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GOVERNOR

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SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

LOUISIANA DEPARTMENT OF HEALTH
MEMORANDUM OF UNDERSTANDING
BETWEEN
OFFICE OF PUBLIC HEALTH, BUREAU OF FAMILY HEALTH (TITLE V)
AND
BUREAU OF HEALTH SERVICES FINANCING (TITLE XIX and XXI)

1. INTRODUCTION AND GOALS

The Louisiana Department of Health (LDH) is the organizational entity within Louisiana state government that is responsible for administering the Office of Public Health (OPH) and the Bureau of Health Services Financing (BHSF). The OPH Bureau of Family Health (BFH) is responsible for the management of the Title V Maternal and Child Health Block Grant.[1] As such, OPH BFH is responsible for the policies, planning, and management of the Title V Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs. The BHSF (Louisiana Medicaid) is responsible for policies, planning, and management of the Title XIX and XXI (CHIP) programs.[2] Federal laws and regulations mandate cooperation between the state agencies responsible for the administration and/or supervision of both Title V and Title XIX of the Social Security Act (See Appendix A). This document serves as the formal agreement that Title V programs are required to establish with their Title XIX agencies.[3]

The overall goal of this Memorandum of Understanding (MOU) is to provide a formal mechanism to coordinate efforts between the parties in order to improve the health of women and their partners, pregnant women, infants, children, adolescents, and CYSHCN and their families in Louisiana. The similarity of both programs' missions and target populations provides an opportunity to collaborate on common goals and objectives and to develop mutually reinforcing activities. Through this MOU, the parties will establish working relationships that will endure organizational and staffing changes. The benefits of such collaboration include: increased communication and alignment of efforts; shared expertise among staff; efficient use of personnel and resources; reduction of duplicative efforts; and assurance that services meet the needs of the populations, are complementary, and are supportive of one another's program goals.

This MOU will be reviewed and amended as needed on an annual basis. The parties will designate specific personnel to meet on a regular basis (a minimum of quarterly) who will serve as the Title V / Title XIX and XXI Coordination Workgroup in order to achieve the intent of this MOU. The Workgroup will develop an annual business plan in order to ensure

[1] Title V of the Social Security Act, 1935. §501 [42 U.S.C. 701]
[2] Title XIX of the Social Security Act, 1965. §1900 [42 U.S.C. §§1396] and Title XXI of the Social Security Act, 1997. §2101 [42 U.S.C. §§1397]
[3] Title XIX of the Social Security Act, 1969. [42 U.S.C. §1902(a)(11)(A)]

implementation of the key operational areas outlined in the MOU and to monitor and evaluate progress. The Title V and Title XIX and XXI Directors may request to amend this agreement at any time.

2. ROLES IN LOUISIANA'S PUBLIC HEALTH AND HEALTH CARE SYSTEMS

A. The Title V Program aims to: (1) Mobilize partners, including families, at the federal, state and community levels in promoting a shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services, and developing supportive policies; (2) Integrate systems of public health, health care, and related community services to ensure access and coordination to assure maximum impact; (3) Conduct ongoing assessment of the changing health needs of the MCH population (as impacted by cultural, linguistic, and demographic characteristics) to drive priorities for achieving equity in access and positive health outcomes; (4) Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and efficient use of resources; (5) Inform and educate the public and families about the unique needs of the MCH population; (6) Promote applied research resulting in evidence-based policies and programs; (7) Promote rapid innovation and dissemination of effective practices through quality improvement and other emerging methods; and (8) Provide services to address unmet needs in health care and public health systems for the MCH population. State-specific priorities are established every five years based on a statewide needs assessment, as required by Title V. The 2015-2020 priorities for Louisiana that were defined through the 2015 Title V MCH Block Grant Needs Assessment include the following: (1) Ensure high performing essential MCH screening and surveillance systems; (2) Improve access to and quality of primary care, reproductive health, and specialty clinical services including care coordination; (3) Improve social and behavioral supports with a focus on child and family well-being and resiliency; (4) Improve the ability of care systems to serve and support children, adolescents, and CYSHCN through transitions; (5) Bolster local-level capacity to promote and protect health and well-being of children, caregivers, and families; (6) Advance understanding of drivers of disparities in MCH and CYSHCN outcomes and boldly work toward equity; and (7) Actively and meaningfully engage youth and families, building local-level leaders across the state.

