

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section F: Service Coordination (Section § 14 of RFP)	170		
F-1	A, B, and C	<p>F.1 DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:</p> <ul style="list-style-type: none"> • How you will identify these enrollees, and how you will uses this information to identify these enrollees, including enrollees who are receiving regular ongoing services; • What additional information you will request from DHH, if any, to assist you in ensuring continuation of services; • How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation; • What information, education, and training you will provide to your providers to ensure continuation of services; and • What information you will provide your members to assist with the transition of care. 	10		

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F-12	A, B, and C	<p>F.2 Describe your approach to CCN case management. In particular, describe the following:</p> <ul style="list-style-type: none"> • Characteristics of members that you will target for CCN case management services; • How you identify these members; • How you encourage member participation; • How you assess member needs; • How you develop and implement individualized plans of care, including coordination with providers and support services; • How you coordinate your disease management and CCN case management programs; • How you will coordinate your case management services with the PCP; and • How you will incorporate provider input into strategies to influence behavior of members. 	85		
F-41	A, B, and C	<p>F.3 Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:</p> <ul style="list-style-type: none"> • Dental • Specialized Behavioral Health • Personal Care Services • Targeted Case Management 	5		

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F-50	A, B, and C	<p>F.4 For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.</p>	10		
F-56	A, B, and C	<p>F.5 Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?</p>	10		
F-64	A, B, and C	<p>F.6 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.</p>	40		
F-81	A, B, and C	<p>F.7 Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.</p>	10		

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F-93	A, B, and C	<p>F.8 Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g. birth control) to members who are entitled to such services.</p>	Included/Not Included		

Question F.1

Continuation of Medically Necessary
Services for Members with Special
Health Care Needs

Section F: Service Coordination

F.1 DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:

Overview

Louisiana Healthcare Connections (LHC) is a joint venture between Centene Corporation (Centene) and Louisiana Partnership for Choice and Access (LPC&A). LPC&A is composed of 19 of the 25 Federally Qualified Health Center (FQHC) members of the Louisiana Primary Care Association (LPCA). For more than 28 years, the LPCA has been an integral component of the health delivery system in Louisiana. LHC will draw upon the Louisiana Medicaid/CHIP experience of LPC&A members and the successful strategies of Centene health plans in 11 states to transition members with special health needs (MSHN) who are already receiving medically necessary services at the time they enroll with LHC. Centene's broad national experience with new program implementations, combined with LPC&A FQHC understanding of the needs and preferences of Louisiana Medicaid/CHIP recipients, providers, and local communities will greatly enhance our ability to successfully transition newly enrolled members. Our approach to continuity of care will ensure continued access with no disruption in services and safe, medically appropriate transitions.

Experience

Centene health plans have significant experience transitioning large numbers of newly enrolled members, including those with special health needs, from fee-for-service (FFS) to coordinated or managed care programs. This includes members in rural areas of the South similar to those in Louisiana, as well as members in urban areas and members on SSI. We understand and have successfully handled the issues involved when state Medicaid and/or CHIP programs make such a significant change in the service delivery system, particularly related to ensuring that members with special health needs experience no disruption in their care.

Centene's Texas health plans have transitioned more Medicaid and CHIP members than any other health plan in that state, which has the third largest Medicaid managed care population in the country,¹ as well as significant rural areas. They have ensured continuity of care for members with special health needs, those eligible due to age and disability, and children in foster care. For the recent implementation of the Texas STAR+PLUS Program, which provides acute care and long term supports and services to members on SSI in the Dallas Service Area, including dual eligibles, our affiliate plan transitioned over 20,000 new adult and child members with Special Health Needs (MSHN) from the FFS program. They ensured continuity of care by authorizing all existing services these members were already receiving at the time they enrolled. The plan also completed and distributed authorizations to the servicing providers within 45 days after the Operational Start Date, and provided a summary report to each provider listing the member, procedure code/s, modifiers if applicable, and diagnosis code to support a seamless billing process. Prior to implementation, our affiliate educated both network and non-network providers about its continuity of care policies and procedures, emphasizing that all current authorizations would be honored regardless of the provider's network status until the plan completed a comprehensive assessment. They also worked with existing providers and the member/family to determine whether and how the member's care could safely be transitioned to a network provider, and completed a new service plan in collaboration with the member/family and providers. The plan worked with the state to identify any services that had been

¹Medicaid Managed Care Enrollees, as of June 30, 2009. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=216&cat=4>

requested but not yet authorized under the FFS program, and prioritized these members for immediate assessment.

Centene's Texas experience also includes transitioning large numbers of rural CHIP members throughout the state, and assessing and authorizing a service plan for every child in the state's STAR Health program (which serves about 30,000 members in foster care), statewide, within the first 120 days of operation. This was a considerable accomplishment given the fragile nature of this population and the structural complexity of the program. In all cases, the plan incorporated data provided by the state into its continuity of care procedures to ensure continuation of services for new members with existing services.

In addition to Texas, Centene plans have transitioned members from FFS to a coordinated care program in Mississippi, Illinois, South Carolina and Georgia. All but Georgia included MSHN. In Mississippi, which also has a significant number rural areas and shares many of the same health and access characteristics as rural areas of Louisiana, our affiliate health plan transitioned 30,000 Aged, Blind and Disabled (ABD) members effective January 1, 2011. Our Illinois affiliate which serves the urban Chicago area transitioned ABD and SSI members, including those with developmental disabilities and serious and persistent mental illness, completing all assessments within 30 days. In South Carolina, the transition from FFS included members on SSI. Our Georgia affiliate plan transitioned about 230,000 TANF and CHIP members on day one of program implementation in 2006, adding another 55,000 members when the state implemented the phase-in of rural southwest Georgia. For all of these new program implementations, the plans used historical claims data (and in Illinois, a list of members in the state's case/disease management program) provided by the state to identify members receiving services and prioritize targeted outreach and assessment activities.

Approach To Continuing Medically Necessary Services for MSHN

LHC will tailor Centene's continuity of care approaches and transition processes to meet DHH requirements and ensure continuation of medically necessary services for our MSHN. We will identify and authorize existing services while working closely with members and providers to ensure a smooth transition to the CCN-P Program. We also will work proactively to identify and communicate with new members receiving out-of-network care by immediately outreaching to and coordinating with out-of-network providers, and providing timely authorization and reimbursement for any out-of-network care required. When we identify a non-network provider serving our members, we will attempt to contract with the provider to enhance continuity of care. In addition, we will deliberately minimize the chance that a new member is receiving out-of-network care at the time of enrollment by offering a network that includes the current Medicaid providers that members typically trust to provide their care. Such providers include our 19 owner-partner FQHCs which are significant traditional providers for the State's Medicaid and CHIP populations. For these members in particular, LHC will represent a seamless transition from FFS to the CCN-P Program. We will also go the extra mile to outreach to all other network and non-network Providers to educate them about how to contact us, our process for automatic authorization of existing services, and how coordinated care processes differ from FFS.

Culturally Competent Service Delivery

The major ethnic cultures we will serve in Louisiana besides Caucasian are African American and Hispanic. In addition to the growing Vietnamese population, we anticipate serving members of Native American, Cajun, Chinese, and Haitian Creole heritage. As one of the most prevalent conditions among members, poverty has a profound impact on attitudes about care and often limits members' ability to access care. Centene affiliate experience has shown that cultural competence is a critical factor in successfully transitioning new members, engaging them in their care, and providing services that meet their individual needs. LHC will ensure culturally competent covered and administrative services by evaluating and designing our service delivery model based on the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (**CLAS Standards**), which operationalize the CLAS

Standards issued by the U.S. Department of Health and Human Services' Office of Minority Health. We will implement and conduct continuous quality improvement for all 14 standards.

We will start by focusing on recruitment, retention, and promotion of diverse staff and management. LHC will emulate the best practice of other Centene health plans by recruiting and hiring local staff who reflect the diversity of our member demographics. The experience of our affiliate health plans is that transitioning new members is most successful when members feel they are talking with a person with whom they have something in common. LHC also will identify and use minority professional organizations such as Minority Professional Network to help recruit a diverse workforce.

Like other Centene health plans, LHC will require all staff, regardless of role or responsibility, to complete our Cultural Competency Training Program upon hire, and at least annually thereafter. We also will require biannual refresher training for staff with member contact. Our initial training will focus on the impact of culture on health care decisions, the employee's own culture and potential biases, including ethnicity and gender, the impact of poverty on health, resources for members with disabilities, and linguistic barriers and resources for members with Limited English Proficiency (LEP) or low literacy. Staff with direct member contact (such as case management staff, Member Services Representatives (MSRs), and MemberConnections® Representatives (MCRs)) will be required to participate in annual recertification training. Our recertification training uses role-playing, presentations, and case discussions with emphasis placed on development of skills to communicate appropriately and address member linguistic and disability-related needs and cultural differences. Training will include topics specific to people with hearing, speech, vision, mobility, respiratory, or cognitive impairment, or multiple/complex physical disabilities and special health care needs.

We will incorporate input and assistance from local experts who are familiar with the unique needs and cultures of our members. For example, we will obtain input and assistance from our LPC&A FQHC partners, which have a long history of serving the Louisiana Medicaid population, including Morehouse Community Health Center (Mexican migrant population), Iberia Comprehensive Community Health Center (Laotian/Hispanic populations), Except (Hispanic population), Jefferson Community Health Care Center (Hispanic/Asian populations) and Techs Action Clinic (Hispanic/Native American populations). We also will incorporate input from local organizations such as the Louisiana Latino Health Coalition for HIV/AIDS Awareness, Institute of Women and Ethnic Studies, and Kingsley House.

Our Case Managers and MCRs will be trained to understand that culture includes, but goes beyond identifying member preferences for the gender, ethnic background, and language of their providers, to encompass such factors as attitudes toward accessing care and appropriate language use that puts people first. Our CLAS Task Force will monitor cultural competency training to ensure it continues to address the needs of our membership.

All LHC staff will have access to **Centene's Cultural Diversity Database**, which provides information on more than 20 different races or ethnicities. The database includes information on specific diseases or conditions for which a particular group is at higher risk and identifies cultural habits, beliefs, and traditions that may influence a person's health care practices. The database helps Case Management staff in particular ensure that members who are not part of a prevalent race or ethnicity within their community receive culturally competent care.

How you will identify these members, and how you will use this information to identify these members, including members who are receiving regular ongoing services;

LHC will identify MSHN, including those receiving regular ongoing services, from a variety of sources, including:

- DHH claims data

- Enrollment data, such as an indicator from DHH’s enrollment broker that a member has self identified as having special health needs, and any standing authorizations
- Information obtained from our initial Health Risk Screening (HRS) completed by/for new members
- Provider requests for authorizations and referrals
- Incoming communication from other providers requesting information and service authorizations for LHC new members in active care
- Contact from members and their family/caregivers.

DHH Claims Data. Within 60 days of receipt of historical claim data during implementation (and within 30 days of receipt of the file on an ongoing basis once initial implementation is complete), LHC will identify members with special health needs. Historical claim and eligibility data will be processed through our state-of-the-art Centelligence™ family of integrated decision support and healthcare informatics solutions. Our Centelligence enterprise platform integrates data from multiple sources and produces actionable information used organization-wide to monitor and improve outcomes. This includes, but is not limited to, Care Gap and Wellness Alerts, Key Performance Indicator (KPI) Dashboards, population-level health risk stratifications, and standard and ad-hoc desktop reports. Centelligence enhances our ability to anticipate, identify, monitor, and address issues and improvement opportunities. Information related to the member’s claims and authorization history, diagnoses and health status will feed into TruCare, our Member-centric health management platform, which integrates care, disease, and utilization management information. Our Transition Coordinator (see details below) will use TruCare to identify new members with existing services reflected in the DHH data, and will prioritize them for immediate, automatic, service authorization to be followed up by outreach and comprehensive assessment.

The Transition Coordinator and our Case Management staff will also use Centelligence™ Foresight (Foresight), our proprietary predictive modeling and care gap/health risk identification suite, to identify and risk stratify new members whose claims history does not indicate current ongoing services, but does indicate a special health need and/or the potential for unmet or future service needs. We will conduct predictive modeling every two weeks to identify high risk members and those with special needs using LHC claims data, DHH claims data, and other data.

LHC’s top priority for use of DHH data will be to immediately identify and reach out to members with existing services and special health needs, and to stratify other members for outreach. LHC also will analyze DHH data to ensure our Integrated Case Management Teams (ICT), which include registered nurses, behavioral health clinicians, disease management Health Coaches (see Section F.2 for more details), are staffed adequately to serve the number of members who meet criteria for Case Management. We will also analyze DHH data to support development of new disease management programs and clinical initiatives that address needs specific to our membership, and to assess disparities in access and quality.

Enrollment and Authorization Data. LHC will use the special needs indicator provided by the enrollment broker to automatically identify a new member as having special health needs, prioritize them for outreach and assessment, and identify and authorize existing services. In addition, we will use other information provided at enrollment, such as any authorizations for non-emergency transportation (NEMT) and certain supplies including oxygen, enteral nutrition, or a specialized wheelchair to identify members as potentially having special health needs and existing services. We will also use pharmacy data provided by the state to identify members with prescriptions that indicate a chronic or complex condition that would meet Case Management criteria, such as short- or long-acting beta agonists indicating asthma and psychotropic medications indicating serious mental illness.

Health Risk Screening. LHC will ask all new members to complete our short Health Risk Screening (HRS) to assist us in identifying health conditions and service needs. Members may complete the HRS

with NurseWise or a Member Services Representative during our New Member Welcome Call, or an MCR, when necessary, to handle initial implementation and periods when we have significantly more new members than usual, through our Member Portal, or in hard copy using the self-addressed, stamped envelope provided with the HRS in the New Member Welcome Packet. The Transition Coordinator, with assistance from Case Management staff, will review all HRS results to identify members with health risks, those in active care, and/or those who may be in need of additional services, and will prioritize them for outreach and follow-up.

Provider Authorization Requests and Referrals. We may identify members with special health needs when network or non-network providers contact LHC to request an authorization or notify us of a special needs member. We may also identify these members if CommunityCARE staff, facility utilization review nurses, or providers contact our Transition Coordinator or Case Managers about a member who will be transitioning to LHC after discharge from their facility or program.

In addition, LHC will implement a Notification of Pregnancy (NOP) program with providers to enhance our ability to identify pregnant members early, which is particularly critical if they have special health needs. Centene's NOP process is a streamlined approach that attempts to identify and engage pregnant members as early in their pregnancy as possible so we can establish a relationship between the member and health plan staff. Early interaction with pregnant members enables us to help them access prenatal medical care, provide them with targeted education on their specific healthcare needs, address their social needs and concerns, and coordinate referrals to appropriate specialists and Start Smart for Your Baby[®] (Start Smart), our high risk pregnancy management program, as needed.

Member and Family/Caregiver Contact. MSRs and Nursewise staff will identify members with special health needs when new members or their family/caregivers call our Member Call Center with questions about previously authorized services or ongoing care. These phone calls will be referred to an LHC Case Manager who will obtain information from the member about the services needed. We may also identify members through Case Managers and MCRs located onsite at FQHCs and other high-volume provider sites. Onsite staff will obtain information from the member about any services they are currently receiving and attempt to schedule the member for a comprehensive assessment.

What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;

To ensure we are able to quickly identify all members who may have existing services and/or special health needs, LHC will request the following information from DHH in addition to claims history. The list below includes information that would be useful both prior to program implementation as well as on an ongoing basis.

- Existing authorizations (as there may be existing services for which no claim has been received)
- Requests for services which have not yet been authorized
- A list of members receiving case and/or disease management (in FFS or from another CCN) and their risk stratification.
- All Non-emergency transportation (NEMT) trips scheduled prior to implementation, to the extent possible.

How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;

Ensuring Continuation of Services. LHC's designated Transition Coordinator will interact with DHH Medicaid Coordination Care section staff (and, after implementation, staff of other CCNs) and coordinate the efforts of our Case Management and Member Services staff to ensure a safe, orderly, and non-

disruptive transition for our new members. When we identify a member with existing covered services, the Transition Coordinator, with assistance from our Utilization Management staff, will enter an authorization into TruCare, and notify the provider within three business days of initiating the authorization about automatic authorization during the transition period, and any authorization requirements for continuing the services past the initial transition period. This will include information about our process for determining whether, how and when services can be transitioned, and our case management assessment and service plan development processes that involve the member, family/guardian/caregiver, and treating providers.

Prior Authorization Requirements. To smooth the transition into managed care for members and providers, LHC will use a strategy that Centene plans have implemented successfully in many states to ensure continuation of existing services. We will automatically authorize existing services for an initial transition period of 30 calendar days to allow for adjustment to a coordinated care environment. We will continue the existing services for up to 90 days or until the member’s care may reasonably be transferred to a network provider (as applicable), whichever is less, and a Case Manager can complete a comprehensive assessment and develop a new service plan with the member, family/guardian/caregiver, and treating providers.

Non-Contract Providers. When we identify a new member with existing services that are being provided by a non-network provider, we will automatically authorize those services during the transition period as described above and require future authorizations as described in the table below. We also will educate these providers about the requirement that the member must be held harmless for the cost of medically necessary benefits and services covered by the program, and how to submit claims and receive assistance from LHC. Whenever we identify members receiving care from non-network providers through the methods described above, a Provider Relations Specialist (PR Specialist) will contact the providers and attempt to contract with them to prevent the need for the member to change providers.

Table F.1.-A: Out Of Network Authorizations

<i>Population Group or Service</i>	<i>Continuation of Service Timeframe</i>	<i>Prior Authorization Requirements</i>
Pregnant Women receiving medically necessary covered services in addition to prenatal services	90 days or until member can reasonably be transferred	None required for the first 30 days regardless of provider network status. May be required after 30 days.
Pregnant Women in the first trimester of pregnancy receiving medically necessary prenatal services on the day before enrollment.	Through post natal care. If the provider is out of network, LHC may transfer the member’s care to a network provider so long as services are not impeded and the member’s health is not jeopardized.	None
Pregnant Women in the second or third trimester receiving medically necessary prenatal services on the day before enrollment.	Through the post partum period	None
Medicaid and CHIP eligibles entering LHC receiving medically necessary covered services	Up to 90 days or until the member can be transferred (in the event that services are delivered by a non-network provider) without disruption.	May be required after 30 calendar days.
Members needing BH services	Through post stabilization and referral to specialized BH provider following a BH emergency.	None

<i>Population Group or Service</i>	<i>Continuation of Service Timeframe</i>	<i>Prior Authorization Requirements</i>
Members receiving medically necessary DME, prosthetics, orthotics and certain supplies	Up to 30 days or until the member can be transferred (in the event that services are delivered by a non-network provider) without disruption.	None

Transportation. LHC will provide emergency and non-emergency transportation for members who lack transportation to and from covered (including carveout services) and non-covered Medicaid/CHIP services, including existing services automatically authorized during implementation. To the extent that DHH can provide information regarding transportation scheduled prior to implementation, LHC will work with LogistiCare, our NEMT vendor, to ensure that all previously scheduled transportation is automatically authorized and trips are confirmed. Since members with special needs often require regularly scheduled trips to receive services such as radiation therapy or outpatient physical therapy, the Transition Coordinator will also review claims data and information provided by DHH to identify those members for whom recurring trips must be scheduled. The Coordinator will then work with LogistiCare to ensure that future recurring trips are scheduled with no disruption, and will contact members and their providers to confirm that transportation will continue.

