has developed 6 action statements for the evaluation, diagnosis, and treatment of ADHD in children. These action statements provide for consistent and quality care for children and families with concerns about or symptoms that suggest attention disorders or problems.

Context

This guideline is intended to be integrated with the broader algorithms developed as part of the mission of the AAP Task Force on Mental Health.[7]

Implementation: A Process-of-Care Algorithm

The AAP recognizes the challenge of instituting practice changes and adopting new recommendations for care. To address the need, a process-of-care algorithm has been developed and has been used in the revision of the AAP ADHD toolkit.

Implementation: Preparing the Practice

Full implementation of the action statements described in this guideline and the process-of-care algorithm might require changes in office procedures and/or preparatory efforts to identify community resources. The section titled "Preparing the Practice" in the process-of-care algorithm and further information can be found in the supplement to the Task Force on Mental Health report.[7] It is important to document all aspects of the diagnostic and treatment procedures in the patients' records. Use of rating scales for the diagnosis of ADHD and assessment for comorbid conditions and as a method for monitoring treatment as described in the process algorithm (see Supplemental Fig 2), as well as information provided to parents such as management plans, can help facilitate a clinician's accurate documentation of his or her process.

Note

The AAP acknowledges that some primary care clinicians might not be confident of their ability to successfully diagnose and treat ADHD in a child because of the child's age, coexisting conditions, or other concerns. At any point at which a clinician feels that he or she is not adequately trained or is uncertain about making a diagnosis or continuing with treatment, a referral to a pediatric or mental health subspecialist should be made. If a diagnosis of ADHD or other condition is made by a subspecialist, the primary care clinician should develop a management strategy with the subspecialist that ensures that the child will continue to receive appropriate care consistent with a medical home model wherein the pediatrician part-

ners with parents so that both health and mental health needs are integrated.

KEY ACTION STATEMENTS FOR THE EVALUATION, DIAGNOSIS, TREATMENT, AND MONITORING OF ADHD IN CHILDREN AND ADOLESCENTS

Action statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** In a considerable number of children, ADHD goes undiagnosed. Primary care clinicians' systematic identification of children with these problems will likely decrease the rate of undiagnosed and untreated ADHD in children.
- **Harms/risks/costs:** Children in whom ADHD is inappropriately diagnosed might be labeled inappropriately, or another condition might be missed, and they might receive treatments that will not benefit them.
- **Benefits-harms assessment:** The high prevalence of ADHD and limited mental health resources require primary care pediatricians to play a significant role in the care of their patients with ADHD so that children with this condition receive the appropriate diagnosis and treatment. Treatments available have shown good evidence of efficacy, and lack of treatment results in a risk for impaired outcomes.
- **Value judgments:** The committee considered the requirements for establishing the diagnosis, the prevalence of ADHD, and the efficacy and adverse effects of treatment as well as the long-term outcomes.
- **Role of patient preferences:** Success with treatment depends on patient and family preference, which has to be taken into account.
- **Exclusions:** None.
- **Intentional vagueness:** The limits between what can be handled by a primary care clinician and what should be referred to a subspecialist because of the varying degrees of skills among primary care clinicians.
- **Strength: strong recommendation.**

The basis for this recommendation is essentially unchanged from that in the previous guideline. ADHD is the most common neurobehavioral disorder in children and occurs in approximately 8% of children and youth[8–10]; the number of children with this condition is far greater than can be managed by the mental health system. There is now increased evidence that appropriate diagnosis can be provided for preschool-aged children[11] (4–5 years of age) and for adolescents.[12]

Action statement 2: To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV-TR) criteria have been met (including documentation of impairment in more than 1 major setting), and information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The use of DSM-IV criteria has lead to more uniform categorization of the condition across professional disciplines.
- **Harms/risks/costs:** The DSM-IV system does not specifically provide for developmental-level differences and might lead to some misdiagnoses.
- **Benefits-harms assessment:** The benefits far outweigh the harm.
- **Value judgments:** The committee took into consideration the importance of coordination between pediatric and mental health services.
- **Role of patient preferences:** Although there is some stigma associated with mental disorder diagnoses resulting in some families preferring other diagnoses, the need for better clarity in diagnoses was felt to outweigh this preference.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

As with the findings in the previous guideline, the DSM-IV criteria continue to be the criteria best supported by evidence and consensus. Developed through several iterations by the American Psychiatric Association, the DSM-IV criteria were created through use of consensus and an expanding research foundation.[13] The DSM-IV system is used by professionals in psychiatry, psychology, health care systems, and primary care. Use of DSM-IV criteria, in addition to having the best evidence to date for criteria for ADHD, also affords the best method for communication across clinicians and is established with third-party payers. The criteria are under review for the development of the DSM-V, but these changes will not be available until at least 1 year after the publication of this current guideline. The diagnostic criteria have not changed since the previous guideline and are presented in Supplemental Table 2. An anticipated change in the DSM-V is increasing the age limit for when ADHD needs to have first presented from 7 to 12 years.[14]

Special Circumstances: Preschool-aged Children (4–5 Years Old)

There is evidence that the diagnostic criteria for ADHD can be applied to preschool-aged children; however, the subtypes detailed in the DSM-IV might not be valid for this population.[15–21] A review of the literature, including the multisite study of the efficacy of methylphenidate in preschool-aged children, revealed that the criteria could appropriately identify children with the condition.[11] However, there are added challenges in determining the presence of key symptoms. Preschool-aged children are not likely to have a separate observer if they do not attend a preschool or child care program, and even if they do attend, staff in those programs might be less qualified than certified teachers to provide accurate observations. Here, too, focused checklists can help physicians in the diagnostic evaluation, although only the Conners Comprehensive Behavior Rating Scales and the ADHD Rating Scale IV are DSM-IV–based scales that have been validated in preschool-aged children.[22]

When there are concerns about the availability or quality of nonparent observations of a child's behavior, physicians may recommend that parents complete a parent-training program before confirming an ADHD diagnosis for preschool-aged children and consider placement in a qualified preschool program if they have not done so already. Information can be obtained from parents and teachers through the use of validated DSM-IV–based ADHD rating scales. The parent-training program must include helping parents develop age-appropriate developmental expectations and specific management skills for problem behaviors. The clinician may obtain reports from the parenting class instructor about the parents' ability to manage their children, and if the children are in programs in which they are directly observed, instructors can report information about the core symptoms and function of the child directly. Qualified preschool programs include programs such as Head Start or other public prekindergarten programs. Preschool-aged children who display significant emotional or behavioral concerns might also qualify for Early Childhood Special Education services through their local school districts, and the evaluators for these programs and/or Early Childhood Special Education teachers might be excellent reporters of core symptoms.

Special Circumstances: Adolescents

Obtaining teacher reports for adolescents might be more challenging, because many adolescents will have multiple teachers. Likewise, parents might have less opportunity to observe their adolescent's behaviors than they had when their children were younger. Adolescents' reports of their own behaviors often differ from those of other observers, because they tend to minimize their own problematic behaviors.[23–25] Adolescents are less likely to exhibit overt hyperactive behavior. Despite the difficulties, clinicians need to try to obtain (with agreement from the adolescent) information from at least 2 teachers as well as information from other sources such as coaches, school guidance counselors, or leaders of community activities in which the adolescent participates. In addition, it is unusual for adolescents with behavioral/attention problems not to have been previously given a diagnosis of ADHD. Therefore, it is important to establish the younger manifestations of the condition that were missed and to strongly consider substance use, depression, and anxiety as alternative or co-occurring diagnoses. Adolescents with ADHD, especially when untreated, are at greater risk of substance abuse.[26] In addition, the risks of mood and anxiety disorders and risky sexual behaviors increase during adolescence.[12]

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Teachers, parents, and child health professionals typically encounter children with behaviors relating to activity level, impulsivity, and inattention who might not fully meet DSM-IV criteria. The DSM-PC[3] provides a guide to the more common behaviors seen in pediatrics. The manual describes common variations in behavior as well as more problematic behaviors at levels of less impairment than those specified in the DSM-IV.

The behavioral descriptions of the DSM-PC have not yet been tested in community studies to determine the prevalence or severity of developmental variations and problems in the areas of inattention, hyperactivity, or impulsivity. They do, however, provide guidance to clinicians regarding elements of treatment for children with problems with mild-to-moderate inattention, hyperactivity, or impulsivity. The DSM-PC also considers environmental influences on a child's behavior and provides information on differential diagnosis with a developmental perspective.

Action statement 3: In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** Identifying coexisting conditions is important for developing the most appropriate treatment plan.
- **Harms/risks/costs:** The major risk is misdiagnosing the conditions and providing inappropriate care.
- **Benefits-harms assessment:** There is a preponderance of benefit over harm.
- **Value judgments:** The committee members took into consideration the common occurrence of coexisting conditions and the importance of addressing them in making this recommendation.
- **Role of patient preferences:** None.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

A variety of other behavioral, developmental, and physical conditions can coexist in children who are evaluated for ADHD. These conditions include, but are not limited to, learning problems, language disorder, disruptive behavior, anxiety, mood disorders, tic disorders, seizures, developmental coordination disorder, or sleep disorders.[23,24,27–38] In some cases, the presence of a coexisting condition will alter the treatment of ADHD. The primary care clinician might benefit from additional support and guidance or might need to refer a child with ADHD and coexisting conditions, such as severe mood or anxiety disorders, to subspecialists for assessment and management. The subspecialists could include child psychiatrists, developmental-behavioral pediatricians, neurodevelopmental disability physicians, child neurologists, or child or school psychologists.