B. The mission of BHSF, which administers the state Medicaid and CHIP programs, is to respond to the health needs of Louisiana's citizens by developing, implementing, and enforcing administrative and programmatic policy with respect to eligibility, licensure, reimbursement, and monitoring of health care services, in compliance with federal and state laws and regulations. Priorities include the following: (1) Improve health outcomes by emphasizing primary care and reducing the number of uninsured persons in Louisiana; (2) Expand existing and develop additional community-based services as an alternative to institutional care; (3) Ensure cost-effectiveness in the delivery of health care services by using efficient management practices and maximizing revenue opportunities; (4) Assure the integrity and accountability of the health care delivery system in an effort to promote the health and safety of Louisiana's citizens; (5) Implement measures that will constrain the growth in Medicaid expenditures while improving services to secure alternative sources of funding for health care in Louisiana; (6) Promote preventive health care and condition-specific care and improve utilization of services to enhance quality of health

care delivery in the state; and (7) Provide ongoing monitoring and evaluation of performance measures that assess the quality of health care provided through managed care health plans.

3. RESPONSIBILITIES

As stated previously, the Title V / Title XIX and XXI Coordination Workgroup will develop an annual business plan that specifies the priorities and anticipated collaborative efforts. This plan will be drafted during the third to fourth quarter of each state fiscal year in order to align with the subsequent state fiscal year and the annual Title V MCH Block Grant application. In addition, the Workgroup will coordinate ongoing and emerging collaborative endeavors centered on the following areas:

A. Policy

(1) Develop complementary, mutually beneficial strategies and plans. Current and recent examples include: the Title V MCH Block Grant Five-Year Needs Assessment and State Action Plan; and Louisiana Medicaid State Plan Amendments, waivers, and requests for proposals.

(2) Work jointly on planned and emergent public health issues and priorities. Current and recent examples include: prevention of Zika virus transmission; access to reproductive health services, prenatal care, post-partum care, well-visits, and other preventive services; and access to specialty care and interventions, such as progesterone administration.

(3) Work jointly on the development of quality measures and performance improvement strategies. Current and recent examples include researching and proposing quality measures for managed care health plans.

(4) Collaborate in the evaluation and development of current and emerging Louisiana Medicaid covered services, benefits, standards of care, protocols, and pilot programs. Current and recent examples include: researching potential covered services at the request of Medicaid, or as proposed by commissions and councils associated with OPH BFH.

B. Data

Exchange and review data, based on agency priorities, in order to evaluate and inform Louisiana Medicaid and public health programs and policies. The ability to exchange OPH and Louisiana Medicaid data and statistics for these purposes was established in the LDH-BHSF, OPH and Office of Behavioral (OBH) Health Data Sharing Agreement (See Appendix B). Recent and potential data that may be of mutual priority include, but are not limited to: findings from Louisiana Medicaid claims and eligibility analyses; managed care health plans quality measure performance; Title V Needs Assessment and National Performance Measures (NPMs); Louisiana State Child Death Review Panel (CDR), Fetal and Infant Mortality Review (FIMR), and Pregnancy Associated Mortality Review (PAMR) findings; and data from Pregnancy Risk Assessment Monitoring System (PRAMS) and the Louisiana Health Insurance Survey (LHIS).

C. Committees and Workgroups

Support and participate as needed and/or requested in one another's high-level

commissions, committees, and workgroups. These joint workgroups generally serve to provide leadership and recommend policy through the unification of both the public health and payer perspectives. Such expertise can benefit both parties as they examine a particular systems-level problem or opportunity and elevate findings in order to improve health and control health care costs. Examples of groups include but are not limited to: Louisiana Commission on Perinatal Care and Prevention of Infant Mortality, the Louisiana State Child Death Review Panel (CDR), the Louisiana Perinatal Quality Collaborative, Louisiana Medicaid Quality Committee, Louisiana Medicaid Performance Improvement Projects (PIPs) and Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC) and other public health and CMS learning collaboratives.

D. Access, Outreach and Referrals
Promote access, facilitate outreach, and strengthen referral pathways within one another's programs and systems of care. Louisiana Medicaid will help ensure that managed care health plans refer their members to Title V programs, services, and resources and provide available educational materials where applicable. In return, BFH will help ensure linkage to coverage by identifying individuals, families, and children who are eligible but not enrolled and refer them to Louisiana Medicaid fee-for-service or managed care health plans. In addition, BFH will help identify those who are enrolled, but have not utilized, their Medicaid coverage and reinforce Louisiana Medicaid benefits and services. Specific examples include, but are not limited to:

(1) Develop outreach strategies and provide educational materials developed by Louisiana Medicaid for Title V to inform individuals about Louisiana Medicaid benefits and services for which they are qualified for in order to maximize enrollment and recertification within programs; such materials will be approved by Louisiana Medicaid and the LDH Bureau of Media and Communications in the event new materials are developed that are not originally produced by Louisiana Medicaid. Title V's state-wide toll-free helpline will provide Louisiana Medicaid contact information for those women and families seeking information and referrals on prenatal care, family planning, and well-child services.