LHC will establish transportation policies and procedures in accordance with Louisiana Medicaid guidelines for non-emergency and emergency transportation that ensures member access to care, and in consideration of whether the member owns a vehicle or can access transportation by friends, relatives or public transit. Please see our response to G.15 for more details on our approach to providing NEMT.

Outreach and Assessment. While we immediately authorize existing services, we will also use the information and methods described above to prioritize members for outreach and comprehensive assessment. Case Management staff will use assessment results to work with our Medical Director, existing providers, the member and family/guardian/caregiver, and applicable network providers to determine whether, how and when the member may safely be transitioned to in-network care and/or a new service plan. Our highest priority for outreach and assessment will include the following members:

- Members with significant conditions or treatments such as enteral feedings, oxygen, wound care and ventilators, medical supplies, transportation on a regular basis, chemotherapy and/or radiation therapy, or are hospitalized at the time of enrollment in LHC
- Members who have received prior authorization for services such as scheduled surgeries, post surgical follow up visits, therapies to be provided after enrollment, or out-of-area specialty services
- Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth
- Members with significant medical conditions such as high risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization.

Assessment will occur within a timeframe consistent with the member’s needs, but no later than 60 days after identification during the initial implementation period, and within 45 days of identification on an ongoing basis.

What information, education, and training you will provide to your providers to ensure continuation of services; and

Some of our Centene affiliate plans have found over multiple implementations that some providers in areas transitioning from FFS to managed care often believe that the contracted health plans will not continue existing services, or that health plans will not continue existing services provided by non-network providers. We have designed our provider education program and materials to try and prevent these misperceptions. Our Provider Relations Specialists (PR Specialists) will educate network and non-network providers about this policy when they attempt to contract with providers. In addition, we will schedule and conduct educational sessions throughout the state to which we will invite all providers regardless of network status, and will disseminate information to such organizations as local medical societies. For newly-contracted providers, we will provide detailed information about our continuity of care policies and processes during our new provider orientation, in our Provider Manual, and on our Provider Web Portal. We also will provide this education when we identify a provider already providing services to a new member when they enroll in LHC.

Our LPC&A owner-partner FQHCs will enhance LHC's efforts to educate providers about ensuring continuity of services. Through this partnership, LHC offers the strengths and experience of Centene, a seasoned national managed care organization, and local providers who are familiar with the provider communities across Louisiana. This partnership will:

- Streamline education and communication with 19 FQHCs providing over 310 PCPs
- Provide a venue for provider orientation for all area providers to encourage broad attendance
- Bring the benefits of Centene's long history of coordinated care experience and service to local communities that are new to this type of delivery system
- Provide local knowledge and experience serving the Louisiana Medicaid and CHIP populations
- Bring to the table established relationships between LPC&A's FQHCs and other traditional Medicaid and CHIP providers.

Initial Orientation, Education, and Training. LHC's community-based PR Specialists will provide in-person pre-implementation provider orientation, usually at physician offices for large practices and at a hotel conference room or community facility for group sessions, with scheduled follow-up training after implementation. We will provide office-based and group training for PCPs, specialists, hospitals, and ancillary providers. After implementation, orientation for new providers will occur within 30 days prior to provider activation, and will normally be conducted at the provider's office. During these pre and post implementation provider orientations, our PR Specialists will educate providers about how to notify LHC of a member with special health needs and those receiving ongoing services; our automatic initial authorization of any existing covered service; authorization requirements beyond the initial implementation/enrollment period; our policies and procedures for safely transitioning members to a network provider and/or new service plan; and our claims submissions processes that are designed to help ensure prompt payment for continued services.

We will also provide educational information to providers regardless of network status, through other venues such as local Medical Societies. This information will address how to contact LHC about members with special needs and those receiving ongoing services, transitioning from FFS to the CCN-P Program, and LHC's continuity of care policies and authorization requirements.

LHC is already visiting with providers across Louisiana to familiarize them with and provide verbal and written information about the CCN-P Program, LHC and Centene's experience in Medicaid coordinated care, and is inviting them to participate in our network. We have also sent letters to all providers enrolled in the LA Medicaid program introducing LHC's program structure and covered services. In addition, we are leveraging our partnership with LPC&A to ensure FQHCs, which already treat a large percentage of

the state's Medicaid and CHIP populations, receive educational information about LHC, including our continuity of care policies and procedures.

Ongoing Education and Training. LHC will use a variety of communications mechanisms on an ongoing basis to ensure that providers receive the information needed to ensure continuation of services. We know through our affiliate plans that in-person education and training is the most effective method of ensuring providers receive and understand critical information, such as continuity of care policies and procedures. As described above, our pre implementation and ongoing provider orientation sessions will be conducted in person. To reinforce and supplement in-person training, we will also provide continuity of care information online through our Provider Portal, and in our Provider Manual. In addition, our Transition Coordinator and Case Management staff will educate providers already serving new members when interacting with them to provide automatic authorizations.

Online and Written Information. LHC's Provider Portal will include information about continuity of care policies and procedures, authorization requirements, and other useful information. Particularly during the period before and during initial implementation, the information will be prominent and easy to find, with a link to these policies on the front page of our Provider Portal. In addition, our Provider Manual, which is available online and in hard copy, will include all continuity of care information.

Transition Coordinator/Case Management Contacts. Our Transition Coordinator, with assistance from Case Management staff, will use methods described above to identify new members receiving services. When a member is identified, the Transition Coordinator or a Case Manager will contact the provider and educate them about our continuity of care processes. A Case Manager also will work with the provider, member and family/caregiver, and our Medical Director to determine whether, how and when the member can safely be transitioned to a network provider, if applicable, and if our comprehensive assessment indicates that a new service plan is needed to fully meet the member's needs for covered services.

What information you will provide your members to assist with the transition of care.

Information LHC Will Provide. Our key message to members will be that they should continue accessing their existing services and supplies during the transition period with no change, regardless of whether their provider currently participates in our network. We also will educate them, upon enrollment, to contact us via our toll-free 24/7 Member Call Center if they are receiving or need services. Our member education will include, but not be limited to, all continuity of care policies and procedures to ensure members understand their rights to continue receiving services; the assistance available through our Case Management Program; and how LHC will determine whether, how and when their care can safely be transitioned to in network providers, as applicable, and/or a new service plan developed as needed to meet their needs for covered services.

Methods and Strategies to Educate Members. LHC will build on the experience of LPC&A FQHCs with Louisiana Medicaid and CHIP members throughout the state, and on the experience, success and creative strategies used by our affiliate health plans, to guide our approach to informing members about LHC covered benefits and services, and assist them through the transition to LHC. Our affiliate plans have experience educating members, family and caregivers, and medical consenters (for members in foster care) about covered services and how to access them. This includes members in rural and remote areas and those with chronic and complex conditions and special health care needs. Centene plans also have extensive experience educating pregnant women and parents of children with special health care needs.

Through these combined experiences, we have learned that member education must be provided in multiple formats (such as print, online, phone, and in person), using multiple strategies (including through providers and Case Managers, mail, calls, at community events) and incorporated as an ongoing, reinforcing process, rather than just a one-time or only annual effort. LHC also will tailor best practices developed by our affiliates to effectively meet a wide variety of cultural and linguistic needs. For

example, we will use our MemberConnections® Program, an intensive, innovative member outreach, education, and assistance program, in which MCRs meet in-person with members to help them understand how to access care and needed resources and assist them in doing so. We will hire MCRs and other Member Services staff from within the Louisiana communities we serve, and will collaborate with LPC&A FQHCs and other community-based organizations, such as Louisiana Latino Health Coalition for HIV/AIDS Awareness and Families Helping Families to develop staff training that reflects local concerns and populations.

Pre-Implementation Community Education Campaign. Prior to program implementation, we will conduct a campaign to educate advocacy groups, community organizations, and others who interact with members about LHC benefits. We have already begun educating the LPC&A FQHCs, which serve many in the CCN-P eligible population. In addition, LHC commenced our Community Advisory Committee (CAC) on March 18, 2011 with representatives from the Institute of Women and Ethnic Studies, Nurse Family Partnership, and the Children’s Defense Fund. Planned Parenthood Gulf Coast and the Mississippi Coalition for Citizens with Disabilities (MCCD) participated telephonically. LHC will engage the CAC, which will include other local advocacy organizations, to obtain input in developing, implementing, and evaluating member education strategies. This approach has worked well for our affiliates. For example, our Mississippi affiliate has a strong relationship with MCCD from which they solicit input on a wide range of plan policies and procedures, such as member outreach methods. LHC is leveraging the experience of MCCD and involving the organization in our CAC to share its experience with Louisiana organizations with similar missions, and to provide input to the Plan. Our CAC will serve as a formalized mechanism for building such relationships in Louisiana, and we will continue to outreach to other organizations throughout the state. This will allow us to disseminate information about continuity of care to organizations that interface routinely with Medicaid and CHIP members.

MemberConnections® Outreach. Our MCRs will be comprehensively trained on covered health benefits, including carveout services. As stated above, we will hire MCRs from Louisiana, preferably from the parishes in their assigned territory, to ensure our staff are knowledgeable about the cultural, geographic, demographic, and other aspects of our members’ communities, and the resources available within the various communities. MCRs will establish relationships with members and deliver personalized service that engages them, resulting in a successful transition. Outreach will occur in a variety of settings, including by phone, in the member’s home, and in provider offices. MCRs will organize and staff community outreach events, an approach that other Centene plans have found successful in reaching members for face-to-face education. For example, MCRs will work with LPC&A member FQHCs, and other social services organizations, to organize Baby Showers for pregnant members. During the showers, MCRs will provide education about prenatal, postpartum, and EPSDT services, including the importance of continuing to access existing services during the transition to the CCN-P Program. Our affiliates have found FQHCs to be excellent partners in helping to facilitate member outreach and education efforts. LHC will work with LPC&A to develop more outreach programs and initiatives such as Back to School fairs at school-based clinics during and after CCN-P implementation.

New Member Welcome Call. NurseWise, our nurse advice line affiliate, will conduct New Member Welcome Calls to all members within 14 days (21 days during implementation) of receipt of the enrollment file from DHH or the enrollment broker identifying the new member. If NurseWise is unable to reach the member, our MSRs and/or MCRs will conduct the Welcome Call during inbound calls from the member or through direct outreach efforts. The call script for new member welcome calls will be submitted to DHH for approval prior to use. These calls will orient members to LHC and the CCN-P Program, including but not limited to continuity of care policies and procedures for members with existing services. For example, the calls will include a discussion to determine whether the member is pregnant, has a chronic condition or any special health needs, and/or is currently receiving services. In addition, NurseWise will ask the member to complete an HRS during the call, which we will use as

described above to identify members who may have existing services and/or special health needs.

Member Orientation and Welcome Packets. In accordance with the Office of Minority Health, Department of Health and Human Services' Culturally and Linguistically Appropriate Services (CLAS) guidelines and DHH requirements, LHC will have written policies and procedures to orient new members and assist them with the transition of care. New member orientation will include, but not be limited to, what to do during the transition period from CommunityCARE 2.0 to LHC, such as how to continue accessing ongoing services and continue their medications. Within 10 business days (21 days during the implementation period), LHC will send new Member Welcome Packets that will include, but not be limited to, information about the importance of continuing any existing services and calling our toll-free Member Call Center to inform us about any such services they are receiving. Please see our response to Section K.1 for details on our member materials.

Question F.2

Approach to CCN Case Management

F.2 Describe your approach to CCN case management. In particular, describe the following:

Experience

Centene. LHC will draw upon the experience of our parent company, Centene Corporation, and our affiliate health plans in providing case management services since 1985 to populations similar to those covered by the CCN-P. These populations include adult and child members with a wide variety of chronic, complex and/or catastrophic conditions and special health care needs. These members include those on SSI; those who are eligible for Medicaid due to age, blindness or disability; those dually eligible for Medicaid and Medicare; and children in foster care in addition to the TANF population. Centene affiliate plans currently serve about 81,500 SSI members. Our affiliates have managed conditions such as high-risk pregnancy, severe and persistent mental illness, diabetes, asthma, congestive heart failure, cancer, transplants, spinal cord injury, para/quadruplegia, amputations, HIV/AIDS, multiple sclerosis, severe trauma with multiple system involvement, traumatic brain injury, autism, bipolar disorder, seizure disorder, cerebral palsy, and co-morbid/co-occurring conditions.

Case Management Model. Centene health plans manage and coordinate preventive, primary, acute, specialty, behavioral health, dental, long term care, vision and other services and community resources to meet members' complex needs through Centene's Coordinated Care Model, which each affiliate health plan adapts to the unique needs of the local population. Through the Coordinated Care Model, the full range of covered and non-Covered Services each member needs is integrated into a seamless, holistic experience of care that improves outcomes and enhances quality of life. This approach has earned recognition as a best practice in serving special needs members in managed care.² It has also earned Centene plans a reputation among member populations for understanding how to meet special needs. For example, in the service areas in which our Texas affiliate participates in the state's STAR+PLUS program (which provides medical, behavioral health and long term care services to members on SSI), 81% of the voluntary SSI child population has chosen to enroll in our affiliate's plan.

Case Management Outcomes. Centene's high risk pregnancy management program, Start Smart For Your Baby (see below) achieved improvements across Centene health plans in key indicators of birth outcomes from 2007 to 2010. This included statistically significant decreases in NICU admission rate and NICU days/1000 births, and decreases in all three measures of low birth weight (see Section J.1 for graphs depicting specific outcomes). Centene has also achieved improvements for members with such chronic conditions as asthma, diabetes and cardiovascular disease. While some of these members received only disease management services, others were enrolled in case management, with both sets of services integrated through the plan's case management program and Coordinated Care Model. Results include:

- Child and adult asthma program participants across all Centene plans significantly improved in all monitored symptom and functional measures in CY 2010.
- In CY2010, for all Centene plans, our diabetes program significantly improved physiologic outcomes. This included a nine percentage point increase in the number of participants reporting LDL levels <100 mg/dl, a five percentage point increase in participants with controlled systolic blood pressure (< 130 mm Hg) and an increase in exercise of 150 minutes per week for 57% of members who started outside of the target goal, all between baseline and most recent reassessment.
- From CY2008 through CY2010, our cardiovascular programs meaningfully impacted the health status of our members, including an 18% reduction in heart failure-related admissions for members with congestive heart failure and 12.7% reduction in coronary artery disease (CAD)-related admissions for members with CAD.

In addition to the case management program outcomes highlighted above, Centene plans have also achieved improvements in member outcomes through targeted initiatives within their case management

² SCHIP Innovations for Children with Special Needs in Managed Care. Center for Health Care Strategies Resource Paper. Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus. February 2003.

programs. For example, our Georgia affiliate, Peach State Health Plan, developed a pain medication management initiative in 2008 targeted at members with high emergency department (ED) utilization who exhibited poly-facility, poly-provider and poly-pharmacy adverse drug seeking behaviors. Identified members were restricted to using program-only pharmacies and enrolled into a provider outreach case management program. Only 21.3% of the 4,733 members identified during baseline period as having 10 or more ED visits continued to have high ED utilization following implementation of the initiative. The decline in utilization of services related to drug-seeking behaviors and associated negative outcomes yielded estimated savings of \$2.3 million, comparing expenditures in 2009 to 2010.

Our Texas affiliate implemented an intensive case management program to reduce readmissions for members with severe and persistent mental illness. The plan implemented such interventions as structured telephone contact after hospital discharge including assessing satisfaction with current outpatient providers and compliance with prescribed medications; joint treatment team meetings between physical health and behavioral health case managers; in-home appointments for members unable to secure outpatient follow up care after hospital discharge; and most recently, in 2010, a pilot of intensive outpatient services, including Assertive Community Treatment and Cognitive Adaptive Training, that are beyond the benefits covered by Medicaid. From 2009 to 2010, the 30-day readmission rate decreased from 30.5% to 26.3% for the plan's SSI/ABD population.

LPC&A Experience. We will also incorporate the expertise of LPC&A's owner-partner FQHCs in developing our Case Management Program. For example, several LPC&A FQHCs evaluated their data to identify their top diagnoses in preparation for becoming Patient Centered Medical Homes (PCMH). This effort identified several diagnoses that are common top diagnoses across the FQHCs including hypertension, diabetes, asthma, obesity and hyperlipidemia. Subsequent to their diagnoses analysis, many of the FQHCs implemented health management support programs, including dietician and nutritionist support, weight management and workout sessions, and certified diabetic educators onsite to provide support services to their diabetic patients.

In addition, LPC&A FQHCs have established many successful partnerships in the community to address prevalent conditions, such as their work with the Bureau of Primary Health Care with the Chronic Disease Collaborative. As a result of this collaborative some of the FQHCs, such as Iberia and Teche Action Clinic, implemented diabetes-specific programs that have improved the care of their patients. For the past five years, Iberia Comprehensive has sponsored a Chronic Disease Academy for their patients, a formal 12 week course that highlights every aspect of diabetes care. The FQHC does pre-labs and vitals; invites guest speakers; incorporates physical activities; cooking demonstrations; lectures and a formal graduation. The importance of self management is a focal point of the program. Teche Action Clinic and Iberia both have Certified Diabetes Educators and Dietitians as part of their programs. LHC will capitalize on diagnosis information and existing FQHC efforts to help us target our case/disease management efforts, such as identifying concentrations of members with a specific diagnosis where we can locate extra outreach staff or partner with the FQHC to introduce or expand condition-specific programs.

Approach To Case Management

The foundation of LHC's approach to Case Management will be the Coordinated Care Model, which reflects lessons learned by Centene affiliate plans serving similar populations in other states. For example, effective case management and care coordination for those with physical and cognitive disabilities and/or mental health issues must go beyond purely clinical determination of needs to identify and address functional status and barriers to care. Improving outcomes requires not only providing services to address a condition; it requires holistic approach such as involving the family as a key player in determining how best to meet a child Member's needs. For example, if a child needs a procedure at a facility in another city, we may pay for the family's travel and hotel. Our Case Managers will not simply manage patients - they will build relationships with Members and their families, allowing them to identify issues that affect health that assessment instruments do not detect. LHC leadership will empower staff to be creative in meeting a Member's needs, a Centene philosophy that has resulted in such approaches as paying for a

homeless Member discharged from the hospital to stay in an extended stay hotel while recuperating. We also recognize the importance of LHC being accessible to caregivers and supporting them as key players in ensuring Member well-being. Our [Online Caregiver Resource Center](#) will offer specialized education and resources to improve caregiver ability to assist Members and cope with stress.