Given the likelihood that another condition exists, primary care clinicians should conduct assessments that determine or at least identify the risk of coexisting conditions. Through its Task Force on Mental Health, the AAP has developed algorithms and a toolkit[39] for assessing and treating (or comanaging) the most common developmental disorders and mental health concerns in children. These resources might be useful in assessing children who are being evaluated for ADHD. Payment for evaluation and treatment must cover the fixed and variable costs of providing the services, as noted in the AAP policy statement "Scope of Health Care Benefits for Children From Birth Through Age 26.[40]

Special Circumstances: Adolescents

Clinicians should assess adolescent patients with newly diagnosed ADHD for symptoms and signs of substance abuse; when these signs and symptoms are found, evaluation and treatment for addiction should precede treatment for ADHD, if possible, or careful treatment for ADHD can begin if necessary.[25]

Action statement 4: The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The recommendation describes the coordinated services most appropriate for managing the condition.
- **Harms/risks/costs:** Providing the services might be more costly.
- **Benefits-harms assessment:** There is a preponderance of benefit over harm.
- **Value judgments:** The committee members considered the value of medical home services when deciding to make this recommendation.
- **Role of patient preferences:** Family preference in how these services are provided is an important consideration.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

As in the previous guideline, this recommendation is based on the evidence that ADHD continues to cause symptoms and dysfunction in many children who have the condition over long periods of time, even into adulthood, and that the treatments available address symptoms and function but are usually not curative. Although the chronic illness model has not been specifically studied in children and youth with ADHD, it has been effective for other chronic conditions such as asthma,[23] and the medical home model has been accepted as the preferred standard of care.[41] The management process is also helped by encouraging strong family-school partnerships.[42]

Longitudinal studies have found that, frequently, treatments are not sustained despite the fact that long-term outcomes for children with ADHD indicate that they are at greater risk of significant problems if they discontinue treatment.[43] Because a number of parents of children with ADHD also have ADHD, extra support might be necessary to help those parents provide medication on a consistent basis and institute a consistent behavioral program. The medical home and chronic illness approach is provided in the process algorithm (Supplemental Fig 2). An important process in ongoing care is bidirectional communication with teachers and other school and mental health clinicians involved in the child's care as well as with parents and patients.

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Children with inattention or hyperactivity/impulsivity at the problem level (DSM-PC) and their families might also benefit from the same chronic illness and medical home principles.

Action statement 5: Recommendations for treatment of children and youth with ADHD vary depending on the patient's age.

Action statement 5a: For *preschool-aged children (4–5 years of age)*, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).

Evidence Profile

- **Aggregate evidence quality:** A for behavior; B for methylphenidate.
- **Benefits:** Both behavior therapy and methylphenidate have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas methylphenidate has some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

Action statement 5b: For *elementary school-aged children (6–11 years of age)*, the primary care clinician should prescribe FDA-approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.

Evidence Profile

- **Aggregate evidence quality:** A for treatment with FDA-approved medications; B for behavior therapy.
- **Benefits:** Both behavior therapy and FDA-approved medications have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas FDA-approved medications have some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference, including patient preference, is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

Action statement 5c: For *adolescents (12–18 years of age)*, the primary care clinician should prescribe FDA-approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.

Evidence Profile

- **Aggregate evidence quality:** A for medications; C for behavior therapy.
- **Benefits:** Both behavior therapy and FDA-approved medications have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas FDA-approved medications have some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference, including patient preference, is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation/recommendation.**

Medication

Similar to the recommendations from the previous guideline, stimulant medications are highly effective for most children in reducing core symptoms of ADHD.[44] One selective norepinephrine-reuptake inhibitor (atomoxetine[45,46]) and 2 selective α_2-adrenergic agonists (extended-release guanfacine[47,48] and extended-release clonidine[49]) have also demonstrated efficacy in reducing core symptoms. Because norepinephrine-reuptake inhibitors and α_2-adrenergic agonists are newer, the evidence base that supports them—although adequate for FDA approval—is considerably smaller than that for stimulants. None of them have been approved for use in preschool-aged children. Compared with stimulant medications that have an effect size [effect size = (treatment mean − control mean)/control SD] of approximately 1.0,[50] the effects of the nonstimulants are slightly weaker; atomoxetine has an effect size of approximately 0.7, and extended-release guanfacine and extended-release clonidine also have effect sizes of approximately 0.7.

The accompanying process-of-care algorithm provides a list of the currently available FDA-approved medications for ADHD (Supplemental Table 3). Characteristics of each medication are provided to help guide the clinician's choice in prescribing medication.

As was identified in the previous guideline, the most common stimulant adverse effects are appetite loss, abdominal pain, headaches, and sleep disturbance. The results of the Multimodal Therapy of ADHD (MTA) study revealed a more persistent effect of stimulants on decreasing growth velocity than have most previous studies, particularly when children were on higher and more consistently administered doses. The effects diminished by the third year of treatment, but no compensatory rebound effects were found.[51] However, diminished growth was in the range of 1 to 2 cm. An uncommon additional significant adverse effect of stimulants is the occurrence of hallucinations and other psychotic symptoms.[52] Although concerns have been raised about the rare occurrence of sudden cardiac death among children using stimulant medications,[53] sudden death in children on stimulant medication is extremely rare, and evidence is conflicting as to whether stimulant medications increase the risk of sudden death.[54–56] It is important to expand the history to include specific cardiac symptoms, Wolf-Parkinson-White syndrome, sudden death in the family, hypertrophic cardiomyopathy, and long QT syndrome. Preschool-aged children might experience increased mood lability and dysphoria.[57] For the nonstimulant atomoxetine, the adverse effects include initial somnolence and gastrointestinal tract symptoms, particularly if the dosage is increased too rapidly; decrease in appetite; increase in suicidal thoughts (less common); and hepatitis (rare). For the nonstimulant α_2-adrenergic agonists extended-release guanfacine and extended-release clonidine, adverse effects include somnolence and dry mouth.

Only 2 medications have evidence to support their use as adjunctive therapy with stimulant medications sufficient to achieve FDA approval: extended-release guanfacine[26] and extended-release clonidine. Other medications have been used in combination off-label, but there is currently only anecdotal evidence for their safety or efficacy, so their use cannot be recommended at this time.

Special Circumstances: Preschool-aged Children

A number of special circumstances support the recommendation to initiate ADHD treatment in preschool-aged children (ages 4–5 years) with behavioral therapy alone first.[57] These circumstances include:

- The multisite study of methylphenidate[57] was limited to preschool-aged children who had moderate-to-severe dysfunction.
- The study also found that many children (ages 4–5 years) experience improvements in symptoms with behavior therapy alone, and the overall evidence for behavior therapy in preschool-aged children is strong.
- Behavioral programs for children 4 to 5 years of age typically run in the form of group parent-training programs and, although not always compensated by health insurance, have a lower cost. The process algorithm (see Supplemental pages s15-16) contains criteria for the clinician to use in assessing the quality of the behavioral therapy. In addition, programs such as Head Start and Children and Adults With Attention Deficit Hyperactivity Disorder (CHADD) (www.chadd.org) might provide some behavioral supports.

Many young children with ADHD might still require medication to achieve maximum improvement, and medication is not contraindicated for children 4 through 5 years of age. However, only 1 multisite study has carefully assessed medication use in preschool-aged children. Other considerations in the recommendation about treating children 4 to 5 years of age with stimulant medications include:

- The study was limited to preschool-aged children who had moderate-to-severe dysfunction.
- Research has found that a number of young children (4–5 years of age) experience improvements in symptoms with behavior therapy alone.
- There are concerns about the possi-

ble effects on growth during this rapid growth period of preschool-aged children.

- There has been limited information about and experience with the effects of stimulant medication in children between the ages of 4 and 5 years.

Here, the criteria for enrollment (and, therefore, medication use) included measures of severity that distinguished treated children from the larger group of preschool-aged children with ADHD. Thus, before initiating medications, the physician should assess the severity of the child's ADHD. Given current data, only those preschool-aged children with ADHD who have moderate-to-severe dysfunction should be considered for medication. Criteria for this level of severity, based on the multisite-study results,[57] are (1) symptoms that have persisted for at least 9 months, (2) dysfunction that is manifested in both the home and other settings such as preschool or child care, and (3) dysfunction that has not responded adequately to behavior therapy. The decision to consider initiating medication at this age depends in part on the clinician's assessment of the estimated developmental impairment, safety risks, or consequences for school or social participation that could ensue if medications are not initiated. It is often helpful to consult with a mental health specialist who has had specific experience with preschool-aged children if possible.

Dextroamphetamine is the only medication approved by the FDA for use in children younger than 6 years of age. This approval, however, was based on less stringent criteria in force when the medication was approved rather than on empirical evidence of its safety and efficacy in this age group. Most of the evidence for the safety and efficacy of treating preschool-aged children with stimulant medications has been from methylphenidate.[57] Methylphenidate evidence consists of 1 multisite study of 165 children and 10 other smaller single-site studies that included from 11 to 59 children (total of 269 children); 7 of the 10 single-site studies found significant efficacy. It must be noted that although there is moderate evidence that methylphenidate is safe and efficacious in preschool-aged children, its use in this age group remains off-label. Although the use of dextroamphetamine is on-label, the insufficient evidence for its safety and efficacy in this age group does not make it possible to recommend at this time.

If children do not experience adequate symptom improvement with behavior therapy, medication can be prescribed, as described previously. Evidence suggests that the rate of metabolizing stimulant medication is slower in children 4 through 5 years of age, so they should be given a lower dose to start, and the dose can be increased in smaller increments. Maximum doses have not been adequately studied.[57]

Special Circumstances: Adolescents

As noted previously, before beginning medication treatment for adolescents with newly diagnosed ADHD, clinicians should assess these patients for symptoms of substance abuse. When substance use is identified, assessment when off the abusive substances should precede treatment for ADHD (see the Task Force on Mental Health report[7]). Diversion of ADHD medication (use for other than its intended medical purposes) is also a special concern among adolescents[58]; clinicians should monitor symptoms and prescription-refill requests for signs of misuse or diversion of ADHD medication and consider prescribing medications with no abuse potential, such as atomoxetine (Strattera [Ely Lilly Co, Indianapolis, IN]) and extended-release guanfacine (Intuniv [Shire US Inc, Wayne, PA]) or extended-release clonidine (Kapvay [Shionogi Inc, Florham Park, NJ]) (which are not stimulants) or stimulant medications with less abuse potential, such as lisdexamfetamine (Vyvanse [Shire US Inc]), dermal methylphenidate (Daytrana [Noven Therapeutics, LLC, Miami, FL]), or OROS methylphenidate (Concerta [Janssen Pharmaceuticals, Inc, Titusville, NJ]). Because lisdexamfetamine is dextroamphetamine, which contains an additional lysine molecule, it is only activated after ingestion, when it is metabolized by erythrocyte cells to dexamphetamine. The other preparations make extraction of the stimulant medication more difficult.