(2) Maximize enrollment through the creation of referral processes to ensure these individuals receive the full potential of the benefits and services for which they are qualified (such as with the Maternal, Infant, and Early Childhood Home Visiting [MIECHV] Nurse-Family Partnership and Parents as Teachers programs).

(3) Advance, reinforce, and promote Title V state and national priorities, such as care coordination, models of mental health consultation, evidence-based early childhood social emotional supports, and developmental screening tools, through integration of these services, where possible, through the managed care health plan contracts and educational campaigns and materials.

(4) Utilize the reach of providers to disseminate program information and to encourage referrals for health programs and access to other systems of care.

E. Insurance Adequacy
Develop strategies to improve adequacy of insurance coverage. According to the National Survey of Children's Health, adequate insurance is defined as insurance that covers needed services, has a sufficient network of providers, and reasonably covers

medical costs. BFH measures insurance adequacy through the Title V National Performance Measure "Percent of children 0 through 17 years who are adequately insured," and Louisiana Medicaid measures this through the Louisiana Health Insurance Survey (LHIS). Examples of strategies may include: strengthening provider networks' provision of care and quality of services; examining reimbursement rates; data analysis; and jointly developing policy changes.

F. Transitions of Care
Develop and implement messaging that will focus on continuity of care for populations transitioning from one level of care to another. Examples include, but are not limited to: children aging out of early intervention services; youth with special health care needs transitioning from pediatric to adult care; youth aging out of the foster care system; and parents transitioning from incarceration to community.

G. Leverage Funds
Per Title V of the Social Security Act[4] and the Medicaid Code of Federal Regulations[5], Medicaid must "Provide, if requested by the Title V grantee in accordance with the arrangements made under this section, that the Medicaid agency reimburse the grantee or the provider for the cost of services furnished beneficiaries by or through the grantee." Therefore, under this agreement, the Title V / Title XIX and XXI Coordination Workgroup will assess this provision to assure the efficient and effective administration of the Title V Maternal and Child Block Grant and the Louisiana Medicaid State Plan. In addition, the Workgroup may assess where Medicaid administrative match or Title V Maternal and Child Health Block Grant may be leveraged to support mutual priorities.

4. SIGNATURES

8/18/17

Parham Jaberi, MD — Date
Assistant Secretary, LDH OPH
Administrator

8/18/17

Amy Zapata, MPH — Date
Director, OPH BFH – Title V

8/18/17

Jen Steele — Date
Medicaid Director, LDH BHSF

[4] Title V of the Social Security Act, Omnibus Budget Reconciliation Acts, 1989. [§1902(a)(11) and (22)(C)
[5] Title 42, Chapter IV, Code of Federal Regulations. §431.615(c)

APPENDIX A - FEDERAL AUTHORIZATION FOR THE TITLE V MCH BLOCK GRANT AND TITLE XIX (LOUISIANA MEDICAID) MEMORANDUM OF UNDERSTANDING

Title V and Title XIX are both authorized by the Social Security Act (42 U.S.C. ch. 7): Title V (1935) & Title XIX (1965). Coordination between state MCH and Medicaid agencies is required by the following statutes and regulations: (§1902(a)(11)(B) of Social Security Act), (Code of Federal Regulation Title 42 - § 431.620, (§505(a)(F)(iv)) https://www.ssa.gov/OP_Home/ssact/title05/0500.htm

Examples include but are not limited to:
OBRA 1989 - The importance of State Title V agencies in meeting requirements set forth in Title XIX of the SSA, with a particular emphasis on coordination, accountability, and reporting requirements:

- Participate in developing and carrying out agreements on coordination of care and services [§1902(a)(11); §505(a)(5)(E)(ii)].
- Coordinate activities with the EPSDT program [§505(a)(5)(E)(i)].
- Assist in identifying and registering pregnant women and infants who are eligible for medical assistance [§505(a)(5)(F)(iv)].
- Provide a toll-free telephone number to help parents obtain information about services under Title V and Title XIX [§505 (a)(5)(E)].
- Expanded requirements for cooperation with health agencies to include Title V [§1902(b)(11)(B)].
- Required Medicaid agencies to act as the payer of first resort
- Use Title V-funded agencies to provide services for Medicaid-eligible clients if such services are included in the State plan [§1902(a)(11)(B)(i)].
- Reimburse agencies for the cost of services provided to any individual for which payment would otherwise be made to the State [§1902(a)(11)(B)(ii)].
- Coordinate information and education on pediatric vaccinations and delivery of immunization services [§1902(a)(11)(B)(iii)].
- CMS Manual states that Medicaid agencies are responsible for reimbursing Title V providers for services provided to Medicaid beneficiaries even if these services are provided free of charge to low-income uninsured families. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1P240.pdf