Because active member direction and engagement are key factors in compliance and improved outcomes, LHC will encourage and support member self-determination in the assessment, service plan development and implementation processes. These processes will integrate the member's and case manager's review of the member's strengths and needs, resulting in a mutually agreed upon, appropriate, and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member. Members will be able to access their [service plans on our secure Member Portal](#) so they can track their own care. For members with special needs, we will provide a [Member profile](#) that summarizes key information such as diagnoses and medications to help the member or family, guardian or caregiver (as applicable) understand and track the member's conditions and care. Service plans will address common needs all members have, such as preventive care, since those with special health needs often underutilize preventive services due to intense use of specialty and other services. As members with special health needs and their families are often overwhelmed with social and other needs that affect their health and access to care, we will connect them to community resources (e.g., food stamps, WIC) and provide them with a Community Resource Guide.

Case Management Resources

LHC will rely on the expertise of our case management staff, Nurtur, our Centene affiliate disease management subcontractor (see below), our owner-partner FQHCs, and sophisticated technology solutions to support our case management activities. We will also implement innovative programs to enhance each member's service plan. These resources will enable us to effectively integrate the full range of medical, behavioral health, and other services each member needs.

Integrated Care Teams (ICTs). Recognizing that multiple co-morbidities often exist in individuals with chronic illness or other special health needs and that the level of support required by these individuals is likely to change over time, LHC will deliver case management services through an Integrated Care Team (ICT) approach. The ICT will include case and disease management staff, including:

- Registered Nurse Case Managers
- Behavioral Health (BH) Case Managers
- Program Specialists (Social Workers)
- Health Coaches (Disease Management)
- Program Coordinators
- MemberConnections® Representatives

ICTs will specialize in one of four areas: Maternal Health, Pediatrics, NICU and Adults. Each ICT will have a primary RN Case Manager, Program Specialist and Program Coordinator. Health Coaches, the Maternal Child Health EPSDT Coordinator, and a Behavioral Health Case Manager will provide support to multiple ICTs as needed to meet the varied and/or changing needs of members assigned to an ICT.

We will co-locate ICT staff to facilitate regular, in-person communication about the member's care and achieve a level of coordination and integration that voicemails and emails among case managers in different locations cannot. Non-clinical staff will take the lead on social and other non-clinical needs. Health Coaches (see below for more detail) will provide disease management and condition-specific education and self-management support. Because Centene health plans have found that locally delivered services achieve the best outcomes, we will hire staff who are from and familiar with the communities they serve and will co-locate our ICT members in our regional offices as well as in high volume provider offices and FQHCs.

Our Case Management Program will include a systematic approach for early identification of eligible members; needs assessment; development and implementation of an individualized service plan that includes member/family education and actively links the member to providers and support services, including peer supports for members with behavioral health/substance abuse conditions; as well as outcomes monitoring. The ICT will support and complement the PCP, specialty medical providers and behavioral health providers (including specialty BH providers) in the following ways:

- Early identification of members with special needs
- Comprehensive assessment of member risk factors
- Member education on the Patient Centered Medical Home and process for referral to a Medical Home
- Development of an individualized treatment plan
- Referrals to specialty, ancillary and other providers
- Care Coordination for medical and BH services; residential, social, community and other support services; and facilitating member access to non-covered community resources
- Supporting the provider's treatment plan
- Improving member appointment show rate
- Facilitating communication and integration among all providers, including but not limited to specialty BH providers outside the network
- Coordinated discharge planning and continuity of care.

Population-Based Disease Management Expertise through Nurtur Health, Inc. (Nurtur). Nurtur has been a leading innovator in disease management since the mid-1990s, offering best-in-class programs for such conditions as coronary artery disease, congestive heart failure, diabetes, asthma, COPD, smoking cessation, hypertension and hyperlipidemia. Nurtur's programs have achieved significant improvements in health status and reduction in inpatient and ED utilization across Centene health plans that serve Medicaid and CHIP recipients. All of Nurtur's disease management programs have received both NQCA and URAC accreditation. LHC will subcontract with Nurtur for population-based disease management programs and the expertise of Health Coaches, who will office with and operate as part of our ICTs. See our response to Sections E.1 and E.2 for more detail on our Chronic Care/Disease Management Programs and approach.

Innovative Technology Support. Our technology solutions enhance our ability to integrate services by ensuring that all information about each member's needs and services is available to all staff and Providers interacting with the Member. Our ICTs are supported by our state-of-the-art Centelligence[™] family of integrated decision support and healthcare informatics solutions. Our Centelligence enterprise platform integrates data from multiple sources and produces actionable information used organization-wide to monitor and improve outcomes. This includes, but is not limited to, Care Gap and Wellness Alerts, Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population-level health risk stratifications, and standard and ad-hoc desktop reports. Centelligence enhances ICT ability to anticipate, identify, monitor, and address issues and improvement opportunities. For example, staff can use Centelligence[™] Foresight (Foresight), our proprietary predictive modeling and care gap/health risk identification suite, to track conditions; monitor care gaps or health risks; identify members with co-morbid conditions and those at risk of developing chronic conditions; identify members in need of additional services or higher levels of management; and take action. The ICT and other clinical staff access this information with one click through TruCare, our Member-centric health management platform that integrates care/service, disease and utilization management. TruCare allows us to proactively monitor members; efficiently document the impact of our efforts; pinpoint where care is needed; and implement customized intervention strategies.

Our Member Relationship Management (MRM) System will support our member outreach efforts. For example, a Case Manager can use MRM to alert Member Services staff to their need to speak with a

Member we have been unable to reach by phone to discuss an identified care gap due to an incorrect phone number on the DHH enrollment file. When the Member calls our Member Call Center, our Member Service Representative (MSR) can see that the Case Manager needs to talk with the Member when they pull up the Member record, and will offer to warm transfer the Member to the Case Manager.

Innovative Programs to Enhance Care. LHC will provide innovative programs to support case management activities and increase integration of care and member compliance for individuals with complex and chronic conditions and/or disabilities. Programs LHC will implement include, but are not limited to the following.

High-Risk Pregnancy Management Program. LHC will implement Centene's successful Start Smart For Your Baby[®] (Start Smart) high risk pregnancy program. Start Smart is a comprehensive pregnancy and postpartum management program, which incorporates the concepts of case management, care coordination, and disease management. Start Smart is designed to improve birth outcomes and infant health by focusing on early identification and risk screening, one-one-one case management, increased frequency of recommended pre- and post-natal care, member and provider incentives, and member education and empowerment. For all pregnant members enrolled in our Start Smart Program, our key objectives will be to extend their gestational period and improve their baby's birth weight; reduce the risks of pregnancy complications, premature delivery, and infant disease; and ensure a healthy first year of life for their newborn. In 2010, this program received the inaugural URAC/ Global Knowledge Exchange Network International Health Promotion Award, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2009, Start Smart was named an NCQA Best Practice.

Within 15 business days of identifying a high risk pregnant member, an LHC Case Manager will contact the Member for assessment and Start Smart enrollment. Start Smart includes, but is not limited to the following components.

Member Outreach, Education and Referrals. A weekly report generated from TruCare will identify newly pregnant Members, triggering the mailing of our Start Smart educational packet. The packet explains Start Smart and our CentAccount Pregnancy Incentive Program, which provides incentives for completing and submitting a Notification of Pregnancy (NOP) form and attending prenatal and postpartum appointments. The packet includes our toll-free phone number and Start Smart website address; member rights and responsibilities; our recommendation and process for changing their PCP to an OB; information about our 24/7 nurse advice line; and pregnancy-specific information. It will also include information about CMS' Text 4 Baby initiative.

We will invite pregnant members to Start Smart events focused on prenatal visits, breastfeeding, stages of birth, oral hygiene and care, mental health, family planning, and newborn care. Start Smart Case Managers, who are Registered Nurses, and our MemberConnections Representatives (MCRs) will partner with providers and community-based organizations such as schools and community centers to present educational workshops and other events. These events provide a venue for expectant moms to ask questions and share concerns, as well as for LHC to identify and outreach to potential high or moderate risk pregnant members and provide education about WIC and other community resources. We provide incentives of nominal value, such as a Start Smart digital thermometer or onesie, to encourage completion of NOPs and participation in events. The Start Smart[®] Baby Shower Program is designed to educate pregnant members about prenatal and postpartum care for themselves and their newborn, and are conducted in a class environment by health plan staff. Led by a registered nurse and assisted by MemberConnections staff, the classes cover the basics of prenatal care, including nutrition; the risk of smoking and benefits of smoking cessation; the progress of a fetus throughout pregnancy; the importance of regular follow-up with medical providers; common health issues that occur during pregnancy; and a review of the LHC Start Smart and MemberConnections Programs. LHC will encourage completion of our Baby Showers Program by offering incentives such as a raffle for an infant car seat. Smart Steps for Your Baby[®] will educate members on the benefits of exercise during pregnancy, and provide information

on how to set up a safe walking program before and after delivery, a log for tracking steps, and a pedometer.

Provider Education. We will offer all providers comprehensive information and support to help improve services for pregnant Members. Provider education about Start Smart will incorporate clinical topics such as use of 17P, prevalence and risk of cesarean section deliveries, and our adopted clinical practice guidelines related to perinatal care. Educational information will also encompass our NOP incentive program and CMS' Text 4 Baby initiative. We will offer this information in the Provider Manual, on our Provider Portal, and in initial and ongoing Provider trainings. Education will be presented in multiple formats to accommodate provider preference and availability.

Pre- and Post-partum Depression Screenings. Our Start Smart Program will include an integrated perinatal depression program. We will include the Edinburgh Depression Scales in the education packets sent to newly pregnant and post-partum Members, and instruct the Member to complete and return the screening via a prepaid, addressed envelope. A Case Manager will complete the Edinburgh screening during prenatal and post-partum outreach calls, if not already completed by the Member. A Case Manager will score the completed tool and analyze results to stratify the Member and determine future interventions. For Members with positive screening results, the Case Manager with support of the ICT will coordinate access to basic and specialty BH assessment and treatment as needed.

Integrated Care Management. Members at high risk of pregnancy complications and poor birth outcomes receive integrated prenatal care management by a Case Manager with obstetrical nursing expertise. For moderate and high risk Members, the Case Manager with support from the ICT will facilitate access to prenatal care, educate the member on health care needs, assist with social needs, and coordinate any specialty referrals. The Case Manager will contact high risk Members by telephone at least every two weeks and moderate risk Members at least monthly to monitor their condition, and ensure access to needed services and community resources. High risk Members will also receive a home visit if an assessment indicates the need for closer monitoring. The ICT will work with providers to contact members who miss prenatal appointments and reschedule or problem solve to address barriers.

17P (alpha-hydroxyprogesterone caproate). LHC will offer our qualifying pregnant members 17P to aid in the prevention of recurrent preterm delivery in those women with a documented history of spontaneous preterm delivery at less than 37 weeks gestation in a previous pregnancy, and current pregnancy at a minimum of 16 weeks gestation confirmed by ultrasound and less than 28 weeks gestation, with no known major fetal anomaly. By offering this to our pregnant members, we will be able to increase the likelihood that the member will be able to deliver a full or near-term baby; thereby decreasing NICU admissions and length of stays and resulting in improved health status for the baby. Centene's long experience with 17P and its impact on birth outcomes was recently reported in the journal "Managed Care".³ From 2004 to 2009, Centene affiliate plan members receiving 17P had a statistically significant 36.6% lower rate of premature birth (less than 35 weeks gestation) than a control group. The NICU admission rate was 25.2% lower for recipient offspring than controls. Our 17P program has been honored with several awards, including a Pinnacle Award from the Ohio Association of Health Plans, and it was recently named a finalist in the 2010 Case in Point Platinum Awards for innovative case management programs.

Home Monitoring Programs. LHC will partner with Alere (previously Matria) to augment our Start Smart program with home monitoring for certain high risk members. Alere offers programs such as preterm labor management including provision of 17P, hypertension management, gestational diabetes, coagulation disorder management, hyperemesis management, and fetal surveillance that may include, but is not limited to patient education, home and telephonic assessment, clinical surveillance of medications,

³ Mason MV, Poole-Yeager A et al, *Impact of 17P Usage on NICU Admissions in a Managed Medicaid Population – A Five Year Review*, *Managed Care* 19;2:46-52 Feb 2010

home uterine monitoring, 24/7 nursing and pharmacist support. Alere will provide a nurse to conduct home monitoring visits for these high risk members, at intervals dictated by the member's unique risk factors and condition. The Alere nurse will report monitoring results to the provider within 24 hours of the visit. The Alere nurse will also provide updates to the Start Smart ICT weekly or sooner as dictated by member condition and needs. Start Smart staff will document Alere monitoring results in TruCare to ensure LHC maintains a full record of all member contact and monitoring, and that all clinical staff working with the member have a complete picture of the member's condition.

Post-partum Follow-up. We will mail members the Start Smart Newborn educational packet within three weeks of delivery. The Case Manager will verify that the Member has scheduled a post-partum visit, and provide information about infant care, breastfeeding, signs of infection following delivery, wound care for cesarean delivery, and post-partum information such as the warning signs and a screening tool for post-partum depression. Post-discharge contact frequency will depend on the child's risk level, required support services, educational needs for both mom and baby, and clinical complications. For example, if the mother is under age 18 or the newborn has complications from congenital anomalies, low birth weight, prematurity, or other complication, the ICT will follow the newborn from hospital discharge through age one year. Discharge needs will be assessed early and coordinated with the parents, caregiver, attending physician and pediatrician to develop a service plan for post-discharge follow up. We will also provide enhanced follow-up for infants who require NICU care. MCRs will make hospital visits to members with babies in the NICU and deliver a NICU packet that includes educational material. An experienced neonatal nurse will be the lead for the ICT, and will follow the baby through the first year of life. The neonatal Case Manager will conduct a home visit during the first 14 days following NICU discharge to help with the transition home, ensuring all discharge services are initiated, and answer any questions the member may have. ICTs following high-risk newborns and those discharged from NICU will be overseen and supported by a Centene Pediatrician who will conduct weekly telephone rounds with the ICT to advise the team on overcoming obstacles, help them identify resources for discharge planning and recommend interventions. The ICT will follow the family to ensure access to recommended preventive services, access to any necessary specialty care, and assist with accessing community resources.

Neonatal Case Management at Centene's Indiana Health Plan, MHS

A premature baby was born at 27 weeks gestation, weighing 1304 grams. The baby remained in the hospital for 6 weeks and was discharged with requirements for oxygen and apnea monitoring equipment. MHS case managers contacted the mother on discharge to coordinate appropriate services, schedule follow-up appointments and assist with general questions and concerns regarding the care of a premature infant. The coordinated services included referral to the state's Early Intervention Program as well as appointment scheduling for hearing and eye screening, Synagis injections (to protect from severe RSV infections) and the two-month immunizations. Ongoing contact with this mother facilitated appropriate healthy behaviors related to child-rearing and preventive care. During a follow-up discussion, the mother stated that she was doing fine and had a happy baby. She wanted to thank everyone at the health plan for all they did to get her through the rough times.

Telemonitoring. LHC will offer in-home telemonitoring services to certain Members with high risk conditions such as diabetes, COPD, and congestive heart failure. This patent-pending, FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing land line, cellular (including a ConnectionsPlus phone) or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as a blood glucose level for a diabetic, or a blood pressure or weight for a member with congestive heart

failure, will be transmitted electronically to the Case Manager, evaluated against patient-specific or national guidelines, and analyzed for favorable or unfavorable trends. The system can then be set at the member-level to alert the Case Manager, trigger an Interactive Voice Response phone call to the member, and/or alert other members of the ICT or the member's provider. The technology is entirely web-enabled; all members are provided a login card that enables them, their family/caregiver, or their physician to access their biometric information from anywhere in the world at anytime, as long as they have access to the Internet.

Augmenting Case Manager Contact: The Special Health Care Needs Member (SHN) In-Home Video Pilot. Beginning in 2Q 2012, we will implement our SHN In-Home Video Pilot with appropriate and interested members in a rural parish. The pilot will be conducted through a partnership with the Microsoft Corporation that will introduce interactive technology within the homes of selected LHC members to engage them in Case Management and their own care and enhance their interactions with Case Managers and ICT staff. In this pilot, we will demonstrate and emphasize the extended reach of our member services application, Member Relationship Management System (MRM - see Section R, Question R.7 and R.11 for details), through the support of on-demand video between selected member (with member consent) and LHC Case Managers and MemberConnections Representatives (MCRs). We will not decrease in-person contacts between our members and LHC. Rather, our In-Home Pilot will demonstrate the viability of on-demand video conferencing to dramatically increase the frequency and augment the quality of member contact with appropriate LHC staff.

Together with Microsoft, we will integrate our MRM with a combination of Microsoft's Kinect intelligent video system, Xbox console, and Lync Server unified communications software. We also are exploring opportunities with residential Internet Service providers (ISP's) throughout Louisiana to offer internet connectivity for members without access in the pilot.

Once deployed in the home, the member can either initiate or receive a request to video conference with their LHC Case Manager and/or MCR. The member or their caregiver need only gesture with their hands at the Kinect camera, placed near their television, to accept a video call request from authorized LHC staff or to select from a menu the LHC staff person (displayed on the member's television) they wish to call (e.g. the member's Case Manager). The member does not have to leave their seat to interact with the Kinect/XBOX system. The Kinect camera also follows the member around if the member moves within the broad area of view in front of the camera. In addition, Kinect's intelligent video system pans and zooms to accommodate another person (e.g. the member's caregiver) who might join the member during the video conference. Using this technology, our ICT staff will be able to increase the amount and quality of interaction with high risk members. By increasing the number of visual interactions, Case Managers will be able to more closely monitor health status and service plan progress and quickly alert the PCP or other providers should we see a need for a specific intervention while video conferencing with the member.

Depending on the results of our LHC SHN In-Home Video pilot, we will refine the functional scope and timing of additional capabilities to potentially include support for interactive health content and programs (with supporting reward based incentives), and the secure, HIPAA compliant collection of health data (all with member consent).