Given the inherent risks of driving by adolescents with ADHD, special concern should be taken to provide medication coverage for symptom control while driving. Longer-acting or late-afternoon, short-acting medications might be helpful in this regard.[59]

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Medication is not appropriate for children whose symptoms do not meet DSM-IV criteria for diagnosis of ADHD, although behavior therapy does not require a specific diagnosis, and many of the efficacy studies have included children without specific mental behavioral disorders.

Behavior Therapy

Behavior therapy represents a broad set of specific interventions that have a common goal of modifying the physical and social environment to alter or change behavior. Behavior therapy usually is implemented by training parents in specific techniques that improve their abilities to modify and

TABLE 1 Evidence-Based Behavioral Treatments for ADHD

Intervention Type	Description	Typical Outcome(s)	Median Effect Size[a]
Behavioral parent training (BPT)	Behavior-modification principles provided to parents for implementation in home settings	Improved compliance with parental commands; improved parental understanding of behavioral principles; high levels of parental satisfaction with treatment	0.55
Behavioral classroom management	Behavior-modification principles provided to teachers for implementation in classroom settings	Improved attention to instruction; improved compliance with classroom rules; decreased disruptive behavior; improved work productivity	0.61
Behavioral peer interventions (BPI)[b]	Interventions focused on peer interactions/relationships; these are often group-based interventions provided weekly and include clinic-based social-skills training used either alone or concurrently with behavioral parent training and/or medication	Office-based interventions have produced minimal effects; interventions have been of questionable social validity; some studies of BPI combined with clinic-based BPT found positive effects on parent ratings of ADHD symptoms; no differences on social functioning or parent ratings of social behavior have been revealed	

[a] Effect size = (treatment median − control median)/control SD.

[b] The effect size for behavioral peer interventions is not reported, because the effect sizes for these studies represent outcomes associated with combined interventions. A lower effect size means that they have less of an effect. The effect sizes found are considered moderate.

Adapted from Pelham W, Fabiano GA. *J Clin Child Adolesc Psychol*. 2008;37(1):184–214.

shape their child's behavior and to improve the child's ability to regulate his or her own behavior. The training involves techniques to more effectively provide rewards when their child demonstrates the desired behavior (eg, positive reinforcement), learn what behaviors can be reduced or eliminated by using planned ignoring as an active strategy (or using praising and ignoring in combination), or provide appropriate consequences or punishments when their child fails to meet the goals (eg, punishment). There is a need to consistently apply rewards and consequences as tasks are achieved and then to gradually increase the expectations for each task as they are mastered to shape behaviors. Although behavior therapy shares a set of principles, individual programs introduce different techniques and strategies to achieve the same ends.

Table 1 lists the major behavioral intervention approaches that have been demonstrated to be evidence based for the management of ADHD in 3 different types of settings. The table is based on 22 studies, each completed between 1997 and 2006.

Evidence for the effectiveness of behavior therapy in children with ADHD is derived from a variety of studies[60–62] and an Agency for Healthcare Research and Quality review.[5] The diversity of interventions and outcome measures makes meta-analysis of the effects of behavior therapy alone or in association with medications challenging. The long-term positive effects of behavior therapy have yet to be determined. Ongoing adherence to a behavior program might be important; therefore, implementing a chronic care model for child health might contribute to the long-term effects.[63]

Study results have indicated positive effects of behavior therapy when combined with medications. Most studies that compared behavior therapy to stimulants found a much stronger effect on ADHD core symptoms from stimulants than from behavior therapy. The MTA study found that combined treatment (behavior therapy and stimulant medication) was not significantly more efficacious than treatment with medication alone for the core symptoms of ADHD after correction for multiple tests in the primary analysis.[64] However, a secondary analysis of a combined measure of parent and teacher ratings of ADHD symptoms revealed a significant advantage for the combination with a small effect size of $d = 0.26$.[65] However, the same study also found that the combined treatment compared with medication alone did offer greater improvements on academic and conduct measures when ADHD coexisted with anxiety and when children lived in low socioeconomic environments. In addition, parents and teachers of children who were receiving combined therapy were significantly more satisfied with the treatment plan. Finally, the combination of medication management and behavior therapy allowed for the use of lower dosages of stimulants, which possibly reduced the risk of adverse effects.[66]

School Programming and Supports

Behavior therapy programs coordinating efforts at school as well as home might enhance the effects. School programs can provide classroom adaptations, such as preferred seating, modified work assignments, and test modifications (to the location at which it is administered and time allotted for taking the test), as well as behavior plans as part of a 504 Rehabilitation Act Plan or special education Individualized Education Program (IEP) under the "other health impairment" designation as part of the Individuals With

Disability Education Act (IDEA).[67] It is helpful for clinicians to be aware of the eligibility criteria in their state and school district to advise families of their options. Youths documented to have ADHD can also get permission to take college-readiness tests in an untimed manner by following appropriate documentation guidelines.[68]

The effect of coexisting conditions on ADHD treatment is variable. In some cases, treatment of the ADHD resolves the coexisting condition. For example, treatment of ADHD might resolve oppositional defiant disorder or anxiety.[68] However, sometimes the co-occurring condition might require treatment that is in addition to the treatment for ADHD. Some coexisting conditions can be treated in the primary care setting, but others will require referral and comanagement with a subspecialist.

Action statement 6: Primary care clinicians should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The optimal dose of medication is required to reduce core symptoms to or as close to the levels of children without ADHD.
- **Harms/risks/costs:** Higher levels of medication increase the chances of adverse effects.
- **Benefits-harms assessment:** The importance of adequately treating ADHD outweighs the risk of adverse effects.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** The families' preferences and comfort need to be taken into consideration in developing a titration plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

The findings from the MTA study suggested that more than 70% of children and youth with ADHD respond to one of the stimulant medications at an optimal dose when a systematic trial is used.[65] Children in the MTA who were treated in the community with care as usual from whomever they chose or to whom they had access received lower doses of stimulants with less frequent monitoring and had less optimal results.[65] Because stimulants might produce positive but suboptimal effects at a low dose in some children and youth, titration to maximum doses that control symptoms without adverse effects is recommended instead of titration strictly on a milligram-per-kilogram basis.

Education of parents is an important component in the chronic illness model to ensure their cooperation in efforts to reach appropriate titration (remembering that the parents themselves might be challenged significantly by ADHD).[69,70] The primary care clinician should alert parents and children that changing medication dose and occasionally changing a medication might be necessary for optimal medication management, that the process might require a few months to achieve optimal success, and that medication efficacy should be systematically monitored at regular intervals.

Because stimulant medication effects are seen immediately, trials of different doses of stimulants can be accomplished in a relatively short time period. Stimulant medications can be effectively titrated on a 3- to 7-day basis.[65]

It is important to note that by the 3-year follow-up of 14-month MTA interventions (optimal medications management, optimal behavioral management, the combination of the 2, or community treatment), all differences among the initial 4 groups were no longer present. After the initial 14-month intervention, the children no longer received the careful monthly monitoring provided by the study and went back to receiving care from their community providers. Their medications and doses varied, and a number of them were no longer taking medication. In children still on medication, the growth deceleration was only seen for the first 2 years and was in the range of 1 to 2 cm.

CONCLUSION

Evidence continues to be fairly clear with regard to the legitimacy of the diagnosis of ADHD and the appropriate diagnostic criteria and procedures required to establish a diagnosis, identify co-occurring conditions, and treat effectively with both behavioral and pharmacologic interventions. However, the steps required to sustain appropriate treatments and achieve successful long-term outcomes still remain a challenge. To provide more detailed information about how the recommendations of this guideline can be accomplished, a more detailed but less strongly evidence-based algorithm is provided as a companion article.

AREAS FOR FUTURE RESEARCH

Some specific research topics pertinent to the diagnosis and treatment of ADHD or developmental variations or problems in children and adolescents in primary care to be explored include:

- identification or development of reliable instruments suitable to use in primary care to assess the nature or degree of functional impairment in children/adolescents with ADHD and monitor improvement over time;
- study of medications and other therapies used clinically but not approved by the FDA for ADHD, such as

electroencephalographic biofeedback;

- determination of the optimal schedule for monitoring children/adolescents with ADHD, including factors for adjusting that schedule according to age, symptom severity, and progress reports;
- evaluation of the effectiveness of various school-based interventions;
- comparisons of medication use and effectiveness in different ages, including both harms and benefits;
- development of methods to involve parents and children/adolescents in their own care and improve adherence to both behavior and medication treatments;
- standardized and documented tools that will help primary care providers in identifying coexisting conditions;
- development and determination of effective electronic and Web-based systems to help gather information to diagnose and monitor children with ADHD;
- improved systems of communication with schools and mental health professionals, as well as other community agencies, to provide effective collaborative care;
- evidence for optimal monitoring by some aspects of severity, disability, or impairment; and
- long-term outcomes of children first identified with ADHD as preschool-aged children.