Appendix B

ORIGINAL

DATA SHARING AGREEMENT
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS (DHH),
BUREAU OF HEALTH SERVICES FINANCING (BHSF),
AND
OFFICE OF PUBLIC HEALTH (OPH),
AND
OFFICE OF BEHAVIORAL HEALTH (OBH)

I) PURPOSE

The Department of Health and Hospitals (DHH), through the Bureau of Health Services Financing (BHSF), the Office of Public Health (OPH), and the Office of Behavioral Health (OBH) will exchange Medicaid claims and eligibility data, public health data and statistics, alcohol and drug treatment records, and behavioral health claims and behavioral health Medicaid population statistics. This exchange of information will assist in the administration and evaluation of Louisiana Medicaid, public health, and behavioral health services. The data will only be used for program planning, implementation, administration, research, and analytical purposes and will not be used to determine eligibility. This agreement will define and permit the reporting exchange among BHSF, OPH, and OBH to address the provision of personal health services, as well as other core public health functions.

II) DEFINITIONS

Definition of terms:
A. "Center for Vital Records and Statistics" refers to that section which codes, tabulates, analyzes, reports, and coordinates vital records and other health status indicators data for OPH.
B. "Consumer" means any individual receiving health services through any program in BHSF, OPH, or OBH that is supported by state or federal resources.
C. "Health services" are defined as those services that include promotion and prevention activities which improve the general well-being of the consumer.
D. "Vital Records," "certificates," or "forms" means paper or electronic reports of birth, death, fetal death, marriage, divorce, dissolution of marriage, or annulment, and data related thereto.
E. "Data Stewards" are those employees who manage the sourcing, use and maintenance of data assets in a program office.
F. "Business Associate" is an identified person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information.

III) JUSTIFICATION FOR ACCESS

A. Federal Requirements

Section 1902 (a) (7) of the Social Security Act (as amended) provides for safeguards which restrict the use or disclosure of information concerning Medicaid applicants and recipients to purposes directly connected with the administration of the Title XIX Medicaid State Plan. 42 CFR 431.302 specifies the purposes directly related to Medicaid State Plan administration. These include: (a) establishing eligibility, (b) determining the amount of medical assistance, (c) providing services for recipients, and (d) conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan. Since Medicaid operates a managed care structure as health plans, they are covered entities by HIPAA. 45 CFR 164.506 permits the disclosure or use of protected health information for treatment, payment, and operations of health care activities.

Managed care structures affect how public health agencies carry out their community-wide public health responsibilities. Data sharing amongst agencies provides the opportunity to study changes in health, utilization, and costs within Louisiana's significant Medicaid population. These linkages involve efforts to enroll, provide, and coordinate care among Louisiana's most vulnerable citizens.

B. State Requirements

Protocols and procedures developed under this agreement will be consistent with the parties' implementation of requirements associated with state statutes, including but not limited to R.S. 46:56 and R.S. 40:41 et seq.

IV) BENEFITS TO BHSF

Open reporting to Medicaid will refer consumers to Medicaid and other programs for inpatient care and other benefits not provided by separate, state programs. This relationship will facilitate improved coordination of state programs for uninsured adults and children and populations with special health care needs. Furthermore, OPH, operating as a Medicaid provider, will also provide laboratory information on consumers who receive services. This collaboration will also contribute to the coordination of care and quality improvement efforts. Moreover, this will enable early detection of pregnancy amongst Medicaid-eligible mothers. Finally, this agreement will –on a per member, per month basis--help facilitate expeditious updating of Medicaid membership rolls (in the event of death or fetal death) so that no unnecessary payments are made to or by managed care organizations.

One challenge BHSF faces with providing substance use disorder (SUD) services is that they are typically funded and provided across multiple funding streams rather than being financed exclusively by Medicaid. As a result, analyzing data relating to SUD disorders requires data linkages. BHSF and its recipients will benefit from linking OBH data to Medicaid administrative claims and encounters by enabling the agency to better measure service utilization, costs, and provider network access. BHSF's goals for improving Medicaid delivery of SUD services include implementation of new payment strategies and improvements to care transitions for Medicaid

recipients with SUD co-morbidities. The ultimate benefit will be lower costs and improved health outcomes.