ConnectionsPlus. Through our ConnectionsPlus[®] Program, we will provide pre-programmed cell phones to high risk Members who lack reliable phone access, allowing them to make and receive calls from Providers, the ICT, other LHC staff, NurseWise, and 911. Members will be educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. The ICT can send the member a text message with health information targeted to the individual member's condition. In rural areas, increased telephonic communication helps overcome the barrier to care that travel distances sometimes pose for members. The program will also provide MP3 players loaded with condition-specific podcasts in Spanish and English, which will be available for download from our website. Examples of podcast topics include diabetes, alcohol abuse, chronic kidney failure, COPD, depression, headaches,

healthy weight, osteoporosis, hypertension, stress, taking your medicine, smoking cessation, generic drugs, heart attacks and advance directives. Centene's ConnectionsPlus® Program received URAC's 2009 *Best Practices in Health Care Consumer Empowerment and Protection* Silver Medalist Award and was a 2009 Medicaid Health Plans of America (MHPA) *Best Practices Compendium* Honoree. There are over 3680 ConnectionPlus cell phones currently in circulation among Centene members. Centene compared outcomes in the 90 days prior to receiving a phone to 90 days following receiving a phone for 347 adults with chronic medical condition enrolled in the program between April 2007 and March 2010. Review of the data showed a 27% decrease in inpatient admissions, an 18% decrease in average length of hospital stay, and a 12% decrease in Emergency Department visits.

Characteristics of members that you will target for CCN case management services;

LHC will target members with a wide variety of conditions and needs including, but not limited to, cancer, organ transplants, spinal cord injury, para/quadruplegia, amputations, HIV/AIDS, multiple sclerosis, severe trauma with multiple system involvement, traumatic brain injury, autism, ADHD, seizure disorder, cerebral palsy, congenital defects, high risk pregnancy, premature birth, behavioral health conditions, organ transplants, cancer, renal dialysis, and other chronic, complex, comorbid and co-occurring conditions. Criteria for Case Management will include but are not limited to members with:

- Two or more active chronic diagnoses that are not stable
- Two or more hospitalizations in the past twelve months with the same or related diagnosis
- Multiple emergency department visits in the past six months
- Significant impairment in one or more of the instrumental activities of daily living, such as preparing meals, shopping, basic housekeeping, etc. particularly when there is a limited support system
- Issues related to medications, including non-adherence to prescribed medications
- Significant issues with any social or economic constraint such as lack of financial support, lack of social, family or significant other support, illiteracy or significant communication or cognitive barriers, access to care issues, transportation, or abuse or suspected abuse
- Members with special health care needs including individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to function in society at risk, requiring individualized health care approaches.
- High risk pregnancy
- Any direct referral for Case Management

How you identify these members;

LHC will use a variety of methods to identify members who may need case management, such as enrollment information, information received during new member welcome calls made to all new members, and ongoing review of data and member contacts. We will also conduct predictive modeling using Centelligence Foresight, which will help us identify members who meet case management criteria but are not already assigned to an ICT. In addition, our Case Managers who will be located at provider sites, including our partner LPC&A FQHCs will identify members who may need case management.

Enrollment Information. LHC will identify members for case management using historical claims and eligibility data provided by DHH, as well as the special needs indicator provided by the enrollment broker. In addition, as described in more detail in Section F.1, our Transition Coordinator will use other information provided at enrollment (such as existing authorizations for specialty services, non-emergency transportation, and certain supplies including oxygen and enteral nutrition) to identify members who may need Case Management.

Member Contacts. LHC may identify members who potentially need Case Management through contacts we make to all new members. Within 10 days after we receive the new member enrollment file,

LHC will mail new members a New Member Welcome Packet which will contain the HRS, a stamped return envelope and instructions for completing and returning the HRS. Within 14 days after we receive the new member enrollment file (21 days during the initial program implementation period), NurseWise, our 24/7 nurse advice line, will attempt to conduct Welcome Calls for all new Members. If reached, NurseWise will help the Member complete a short Health Risk Screening (HRS) to identify potential needs which indicate the need for Case Management. The HRS includes questions about diagnoses, medications, hospital and emergency department use, BH conditions, and use of medical equipment and supplies. It also includes questions to determine whether the member may be pregnant, have a chronic condition or other special health needs. The NurseWise staff will immediately offer assistance in making an appointment with the PCP (or OBGYN in the case of pregnancy) for members who appear to have these issues.

Centene's experience in other states indicates that a small number of Members will either refuse the HRS, or we will not be able to contact them. In certain large volume practices, FQHCs, and RHCs, LHC will locate a Case Manager or MCR onsite who can assist with locating new members and completing the HRS. We will also send MCRs to the member's address to complete the HRS in the home if other efforts to locate the member, such as reverse look up for phone numbers, are unsuccessful. If the member is not home, the MCR will leave a door hanger asking the member to call our toll-free number about their health care. After three unsuccessful attempts to reach a new member, LHC will include the member's name, phone number and Medicaid Recipient ID Number on the monthly report to DHH of members who cannot be contacted after three attempts.

We will also identify members who need or desire Case Management when members contact our Member Call Center; when our Medical Management Department receives an authorization request; when a member is admitted to the hospital; or when a member seeks care in the emergency department. Identifying members at these contact points is possible through our Member Relationship Management (MRM) system and TruCare, which integrates member demographic, assessment, authorization and service plan information, as well as all LHC contacts with the member. All LHC clinical staff who have member contact will have access to the information in TruCare, which will indicate whether the member has completed an HRS or comprehensive assessment, or has claims, authorizations or other indicators that the member may need Case Management. In addition, TruCare generates flags in our MRM system that indicate to Member Services Representatives (MSRs) whether a specific member calling LHC has completed an HRS or is assigned to an ICT. MRM will allow us to quickly identify and outreach to members whose needs have not been assessed. In such cases, MSRs speaking to the member can see an alert in MRM and immediately connect the member to ICT staff to complete the HRS or arrange for comprehensive assessment. If the contact comes through a provider, we will obtain and forward member contact information to the ICT so they can contact the member and complete the HRS. If a member's first contact with us is through a hospital admission or ED visit, TruCare indicates HRS and Case Management status to the concurrent review (CRN) nurses who monitor all inpatient members. This highly-integrated system and the corresponding processes constitute a best practice approach to members with multiple, chronic and/or complex needs. Identified members will receive a comprehensive assessment as described below.

Identifying Pregnant Members. We will maximize self-identification by educating all Members about the positive benefits of early prenatal care and the Start Smart Program. We will also identify pregnant Members via enrollment information from DHH and a monthly report we will generate from claims that indicates pregnancy diagnoses or prenatal vitamin prescriptions. Using our Avaya Voice Portal predictive dialing capability, we will send audio postcards to these Members describing Start Smart and encouraging them to call our toll-free number if they are pregnant.

Our Notification of Pregnancy (NOP) process will identify pregnant Members at risk for complications so we can establish a relationship between the Member, Provider, and health plan staff as early as possible. We will incentivize Providers to notify us via fax, mail or telephone as soon as they become aware of a

pregnancy. Members may also complete the NOP form by calling our toll-free hotline. Any Medical Management or Member Services staff who identify a pregnant Member will work with them to fill out the NOP form, which assesses over 20 factors related to the Member's obstetric history. We will use this information to stratify and determine intensity of interventions.

LHC is exploring working with our LPC&A FQHC partners on a Mom and Baby Mobile Health Center, which would enhance our ability to identify pregnant members. This mobile health unit is available through Southwest Louisiana Health Education Center (SWLAHEC) and March of Dimes. The original mission of the mobile health unit program was to provide prenatal and well infant care to women and children in hurricane-affected regions of Louisiana. LHC would like to partner in this effort in order to outreach to and identify pregnant members in rural parishes within Regions 4 and 5 (such as Lafayette and Iberia).

Referrals. LHC will identify members who may need case management through referrals from members, families, caregivers, providers, community organizations, and LHC personnel. Referrals may be made via phone, fax, mail, email or our Member or Provider Portal. Referrals may also be made in person to LHC staff such as MCRs at community outreach events, Case Managers onsite at FQHCs, and concurrent review nurses onsite at network hospitals. When we receive a referral, ICT staff will attempt to contact the member by phone within the timeframes described below for high risk members, unless the referral is from a provider who indicates a lower risk level for the member in which case we will use the outreach timeframe for moderate or low-risk members (described below) as applicable.

Predictive Modeling and Risk Stratification. LHC will use Centelligence Foresight, our multi-dimensional, episode-based predictive modeling and care management analytics tool, which uses clinical, risk, and administrative profile information obtained from medical, behavioral and pharmacy claims data and lab value data (received from network lab vendors) to identify members who may need Case Management. This will allow us to identify members who may not yet have a diagnosis or identified condition that would trigger assessment for Case Management, but are at risk for future utilization. With appropriate Case Management and monitoring, we may prevent, delay or reduce the disease process and the need for high utilization by ensuring these members access to appropriate preventive and primary care, long term services and supports, and non-Covered Services and community resources.

Identification and risk stratification will involve the following key steps:

- Identify the clinical risk markers observed for a member. Clinical risk markers describe a member's array of clinical conditions and their use of health care services in the context of those conditions. Risk markers are important in defining a member's clinical profile and how that clinical profile can be used in differentiating their risk versus the risk of other members. Examples of risk markers include: congestive heart failure (CHF) with co-morbidity; CHF with co-morbidity, recent inpatient stay last three months; and CHF with co-morbidity, significant episode clusters (a measure of unique physician encounters), last three months. Other risk markers may be assigned according to member age and/or gender, prescription drug use and the use of significant services such as durable medical equipment.
- Assign risk weights to each clinical risk marker. The risk weights describe the incremental contribution to risk of having a clinical marker. Different risk outcomes use different risk weights. A risk weight is assigned to each marker of risk for the member.
- Calculate member risk. A member's risk score for an outcome is the sum of the risk weights for all their markers of risk observed.

We will be able to add additional risk markers or adjust the risk weights to support the unique characteristics of our enrolled population. For example, other Centene health plans have added risk markers and weights to stratify pregnant members. LHC's risk assessment for pregnant members will automatically result in referral to Case Management through Start Smart if the member has one or more

risk factors described in the American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care "Factors That May Increase Pregnancy Risks."

LHC will evaluate the range of risk scores and assign a range to each stratification level. Regardless of the risk score calculated by Foresight, members with specific conditions such as diabetes and SMI will automatically trigger a Case Management assessment. Case Management staff will contact all members identified as potentially meeting criteria for Case Management to complete a comprehensive assessment to confirm appropriate risk stratification, determine goals, and develop a customized service plan. Because a member may receive a new diagnosis or have an exacerbation of a previously well-controlled condition after the initial stratification, we will generate biweekly reports from Foresight to frequently reassess risk levels.

Based on the experience of our affiliate health plans, we expect that after initial stratification, some members will be identified as not having current risks so will not require intervention. For example, a member with physical disabilities may not have existing co-morbid conditions, have an adequate support system in place, and therefore not require additional assessment or intervention. For all other members, LHC will use risk stratification and primary condition to determine timeframes for assessment.

How you encourage member participation;

LHC will encourage members to participate in Case Management and engage in their own care using successful strategies of other Centene health plans for similar populations in other states. These populations include individuals with chronic illness, physical and developmental disabilities, and serious mental illness. Member participation contributes to a greater level of compliance, optimal health outcomes and quality of life. However, many Medicaid members require intensive support and education to do so effectively and to sustain their involvement. To address these needs, LHC will provide multiple levels of support and information to support member (and family/guardian or caregiver, as appropriate) participation in Case Management including, but not limited to active engagement in service plan development. A fundamental aspect of providing this support will be to proactively seek member and family/guardian input on who to include in the process.

Our affiliate plans and LPC&A's FQHCs understand, based on experience, that one-on-one and in-person support is more effective for Medicaid and CHIP members than written materials. Thus, while we will provide a variety of written educational materials, our strategies will focus heavily on direct member contact. For example, LHC staff providing education in person will immediately determine whether and to what extent the member understands the information being provided, and will allow staff to quickly ask if the member has questions, or repeat information as needed to ensure understanding. Our staff will also establish personal relationships with the member and their families/guardians, because these members often need a relationship of trust to be established before they can feel comfortable asking questions or consider health advice that conflicts with cultural beliefs about health and health care.

In addition, LHC will leverage our relationship with LPC&A FQHCs, known and trusted organizations and Medicaid/CHIP providers throughout Louisiana, to provide credibility for and confidence in our Case Management outreach efforts. There is a high likelihood that members eligible for Case Management may already be in treatment, have previously sought care from, or be familiar with one of the LPC&A FQHCs. Since these FQHCs are woven into the fabric of the communities they serve, LHC's efforts to identify, outreach to, and engage members in Case Management will benefit from their established relationships with social service and community-based organizations that may have existing relationships with these members.

LHC's affiliate health plans and Nurtur, our disease management subcontractor, have successful track records with engaging members in Case Management. For example, Nurtur has a long-standing track record of engaging 75-90% of individuals their staff are able to successfully contact. LHC's Case Management Program will use strategies our affiliates have successfully used to ensure that members are

engaged and active participants in the program. Because different people prefer different methods of communication, our program will use multiple communication strategies, including written materials, telephonic outreach, web-based information, and in-person interactions as described above. During our initial conversations with our members we will attempt to gauge which methods and style of communication the member prefers. The Case Manager will document this information in TruCare so that it is available to all ICT and other clinical staff during future interactions.

Integrated Care Team Support. Case Managers and other members of the ICT who work with members on assessment and service planning will educate them about the importance of and their right to participate in and direct service plan development, and that member self-determination is a guiding principle of our Case Management Program. Because some members may not be familiar with these concepts, our staff will describe the types of activities involved in directing service plan development, such as deciding who else the Case Manager should include in discussions about assessment results and development of goals and preferences; deciding which available service options the member thinks will best meet their needs; and selecting their own Providers. We will also educate the member about the support available through the ICT, including that the member can reach a Case Manager by phone at any time 24/7 if they have questions or concerns. If the member's assigned Case Manager is not immediately available via phone, the call will never be sent to voicemail. Instead the member will always have the option of speaking to another Case Manager.

Case Managers will complete assessments with the assistance of the member and others as desired by the member, including family, caregivers and informal supports. Once assessments are complete, the Case Manager will review the results and discuss medical, behavioral health, functional and other assessed needs and conditions with the member so that they are equipped to evaluate service options in relation to those needs and conditions. Health Coaches will provide additional education related to specific chronic conditions. Case Managers will help members identify goals related to health, behavioral health, functional status, and quality of life such as daily engagement in meaningful activity, losing weight or remaining in their home. With assessed needs and goals established, the Case Manager will discuss available service options with the member, including Covered Services and those that are available outside the plan, and determine preferences for services and providers. The Case Manager and, as applicable the Health Coach, will work with the member to develop an action plan for each goal, with milestones and assigned responsibility for the different components of each plan. The member will be asked to evaluate their own progress against goals. ICT staff will educate the member on strategies for taking responsibility for the service plan, such as taking medications as scheduled or calling the Case Manager in advance if they think they might not be able to get to a provider appointment. This will also include strategies related to non-Covered Services the member needs, such as who to contact if the Personal Care Services provider does not show up on time.

LHC will train and require Case Managers to put the member and their autonomy first, rather than assume they know best what the member needs. This approach respects members as individuals whose lives are deeply affected by their services, and thus should be encouraged to make their own decisions about those services with our support. However, health literacy even among the general population is relatively low, and among the Medicaid and CHIP populations can be extremely low. Thus, effective decision support for these individuals requires a level of personal interaction and investment of one-on-one time that other managed care organizations do not typically provide, but that is a hallmark of our Case Management model.

Our Case Managers will be trained and highly skilled in identifying and discussing barriers to compliance, and adept in facilitating a readiness for change, obtaining true buy-in for behavioral modification, and encouraging solution-oriented problem solving. LHC's approach to addressing member needs, goals and preferences will recognize that although each individual and service plan is unique, successful service plans are built on a common groundwork that is based on the following:

- Assessing readiness to change and accommodating interventions based on that assessment

- Providing an active, high-quality, responsive platform of intervention methods, beginning with the first member interaction, to ensure active engagement from the start
- Helping members identify goals they see as important to their quality of life (such as walking to the mailbox, earning their own money, or remaining in their own home)
- Providing member-centric information in easy-to-understand formats and context through a variety of methods to meet preferred learning styles
- Designating action steps that members agree to take responsibility for in the service plan (such as getting their prescriptions filled on time and taking medications as scheduled checking blood glucose levels, or calling ICT staff in advance if they think they might not be able to get to a provider appointment);
- Asking members to evaluate their own progress on action steps
- Discussing barriers to and alternative steps for achieving goals
- Minimizing repetitiveness where possible, especially for those with multiple co-morbid conditions
- Encouraging and supporting active member involvement with an underlying emphasis on personal accountability for their own health and wellness.

Trigger Events. LHC will use biweekly predictive modeling identification reports from Centelligence Foresight not only to identify potential new Case Management participants, but also to identify certain trigger events for our existing participants. Examples of these events include an inpatient admission, an emergency department visit, a heart attack or a stroke. The experiences of our affiliate health plans have taught us that significant health events such as these often motivate a person to participate and engage more in their care. When such an event is identified, a member of the ICT will reach out to the member by phone to check on their condition, ask about any current unmet needs and determine if the service plan needs updating. This type of proactive outreach following a significant event demonstrates our concern for the member, which can increase their willingness to participate or remain in Case Management.

Home Visits. LHC recognizes the important role home care, including home visits and telemonitoring, plays in serving individuals with chronic illness or disabilities. We believe that “meeting members where they are” through home visits, is an effective approach to building supportive relationships with our members and providing an opportunity to observe members and their behaviors in a familiar and comfortable setting. This approach also allows ICT staff to establish stronger relationships with our members than would be possible by telephonic contact alone; conduct a more thorough assessment by observing symptoms or non-verbal communications that may indicate the need for additional questions; and by conducting an environmental risk assessment to identify any barriers to improved health status that may exist in the member’s home. Home visits will be possible for LHC members because we will co-locate ICT and MemberConnections staff in the communities they will be serving, such as at LPC&A’s 19 FQHCs and large provider group practices, rather than conducting case management activities out of a centralized call center with staff who may never have set foot in the member’s GSA.

MemberConnections® Outreach. Another key element of our highly personalized approach to Case Management and Member Services activities will be our unique community-based MemberConnections® community outreach and education program. MemberConnections® Representatives (MCR) will assist the ICT in supporting member participation in Case Management and care. MCRs are locally hired and familiar with the communities and service challenges encountered by our members and play an important role in locating and engaging members. They will assist the ICT with telephonic and in-person outreach to educate members and help them address barriers to participation. MCRs will also help locate hard to reach members. Because they are part of the community, MCRs are familiar with and know the local businesses and church representatives who in turn are more likely to share with us the potential location of the member. We will also locate MCRs at some of LPC&A’s FQHCs and our large provider group offices. If telephonic outreach attempts or those made through the provider are unsuccessful or if we fail to find a valid telephone number for the member, a MCR will go to the member’s home to provide

education, such as appropriate emergency department use, and will identify and address barriers to participation in Case Management or access to care. If the member is not home, the MCR will leave a door hanger with a request that they call LHC's toll-free number to discuss their health care.