SUBCOMMITTEE ON ATTENTION DEFICIT HYPERACTIVITY DISORDER (OVERSIGHT BY THE STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT, 2005–2011)

WRITING COMMITTEE

Mark Wolraich, MD, Chair – *(periodic consultant to Shire, Eli Lilly, Shinogi, and Next Wave Pharmaceuticals)*
Lawrence Brown, MD – *(neurologist; AAP Section on Neurology; Child Neurology Society) (Safety Monitoring Board for Best Pharmaceuticals for Children Act for National Institutes of Health)*
Ronald T. Brown, PhD – *(child psychologist; Society for Pediatric Psychology) (no conflicts)*
George DuPaul, PhD – *(school psychologist; National Association of School Psychologists) (participated in clinical trial on Vyvanse effects on college students with ADHD, funded by Shire; published 2 books on ADHD and receives royalties)*
Marian Earls, MD – *(general pediatrician with QI expertise, developmental and behavioral pediatrician) (no conflicts)*
Heidi M. Feldman, MD, PhD – *(developmental and behavioral pediatrician; Society for Developmental and Behavioral Pediatricians) (no conflicts)*
Theodore G. Ganiats, MD – *(family physician; American Academy of Family Physicians) (no conflicts)*
Beth Kaplanek, RN, BSN – *(parent advocate, Children and Adults With Attention Deficit Hyperactivity Disorder [CHADD]) (no conflicts)*
Bruce Meyer, MD – *(general pediatrician) (no conflicts)*
James Perrin, MD – *(general pediatrician; AAP Mental Health Task Force, AAP Council on Children With Disabilities) (consultant to Pfizer not related to ADHD)*
Karen Pierce, MD – *(child psychiatrist; American Academy of Child and Adolescent Psychiatry) (no conflicts)*
Michael Reiff, MD – *(developmental and behavioral pediatrician; AAP Section on Developmental and Behavioral Pediatrics) (no conflicts)*
Martin T. Stein, MD – *(developmental and behavioral pediatrician; AAP Section on Developmental and Behavioral Pediatrics) (no conflicts)*
Susanna Visser, MS – *(epidemiologist) (no conflicts)*

CONSULTANT

Melissa Capers, MA, MFA – *(medical writer) (no conflicts)*

STAFF

Caryn Davidson, MA

ACKNOWLEDGMENTS

This guideline was developed with support from the Partnership for Policy Implementation (PPI) initiative. Physicians trained in medical informatics were involved with formatting the algorithm and helping to keep the key action statements actionable, decidable, and executable.

REFERENCES

1. American Academy of Pediatrics, Committee on Quality Improvement and Subcommittee on Attention-Deficit/Hyperactivity Disorder. Clinical practice guideline: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. *Pediatrics*. 2000;105(5):1158–1170
2. American Academy of Pediatrics, Subcommittee on Attention-Deficit/Hyperactivity Disorder, Committee on Quality Improvement. Clinical practice guideline: treatment of the school-aged child with attention-deficit/hyperactivity disorder. *Pediatrics*. 2001;108(4):1033–1044
3. Wolraich ML, Felice ME, Drotar DD. *The Classification of Child and Adolescent Mental Conditions in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC), Child and Adolescent Version*. Elk Grove, IL: American Academy of Pediatrics; 1996
4. *EndNote* [computer program]. 10th ed. Carlsbad, CA: Thompson Reuters; 2009
5. Charach A, Dashti B, Carson P, et al. *Attention Deficit Hyperactivity Disorder: Effectiveness of Treatment in At-risk Preschoolers; Long-term Effectiveness in All Ages; and Variability in Prevalence, Diagnosis, and Treatment*. Rockville, MD: Agency for Healthcare Research and Quality; 2011. Comparative Effectiveness Review. 2011; in press
6. American Academy of Pediatrics, Steering Committee on Quality Improvement. Classifying recommendations for clinical practice guidelines. *Pediatrics*. 2004;114(3):874–877
7. Foy JM; American Academy of Pediatrics Task Force on Mental Health. Enhancing pediatric mental health care: report from the American Academy of Pediatrics Task Force on Mental Health. Introduction. *Pediatrics*. 2010;125(suppl 3)S69–S174
8. Visser SN, Lesesne CA, Perou R. National estimates and factors associated with medication treatment for childhood attention-deficit/hyperactivity disorder. *Pediatrics*. 2007;119(suppl 1):S99–S106
9. Centers for Disease Control and Prevention. Mental health in the United States: prevalence of diagnosis and medication treatment for attention-deficit/

hyperactivity disorder—United States, 2003. *MMWR Morb Mortal Wkly Rep*. 2005; 54(34):842–847

10. Centers for Disease Control and Prevention. Increasing prevalence of parent-reported attention deficit/hyperactivity disorder among children: United States, 2003–2007. *MMWR Morb Mortal Wkly Rep*. 2010;59(44): 1439–1443
11. Egger HL, Kondo D, Angold A. The epidemiology and diagnostic issues in preschool attention-deficit/hyperactivity disorder. *Infant Young Child*. 2006;19(2):109–122
12. Wolraich ML, Wibbelsman CJ, Brown TE, et al. Attention-deficit/hyperactivity disorder among adolescents: a review of the diagnosis, treatment, and clinical implications. *Pediatrics*. 2005;115(6):1734–1746
13. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Text Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Association; 2000
14. American Psychiatric Association. Diagnostic criteria for attention deficit/hyperactivity disorder. Available at: www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=383. Accessed September 30, 2011
15. Lahey BB, Pelham WE, Stein MA, et al. Validity of DSM-IV attention-deficit/hyperactivity disorder for younger children [published correction appears in *J Am Acad Child Adolesc Psychiatry*. 1999;38(2):222]. *J Am Acad Child Adolesc Psychiatry*. 1998;37(7):695–702
16. Pavuluri MN, Luk SL, McGee R. Parent reported preschool attention deficit hyperactivity: measurement and validity. *Eur Child Adolesc Psychiatry*. 1999;8(2): 126–133
17. Harvey EA, Youngwirth SD, Thakar DA, Errazuriz PA. Predicting attention-deficit/hyperactivity disorder and oppositional defiant disorder from preschool diagnostic assessments. *J Consult Clin Psychol*. 2009; 77(2):349–354
18. Keenan K, Wakschlag LS. More than the terrible twos: the nature and severity of behavior problems in clinic-referred preschool children. *J Abnorm Child Psychol*. 2000; 28(1):33–46
19. Gadow KD, Nolan EE, Litcher L, et al. Comparison of attention-deficit/hyperactivity disorder symptoms subtypes in Ukrainian schoolchildren. *J Am Acad Child Adolesc Psychiatry*. 2000;39(12):1520–1527
20. Sprafkin J, Volpe RJ, Gadow KD, Nolan EE, Kelly K. A DSM-IV-referenced screening instrument for preschool children: the Early Childhood Inventory-4. *J Am Acad Child Adolesc Psychiatry*. 2002;41(5): 604–612
21. Poblano A, Romero E. ECI-4 screening of attention deficit-hyperactivity disorder and co-morbidity in Mexican preschool children: preliminary results. *Arq Neuropsiquiatr*. 2006;64(4):932–936
22. McGoey KE, DuPaul GJ, Haley E, Shelton TL. Parent and teacher ratings of attention-deficit/hyperactivity disorder in preschool: the ADHD Rating Scale-IV Preschool Version. *J Psychopathol Behav Assess*. 2007;29(4): 269–276
23. Young J. Common comorbidities seen in adolescents with attention-deficit/hyperactivity disorder. *Adolesc Med State Art Rev*. 2008;19(2): 216–228, vii
24. Freeman R; Tourette Syndrome International Database Consortium. Tic disorders and ADHD: answers from a worldwide clinical dataset on Tourette syndrome [published correction appears in *Eur Child Adolesc Psychiatry*. 2007; 16(8):536]. *Eur Child Adolesc Psychiatry*. 2007;16(1 suppl):15–23
25. Riggs P. Clinical approach to treatment of ADHD in adolescents with substance use disorders and conduct disorder. *J Am Acad Child Adolesc Psychiatry*. 1998;37(3): 331–332
26. Kratochvil CJ, Vaughan BS, Stoner JA, et al. A double-blind, placebo-controlled study of atomoxetine in young children with ADHD. *Pediatrics*. 2011;127(4). Available at: www.pediatrics.org/cgi/content/full/127/4/e862
27. Rowland AS, Lesesne CA, Abramowitz AJ. The epidemiology of attention-deficit/hyperactivity disorder (ADHD): a public health view. *Ment Retard Dev Disabil Res Rev*. 2002;8(3):162–170
28. Cuffe SP, Moore CG, McKeown RE. Prevalence and correlates of ADHD symptoms in the national health interview survey. *J Atten Disord*. 2005;9(2):392–401
29. Pastor PN, Reuben CA. Diagnosed attention deficit hyperactivity disorder and learning disability: United States, 2004–2006. *Vital Health Stat 10*. 2008;(237):1–14
30. Biederman J, Faraone SV, Wozniak J, Mick E, Kwon A, Aleardi M. Further evidence of unique developmental phenotypic correlates of pediatric bipolar disorder: findings from a large sample of clinically referred preadolescent children assessed over the last 7 years. *J Affect Disord*. 2004;82(suppl 1):S45–S58
31. Biederman J, Kwon A, Aleardi M. Absence of gender effects on attention deficit hyperactivity disorder: findings in nonreferred subjects. *Am J Psychiatry*. 2005;162(6): 1083–1089
32. Biederman J, Ball SW, Monuteaux MC, et al. New insights into the comorbidity between ADHD and major depression in adolescent and young adult females. *J Am Acad Child Adolesc Psychiatry*. 2008; 47(4):426–434
33. Biederman J, Melmed RD, Patel A, McBurnett K, Donahue J, Lyne A. Long-term, open-label extension study of guanfacine extended release in children and adolescents with ADHD. *CNS Spectr*. 2008;13(12): 1047–1055
34. Crabtree VM, Ivanenko A, Gozal D. Clinical and parental assessment of sleep in children with attention-deficit/hyperactivity disorder referred to a pediatric sleep medicine center. *Clin Pediatr (Phila)*. 2003;42(9): 807–813
35. LeBourgeois MK, Avis K, Mixon M, Olmi J, Harsh J. Snoring, sleep quality, and sleepiness across attention-deficit/hyperactivity disorder subtypes. *Sleep*. 2004;27(3): 520–525
36. Chan E, Zhan C, Homer CJ. Health care use and costs for children with attention-deficit/hyperactivity disorder: national estimates from the medical expenditure panel survey. *Arch Pediatr Adolesc Med*. 2002; 156(5):504–511
37. Newcorn JH, Miller SR, Ivanova I, et al. Adolescent outcome of ADHD: impact of childhood conduct and anxiety disorders. *CNS Spectr*. 2004;9(9):668–678
38. Sung V, Hiscock H, Sciberras E, Efron D. Sleep problems in children with attention-deficit/hyperactivity disorder: prevalence and the effect on the child and family. *Arch Pediatr Adolesc Med*. 2008; 162(4):336–342
39. American Academy of Pediatrics, Task Force on Mental Health. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit* [CD-ROM]. Elk Grove Village, IL: American Academy of Pediatrics; 2010
40. American Academy of Pediatrics, Committee on Child Health Financing. Scope of health care benefits for children from birth through age 26. *Pediatrics*. 2012; In press
41. Brito A, Grant R, Overholt S, et al. The enhanced medical home: the pediatric standard of care for medically underserved children. *Adv Pediatr*. 2008;55:9–28
42. Homer C, Klatka K, Romm D, et al. A review of the evidence for the medical home for children with special health care needs. *Pediatrics*. 2008;122(4). Available at: www.pediatrics.org/cgi/content/full/122/4/e922
43. Ingram S, Hechtman L, Morgenstern G. Out-