V) BENEFITS TO OPH

Medicaid data and behavioral health data are essential to OPH for population-based services and targeted interventions including planning, programming, policy-making/analysis, and community engagement. This agreement will help to simplify sharing of timely, relevant, and high-quality Medicaid data needed for population-based planning and to prevent disease and injury, especially within vulnerable populations such as newborn infants, women, children and individuals with chronic conditions, physical and emotional disabilities, and communicable diseases. Understanding substance abuse and mental health treatment is integral to providing appropriate care at clinics operated by OPH and for understanding the full picture of health statistics for the population of Louisiana. Medicaid will provide claims (inclusive of Medicaid ID number, specific codes related to procedures, diagnoses, pharmacy, and costs), eligibility (income, % FPL, type of Medicaid plan and utilization statistics on clients who receive services to inform and guide OPH public health interventions and augment statistics services; and identify emerging needs in the areas of environmental health, emergency preparedness, and targeted prevention efforts for program areas such as HIV/STD, Bureau of Family Health (Maternal Child Health and Family Planning), WIC, Genetic Disease, Oral Health, and Chronic Disease. OBH will provide electronic health record data for linkage with other primary care sources within OPH.

OPH makes frequent requests for data to help determine the prevalence, morbidity, costs, health care access, and economic burden related to chronic and communicable diseases and other health risk factors in Louisiana. OBH and Medicaid data and information help OPH's workforce to advance operations and inform program and managerial decisions regarding performance improvement, program evaluation and analysis, health outcome assessment, parish health unit administration and clinical services, population demographics, quality assurance, utilization and demand, and cost-effectiveness.

VI) BENEFITS TO OBH

Medicaid encounter data will allow OBH to identify persons who received services funded by Medicaid or are counted as Medicaid waivers with mental illness, addictive disorders, or co-occurring mental health and addictive disorders served. Medicaid MARS Data Warehouse includes claims, eligibility, provider, and reference information which will help OBH's workforce ensure accurate and complete encounter reporting and also will be required for use in quality management and performance accountability for encounter-related projects. Data will be obtained from the MARS data warehouse for performance measures which include Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality (AHRQ) measures and other measures as defined by DHH-OBH.

Moving toward integrated care requires OBH to crosswalk behavioral health data with public health data to develop a holistic picture of the patients under the care of our Statewide Management Organization (SMO). By sharing data with OPH, OBH and/or OPH can perform data analyses to understand the prevalence of disease conditions (STDs, for example) amongst patients in our partnership. In addition, OBH access to LaHIDD (the state inpatient database) data assists OBH in identifying Medicaid utilization in conjunction with principal diagnosis. With the OBH goal of lowering readmission rates, information from LaHIDD can help the agency target super-utilizer behavioral health populations. OBH can also utilize the Behavioral Risk Factor Surveillance System (BRFSS) which is a chronic disease survey that would foster a better understanding of the health and habits of OBH recipients. OBH anticipates using the Louisiana Early Event Detection System (LEEDS) data for behavioral health surveillance. Newborn screenings and birth records will assist OBH in targeting interventions aimed at the early detection and treatment of pregnant women with Substance Use Disorder (SUD). OBH will analyze the data on the newborn to measure the health outcomes of those receiving and those not receiving SUD treatment during pregnancy.

VII) MUTUAL BENEFITS

There are mutual benefits to both organizations including but not limited to: development of State-level, integrated information systems to support the evolving role of State government in assuring appropriate, accessible, cost-effective care for vulnerable populations; improvement of Louisiana's technical capacity to analyze data from multiple sources to support policy decision making and program monitoring; development and implementation of common performance measures across multiple programs to improve their effectiveness; and utilization of Medicaid encounter data to assist in public health and behavioral health surveillance, thereby ensuring appropriate care for the Medicaid population.

VIII) DESCRIPTION OF DATA

The LMMIS MARS Data Warehouse (MDW) is a client/server computing platform developed to house a minimum of five full fiscal years (state and federal) of LMMIS claims, eligibility, provider, and reference information. The purpose of the MDW is to provide an independent, isolated computing platform that will be used to generate CMS and State MARS reports. It also supports the data mining efforts required by DHH to manage the Medicaid program. Ultimately, the MDW will enable DHH to establish a solid foundation for fiscal and program trend analyses. The MDW is a relational database system carrying information related to the Medicaid claims processed for the period of January 1995 through the last full month. New eligibility and provider data is loaded into the MDW on a monthly basis, while new claims data is loaded weekly. The claims tables are appended each Sunday to the existing claims data tables. Generally, by the first or second weekend of every month, eligibility and provider tables are loaded with a complete refresh of data. The data for the weekly load of claims is downloaded from the Mainframe via several extract programs that run weekly on Sunday. The data for the monthly load is downloaded from the Mainframe via several extract programs that run after

the last check write for the month. Schema and data element specifications are described in Addendum B.