Culturally Competent Communications. LHC recognizes cultural competency as a key factor in engaging and retaining members in Case Management as well as in ensuring access to care. Culture includes linguistic and disability-related needs as well as beliefs, expectations, assumptions and preferences due to ethnicity, racial, religious or national background. We have designed our Case Management processes to identify and respond to what is important to each individual, including strengths, goals and cultural considerations, so each member understands how and why to access Case Management services and feels comfortable and empowered to do so. The major ethnic cultures we will serve besides Caucasian are African American and Hispanic. In addition to the growing Vietnamese population, we anticipate serving members of Native American, Cajun, Chinese, and Haitian Creole heritage.; although in developing outreach and engagement strategies, we take into account all cultures. For example, poverty is one of the most prevalent conditions among our members, and has multiple significant effects on their ability to access care and beliefs about care. The 2009 DHH report entitled *Eliminating Health Disparities* notes that in 2007, African-Americans were approximately 32% of the Louisiana population, and almost 1.2 times more likely to be living in poverty than whites in 2003.⁴ The report cites the greater impact of poverty on African American health status. Heart disease and diabetes are leading causes of death in Louisiana, with chances of death for African American Americans 1.4 (heart disease) and 1.2 (diabetes) times higher than whites⁵ from 2000–2005. Understanding such information will help Case Management staff educate members about their relative risk factors and encourage them to participate in Case and Disease Management to receive support for improving their own health.

LHC will emulate the best practice of other Centene health plans by recruiting and hiring local staff who reflect the diversity of our member demographics. Particularly for staff with member contact, hiring from the local area helps ensure that staff have a personal familiarity with the region, cultural norms, and how people access health care, which helps foster the trust needed for effective member communication and education. The experience of our affiliate health plans is that engaging members, influencing their health behaviors and providing health education are most successful when members feel they are talking with a person with whom they have something in common.

In addition, we will train all staff to use People First language, and design written and oral communications to emphasize the person rather than the disability, and convey abilities and needs rather than limitations and problems. Like other Centene health plans, LHC will require all staff, regardless of role or responsibility, to complete our Cultural Competency Training Program upon hire, and at least annually thereafter. For all ICT staff, we will require biannual refresher training as well as annual recertification training which is based on the CLAS Standards. This recertification training uses role-playing, presentations, and case discussions with emphasis placed on development of skills to communicate appropriately and address member linguistic and disability-related needs and cultural differences. ICT staff will be trained on the impact of culture on health care decisions, the employee's own culture and potential biases, including ethnicity and gender, the impact of poverty on health, disability sensitivity, resources for members with disabilities, and linguistic barriers and resources for members with Limited English Proficiency (LEP) or low literacy. LHC has identified regional advocacy groups to collaborate with in customizing and conducting our staff cultural competency training. For example, the Mississippi Coalition for Citizens with Disability (MCCD) and the Coalition of Texans with Disabilities have provided training or other support activities to our affiliate health plans in, respectively,

⁴ <http://www.dhh.state.la.us/offices/publications/pubs-90/Health%20Disparities%20Report2008-09.pdf>

⁵ Ibid.

Mississippi since 2008 and Texas since 2007. See our responses to Sections L.1 and L.2 for more details about our approach to cultural competency, limited English proficiency, and communication impairments.

LHC is leveraging the experience of MCCD and Louisiana advocacy groups and convened the first meeting of our Community Advisory Committee (CAC) on March 18, 2011. To date our CAC includes local representatives from the Institute of Women and Ethnic Studies, Nurse Family Partnership, Children's Defense Fund, and Planned Parenthood Gulf Coast, and MCCD. LHC will engage these groups and other Louisiana advocacy organizations to obtain local input and collaborate in developing, implementing and evaluating member education strategies and targeted services. This approach has worked well for our affiliates to ensure that health plan service delivery meets member needs and reflects the experience and perspective of community stakeholders.

Connections Plus®. ConnectionsPlus® is Centene's award-winning program that improves member participation in Case Management, engagement in care, and health outcomes through use of familiar technology. Many Medicaid members lack reliable telephone access, which hampers their ability to contact a Case Manager or provider with questions, or to report a change in condition. It also hampers LHC and provider ability to reach the member with education, reminders, and other information critical to their care. With approval from DHH, LHC will provide restricted-use cell phones to certain high-risk members who lack reliable phone access (i.e. homeless, no home phone), have serious mental illness, or have other chronic and complex needs. The phones will be pre-programmed with important numbers such as the PCP, other treating physicians, the LHC Case Manager, NurseWise (our after-hours nurse advice line), and 911. By providing a member with reliable phone access, we provide them with the means to contact critical members of their health care team and empower them to accept more personal accountability for their health care needs. Through ConnectionsPlus® we will also provide podcasts in English and Spanish on a variety of health-related topics, such as self-care for diabetics, enhancing the member's understanding of their own condition so that they may more effectively participate in Case Management and engage in their own care. ConnectionsPlus® received URAC's 2009 *Best Practices in Health Care Consumer Empowerment and Protection* Silver Medalist Award and was a 2009 Medicaid Health Plans of America (MHPA) *Best Practices Compendium* Honoree.

Member Incentives. The CentAccount™ member incentive program is widely used by Centene health plans and promotes personal health care responsibility and member participation in care through positive reinforcement. Eligible members will be able to earn rewards for completing an annual well visit or for receiving certain chronic disease care screenings. The reward will be loaded onto a LHC-issued CentAccount MasterCard® debit card. Members can use this card at many merchants they already use every day, such as CVS and Wal-Mart stores, and other stores throughout the state, to buy a wide variety of health-related items including some over-the-counter medications. Members may use the funds on their CentAccount cards toward health care goods and services not provided under Medicaid and CHIP coverage. Goods and services qualify for card purchases if they are recognized by the U.S. Internal Revenue Service (IRS) as health care expenses for a Flexible Spending Account and flagged by the retailers' Inventory Information Approval System.

Member Education. LHC will provide a variety of education to support member participation. This will include, but is not limited to information provided in the Member Handbook about the importance of and member's right to participate in Case Management and direct their own care, and the process and support we provide for doing so. In addition, we will provide written information about recommended care for a variety of health and behavioral health conditions. For example, Health Coaches will provide condition-specific material when members are first assessed and enrolled in disease management that provide information about their disease/condition and how to manage it, how to prevent complications, and how to improve their overall health and well being. Our educational materials, written at no higher than a 6.9 grade level, will be presented in many formats and methods of delivery. Members can access educational information on our Member Portal, mailed material, via DVD such as those provided to our members with asthma, informational Call Center phone queue on-hold messages, and in-person. We will take the

opportunity with every interaction we have with the member to address issues of concern to them, answer questions, and ensure they understand the education provided. Each mailing to our members enrolled in Case Management will include reminders about the benefits of participating in the Case Management Program and receiving the screenings and preventive care required for their particular condition; as well as such services as assistance scheduling appointments and arranging for transportation. Mailings also will include our toll-free phone number for contacting the ICT and NurseWise, our 24/7 nurse advice line, and reminders about the financial and non-financial incentives available through the CentAccount program. In addition, with each reminder about a needed preventive service or screening, whether in writing or by phone, we will include a reminder about the risks associated with progression of their disease and about any available incentives for receiving the service.

Our Member Portal will provide a wide variety of health information such as education on specific chronic conditions, covered services and how to access them and how to contact a Case Manager or our nurse advice line with questions or concerns. In addition, members will be able to access a list of care opportunities and care gaps, which indicate recommended services for their condition that are coming due or are overdue. For example, a member with diabetes would see a care opportunity if it is almost time for the annual nephrology exam, or a care gap if they have not had their HbA1c checked within the recommended timeframe. Members will also be able to access their own service plan online.

Provider-Based Assistance. LHC will encourage Providers to support members in actively participating in their own care as well as participating in the Case Management Program when applicable. We will provide a copy of the member's service plan to the PCP so they can review and discuss it with the member as needed during appointments. It will also include providing access to the member's care opportunities and care gaps online. This feature will enable providers to outreach to the member as needed to schedule appointments and discuss needed care during appointments. We will also educate providers about the support and information we will provide members to direct their service planning. In addition, we will contact providers for assistance when the ICT is unable to reach the member. More information on the technology and other support we will offer providers to influence member behavior and engage them in Case Management and their own care is provided below.

Community-Based Supports. Engaging advocacy organizations and peers is often the most effective way to provide member support. LHC will work with local advocacy groups and peer organizations such as Families Helping Families in locations throughout the state, Second Beginning Peer Support Center in Ruston, and Centerpoint Community Services in Shreveport to provide support to members in engaging their own care, including but not limited to Case Management and service plan development. For some members, such as those with severe cognitive and/or communication impairments, obtaining accurate information about their goals and preferences is a challenge. We will work with community organizations such as Louisiana Assistive Technology Access network, serving people who have developmental disabilities, to incorporate service goals into self-direction supports.

Members Who Are Difficult To Engage. Our affiliates and owner-partner FQHCs have learned that even the most creative education strategies may not motivate members with chronic conditions to participate in Case Management and/or access appropriate care. LHC will implement strategies and then continually look for ways to address this barrier. We will solicit input from our partner FQHCs and our Community Health Advisory Committee to help develop strategies for increasing motivation.

LHC's approach to interventions recognizes that the best way to encourage difficult-to-serve members is by:

- Providing an active, high-quality, responsive platform of intervention methods, beginning with the first member interaction, to ensure active engagement from the start
- Providing member-centric information in easy-to-understand formats and context through a variety of methods to meet preferred learning styles

- Helping members identify health-related goals they see as important to their quality of life (such as losing weight, going to work, or remaining in their own home)
- Designating action steps for which members agree to take responsibility in the service plan (such as filling their prescriptions on time and taking medications as scheduled, or calling the Case Manager in advance if they think they might not be able to get to a provider appointment)
- Asking members to evaluate their own progress on action steps
- Discussing barriers to and alternative steps for achieving goals
- Minimizing repetitiveness where possible, especially for those with multiple co-morbid conditions.
- Encouraging and supporting active member involvement with an underlying emphasis on personal accountability for their own health and wellness

Health Literacy. Health literacy will be a key determinant of the *style* and *pace* of education provided by our ICT and MemberConnections staff to ensure that we are keeping members engaged and interested in participating in the program. Individuals with low health literacy will be provided simple information about their disease and how to self-manage, while individuals with high health literacy may be provided more advanced information, perhaps even through the provision and discussion of more focused articles regarding emerging therapies for a given condition.

Telephonic Outreach. LHC will implement a telephonic outreach program to educate and assist members in accessing services and managing their care. Calls will be placed by Nursewise[®], our 24/7 nurse advice line, to new members and to members who are identified or enrolled in disease, care or case management; have frequent emergency department utilization; or who are due or past due for services. We also will place calls within 48 hours of a member presenting to a network provider or contacting our Member Call Center or ICT staff indicating the need for emergency behavioral health services. A BH clinician Case Manager will place calls Monday through Friday, while NurseWise will place calls on weekends with a report to a BH clinician Case Manager for Monday morning follow up if needed. The purpose of the follow up call is to determine whether the member accessed appropriate services and attempt to schedule a time for a BH clinician Case Manager to conduct a comprehensive assessment. The Case Manager will work with the member to ensure they access a post-discharge follow-up appointment (within seven days of discharge if possible). This may include helping the member locate a specialty BH provider if they do not have an existing relationship with one, and assisting with scheduling and arranging transportation as desired by the member.

For members who do not answer the phone or whose phone line is busy, we will make at least three phone call attempts. If the number is found to be the wrong phone number for the member or is disconnected, the MCR will conduct research to identify an alternate phone number such as using reverse look-up systems, searching the internet, checking with providers who last saw the member, or pharmacies who last dispensed medicine to the member. After three unsuccessful attempts, we will include the member's name, phone number and Medicaid ID number on the monthly report to DHH of members who cannot be located after three attempts.

Members Who are Mobile, Difficult to Locate, or Homeless. LHC will use a multifaceted approach to contact members similar to that taken by our affiliates in other states with similar populations. We will outreach to members using continual, integrated documentation, culturally competent communications, repeated contact attempts using multiple strategies (written, telephonic, online, and in-person), and a strong method for tracking contact attempts and enrollee contact information. LHC will capitalize on every member contact to obtain and update their contact information.

Continual, Integrated Member Information and Tracking. LHC's Member Relationship Management system (MRM) is a powerful contact management system specifically designed for member data and processing workflow needs in health care administration. MRM will enable LHC to systematically identify and engage our members and their families in a coordinated fashion, connecting administrative,

financial, and personal health information in one location. MRM will have three core integrated components:

- The **Member Demographics System** provides processes for collecting, aggregating, matching, consolidating, quality-assuring, persisting and distributing member data throughout our organization to ensure consistency and control in the ongoing maintenance and application use of member data
- **MemberReach** will automate, manage, track and report on our workflows for *outbound call and in-person outreach* member campaigns as well as targeted outbound interventions (such as engaging high risk members in disease management programs).
- **MemberConnect** will support *inbound campaign management* offering a solution for alerting the LHC staff person who answers the call if another department has been trying to contact the member, including ICT for disease/care management assessment.

Using this system, LHC will maintain comprehensive and up-to-date contact information for members including phone numbers and home addresses. Unlike demographic information received through the eligibility process, the MRM will maintain all historical and current contact information for each member with the ability to note the primary or preferred method of contact. MRM will also allow LHC staff to record multiple addresses (i.e. physical address and mailing address), multiple phone numbers (i.e. daytime phone number, evening phone number, or neighbor's phone number) and email addresses. LHC staff will reconfirm contact information with members during each telephonic interaction, regardless of whether the member is calling into LHC Member Call Center or our ICT staff is calling out to the member.

Point of Service. Often the best place to reach members who are mobile, hard to reach, or homeless is at the point of care such as a doctor office, pharmacy, mental health service center, or during a home health or physician home visit. LHC's model of embedding Case Management and MemberConnections staff in local FQHC and high volume PCP offices, and onsite concurrent review at high volume hospitals will afford us the opportunity to be present when a member comes in for a scheduled appointment or as a walk-in, or is hospitalized. The onsite LHC staff will establish a relationship with the member to ensure needed assessments and service plan updates are completed, provide education, answer member questions, and assist the member with accessing needed services. If the member is homeless, the LHC staff will link them to available community resources and assist the member with scheduling needed referrals and transportation to the visits as needed. Our staff will also use this opportunity to identify the best way to reach the member and if needed, schedule a follow-up meeting at the point of service or other location of the member's choice. If the member is high risk and does not have reliable phone service, our onsite staff can assess whether the member meets criteria for our ConnectionsPlus program.

Other Methods. We will also use the following methods which have been used successfully by Centene health plans to locate members:

- Track pharmacy data provided by DHH to identify approximate refill dates and ask the pharmacy to notify us when the member is there
- Identify approximate location of the member and interview local community service staff, homeless shelters and area residents
- Conduct onsite visits when members are admitted to the emergency department or hospital. This face-to-face interaction with the member will build trust, let the member know LHC can provide help, and encourage the member to keep in contact with the Case Manager/ICT.

How you assess member needs;

Quick and accurate assessment is essential to reaching the member before an acute episode occurs and implementing interventions that improve outcomes. LHC will begin risk assessment and stratification at the time of enrollment, using information from DHH and the previous CCN such as historical claims data; our Health Risk Screening (HRS) tool, which we will ask all new members to complete; information obtained during New Member Welcome Calls; and information obtained during Case Management outreach to new members already receiving care at the time of enrollment with LHC. As the member's tenure with LHC extends, we will also use LHC claims and other administrative data.

LHC's stratification approach will be based on Centene health plan experience with similar populations and algorithms from predictive modeling approaches we use in other states, all of which are industry validated. We will combine clinical information, functional and psychosocial information, such as the need for assistance with activities of daily living or home management skills, unreliable support systems, active substance addiction, and domestic violence and homelessness, to stratify members. Many Centene health plans have not been provided with historical claims data at program implementation, and have successfully used our HRS and New Member Welcome Calls to gather information needed for initial risk stratification. LHC will use all available information to risk stratify upon implementation. If we receive historical claims data, we will also incorporate predictive modeling risk scoring data into the initial stratification process as further described below; otherwise, we will begin predictive modeling as soon as claims data becomes available.

Health Risk Screening. Our Health Risk Screening tool (HRS) will use a weighted scoring system to determine a member's level of risk based on their responses to each question. Each question on the HRS has a certain point value and a member's total score will determine their initial risk level. In some cases a response to one question, such as presence of disabilities or serious mental illness (SMI), will automatically trigger need for Case Management. In other instances it may be a combination of member responses that escalate them to a high-risk category. For example, a member who indicates that they have seizures and have not seen a doctor in the past 12 months or a member who indicates that they have depression and diabetes would be assigned for Case Management follow up and assessment. A member who indicates that they have a condition for which LHC has a disease management program, such as asthma or diabetes, and whose HRS indicates no other health risks would be assessed by a Health Coach for population-based disease management.

Assessment and Reassessment. During the first 90 days of program implementation, we will assess members within a timeframe consistent with their risk stratification but no later than 60 days after identification. On an ongoing basis, assessment will occur based on risk level but no later than 45 days after identification.

- **High Risk: Unstable members.** The Case Manager initiates contact with the member within three business days of identification, with assessment completed as quickly as the member's health condition requires but no later than seven days after identification. Characteristics of high risk members include, but are not limited to: unstable and/or has a chronic or complex condition with ongoing physical or behavioral health needs; currently hospitalized; symptomatic and at risk for immediate emergency department visit, admission or readmission.
- **Moderate Risk: Complex but stable members.** The Case Manager contacts the member within 14 days of identification, with assessment completed as quickly as the member's health condition requires but no later than 30 days of identification. Characteristics of moderate risk members include, but are not limited to: current need for routine ongoing physical or behavioral health care, which may include but is not limited to PCP visits, specialist visits, home care provider, lab work, medications, or referral and intervention by community organizations.
- **Low Risk: Stable members with multiple or co-morbid conditions.** The Case Manager contacts the member within 30 days of identification and completes the assessment as quickly as the

member's health condition requires, but no later than 45 days of admission to case management. Characteristics of low risk members include, but are not limited to: possible risk for a potential problem or complication; history of illness or injury but currently requires little or no medical, behavioral, or social support services or, if they do, the member/family is managing the care well.