come issues in ADHD: adolescent and adult long-term outcome. *Ment Retard Dev Disabil Res Rev*. 1999;5(3):243–250

44. Barbaresi WJ, Katusic SK, Colligan RC, Weaver AL, Jacobsen SJ. Modifiers of long-term school outcomes for children with attention-deficit/hyperactivity disorder: does treatment with stimulant medication make a difference? Results from a population-based study. *J Dev Behav Pediatr*. 2007;28(4):274–287
45. Cheng JY, Cheng RY, Ko JS, Ng EM. Efficacy and safety of atomoxetine for attention-deficit/hyperactivity disorder in children and adolescents-meta-analysis and meta-regression analysis. *Psychopharmacology*. 2007;194(2):197–209
46. Michelson D, Allen AJ, Busner J, Casat C, Dunn D, Kratochvil CJ. Once daily atomoxetine treatment for children and adolescents with ADHD: a randomized, placebo-controlled study. *Am J Psychiatry*. 2002; 159(11):1896–1901
47. Biederman J, Melmed RD, Patel A, et al; SPD503 Study Group. A randomized, double-blind, placebo-controlled study of guanfacine extended release in children and adolescents with attention-deficit/hyperactivity disorder. *Pediatrics*. 2008;121(1). Available at: www.pediatrics.org/cgi/content/full/121/1/e73
48. Sallee FR, Lyne A, Wigal T, McGough JJ. Long-term safety and efficacy of guanfacine extended release in children and adolescents with attention-deficit/hyperactivity disorder. *J Child Adolesc Psychopharmacol*. 2009;19(3):215–226
49. Jain R, Segal S, Kollins SH, Khayrallah M. Clonidine extended-release tablets for pediatric patients with attention-deficit/hyperactivity disorder. *J Am Acad Child Adolesc Psychiatry*. 2011;50(2):171–179
50. Newcorn J, Kratochvil CJ, Allen AJ, et al. Atomoxetine and osmotically released methylphenidate for the treatment of attention deficit hyperactivity disorder: acute comparison and differential response. *Am J Psychiatry*. 2008;165(6):721–730
51. Swanson J, Elliott GR, Greenhill LL, et al. Effects of stimulant medication on growth rates across 3 years in the MTA follow-up. *J Am Acad Child Adolesc Psychiatry*. 2007; 46(8):1015–1027
52. Mosholder AD, Gelperin K, Hammad TA, Phelan K, Johann-Liang R. Hallucinations and other psychotic symptoms associated with the use of attention-deficit/hyperactivity disorder drugs in children. *Pediatrics*. 2009;123(2):611–616
53. Avigan M. *Review of AERS Data From Marketed Safety Experience During Stimulant Therapy: Death, Sudden Death, Cardiovascular SAEs (Including Stroke)*. Silver Spring, MD: Food and Drug Administration, Center for Drug Evaluation and Research; 2004. Report No. D030403
54. Perrin JM, Friedman RA, Knilans TK, et al; American Academy of Pediatrics, Black Box Working Group, Section on Cardiology and Cardiac Surgery. Cardiovascular monitoring and stimulant drugs for attention-deficit/hyperactivity disorder. *Pediatrics*. 2008;122(2):451–453
55. McCarthy S, Cranswick N, Potts L, Taylor E, Wong IC. Mortality associated with attention-deficit hyperactivity disorder (ADHD) drug treatment: a retrospective cohort study of children, adolescents and young adults using the general practice research database. *Drug Saf*. 2009;32(11): 1089–1110
56. Gould MS, Walsh BT, Munfakh JL, et al. Sudden death and use of stimulant medications in youths. *Am J Psychiatry*. 2009;166(9):992–1001
57. Greenhill L, Kollins S, Abikoff H, McCracken J, Riddle M, Swanson J. Efficacy and safety of immediate-release methylphenidate treatment for preschoolers with ADHD. *J Am Acad Child Adolesc Psychiatry*. 2006;45(11): 1284–1293
58. Low K, Gendaszek AE. Illicit use of psychostimulants among college students: a preliminary study. *Psychol Health Med*. 2002; 7(3):283–287
59. Cox D, Merkel RL, Moore M, Thorndike F, Muller C, Kovatchev B. Relative benefits of stimulant therapy with OROS methylphenidate versus mixed amphetamine salts extended release in improving the driving performance of adolescent drivers with attention-deficit/hyperactivity disorder. *Pediatrics*. 2006;118(3). Available at: www.pediatrics.org/cgi/content/full/118/3/e704
60. Pelham W, Wheeler T, Chronis A. Empirically supported psychological treatments for attention deficit hyperactivity disorder. *J Clin Child Psychol*. 1998;27(2):190–205
61. Sonuga-Barke E, Daley D, Thompson M, Laver-Bradbury C, Weeks A. Parent-based therapies for preschool attention-deficit/hyperactivity disorder: a randomized, controlled trial with a community sample. *J Am Acad Child Adolesc Psychiatry*. 2001;40(4):402–408
62. Pelham W, Fabiano GA. Evidence-based psychosocial treatments for attention-deficit/hyperactivity disorder. *J Clin Child Adolesc Psychol*. 2008;37(1):184–214
63. Van Cleave J, Leslie LK. Approaching ADHD as a chronic condition: implications for long-term adherence. *J Psychosoc Nurs Ment Health Serv*. 2008;46(8):28–36
64. A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. The MTA Cooperative Group. Multimodal Treatment Study of Children With ADHD. *Arch Gen Psychiatry*. 1999;56(12):1073–1086
65. Jensen P, Hinshaw SP, Swanson JM, et al. Findings from the NIMH multimodal treatment study of ADHD (MTA): implications and applications for primary care providers. *J Dev Behav Pediatr*. 2001;22(1):60–73
66. Pelham WE, Gnagy EM. Psychosocial and combined treatments for ADHD. *Ment Retard Dev Disabil Res Rev*. 1999;5(3):225–236
67. Davila RR, Williams ML, MacDonald JT. Memorandum on clarification of policy to address the needs of children with attention deficit disorders within general and/or special education. In: Parker HC *The ADD Hyperactivity Handbook for Schools*. Plantation, FL: Impact Publications Inc; 1991:261–268
68. The College Board. Services for Students With Disabilities (SSD). Available at: www.collegeboard.com/ssd/student. Accessed July 8, 2011
69. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA* 2002;288:1775–1779
70. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. *JAMA* 2002;288:1909–1914

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

Pediatrics originally published online October 16, 2011;

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

Pediatrics originally published online October 16, 2011;

Attachment 2.10.11.6-1 AmeriHealth Caritas NCQA Ratings

This page is intentionally left blank.

1. On the NCQA Star Ratings sheet, at the top, insert Proposer's name.
2. On the NCQA Star Ratings sheet, enter details for all of the Proposer's Medicaid managed care contracts, including the Overall, Consumer Satisfaction, Prevention, and Treatment sub-ratings from the NCQA Health Insurance Plan Ratings 2018-2019 Summary Report (Medicaid). The Proposer shall provide complete and accurate information in all fields, consistent with the NCQA Summary Report (Medicaid).
3. The Proposer should include the NCQA STAR rating information for all Medicaid managed care plans operating in Louisiana.
4. The Proposer should only include NCQA STAR rating information for Medicaid managed care programs operating outside of LA if the plan's NCQA accreditation is listed as a "YES" on the Medicaid summary report indicating that it has full, non-interim, NCQA Accreditation. The Proposer should NOT include Medicaid plans operating outside of LA: (1) with interim NCQA Accreditation or (2) for which NCQA STAR rating information was issued at the time of interim NCQA Accreditation.