OPH has multiple data information systems that contain consumer information vital to OPH programs, such as: maternal child health planning, family planning, chronic and infectious disease tracking and prevention, referral for medical treatment not provided by OPH, environmental health, and emergency preparedness and syndromic surveillance; immunizations; laboratory information management system. Other systems include the Metabolic Screening Database System for Newborn Screening; Various maternal/child systems, Maternal, Infant and Early Childhood Home Visiting Data System, Healthy Homes & Lead Poisoning Prevention Database, Bureau of EMS Portal (licensure, education, and training data); sanitarian software for permitting and inspections of food, restaurants and other commercial ventures requiring permits, Environmental Public Health Tracking Program Network which is a web-based, user-defined query portal with statistics on pesticide exposure, occupational health/adult blood lead poisoning, indoor air quality; other program information such as asthma, carbon monoxide poisonings, heat stress, heart attacks, water and air quality, birth outcomes, birth defects, cancer, and childhood lead poisonings. OPH conducts the annual phone survey known as Behavioral Risk Factor Surveillance System (BRFSS) that collects data on various behaviors related to health that residents employ. Many of these databases have a clear overlap with Medicaid-eligible clients.

OPH can also provide encounter data on services offered in the Parish Health Units, much of these services being provided for Medicaid-eligible citizens.

OPH expects to begin implementing electronic health records (EHR) in all parish health units in the 2014 fiscal year. The EHR will include clinical management system, practice management software system and insurance eligibility verification capabilities and billing for public and private insurance plans, including the Bayou Health and Medicaid umbrellas.

OBH data sets include data submitted by the Statewide Management Organization (SMO), which is collected using the SMO's electronic health record, OBHIIS, and LADDS. OBH data are required for federal reporting to Substance Abuse and Mental Health Services Administration (SAMHSA) and also structured to facilitate analysis, reporting, and submittal of data to meet the reporting requirements of various parties. Data sets are transmitted to the OBH secure FTP site and are processes and stored in OBH data warehouse. OBH data provides consumers served, services provided, and treatment outcomes for mental health and addictive disorders.

IX) METHOD OF DATA ACCESS OR TRANSFER

The data sharing permitted under this agreement does not apply to direct access to secure servers. This agreement permits the provision of case level data at the direct request of analysts in each program office, as necessary to fulfill job duties and support the efficiency and effectiveness of their respective program offices.

Data will be read-only, downloaded to the DHH SAS server, and securely exchanged via SMTP messaging with TLS encryption. Records are to be stored in secure locations and accessed with local PCs encrypted with BitLocker Drive Encryption. In addition, data may be accessed through restricted access shared folders which contain data which is not real-time.

X) REGULATORY COMPLIANCE AND ACCESS TO RECORDS

A. Medicaid and HIPAA Requirements

To the extent applicable to this Data Sharing Agreement, parties agree to information exchange in compliance with all applicable state and federal confidentiality requirements, including but not limited to state requirements under R.S. 46:56, and including but not limited to the requirements of federal Medicaid regulations, 42 C.F.R.431.300 et seq. and the federal privacy, security, and standards for electronic transactions regulations (45 C.F.R. Parts 160-164) promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (all of which are collectively referred to herein as "HIPAA requirements").

The parties agree to comply with the provisions of the HIPAA Security Rule (45 C.F.R. Part 164, Subpart C) and to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III, "Security of Federal Automated Information System", which sets forth guidelines for security plans for automated information systems in Federal agencies.

B. Health Information Technology for Economic and Clinical Health Act (HITECH)

To the extent applicable to this Data Sharing Agreement, parties agree to comply with the Health Information Technology for Economic and Clinical Health Act, codified at 42 U.S.C. §17931. Users will follow DHH security incident response plans regarding security breach response. Penalties for a covered entity or business associate violating HITECH range from $100 per violation to $1.5 million for all violations in a calendar year. Criminal penalties for the deliberate mistreatment of PHI or failure of timely breach reporting may apply directly to any DHH employee responsible for the offense. Penalties for individuals cannot exceed $250,000 and/or imprisonment not more than ten years.

C. Confidentiality of Alcohol and Drug Abuse Patient Records

To the extent applicable to this Data Sharing Agreement, parties agree to comply with the Drug Abuse Prevention, Treatment and Rehabilitation Act; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and applicable sections of the Public Health Service Act, codified at 42. U.S.C. 290dd-2 ("the Privacy Statute"). Parties also agree to strictly maintain the confidentiality of patient records of drug, alcohol, and other drug treatment programs in addition to treatment and assessment for pathological or compulsive gambling. Parties agree to comply with the Privacy Statute and any of its current and future accompanying regulations (42 C.F.R. Part 2).