Case Management Assessment. During the assessment, the Case Manager will educate the member and family/guardian, caregiver or other participants as determined by the member about our Case Management program and the member's right to opt out at any time with no loss of services. The Case Manager will work with the member and others determined by the member to assess elements that include, but are not limited to member clinical history and status; functional status; mental health status including psychosocial factors and cognitive function; caregiver resources including family involvement and their participation in decision making; life planning activities including wills, living wills, or advance directives; and cultural and linguistic needs and preferences. This assessment is holistic, featuring open-ended questions that foster an understanding of the individual's overall health and needs, including, but not limited to:

- Special needs such as developmental delay, severe orthopedic or persistent muscle tone abnormalities, seizure disorder, or major chromosomal abnormalities
- Assistance needed with activities of daily living (e.g. bathing, toileting, dressing, ambulating) or instrumental activities of daily living (e.g. preparing meals, shopping, basic housekeeping, etc.) particularly when there is no support system
- Social or economic constraint such as lack of financial support, lack of social, family or significant other support, illiteracy or significant communication barriers, access to care issues, transportation, or abuse or suspected abuse.

As applicable to each member, Case Managers will also complete an environmental assessment of the member's home, a depression screening, a brief mental status exam and a confusion/dementia assessment.

Disease Management Assessment. For members requiring Disease Management (DM) services, Health Coaches will conduct condition-specific assessments to identify acuity, co-morbidities and member self-management capability and barriers. A Health Coach will contact the member by phone following an introductory DM program mailing to complete an Initial Health Assessment (IHA). Through the IHA, the Health Coach will gather information about primary and co-morbid conditions and any socioeconomic barriers impacting health. For members considered to be at moderate or high risk based on the IHA, the Health Coach will conduct a Baseline Call Assessment (BCA), which is condition-specific and includes questions about symptom severity, medications, hospital and ED use, activities of daily living, pain, medical or behavioral health co-morbidities, use of medical equipment or supplies, health literacy, unmet social needs (such as housing or food supply), family and other support, medical home, and willingness to participate. This holistic assessment features open-ended questions that foster an understanding of both the individual's clinical co-morbidities, including behavioral health conditions, and general psychosocial status. The Health Coach will also assess the member's current readiness for self-management in the following areas of health care:

- Daily monitoring of health indicators for the member's chronic health condition for self-triage
- Consistent self-management of acute clinical symptoms in the home/community setting
- Correct use of all prescribed medications and medication adherence over time
- Appropriate lifestyle decisions based on the member's chronic health condition and physician recommendations
- Management of depression and other mental health correlates of chronic disease
- Access to support for self-management (such as family, friends, and community services).

Reassessment. Reassessment will occur at least annually for low risk members, quarterly for moderate risk members, and daily to monthly for high risk members. Reassessment also will occur anytime the

member's condition changes, new needs develop or the member is admitted to the hospital or emergency department.

How you develop and implement individualized plans of care, including coordination with providers and support services;

Service Plan Development. The Case Manager will develop and implement the service plan in collaboration with the member, family/guardian, caregiver, others as determined by the member, and providers of covered and non-Covered Services including community resources and support services. The service plan will be individualized and identify the member's long and short term goals; authorized services including standing referrals to specialists; member and caregiver/family participation including the member's self- management responsibilities; plan for addressing barriers; and community linkages and support. All service plans will address social and other needs such as non-covered Medicaid services, WIC, transportation, Food Stamps, housing services, or services provided through local social services organizations such as assistance with utility bills.

The Case Manager will use assessment information (along with other information such as utilization) to help the member articulate desired physical health, behavioral health, functional, social and other goals and the range of service options and settings. Goals will be measurable and the Case Manager and member will identify a plan to achieve each goal. The Case Manager will provide applicable health education and help the member identify barriers to articulated goals and suggest acceptable approaches for overcoming such barriers. The Case Manager will ensure the member understands their role in self management and agrees to specific steps in making progress toward overcoming barriers to care and meeting goals. For members with co-morbid physical/ behavioral health conditions, the lead Case Manager will obtain input from his or her physical or behavioral health counterpart on the ICT. The Case Manager will contact the member's medical home provider, behavioral health provider (including specialty BH provider when applicable), and other providers, with the member's permission, to obtain their input into the service plan. In collaboration with the member's PCP and other providers, the Case Manager will identify short- and long-term treatment objectives and desired outcomes (both clinical and non-clinical) based on the member's needs and goals.

Once the Case Manager and member have agreed on a plan of care, the Case Manager will contact, as applicable, the member's PCP, behavioral health provider and other treating providers. The Case Manager will use fax, phone and other secure methods to share and discuss assessments, member goals/preferences, and service plan recommendations with the provider(s) as appropriate. If a provider suggests changes to the service plan, the Case Manager will consult with the member to determine if the change is acceptable. If not, the Case Manager will communicate the member's concerns to the Provider and work with the member and Provider to reach a mutually acceptable solution. When the member agrees to the final service plan, ICT staff will enter the service plan into TruCare. All members of the ICT as well as other clinical staff will be able to access the service plan as needed to assist the member.

Service Plan Implementation. The Case Manager will authorize needed services, and with assistance of ICT staff provide authorization information to providers. The ICT will assist the member as necessary with such issues as scheduling appointments and arranging transportation to ensure access to care. The Case Manager may assign other tasks to ICT staff as follows:

- Program Specialist - to manage or assist with psychosocial issues
- Program Coordinator - to assist with coordination of non-clinical functions such as verifying appointments and obtaining lab results
- MemberConnections Representative (MCR) - to assist with community referrals, in-home or office visits, coordination of care, and outreach activities.

The ICT will follow-up with members based on their risk level to monitor provision of authorized services and ensure they are meeting the member's needs. During each follow-up contact, the Case

Manager or other ICT staff will review the service plan with the member (and family, caregiver or guardian as applicable) to assess progression on goals, reassess preferences and needs, and make any necessary modifications based on changes in the member's health or psychosocial status. The Case Manager will work with the member, family and Providers to update the service plan as needed using the same process for initial service plan development. The Case Manager will obtain needed authorizations, and provide copies of the updated plan to the member/family and providers.

How you coordinate your disease management and CCN case management programs;

LHC will deliver Case and Disease Management services through an Integrated Care Team (ICT) approach as described above. Through this approach, we will ensure that all care and services for a single member, including Case and Disease Management services, are integrated through a single service plan and a multidisciplinary approach that looks holistically at the member's entire range of needs.

For members with complex and/or co-morbid conditions, a nurse or BH clinician Case Manager will lead the ICT and direct all activities including needed disease management services. For members who need disease management but do not have other chronic or co-morbid conditions, the Health Coach will be responsible for coordinating ICT activities for the member, obtaining input as needed from the ICT nurse and BH clinician if other issues arise. The member will have a single service plan housed in TruCare, which all ICT and clinical staff with member contact will have access to. Co-location of the ICT will facilitate regular, in-person communication about the member's care. In addition, the ICT will participate in weekly case conferences in which nurse and BH Case Managers will discuss the member's condition and care with the Health Coach providing disease management support.

LHC's integrated care approach is structured to maximize the impact of care management resources for the population as a whole, while providing the most appropriate level of services for individual members, ranging from those with poorly controlled or multiple co-morbid chronic conditions to those with the best health status or no chronic condition. For example:

- **High risk.** Members with high predicted risk for hospitalization, higher than expected utilization, poor outcomes, multiple co-morbidities (medical or behavioral health), or special health care needs will receive case management services from the ICT. An RN or BH clinician (depending on primary diagnosis) will be responsible for overall direction and coordination of the member's case and disease management services, to ensure appropriate clinical oversight of ICT staff activities. This will include coordination with the Health Coach for needed disease management services.
- **Moderate risk.** Members with a single chronic condition (asthma, congestive heart failure, diabetes, hypertension, obesity, and low back pain) will be referred to a Health Coach for motivational interviewing, health education, training in self-management skills, and coordination of care and services. Health Coaches will coordinate with other ICT staff to ensure that these members receive the most appropriate mix of services to support their adherence to their treatment plan and optimize health status.
- **Low risk.** Members with no chronic condition or with a well managed condition will receive general education through our health education programs and assistance as needed through our MCRs or through our Member Services Call Center.

“As a member of the Peach State physician network, I appreciate the plan’s case management philosophy which is designed to help members get all the care they need in the proper settings. There aren’t limits to PCP visits and patient care is highly coordinated so that members take care of their own health — and stay out of the emergency room.”

—Sharne Hampton, M.D., Family Practitioner/Centers

How you will coordinate your case management services with the PCP; and

The PCP as the medical home oversees the member's full range of care. We will educate all PCPs about the availability of our Case Management program to support them in carrying out their medical home responsibilities and ensuring that all care a member needs is well-coordinated. Case Managers and ICT staff will communicate with PCPs during service plan development and monitoring, and facilitate coordination among PCPs, specialists, and other treating providers. We will locate ICT staff onsite at certain partner FQHCs, and high-volume providers to facilitate coordination of Case Management activities with the medical home provider.

Provider Education. Provider education and training on the Case Management program is critical to establish good relationships that facilitate coordinated care that complies with evidence based guidelines and improves member outcomes. We have already begun soliciting input from LPC&A member FQHCs regarding design of our provider outreach and education program, including educational materials and preferred methods for receiving materials, and ongoing collaboration regarding member service plans. We will continue to solicit ongoing input from LPC&A members after the operational start date. In addition, we will solicit and document ongoing input no less than quarterly from other network providers through our Provider Relations staff and provider representation on our QAPIC and quality subcommittees such as the Utilization Management and Provider Advisory Committees.

LHC will use a variety of methods to communicate program components and goals, facilitate coordination between providers and Case Management staff, improve awareness, and promote compliance with evidence based guidelines. This education will be provided during new provider orientation, in the Provider Manual, and on the Provider Portal. Ongoing education will include new requirements, processes or initiatives, program priorities such as coordination requirements, and program performance measures and results. This education will be provided via group sessions, online and with individual PCPs and their staff when requested, or when we identify the need for additional education through monitoring.

In addition to this general information about the Case Management program, we will provide targeted education when a PCP's linked member is enrolled in Case Management. This letter will include an overview of the Case Management Program and contact information including telephone numbers and email addresses for ICT staff, as well as Provider Relations and Pharmacy staff, our toll-free provider call center. The letter will also summarize and refer the provider to information on the Provider Portal to support medical home efforts to coordinate care. Based on feedback from providers at Centene affiliate plans about the overabundance of written information they receive in the mail, we will not send hard copies to each provider, but the introductory letter will inform them that significant resources are available through our Provider Portal, we will mail hard copies upon request. Program information on the Provider Portal will include:

- Case Management policies and procedures, including how the provider can contact the Case Manager and other members of the ICT for assistance or to refer a member for Case Management
- The member's service plan
- Educational materials, including information about evidence-based clinical practice guidelines, including quick reference guides and best practices in the treatment of the chronic diseases included in the disease management program.
- Forms that can be customized for member referral to disease management program services
- Member chart forms to track regular screenings and key metrics

Case Manager/ICT Interaction with Providers. The Case Manager, Health Coach and other ICT staff, as needed, will communicate via phone, fax and email with the PCP to provide assessment results,

member goals and preferences, service plan recommendations, and to obtain input on the service plan. The final service plan will be available to the PCP via the Provider Portal and available in hard copy on request. The Case Manager, Health Coach or other ICT staff will also communicate monitoring results to the provider via phone, fax and email, such as alerting the PCP when a member is hospitalized, has a gap in recommended care, experiences an exacerbation of a chronic condition, reports a medication side effect, or is non-compliant with treatment or medication regimen. We may invite the PCP to participate in case rounds for members with complex conditions, and we will reimburse PCPs to encourage their participation in case rounds.

For members receiving disease management, the following are key components of communications that the Health Coach will use to interact with member's treating physicians:

- *Respiratory Program Action Paths* will be sent to PCPs upon completion of the baseline assessment and include current self-reported symptoms and medications. Providers can then confirm or make changes to the treatment plans which are then reinforced by the care management staff.
- *Medical Information Forms* will be sent to providers upon completion of non-respiratory baseline assessments to request current biometrics, confirm presence of complications/co morbidities and request physician input and recommendations to the coaching process.
- *Lab Update Forms* will be provided annually and more often as needed to inform providers of changes in any relevant lab data for their members.
- *Medical Alert Fax* will be sent anytime a member is in a potentially urgent situation.
- *Quarterly Provider Newsletters* that provide refresher information about the disease management program, program enhancements, any updates to CPGs or relevant new technologies, updates on measures of the program's success, success stories that highlight a member's success or a provider's success in improving patient health outcomes, and the names of providers who have been presented awards by LHC.

Integrating Case Management Staff with Local Providers. In collaboration with our partner, LPC&A, LHC will imbed Case Managers in their locations. The onsite Case Managers will work with provider staff to complete assessments on members we have been unable to reach by phone; collaborate on service plan development; provide member education; and participate in case conferences with provider staff. These field-based staff will carry laptop computers, enabling them to stay connected to other ICT members and to document their activities in TruCare. While these Case Managers will still be assigned to an ICT to ensure multidisciplinary input and oversight of the service plan, LHC recognizes the value of maintaining the existing relationships between provider case management staff and members. Our Case Managers will support and supplement provider staff, building on and enhancing the existing service infrastructure within the service area. A recent review recognized this embedded Case Manager approach for people with serious mental illness, citing evidence for increased receipt of evidence-based services and increased likelihood of having a usual source for primary care services.⁶

Technology Support For Coordinating With PCPs. LHC will offer an innovative package of technology solutions to support our efforts to communicate and coordinate services with our PCPs.

Appointment Scheduling. If the PCP or FQHC uses an electronic appointment scheduling system that supports the HL7 Scheduling Information Unsolicited (SIU) data exchange standard, we will support remote appointment scheduling from MRM. If ICT or Member Services staff are in contact with a member who requests or is in need of an appointment, they will be able to use our HL-7 SIU equipped MRM application to determine provider availability and book an appointment for the member directly into the provider's appointment scheduling software. Further, after the appointment is scheduled on the

⁶ Alakeson V, Frank RG, Katz RE, Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders, Health Affairs 29(5) 2010; 867-873

provider system, the appointment data will be captured in MRM, allowing MRM to notify the member that the appointment has been booked and the date and time of the appointment.

Coordinating Outreach. MRM will also have the capability of coordinating outreach through our MRM MemberConnect application. Should ICT staff be attempting to contact a member about a gap in needed care, MRM will take that information from TruCare, our integrated health management system, and present it as an alert to an MSR, for example, when they are responding to an inbound call from the member for unrelated reasons. This feature will enable our ICT staff to more effectively intervene when care gaps are identified and facilitate the delivery of timely preventive and other needed services by the member's PCP.

Multi-Level Provider Portal. We will support and coordinate with our PCPs as well as other providers with an integrated family of secure, web-based tools for administrative productivity, operational efficiency, and clinical quality improvement. Each of our three Provider Portal offerings builds on the other, to offer the right applications to the appropriate provider audience.

Provider Portal: Supporting All Network Providers. Our secure, web-based Provider Portal will notify provider users of important member medical considerations via our Online Care Gap Notification (OCGN) feature, supplementing ICT staff contact with PCPs to provide updates on the member's condition and care. OCGNs will notify Provider Portal users of the potential need for necessary preventive services including intervention needs based on diagnostic and lab results. Our Centelligence™ Foresight predictive modeling system will identify preventive care gaps by analyzing medical, behavioral, and pharmacy claims data, health risk assessment information, lab test results and other information housed in our Enterprise Data Warehouse (EDW). These care gaps will be systematically presented to Provider Portal users via our OCGN feature - either when the Provider Portal user views member eligibility, and/or when a PCP views their Online Member Panel Rosters on our Provider Portal. Our Online Member Panel Rosters will also include information on a member's special health needs and/or significant health issues. This information will augment ICT contact with the PCP to report care gaps and monitoring results, ensuring the PCP has current information about the member's condition and care.

Clinical Portal: Information For Coordinated Care and Provider Collaboration. The Clinical Portal, available to all authorized network providers (subject to HIPAA Minimum Necessary Rules), will build on the functionality of the Provider Portal to deliver a set of medically oriented informational tools to the provider. Our Clinical Portal will house evidence-based Clinical Practice Guidelines, customized for the health considerations of our Louisiana CCN membership; and designed to support clinical best practices in our network; as well as to help providers with some of their NCQA or JCAHO Medical Home accreditation efforts. Clinical Portal users will also be able to view a member's service plan, which will include identified health problems, treatment goals and objectives, milestone dates and progress, in an engaging, well organized online format. The Clinical Portal will offer online access to HEDIS reports and Provider Overview Report as viewable and printable PDF documents. The Provider Overview Report will present timely utilization measures and preventive care performance information, offering the provider cues to clinical focus areas for ongoing care quality enhancement. Please refer to Section G, Question G.13 for more information.

The Clinical Portal's online summary Member Health Record (MHR) will offer a well-organized view of a member's care gaps as well as a cursory clinical "face sheet" for each member for which we have supporting data. Our MHR is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received and processed in our Enterprise Data Warehouse (EDW). In addition, any provider with Provider Portal or Clinical Portal access will be able to view our Emergency Care Record (ECR). The ECR contains a subset of information from the CenTraCare Member Health Record (see below); with content specifically focused on the most vital information for a provider who is otherwise unfamiliar with the member. Our Provider Portal captures all ECR access information in full compliance with § 164.312 of the HIPAA Security Rule

(emergency access to medical records) and associated audit trail requirements, through the use of a “Break Glass” affirmation from provider that access is needed.

CenTraCare: Empowering Medical Homes with Meaningful Clinical Information. For network PCPs and FQHCs who are accredited as NCQA Patient Centered Medical Homes or JCAHO accredited Primary Care Medical Homes (both designations abbreviated "PCMH" for purposes of this section), or that commit to attaining PCMH recognition from either NCQA or JCAHO, we will provide access to our CenTraCare Clinical Portal (CenTraCare) for additional clinical and care coordination capabilities beyond those in our Clinical Portal. These PCMH providers will be able to access CenTraCare through a secure, efficient "single sign on" to our secure Provider Portal. CenTraCare is specifically designed with PCMH provider information needs in mind, and offers a more data rich and interactive version of our online Member Health Record (MHR), with a well-organized view of a member's care gaps; full member-specific clinical profiles; lab data with trending analysis; and cursory clinical records for individual members. CenTraCare's MHR is a superset of the summary MHR and ECR found in our Clinical Portal, and is based on medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received, integrated and processed in the Enterprise Data Warehouse (EDW) component of our Centelligence™ informatics platform.

CenTraCare also offers online Clinical Quality Improvement reports that go beyond those offered in our Clinical Portal, and include practice level HEDIS measures covering all aspects of our members' care, not just dimensions of care provided by the Medical Home. CenTraCare also offers additional morbidity adjusted quality, cost, and utilization information at the aggregate provider practice level and by episode, and with costs broken out both as direct PCMH costs and as episode-related external costs (hospitals, pharmacy, lab and specialty). Our overarching objective with CenTraCare is to give the PCMH provider a holistic view of the member's healthcare experience and support the concept of care accountability that is central to the PCMH concept. When combined with the other features of our Provider and Clinical Portal, including online care gap notifications, online member panel roster with special health needs registry, and online clinical practice guidelines, CenTraCare will offer a powerful informational assist for collaborative care coordination and ongoing clinical quality improvement for our PCMH providers and our members.