Insert Proposer Name

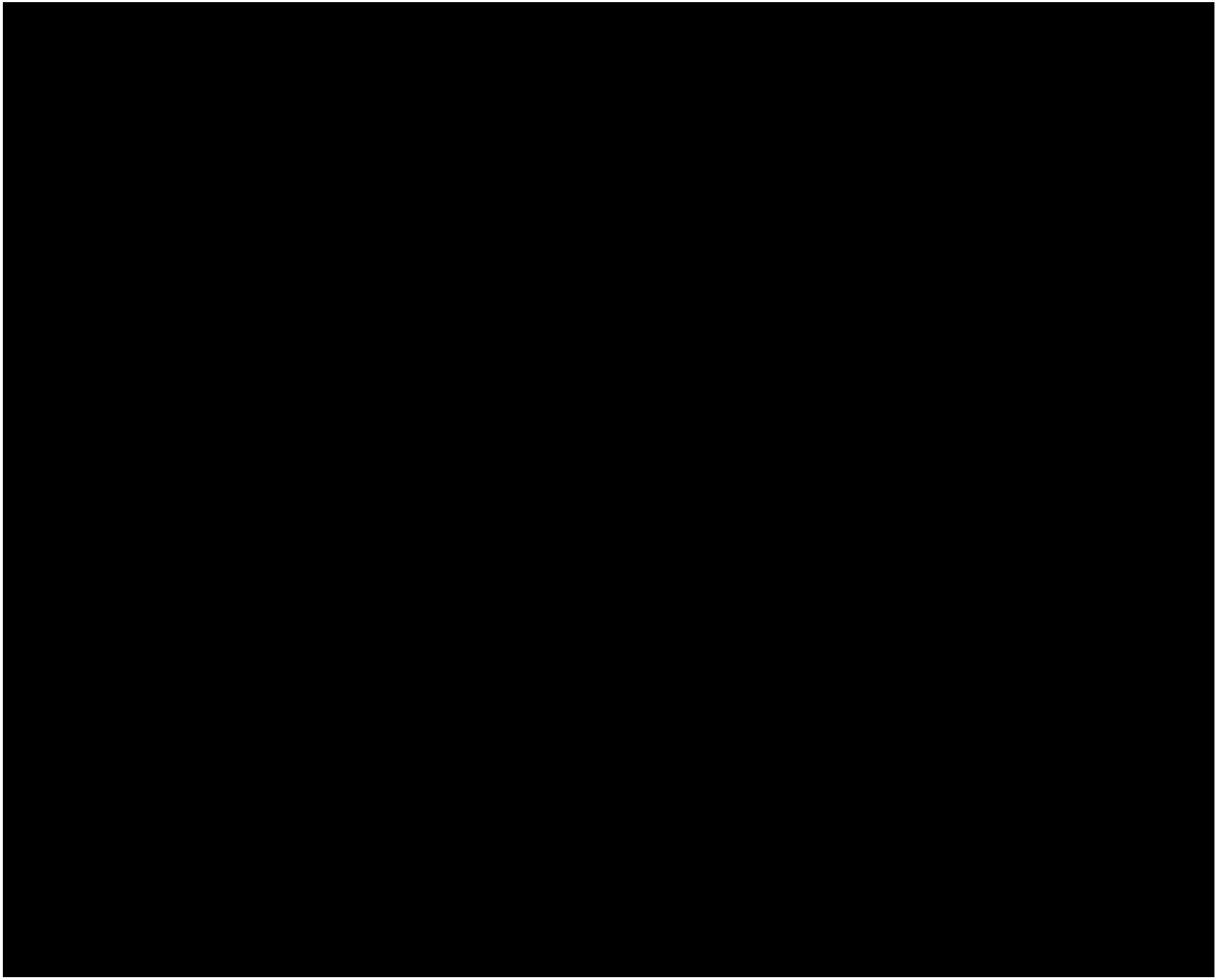
						2018-2019 NCQA Star Rating Summary (Medicaid)			
Number	State	Medicaid "HMO" Plan Name	Medicaid Enrollment in December 2018	Populations included (e.g., ABD, TANF, Expansion, LTSS)	Benefits provided (e.g., full benefits, behavioral health only, Medicare/Medicaid integrated)	Overall	Consumer Satisfaction	Prevention	Treatment
1	DC	AmeriHealth Caritas District of Columbia	122878	Families and children, CHIP, and District of Columbia Health Care Alliance (Medicaid expansion).	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.	3.5	2.0	3.5	3.0
2	LA	AmeriHealth Caritas Louisiana	209387	Families and children; pregnant women; Medicaid expansion adults; Supplemental Security Income (SSI); aged blind, and disabled (ABD); enrollees diagnosed with breast or cervical cancer; foster care children; Home and Community-Based Services (HCBS); waiver population for non-HCBS services only; residential facility and dual eligible enrollees.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services. The health plan manages a limited benefit package of specialized behavioral health and non-emergency ambulance transportation services.	3.5	4.5	3.0	2.5
3	MI	Blue Cross Complete of Michigan	209883	Families and children, ABD, Children's Special Health Care Services, Healthy Michigan Plan (Medicaid Expansion), Medicaid coverage for dual eligible enrollees in counties not participating with the Medicare-Medicaid Plan demonstration project, and uninsured children of Michigan's working families.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.	3.5	3.0	3.0	3.5
4	PA	Keystone First	429169	Families and children, SSI beneficiaries, enrollees diagnosed with breast or cervical cancer; newly eligible enrollees who are new to Medicaid due to expansion; enrollees receiving maternity care.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.	4.0	2.5	4.0	3.5
5	PA	AmeriHealth Caritas Northeast	90256	Families and children, SSI, enrollees diagnosed with breast or cervical cancer; newly eligible enrollees who are new to Medicaid due to expansion; enrollees receiving maternity care.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.	4.0	4.0	2.5	3.5
6	PA	AmeriHealth Caritas Pennsylvania	193969	Families and children, SSI, enrollees diagnosed with breast or cervical cancer; newly eligible enrollees who are new to Medicaid due to expansion; enrollees receiving maternity care.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.	4.0	3.5	4.0	3.5
7	SC	Select Health of South Carolina	376114	Families and children, SSI and CHIP beneficiaries, foster children, and Sixth Omnibus Budget Reconciliation Act coverage for low-income, pregnant women and infants.	Providing, arranging, and coordinating preventive, primary, acute care, behavioral health, and pharmacy services.	4.0	4.5	3.5	2.5
		* Plans with Interim Accreditation are not listed							

Attachments to 2.10.13 Claims Management and Systems and Technical Requirements

AmeriHealth Caritas™
Louisiana

Attachment 2.10.13.2-1
Data and Process Flows for Business Processes
MIS Overview

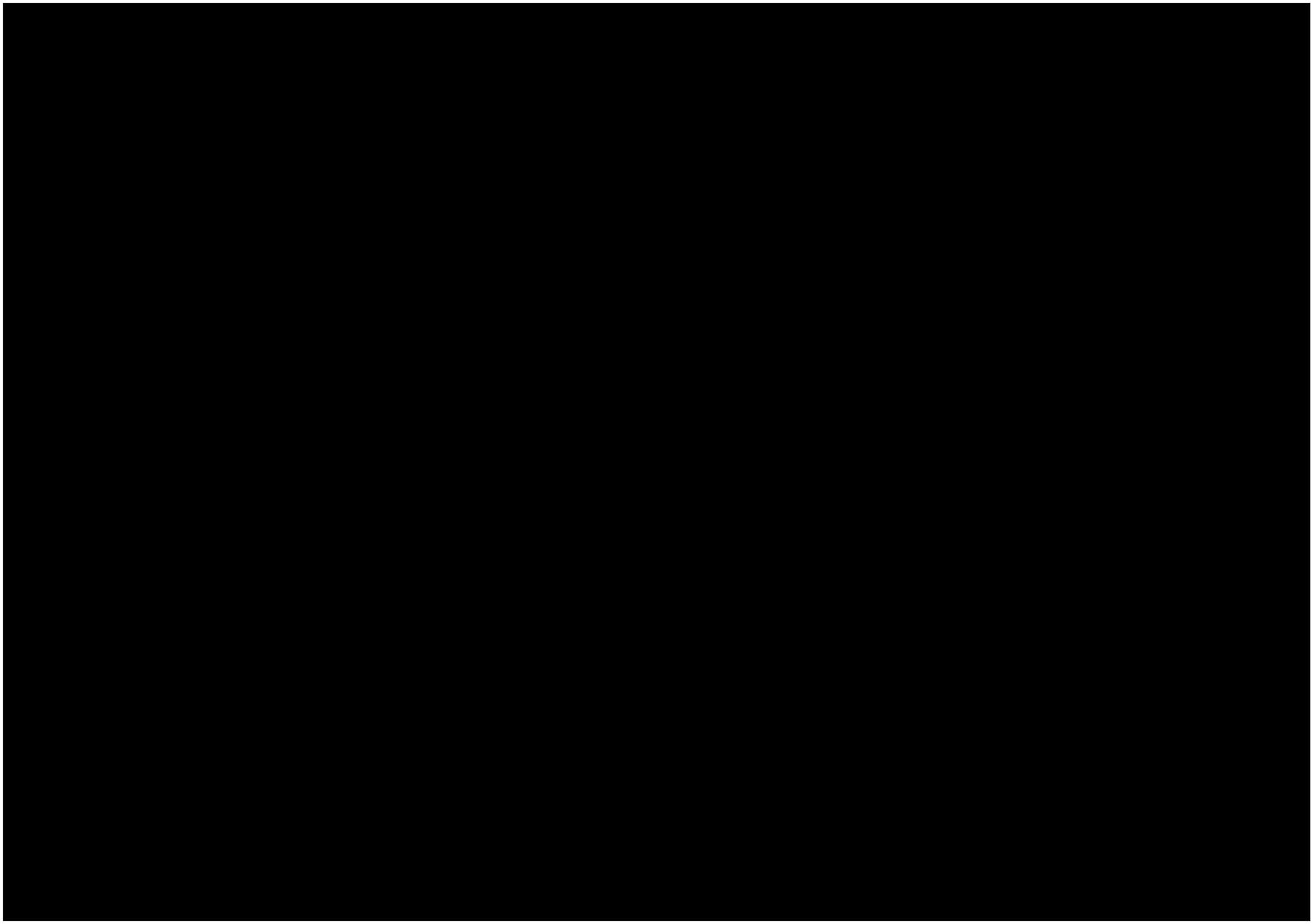
This page is intentionally left blank.



This page is intentionally left blank.