D. Vital Records Data Confidentiality

To the extent applicable to this Data Sharing Agreement, Parties agree to comply with the Vital Statistics Laws, codified at LA R.S. 40:41 et seq. Pursuant to these laws, the agencies agree that data contained in the vital records registry shall be made available for review or use by DHH in evaluating the effectiveness of departmental programs. The data shall only be utilized for this specific purpose. The agencies also agree that any DHH employee using data that may contain identifying information shall sign a statement ensuring confidentiality; any identifying data shall also be stripped from resulting databases as soon as the need for it has expired. Agencies agree that all data shall be destroyed or returned to the office of vital records by DHH upon the finalization of the evaluation process.

XI) DISCLOSURE

Parties to this agreement affirm that data will only be accessed and utilized in accordance with established and approved protocols and procedures, which may include sharing protected health information with OPH, OBH, and BHSF business associates for contracted purposes, including care coordination, quality assurance, and performance improvement. Data provided by this agreement can only be used for the legitimate business purposes of the program that allow for the data to be collected and reported. Data provided shall only be made available to authorized personnel in the program area with a need for access. All personnel shall maintain privacy and confidentiality and shall continually safeguard all client-specific information as required by both state and federal law; confidential data shall not be publicly distributed, released for viewing, or accessed through the Internet.

Program offices will maintain users' access and security files so that individuals who are no longer authorized to use the data are deleted in a timely manner. An audit of users will be conducted by each program office quarterly. Each agency agrees to provide audit trails for the inquiries and use of the data. All requests for protected health information must be approved by the respective Section Chiefs.

All staff who access data must sign a User Agreement (see Addendum B below).

XII) LOCATION OF MATCHED DATA AND CUSTODIAL RESPONSIBILITY

Parties to this agreement affirm that: The parties mutually agree that the original program office will be designated as "Custodian" of the file(s) and will be responsible for the observance of all conditions for use and for establishment and maintenance of security agreements as specified in this agreement to prevent unauthorized use. Matched data will remain under the purview of the original program office and will not be disclosed to persons outside the agency or office without written authorization.

This agreement represents and warrants further that, except as specified in an attachment or except as authorized in writing, that such data shall not be disclosed, released, revealed, showed, sold, rented, leased, loaned or otherwise have access granted to the data covered by

this agreement to any person. Access to the data covered by this agreement shall be limited to only those individuals necessary to achieve the purpose stated in this agreement and to those individuals on a need-to-know basis only. Individuals are listed in Addendum A.

Any results of the data matching which contains individually identifiable data cannot be released outside the agency unless the release is approved by the Medicaid Director and the Assistant Secretaries for the Office of Public Health and the Office of Behavioral Health. Any summary results, however, can be shared. Summary results are those items which cannot be used to identify any individual. It should be noted that the stripping of an individual's name or individual identification number does not preclude the identification of that individual, and therefore is not sufficient to protect the confidentiality of individual data.

XIII) AUTHORIZATION

The data sharing outlined in this agreement is limited to the analysts authorized in Addendum A. This list will be updated upon changes in employee status or turnover. In addition, the list will be audited and updated quarterly. Changes to the list of authorized reporters must be approved with signature by the Liaison Officials listed below. Updates and changes to the list in Addendum A will not require formal amendments as provided in paragraph XV of this agreement.

XIV) EXCLUSIONS

This agreement is exclusive of any other current agreements between the Office of Public Health and/or the Office of Behavioral Health and/or Medicaid.

XV) PERIOD OF AGREEMENT

a) This agreement becomes effective on December 1, 2013 and terminates on December 31, 2018.

b) This agreement may be cancelled by either party with 30 days written notice.

c) In the event of a state of emergency, including but not limited to any form of natural disaster, either agency may be forced to suspend services. This agreement will remain in effect during such suspensions and the services will resume when the affected agency resumes normal operations.

XVI) AMENDMENTS

a) Changes made to this agreement will be added as a formal amendment which requires all parties to acknowledge by signature.

b) This agreement shall be reviewed annually to determine if any revisions are necessary.

c) In the event it becomes necessary to change all or part of this agreement to reflect the changing needs of the parties, new laws, regulations, etc., either party may request discussion of proposed amendments through the designated liaison officials. Modifications of the provisions of this agreement shall be valid only when reduced to writing and duly signed by the authorized representatives of each party.