How you will incorporate provider input into strategies to influence behavior of members.

Incorporating Provider Input. Providers often have valuable insights into member behavior and suggestions for encouraging members to access care appropriately, take responsibility for their own health, and self-manage chronic conditions. Case Managers will communicate with providers to obtain input on the service plan. This will include informing the PCP and treating providers not only about assessment results but also member goals and identified barriers to appropriate access to care and healthy behaviors. The Case Manager also will ask for provider input into development of the action plans for each member goal, strategies for addressing identified barriers, and incorporate the provider’s suggested strategies into the service plan.

Since the member and provider/office staff often have established relationships, the provider may have a better understanding of a member’s barriers and preferences. For example, provider staff may know that a member does not feel comfortable sharing personal information with females, but a member may not inform Case Management staff of this fact. LHC would use this information to assign the member a male Case Manager. Provider staff may also be aware that while a member can speak English, they feel more comfortable and are more fluent using Spanish. LHC would ensure that such members are assigned Case Managers who are fluent in Spanish. Particularly during the transition from FFS to the CCN-P, these sorts of insights will be important in gaining member trust so that Case Management and MemberConnections staff can provide suggestions and support for positive behaviors that the member will accept.

Centene affiliate plans and our owner-partner FQHCs know that members trust their doctor and often take health-related direction from them more seriously than they do from other sources. LHC will work with LPC&A FQHC partners to explore such strategies as sending reminder postcards signed by the PCP rather than LHC. We will also support the Patient Centered Medical Home (PCMH) in conducting outreach and encouraging for positive behaviors. See Section G8 for more information on our PCMH approach.

Supporting Provider Efforts To Influence Member Behavior. LHC will provide multifaceted support to assist our providers in influencing member behavior. This will include support to promote member responsibility for their own care and health, including appropriate utilization, compliance with treatment and medication regimens and other healthy behaviors.

Provider Education and Training. LHC will educate our providers on our medical home policies, Case and Disease Management services, and availability of NurseWise during provider orientations, in the Provider Manual and on our Provider Portal. LHC training will engage providers new to coordinated care and help them understand their role in educating our members on appropriate use of services. In addition, we will provide information about these policies in our quarterly provider newsletter and during Provider Relations follow up visits. For example, our Provider Relations staff will follow up with PCPs that have a disproportionate number of members with high ED use to explore potential access issues, such as appointment availability, office hours, and well-translated answering machine messages.

Educational Materials. We will offer providers brochures, posters and tool kits on various health promotion or disease-related topics that they can use with members to reinforce appropriate use of services and taking responsibility for self care. For example, for smoking cessation, we will educate our providers about the DHH Tobacco Control Program, the Quitline, how to become a certified Fax to Quit Provider (if they are not already), and how to access important tobacco cessation resources for their practice, such as the Certified Health Care Provider Toolkit.

Case Management Support. Our ICT staff will support provider-based member education and motivation by contacting PCPs within three days of members' Case Management assessment, informing PCPs of the service plan, including any gaps in care, and requesting PCP input on and support for the service plan. We also will work with providers to help meet the need for after-hours or urgent care services. For example, our Texas affiliate worked with a large physician group to develop a code-based per-visit financial incentive for evening and weekend office visits, which supports members going to their PCP rather than the ED. Our affiliate also worked with a large El Paso group practice that wanted to expand its urgent care services. Our affiliate helped finance the group's establishment of an urgent care center in Austin to meet growing demand for urgent care services there.

Provider Portal. As illustrated in detail above, our Provider Portal will help network providers influence members' healthy behaviors and appropriate use of services. The Online Care Gaps will allow network providers to see when checking member eligibility whether the member is due for a test, check-up or other health screen. Our monthly performance reports will give them feedback about their performance against an appropriate peer group, which will help show them opportunities for improvement in their medical home operations, including when members are over-utilizing or under-utilizing services (and could be better educated or treated in a different manner). Our Portal ED check box prompts hospitals to indicate in real-time when a member visits the ED. The system will immediately notify the member's Case Manager, who then follows up with the member and contacts the member's PCP, to help engage the PCP in follow up care and, if appropriate, preventing future unnecessary ED visits. The Member Health Record will also include full clinical profiles for each patient, lab data with trending analysis, and summary clinical records for individual members, which will help give context to providers not only in treating our members, but also in educating and influencing them about self care and appropriate use of services.

Health Check Days. Health Check Days are preventive health check-up programs for LHC members. At these events, which will target well child/EPSDT visits, mammography screenings, and diabetic screenings, LHC will partner with provider offices and FQHCs across Louisiana to identify members who have missed preventive care visits. LHC staff will then contact the member to encourage them to make an appointment for the needed service on a certain day set aside by the practice. LHC staff will be at the providers' offices on these days to reinforce the importance of preventive care and answer questions about the member's health plan benefits.

Obtaining Input on Plan-Wide Strategies For Influencing Member Behaviors. In addition to incorporating provider input into strategies for individual members, LHC will obtain and incorporate provider input using the following methods.

Provider Summits. LHC will hold Provider Summits that are informal meetings with local providers to gather input on a wide range of issues, including but not limited to strategies for influencing member behavior to promote health and appropriate access. We will invite contracted and non-contracted providers to the Summits, which will be held at locations around the State. Topics will typically include local issues affecting care (such as community patterns of access, housing issues, availability and use of transportation services), and how LHC can assist in addressing these issues to improve member outcomes.

Provider Participation on Committees. We will include providers on many committees that develop and monitor strategies for influencing member behavior. For example, our Quality Assessment Performance Improvement Committee (QAPIC), which will oversee all clinical and service activities, will include physicians representing a variety of specialties. The QAPIC will use provider feedback to improve our operations and clinical performance, including strategies for engaging members in Case and Disease Management programs and influencing compliance and other healthy behaviors. Our Utilization Management Committee (UMC), which will include six network physicians, will provide oversight of the Utilization Management (UM) Program and promote appropriate utilization of services in coordination with all functional areas. The committee will be responsible for analysis of UM data, identification of trends, and addressing identified issues such as over- and under-utilization of services. This will include recommendations for and evaluation of strategies to promote appropriate utilization of services. Our Physician Advisory Committee (PAC), which will include eight medical home providers, will provide input to senior leadership that will include suggestions for improving performance on quality and utilization metrics through implementing strategies to influence member behavior, such as modifications to our member incentive program to encourage appropriate service utilization.

Question F.3
Coordinating Carved Out Services

F.3 Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:

- Dental
- Specialized Behavioral Health
- Personal Care Services
- Targeted Case Management

Overview

LHC will apply the lessons learned from Centene affiliate plans and capitalize on the experience of LPC&A FQHC members in coordinating carved out services with covered and other services our members need. Below we provide information on Centene and LPC&A's experience coordinating carved out services; our overall approach to coordinating carved out services; and how we will coordinate specific to each carved out service covered by this question.

Experience

Centene. Centene affiliate health plans routinely coordinate a wide variety of carved out services, including Medicaid services that continue to be provided through the fee-for-service (FFS) Medicaid program, with the services provided by the health plan. This includes, but is not limited to, dental, behavioral health (BH), personal care and other long term services and supports for members on SSI and/or with disabilities, and targeted case management for members with special health needs. Entities with which our health plans coordinate include, but are not limited to, individual Medicaid and Medicare providers, state agencies, other state contractors (such as health plans and private case management agencies), Medicare Advantage/Special Needs Plans, and social service agencies. Our approach is holistic, recognizing that optimal health outcomes are only achieved when the full range of medical, behavioral, long-term care, social, and other services are integrated and coordinated. For example:

- Dental. Untreated dental issues can have significant health consequences, particularly for those with chronic illness or pregnancy. Centene Case Management staff and MCRs often assist adult members, including those with chronic and complex conditions, in identifying and accessing carved out or non-Medicaid sources of dental care that may be available through state agencies and local social services organizations. Through Centene's Start Smart for Your Baby pregnancy management program (see Section F2 for more details), Centene plans ensure pregnant members are referred to all needed services, including carved-out dental services, and that the member's OBGYN is aware of all services the member is receiving.
- Specialized Behavioral Health. Centene plans routinely coordinate with network and non-network behavioral health and substance abuse providers to ensure integration of care for co-occurring conditions. For example, effective pain treatment provided by a primary care provider must take into account a member's substance abuse disorder (SUD) and other behavioral health issues in order to avoid undermining SUD/BH treatment. In some states, our affiliates provide these services through our behavioral health affiliate, but in others they are carved out and the plans are required to coordinate services through designated entities. For example, Centene's Texas plan that serves members on SSI in the Dallas Service Area uses its BH clinician case managers to coordinate BH services provided through the state's contracted Managed Behavioral Health Organization.
- Personal Care Services. Members with disabilities or chronic/complex conditions may require personal care or other long term services and supports in order to prevent, delay or avoid exacerbations of their physical health condition and the need for hospital or nursing facility admission. While some of Centene's plans cover these services, other plans serving members on SSI who may qualify for long term services coordinate with the applicable state agency and providers to integrate those services with the preventive, primary, acute and other services

provided by the plan. This includes securing physician orders when required, and sharing information with the state case manager about the member's condition that may indicate the need for additional assistance with activities of daily living.

Targeted Case Management. Some Centene plans have members who are also eligible for Targeted Case Management (TCM) provided through the FFS program. In such cases, the health plan case manager works with the TCM provider as needed to determine roles and responsibilities and to ensure all case management activities are well-coordinated, such as inviting TCM providers to participate in case conferences for service plan development or discharge planning. Since the TCM provider has frequent, sometimes daily, contact with the member, such as members with severe mental illness, there is a high level of comfort and trust with the TCM provider. In such cases, a Case Manager may leverage this relationship by working through the TCM provider to get the member to show up at scheduled medical appointments. In addition, the Centene Case Manager incorporates TCM provider input into service planning and support services. For example, the TCM provider may discourage the health plan from providing cab rides to appointments for members who need to work on independent living skills such as planning and successfully riding the bus on their own. In this case, our Case Manager would provide bus passes to support the TCM provider recommendation.

In another example, our Wisconsin affiliate plan had a member with 26 behavioral health admissions for the previous year. The health plan Case Manager and TCM provider determined that the member was not engaging in care, such as by staying in her room rather than joining group therapy sessions, and this was a key factor in her repeat admissions. They also discovered that the facility was automatically admitting the member when she presented with behavioral health needs rather than considering whether an observation stay would be appropriate. Our affiliate Case Manager and TCM provider held a joint discussion with the member about the importance of engaging in care. They also coordinated a case conference at the hospital with the hospital discharge staff to discuss encouraging the member to engage in care as well as the potential for observation stays to address immediate needs but prevent or reduce readmissions. Since this case conference, the member has not readmitted to that facility and has only had 3 admissions, which represents a significant decrease in frequency. Our health plan Case Manager and TCM provider plan to jointly outreach to the other facilities at which the member sought care, and communicate regularly to reassess the member's service plan and determine how they can continue to coordinate their efforts to help the member meet her service plan goals.

One issue that often arises when attempting to coordinate with TCM providers is member confidentiality. Centene plans address this issue by working with the member, TCM provider, and, when necessary, the state Medicaid agency, to obtain and document member consent, and complete and maintain necessary information release agreements that comply with applicable state and federal privacy laws and regulations.

Affiliate health plans coordinate carved out services through Case Management staff (including Case Managers and non-clinical Program Coordinators) as part of service plan development, implementation, and monitoring. These staff receive assistance in coordinating carved out services through our MemberConnections[®] Program, which uses MemberConnections[®] Representatives (MCRs) who are hired from within the communities they serve. These MCRs receive comprehensive training to help them effectively facilitate their community and member outreach efforts. Hiring from within the community ensures MCRs are knowledgeable about the cultural, geographic, demographic, and other aspects of our members' communities, and the resources available within each. They literally 'speak the language' members speak and are more likely to be viewed with trust by members than health plan staff who do not look or speak like members or come from the local area. MCRs establish relationships with members and deliver personalized service in community-based settings that engage them, resulting in improved access and outcomes.

Centene health plans include in the member's service plan the full range of needed services, whether covered or not. Case management staff coordinate with external entities, including FFS Medicaid and

non-Medicaid service providers, to ensure all needs are met and that treatment for one issue does not undermine or conflict with treatment by a different provider for another type of issue.

LPC&A. The owner-partner FQHCs that comprise LPC&A have a long history of coordinating services they provide with other Medicaid services their clients need. For example, FQHCs help children with BH needs access specialty BH services through the Department of Family and Children, and provide assessment and medical treatment information to the BH provider. Some of our FQHCs provide some services which will remain in FFS rather than be provided through the Coordinated Care Program. For example, a number of our FQHCs provide dental services. In 2010, Louisiana FQHCs provided dental services to over 51,500 individuals. The Innis FQHC in Innis, Louisiana provides full service dental care for adults and children and a mobile dental van that provides dental services at schools. Rapides Primary Health Services in Alexandria holds two ‘dental days’ each month for children with mental retardation and/or developmental disabilities who live at a nearby group home. Iberia Comprehensive Community Health Center (ICCHC) works with the Acadiana Cares Agency which provide a variety of services for persons with HIV/AIDS including access to dental care.

Behavioral health services are offered by 12 of the 19 LPC&A FQHCs ranging from counseling services to psychiatry services. For example, Capitol City Family Health Center in Baton Rouge, David Raines, Excelth, and ICCHC provide LCSW and psychiatrist appointments onsite. Primary Care Providers for a Healthy Feliciana (PCPFHF), servicing the residents of East Feliciana Parish and West Baton Rouge Parish in Region II, is finalizing a partnership with the Child and Adolescent Bereavement Program formerly funded by Capital Area Human Services District, United Way, and the Baton Rouge Area Foundation, to continue its mental health program that currently services over 100 schools. Jefferson Community Health Care Center (JCHCC), located in Region I, is working with the Jefferson Parish Human Services Authority to integrate primary care into its system that currently serves persons with severe and persistent mental illness and substance use disorders. These FQHCs are uniquely positioned to help LHC coordinate the carved out services they will continue to provide with the services that will be covered through LHC.

Overall Approach To Coordinating Carved Out Services

Our approach to coordinating all carved out services, including, but not limited to Medicaid services which will continue to be provided by the FFS Medicaid program, will include:

- Comprehensive assessment for members with special needs to identify the full range of their medical, BH, long term, social and other needs.
- Developing service plans that incorporate all needed services regardless of payer source for special needs members.
- Providing member education and assistance in accessing all needed services, whether covered or not.
- Sharing assessment, service plan and monitoring information, with member consent and in accordance with all state and federal requirements, among the member’s providers, regardless of network status.
- Offering members a Patient Centered Medical Home that coordinates all covered and carved out services.

Comprehensive Assessment. LHC will use a comprehensive, holistic assessment process that features open-ended questions to foster an understanding of the member’s clinical co-morbidities, including behavioral health conditions, as well as psycho-social status. This approach is designed to identify the full range of member needs, and not just needs related to core benefits and services. Information we will gather during the assessment includes, but is not limited to, member clinical history and status; functional status related to activities of daily living; mental health status including psycho-social factors and cognitive function; caregiver resources including family involvement and their participation in decision

making; life planning activities including wills, living wills, or advance directives; and cultural and linguistic needs and preferences.

Our assessments will also include disease-specific Clinical Health Assessments (CHA). If a member has more than one condition, multiple CHAs may be completed. Completion of the CHA will allow the Case Manager to gather information about diagnoses and co-morbidity risks, comprehension of medication regime, hospital and emergency room use, activities of daily living, pain levels, confidence level in ability to manage primary condition, presence of behavioral health conditions and disorders, psychosocial barriers to treatment compliance, and cultural and religious beliefs that affect health status. The CHA helps to further identify clinical history and needs that may not be available through claims data and predictive modeling. This includes, but is not limited to:

- Special needs such as developmental delay, severe orthopedic or persistent muscle tone abnormalities, seizure disorder, major chromosomal abnormalities, etc.
- Assistance needed with activities of daily living (e.g. bathing, toileting, dressing, ambulating) or instrumental activities of daily living (e.g. preparing meals, shopping, basic housekeeping, etc.) particularly when there is no support system
- Social or economic constraint such as lack of financial support, lack of social, family or significant other support, illiteracy or significant communication barriers, access to care issues, transportation, or abuse or suspected abuse.

Service Planning. In collaboration with the Member, family/caregiver, and network and non-network providers, as applicable, the Case Manager will develop a service plan within 30 days of the member agreeing to receive Case Management. The service plan will be individualized and identify the Member's long and short term goals; desired service types, amounts and settings; Member and caregiver/family participation, including the Member's self-management responsibilities; plan for addressing barriers; and community linkages and support. To ensure that all services are well-coordinated, we will incorporate carved out services into the service plan. This will include carved out dental, BH, personal care, and Targeted Case Management services, as well as non-Medicaid services and those provided by community resources.

Case Managers will document the service plan in TruCare, our Member-centric health management platform that integrates care/case, disease and utilization management. TruCare allows us to proactively monitor Members; efficiently document the impact of our efforts; pinpoint where care is needed; and implement customized intervention strategies. Case Managers can use TruCare to plan and track coordination activities with providers, and create reminders to follow up with a member to make sure they access scheduled carved out services.

Member Education, Referrals and Assistance. LHC will educate all members about carved out Medicaid services, how to access them, and the assistance available through LHC. Our Member Handbook, which will be included in the New Member Welcome Packet mailed to all new members and available on our Member Portal will include a list of carved out Medicaid services and information on accessing them and obtaining LHC assistance. Our Member Services Representatives and NurseWise nurse advice line staff will educate members about carved out services when they call our toll-free Member Call Center or nurse advice line asking about the services. In addition, our Case Managers will educate members as part of the assessment and service plan development process.

For all needed carved out services, Case Management staff or MCRs will provide information about the service. The Case Manager, Program Coordinator or MCR, as applicable, will also do the following, as desired by the member, to assist them in accessing the services:

- Help the member identify available providers as well as provider contact information
- Assist with appointment scheduling, as desired, by either establishing a three-way call with the member and selected provider to schedule an appointment or by scheduling the appointment and

communicating the information to the member by phone, secure messaging through our Member Portal, or by mail as preferred by the member

- Arrange transportation as needed
- Schedule a reminder in TruCare for the staff member to remind the member in advance of the appointment.