Attachment 2.10.13.2-2
Data and Process Flows for Business Processes
Core Administration Platform

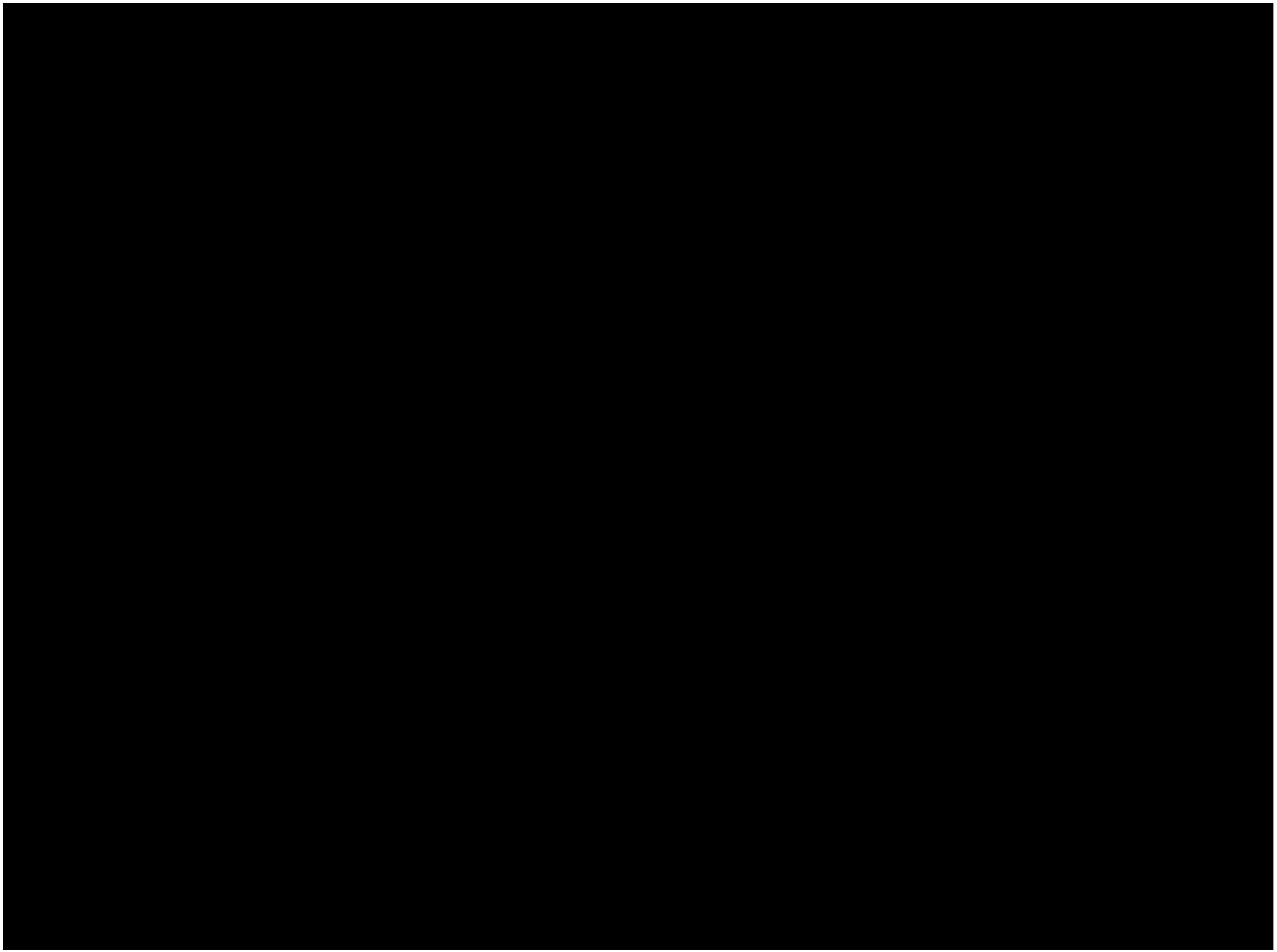
This page is intentionally left blank.



This page is intentionally left blank.

Attachment 2.10.13.2-3
Data and Process Flows for Business Processes
Integrated Population Health Platform

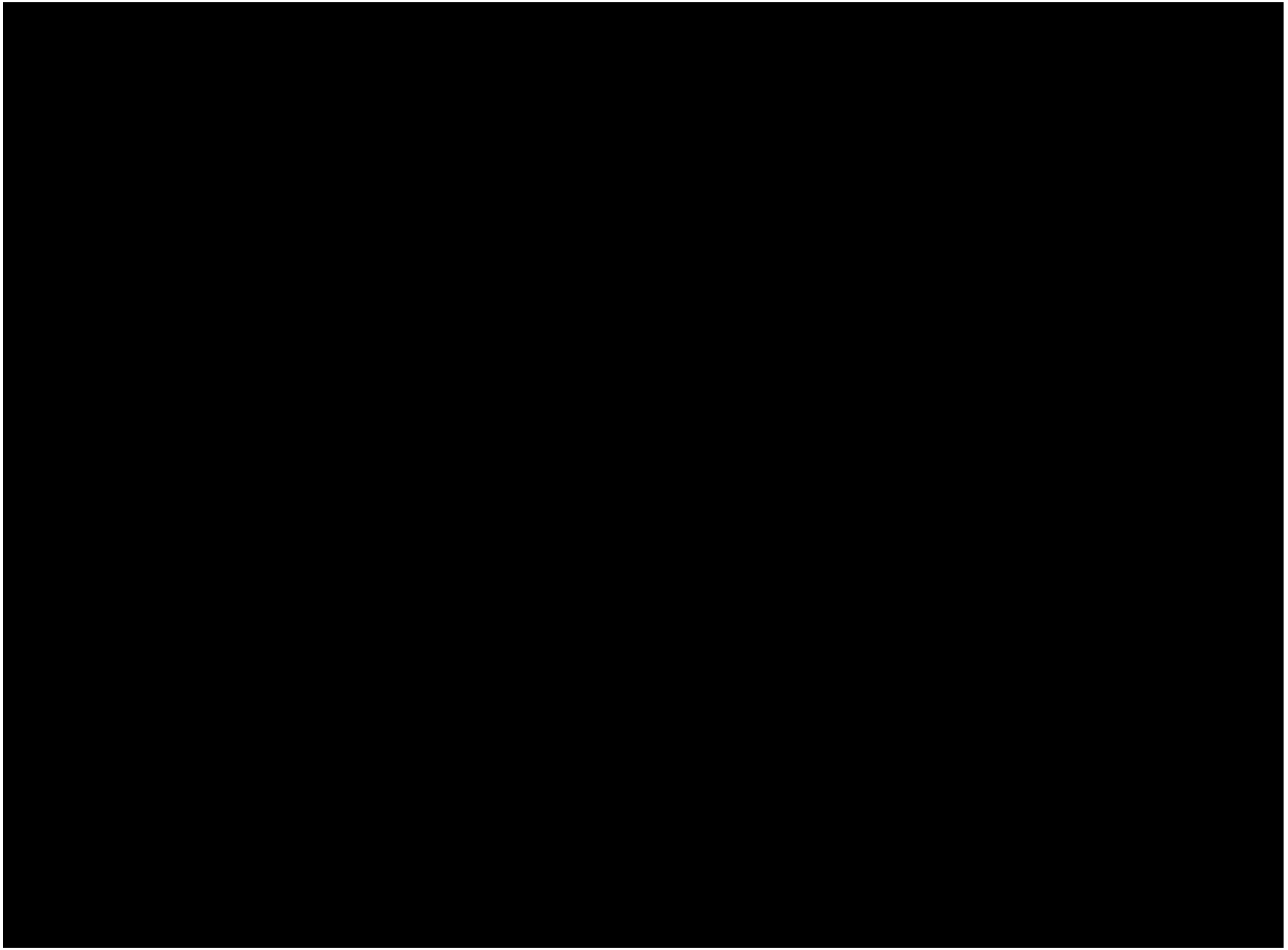
This page is intentionally left blank.



This page is intentionally left blank.

Attachment 2.10.13.2-4
Data and Process Flows for Business Processes
Customer Service Platform

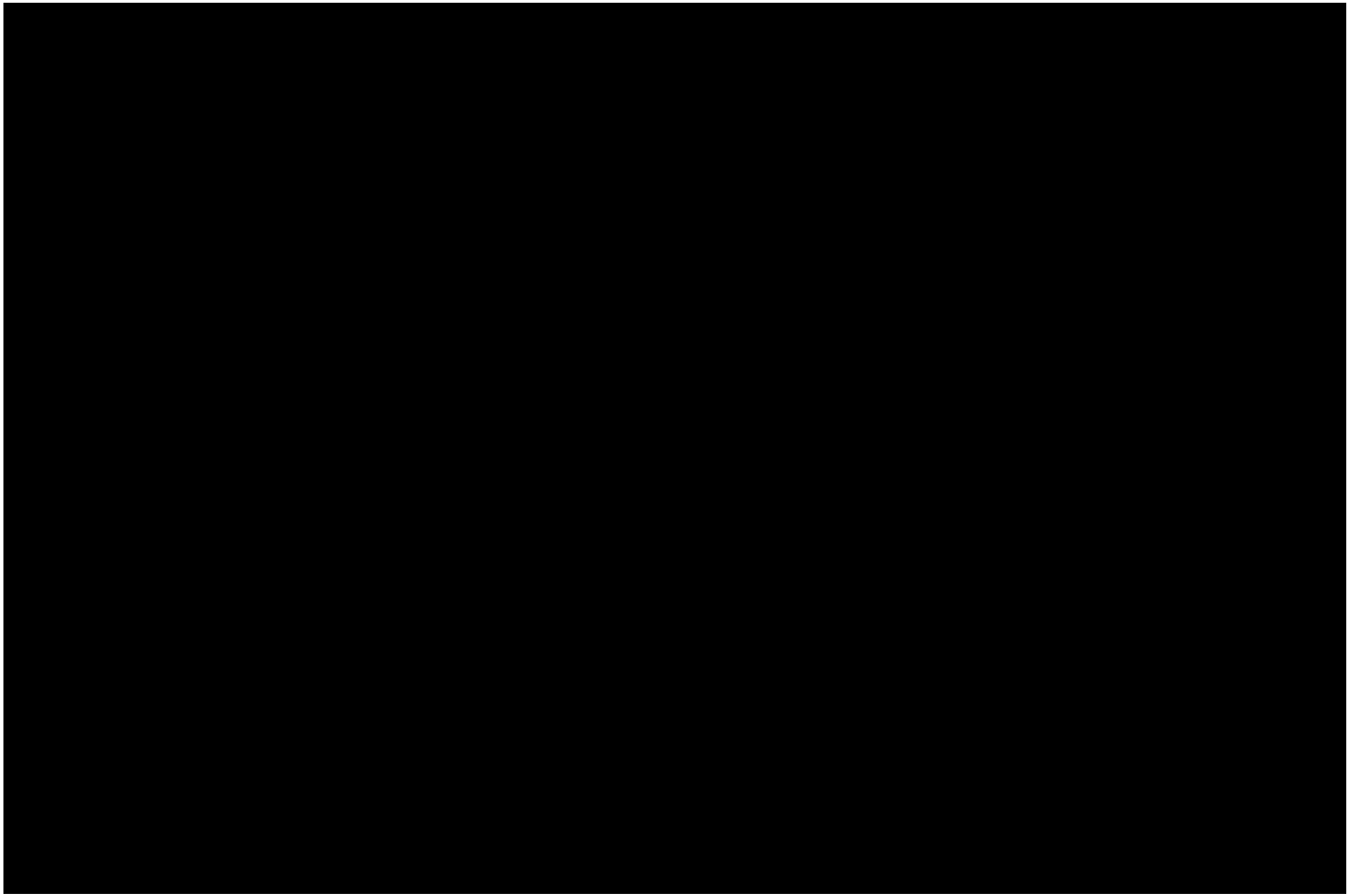
This page is intentionally left blank.