XVII) LIASION OFFICIALS

For the BHSF: Beverly Hardy-Decuir, Medicaid Program Manager
For OPH: Joseph Foxhood, Director, Center for Population Health Informatics
For OBH: Michael Carrone, Program Manager, Health Informatics

The remainder of this page is intentionally left blank.

Signature pages follow.

XVII) SIGNATURES

By signing this data sharing agreement, the BHSF, OBH, and OPH agree to all requirements contained herein.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the date(s) written below.

By: _____ Date: 2/13/15
Diane Batts
Acting Medicaid Director, DHH/BHSF

ORIGINAL

By: _____ Date: 2/13/15
J.T. Lane
Assistant Secretary, Office of Public Health

ORIGINAL

By: _____ Date: 02/26/15
Dr. Rochelle Head-Dunham
Assistant Secretary, Office of Behavioral Health

Addendum A

ORIGINAL

BHSF Access Roster

1. Mary TC Johnson, Medicaid Deputy Director, Health Care Delivery Systems
2. Joshua Hardy, Section Chief, Medicaid Quality Management, Statistics and Reporting
3. Kang Sun Lee, Program Manager 2
4. Tim Williams, Program Manager 2
5. Baogong Jiang, Program Manager
6. Baifu Xu, Program Manager
7. Taehee Han, Program Manager
8. Jen Steele, Medicaid Deputy Director, Medicaid Budget
9. Kerri Lea, Program Manager
10. Ekwutosi Okoroh, CDC Medicaid Medical Epidemiologist
11. Bhaskar Toodi, Section Chief, Health Economics
12. Mahesh Pandit, Health Economist
13. Cristian Nedelea, Health Economist
14. Augustus Matekole, Health Economist
15. Arun Adhikari, Health Economist

OPH Access Roster

16. Ryan Bilbo, GIS Manager
17. Joseph Foxhood, CPHI Director
18. Alok Bhoi, Public Health Epidemiologist
19. Kolynda Parker, LaHIDD Manager
20. Laurie Freyder, BRFSS Coordinator
21. Melissa Brown, MCH Epidemiologist
22. Lyn Kieltyka, Sr. MCH Epidemiologist
23. Jessica Diedling, MCH Epidemiologist
24. Daniel Anderson, MCH Epidemiologist
25. Denver Bailey, MCH Epidemiologist
26. Tri Tran, Senior Children's Special Health Services Epidemiologist
27. Raoult Ratard, State Epidemiologist
28. Theresa Sokol, Assistant State Epidemiologist
29. Gary Balsamo, State Public Health Veterinarian
30. Rishu Garg, Public Health Epidemiologist Specialist
31. Quan Le, Program Manager
32. Ruben Tapia, Immunization Director
33. Clay Trachtman, Supervisor
34. Kate Streva, Environmental Health Scientist Coordinator
35. Michelle Lackovic, *Epidemiologist Consultant*
36. Jocelyn Lewis, Environmental Health Scientist Coordinator
37. Mei-Hung Sun, Environmental Health Scientist Coordinator
38. Vanessa Paul, Epidemiologist
39. Jeanette Webb, Follow-up Coordinator, Hearing Speech and Vision
40. Nicole Deleon, Guide By Your Side Parent Consultant
41. Marbelly Barahona, EHDI Bilingual Parent Consultant
42. Dawne McCabe, LA EHDI Data Clerk
43. Jessica Fridge: STD/HIV Surveillance Manager

44. Debbie Wendell: STD/HIV Data Management/Analysis Manager
45. Nicole Richmond, Epidemiologist/Research Associate
46. Jie Li, SEET Epidemiologist
47. Ngoc Nyugen, Lead Program
48. Jake Causey, SDWP
49. Caryn Benjamin, SDWP
50. Amanda Laughlin, SDWP
51. John French, SDWP
52. Sean Nolan, SDWP
53. Johan Forsman, SDWP
54. Yuanda Zhu, SDWP
55. Heng Gao, SDWP

OBH Access Roster:

56. Amanda Joyner, Program Manager, HPM Fiscal Policy
57. Michael Carrone, Health Informatics
58. Jing Liu, Health Informatics
59. Kashunda Williams, PhD, Analytics
60. Cindy Casarez, Program Manager, HPM Fiscal Policy
61. Robyn McDermott, Program Manager, HPM Fiscal Policy
62. Annette Giroir, Analyst
63. Terri Cochran, Analyst

Addendum B

The signed copies of each analyst's confidentiality agreement, to be developed with the Chief Security Officer upon finalization of this data sharing agreement, will be attached as Addendum B.