This page is intentionally left blank.

Attachment 2.10.13.2-5
Data and Process Flows for Business Processes
Corporate Services Platform

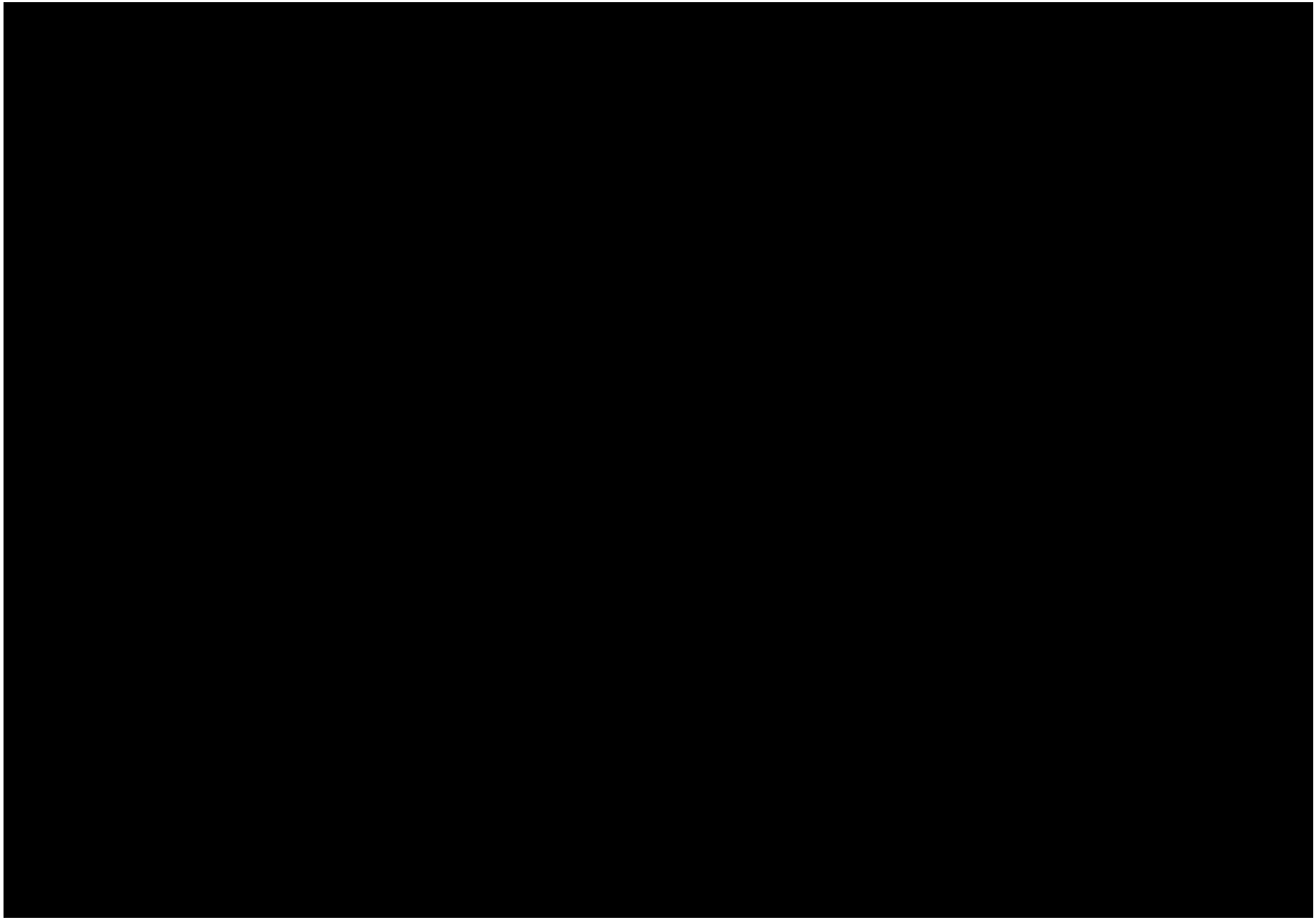
This page is intentionally left blank.



This page is intentionally left blank.

Attachment 2.10.13.2-6
Data and Process Flows for Business Processes
Provider Network Management

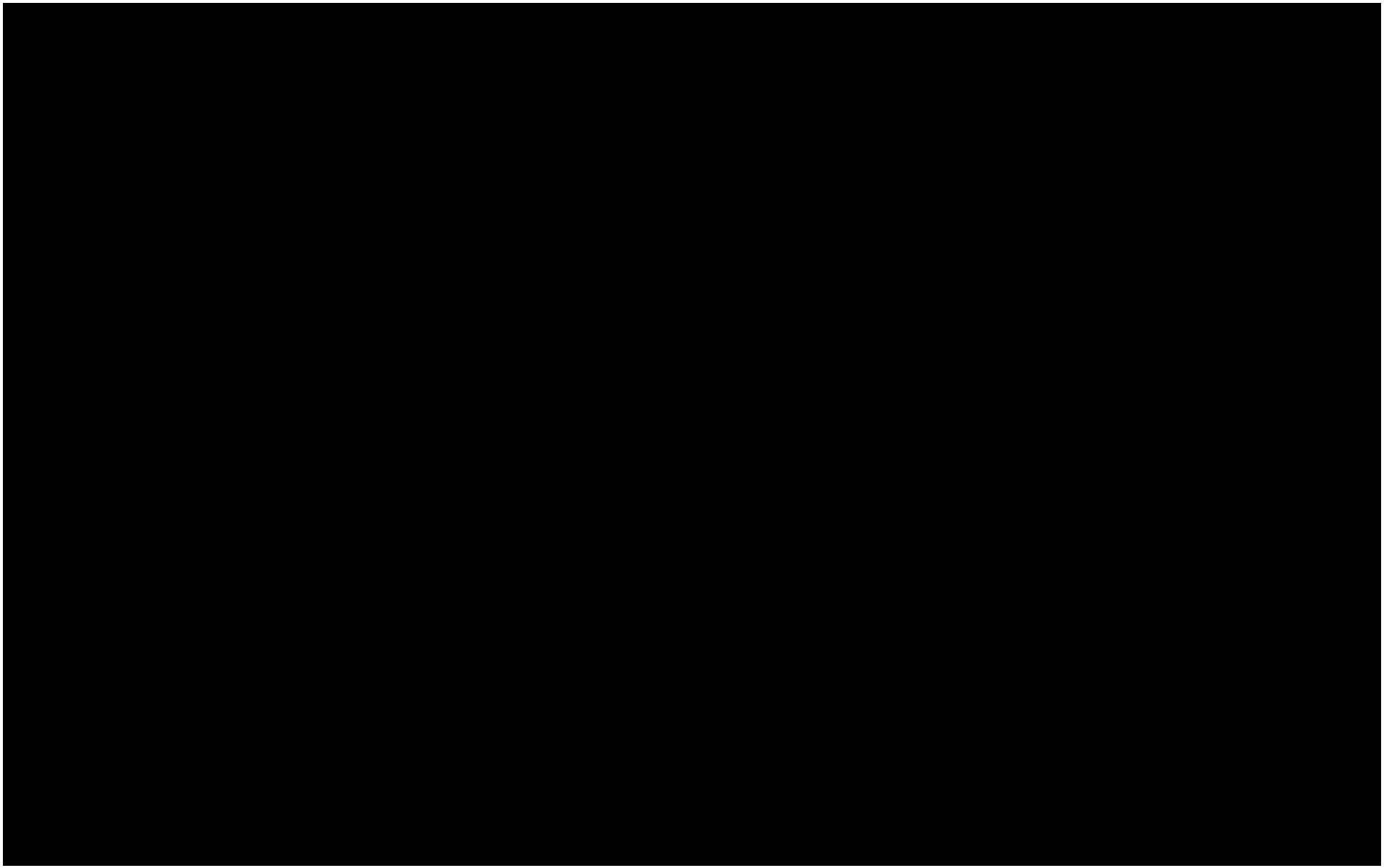
This page is intentionally left blank.



This page is intentionally left blank.

Attachment 2.10.13.2-7
Data and Process Flows for Business Processes Reporting and Analytics Platform

This page is intentionally left blank.



This page is intentionally left blank.