Centene's affiliate health plans and LPC&A FQHCs have both learned that while written and telephonic communications are important, in-person interaction is the most effective means of educating and assisting Medicaid members. Our MemberConnections® Program will assist members in accessing services, including carved out services and community resources. MemberConnections is a unique, intensive, highly personal, and culturally competent approach to member outreach. Our local MCRs will be familiar with the communities and service challenges encountered by our members, and they will assist with outreach campaigns, arranging community events, conducting member education in various settings, and helping locate hard to reach individuals. Because MCRs come from the community, they are familiar with and know the local businesses, church representatives, and other organizations that Medicaid members know and trust. They will leverage this knowledge to build their own relationships of trust with members who may not initially understand the importance of, or welcome assistance with, accessing health care. MCRs will meet members in person, such as in their homes or community locations, to educate members about covered services (including carved out services) and healthy behaviors, help them access the covered and carved out services they need, and identify and address any barriers the member may face.

Addressing Barriers to Accessing Carved Out Services. Our approach accounts for cultural, language and other needs that affect member willingness and ability to seek care. For example, to address financial issues that may impact the member's health or ability to access services, a Case Manager or MCR may connect the member to social services programs that can assist with such issues as paying utility bills. For example, ICCHC partners with United Way of New Iberia, United Way of Acadiana and Community Action Agency which assist with transportation and utilities.

Case Management staff and MCRs will also identify and address other barriers such as lack of transportation or cultural barriers, which will be addressed with interventions such as providing an interpreter for appointments and identifying providers with the same ethnic background or language. We will also use input and assistance in identifying and addressing cultural barriers to accessing carved out services from our owner-partner FQHCs which have a long history of serving the Louisiana Medicaid population, including EXCELth (Hispanic/Latino population), Jefferson Community Health Care Center (Latino and Asian populations), and Teche Action Clinic (Hispanic and Native American population), agencies such as Institute of Women and Ethnic Studies and Kingsley House to address the cultural needs of our members. We also will support caregivers and families since their stress level and ability to provide care can impact the member's health and care. We will help families navigate the system and more effectively support the member. We will connect families and caregivers to support groups and other resources such as Families Helping Families in Pineville; the Louisiana Parent Training and Information Center in Harahan; TARC in Hammond; and Centerpoint Community Services in Shreveport.

Sharing Information With Providers. LHC will share information with network and non-network providers serving our members, with other CCNs, and other insurance payers as specified by DHH and in accordance with 42 CFR 438-208(b). In doing so, LHC will ensure each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable.

Our **Provider Portal**, including our **Clinical Portal** and our **CentraCare Clinical Portal** (for PCMH providers and those pursuing recognition) will provide cutting edge technology solutions through which we can share information with providers, including related to carved out services. In particular, through LHC's secure Clinical Portal, all authorized PCPs and network providers can view a member's TruCare

service plan. The TruCare Service Plan displays the member's identified health problems, treatment goals and objectives, milestone dates and progress - in an engaging, well organized online format. The Clinical Portal's online summary Member Health Record (MHR) offers a well organized view of a member's care gaps as well as a cursory clinical "face sheet" for each member for which we have supporting data. For emergency scenarios, any provider with Provider Portal or Clinical Portal access will be able to view our Emergency Care Record (ECR). The ECR contains content specifically focused on the most vital information a provider needs when treating a member with whom they are not familiar. Our Provider Portal captures all ECR access information in full compliance with §164.312 of the HIPAA Security Rule (emergency access to medical records) and associated audit trail requirements, through the use of a "Break Glass" affirmation from the provider that access is needed.

For network PCPs and FQHCs who have achieved NCQA Patient Centered Medical Home or JCAHO Medical Home recognition (both designations abbreviated "PCMH" for purposes of this section), or that commit to attaining PCMH recognition from either NCQA or JCAHO, we will provide access to our CenTraCare Clinical Portal (CenTraCare) for additional clinical and care coordination capabilities beyond those provided in our Clinical Portal. Our PCMH providers will be able to access CenTraCare through a single sign on to our secure Provider Portal. CenTraCare is specifically designed with PCMH provider information needs in mind, and offers a more "data rich" and interactive version of our online Member Health Record (MHR) described above. CenTraCare's MHR is a superset of the summary MHR and ECR offered in our Clinical Portal, and is based on medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received, integrated and processed in our Enterprise Data Warehouse. Our overarching objective with CenTraCare is to give the PCMH provider a *holistic view* of the member's healthcare experience and support the concept of care accountability that is **central** to the PCMH concept. When combined with the other features of our Provider and Clinical Portals, CenTraCare is a *powerful informational assist* for collaborative care coordination and ongoing clinical quality improvement for our PCMH providers and our members.

LHC also intends to participate in health information exchanges as they develop in Louisiana to facilitate our ability to share data with PCMHs and other PCPs with electronic medical record systems. For selected PCMH providers equipped with Office of National Coordinator (ONC) certified Electronic Medical Record (EMR) technology, we propose to pilot in 2012, the exchange of CCD/CCR formatted Electronic Health Records between LHC and these providers. We will work with the Louisiana Health Care Quality Forum (LHCQF) and the LaHIE project (at DHH's direction), and share results of our pilot programs with LHCQF, with the ultimate goal of being a participant (along with our providers) in LaHIE. Please see Question R.15 for more information on our approach to sharing Electronic Health Record information with PCMHs.

For members receiving case management, the **Case Manager** will communicate assessment results, member goals and service preferences, and other information to the PCP and relevant treating providers, including providers of carved out services, in developing the service plan. Once the service plan is complete, the Case Manager will provide a copy to network providers via the Provider Portal and will provide a hard copy to providers of carved out services. The Case Manager will also share information with the PCP and network and non-network treating providers about ongoing communication with the member and results of monitoring service delivery and member condition and needs. The Case Manager will also coordinate among providers as needed to ensure each has all needed information about treatment being provided by others and recommendations for handling co-morbid and co-occurring conditions. For example, the Case Manager will coordinate between the specialized BH provider and the PCP as needed to ensure treatment for one type of condition does not undermine treatment for or exacerbate the other type of condition. The Case Manager will assist personal care services providers as needed in obtaining physician orders for services.

Patient Centered Medical Home. LHC will promote coordination across the care continuum by supporting providers in achieving recognition as a Patient Centered Medical Home (PCMH). The

enhanced care coordination services offered by the PCMH will improve the coordination of all services the member receives, including carved out services. LHC will actively partner with our providers, with community organizations and groups representing our members to increase the numbers of providers who have achieved NCQA or JCAHO recognition, or are pursuing recognition, as PCMHs and who achieve the meaningful use of health information technology. Beyond that, we will support the development of medical neighborhoods that build from the PCMH out to other clinicians providing health care services to patients within it and that include community and social service organizations and State and local public health agencies, including but not limited to, those that provide carved out and non-Medicaid services. See our response to Section G8 for more information on our efforts to promote the PCMH.

Targeted Approach to Coordinating Carved Out Services

Coordinating Dental Services. For members receiving Case Management, the member's Case Manager or a Program Coordinator working as part of the member's Integrated Care Team (ICT; see Section F2 for details) will provide referrals and other assistance, and will coordinate dental services as described above. For all members, including those who are not receiving Case Management services, we will provide information about the availability of these services and how to access them, as well as assistance available through LHC, in the Member Handbook, on the Member Portal, and in quarterly newsletters. Our MCRs will routinely provide information about accessing dental services at health fairs and other community events and when meeting in person with members. We will also provide information and referrals when members contact our Member Call Center or nurse advice line to ask about dental services. We will educate PCPs about the importance of referring members for dental services through initial provider orientation, in the Provider Manual and on the Provider Portal. In addition to the FQHCs that provide dental services directly, LPC&A member FQHCs participate on the state Oral Health Coalition and the Oral Health for the Elderly Task Group. LHC will leverage these connections to identify additional ways we can work to coordinate dental services with core benefits and services and other services members receive.

Coordinating Specialized Behavioral Health Services. If a member or member's family calls our 24/7 Member Call Center or 24/7 nurse advice line, NurseWise, a Case Manager, or contacts any other LHC staff with an emergent need for specialized behavioral health services, LHC staff will instruct the member to seek help from the nearest emergency medical provider. LHC staff will enter a reminder into TruCare for the Case Manager to outreach to and follow up with the member within 48 hours to establish that appropriate services were accessed and to provide assistance in scheduling appointments for follow up care and transportation.

For members calling to request non-emergent specialized BH services, the MSR who received the call will provide education about these services and how to access them, and offer to assist the member in making an appointment with the provider of their choice or. If applicable, the MSR will contact the Department of Children and Family Services' coordinated system of care and State Management Organization to access specialty BH services. If the member does not have a current provider or wishes to change providers, the MSR will assist the member as desired in identifying a conveniently located provider and scheduling an appointment. If the member has not previously been identified for Case Management, the MSR will attempt to connect the member to a Case Manager for comprehensive assessment as described above.

The Case Manager will work with case management staff from the State Management Organization (SMO) or other applicable entity to coordinate the member's service plan with needed specialty BH services. This will include, with appropriate member consent, communication via phone, fax and email about assessment results, authorized services, medications, member goals and preferences, contact information for LHC providers serving the member, PCP recommendations and referrals relating to BH needs and monitoring information. As applicable, the Case Manager will invite SMO staff or the specialty

BH provider to provide input on the service plan, case rounds, and strategies for promoting member engagement in care and positive behaviors.

PCPs will be a key component in coordination of care process, particularly specialty BH care. LHC will require PCPs to coordinate all care, including specialty BH care, with appropriate member consent. Through their regular long-term contact with patients, PCPs are often in the best position to identify potential or actual BH conditions that may require specialty BH care. We will require PCPs to screen, evaluate, detect and either treat (as appropriate) or refer for any known or suspected BH problems and disorders. PCPs must document in the medical record any BH screenings, DSM-IV diagnoses, and other BH-related assessment or outcome information. LHC will educate PCPs on topics such as how to screen for and identify BH disorders, how to refer members for specialty BH services, and best PCP practices in coordination and treatment. We will provide additional information about coordination and quality initiatives through Provider Newsletters, the Provider Manual, and group trainings. We will also support PCPs by providing clinical practice guidelines for PCP detection and treatment of common BH disorders, and by supplying practice management toolkits on such topics as ADHD. Providers will be able to download from the Provider Portal a form modeled on one developed by Centene's Indiana health plan to obtain any required member consent for the PCP and specialty BH provider to share information about the member.

For those PCPs who have achieved or are pursuing PCMH recognition, we will offer technical assistance with helping them determine how and when to introduce BH services into their practices. We will include education on integrating services for special populations, how to identify who should receive services and where services should be delivered, screening processes, and diagnostic and monitoring instruments that should be available for routine use in primary care practices. We will also offer PCMH staff appropriate BH education such as methods to deliver psychosocial interventions. As stated above, our online Clinical Portal will include a copy of the service plan and a care coordination fax form providers can download and use to facilitate communication with the specialty BH provider about member symptoms, services and medications. We will offer training on the use of the form in initial orientation and ongoing Provider trainings.

Coordinating Personal Care Services. Personal Care Services (PCS) are critical for individuals who need assistance with activities of daily living. For all members currently receiving Personal Care Services at enrollment or for whom DHH claims data indicates a history of receiving them, a Case Manager will conduct a comprehensive assessment to determine the member's needs. If the member appears to need but is not currently receiving Personal Care Services, the Case Manager will refer the member to the Office of Aging and Adult Services, assist as needed with making the contact, and provide assessment and other relevant information, with appropriate member consent, to assist the PCS provider in its own assessment and service plan development. The Case Manager will document contact information for the PCS provider in TruCare. Our ICT will coordinate any needed physician orders, obtain regular monitoring updates from the state case manager and share pertinent information about the member's covered services with the state case manager.

Coordinating Targeted Case Management Services. LHC understands that Targeted Case Management (TCM) services for NOW Waiver Recipients, HIV Disabled Individuals, and Nurse Family Partnership participants are DHH covered services and will continue to be administered by DHH. When we identify during our new Member Welcome Call a member receiving TCM services, such as DHH claims history indicating receipt of these services, a Case Manager will contact the member according to risk stratification level (see Section F.2 for more detail on risk stratification) to conduct a comprehensive assessment, since receipt of TCM may indicate the need for ongoing services and/or case management through LHC. During the assessment, the Case Manager will obtain the name and contact information for the TCM provider. The Case Manager will document this information in TruCare and outreach to the TCM provider to coordinate the LHC service plan with TCM services. For example, when a member is hospitalized, the Case Manager will notify the TCM provider and involve them in discharge planning as

applicable. Case Managers also will identify members who may be eligible for but not receiving TCM services, and will provide referrals and assist members in navigating the TCM eligibility process and accessing the services. LHC will work with representatives of organizations that serve members who are eligible for TCM services to identify additional mechanisms for coordinating services covered by LHC with TCM services. For example, Christine S. Brennan from Nurse Family Partnership participated in our Community Health Advisory Committee meeting in March 2011.

Question F.4

Coordinating Service Plan and
Delivery of Home Health Services

F.4 For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.

LHC will coordinate discharge planning for members who need home health services using our Concurrent Review Nurses (CRNs) and multidisciplinary Integrated Care Team (ICT), which includes a nurse Case Manager, behavioral health clinician Case Manager, disease management Health Coach, social worker and other non-clinical staff. The CRN and ICT will work together to safely transition the member to the home and prevent readmission through ensuring provision of home health services and addressing barriers to care. Our home health monitoring and oversight processes will ensure that service initiation delays or timeliness issues are identified and addressed immediately. All members discharged with home health services will be considered at risk, and will receive transitional coaching from ICT staff to ensure post-hospital stabilization. For our highest risk pregnant members and infants discharged from NICU, we will use an intensive program that relies on home visits from an experienced obstetrics (OB) nurse.

Based on current letters of intent (LOI), our network already includes home health providers in 25 locations across the three GSAs. GeoMapping indicates that we can already ensure required access across the state, including for members in rural areas. Our LPC&A owner-partner FQHCs also have established relationships with home health agencies across the state to which they refer patients. LHC will attempt to contract with any of these agencies for which we do not already have an LOI to maintain our members' ability to access care from the traditional providers that have served the CCN-P population. We will also look to these established relationships when assisting members in selecting a home health agency to provide any needed post-discharge services.

Coordinating Discharge Planning For Members Who Need Post-Discharge Home Health

LHC will implement an integrated discharge planning program to ensure a smooth transition for our members from hospital to home and to avoid preventable readmissions. Through this program we will integrate the efforts of Case, Utilization, and Disease Management staff; hospital discharge planning staff; and all providers involved in the member's post-discharge care.

Our approach is based on the experience of Centene affiliate health plans in coordinating hospital discharge planning and post-discharge service delivery for Medicaid and CHIP members in 11 states, including members with chronic, complex, and/or catastrophic conditions that require extensive services and coordination among multiple providers. We have learned through our affiliate plans that early discharge planning (either before or shortly after admission), and identification and initiation of post-discharge services prior to discharge result in better health outcomes and avoidable readmissions. We will also address the additional support Medicaid members often need to identify and address barriers to accessing post-discharge care.

Identification of Hospitalized Members. We will work with our hospital providers to quickly identify LHC members whose hospitalizations are unplanned, and will capture information about our members who are hospitalized in a number of ways including:

- Requests for prior authorization for scheduled hospital admissions
- Notifications from hospital providers of emergency admissions and subsequent requests for authorization
- Our concurrent review nurses (CRNs) who will be onsite at some network hospitals to identify and monitor inpatient members

Discharge Planning. When we identify an inpatient member, a CRN will contact the facility Utilization Review (UR) Nurse to begin assessing the member's post discharge needs. The CRN may continue working with the facility UR Nurse or the facility's case manager if applicable. The CRN will discuss the

member's status and discharge needs at intervals based on member acuity and as established with the facility staff. For example, we may do case review every four to five days on a premature infant receiving neonatal intensive care unit (NICU) services until closer to expected discharge. In addition, for members at high risk for readmission (such as those who have had major surgery, and/or need post-discharge medical supplies or home health services after discharge) who are inpatient at facilities where we have CRNs onsite, the CRN will conduct a discharge screen with the member prior to discharge and ensure needed follow up appointments with the PCP and/or specialists are scheduled before the member leaves the hospital.

CRNs, LHC's Medical Director, Case Managers, and as applicable, our disease management Health Coaches, will conduct case rounds on hospitalized members weekly. The team will discuss each hospitalized member in detail to determine a plan to improve outcomes post-discharge and identify barriers to success. The CRN will work with the facility UR nurse/discharge planner, the member and family/guardian/caregiver, treating provider, and PCP to identify home health needs, choose a participating provider, arrange the services, and provide any necessary authorizations.

The CRN, with assistance from Case Management staff, will help the member identify home health agencies with necessary expertise, such as agencies that specialize in serving infants discharged from NICU. LHC may authorize services with a non-network agency if required to meet the member's special home health needs, such as an agency that specializes in caring for in-home patients on a ventilator. The CRN or Case Management staff will contact the home health agency chosen by the member and provide all necessary information and authorization for the agency to initiate services according to the discharge plan. The CRN will also work with the hospital discharge planner to coordinate and authorize other home support services such as medical supplies and durable medical equipment (DME). For example, for a member being discharged home following hip replacement, the CRN would evaluate and authorize the appropriate level and frequency of home health services as well as the need for a walker, wheelchair, commode or other items needed to support the member at home.

Back up Plans. Members who need post-discharge home health services are often at increased risk for readmission. Timely delivery of needed home health services is critical to preventing readmission. In addition, the greater travel distances in rural areas often result in gaps in home health services for members living in those areas, increasing their risk of readmission. To prevent breaks in needed home health services, the CRN will work with hospital discharge staff and the member and family to develop a back-up plan prior to discharge. This plan will establish the steps to be taken when the home health provider does not show up as scheduled. These steps will include the timeframe within which the member will call the provider or Case Manager; whether the member will receive back up services from the original agency or through a pre-designated alternative; the timeframe within which the alternate services will be initiated; and the timeframe within which the Case Manager will confirm initiation of services. For tasks which can be performed by non-clinicians such as dressing changes and tracheotomy care, the Case Manager will authorize time for the home health provider to teach the task to family members or friends who may perform the task while awaiting the back up provider, as agreed to by the member, attending physician and PCP. In addition to helping fill any immediate gaps that may occur, teaching family members or informal supports to take on non-clinical tasks will also smooth the transition off of home health services when medically appropriate.

Technology Support for Coordination Between CRN and ICT. The CRN will document all activities in the discharge planning fixed notes and freeform narrative fields of the UM module in TruCare, our member-centric health management platform that integrates care/case, disease and utilization management. TruCare houses the member's service plan and integrates all authorizations and LHC contacts with the Member. All LHC clinical staff who have member contact will have access to the information in TruCare, which ensures a global perspective on the member's care. TruCare allows us to proactively monitor members, efficiently document the impact of our efforts, pinpoint where care is

needed, and implement customized intervention strategies. The CRN will notify the Case Manager via TruCare of the date of discharge and need for post-discharge monitoring and follow up.

PCP Follow Up. Case Management staff will generate reports daily from TruCare, notifying PCPs when a member on their panel has been discharged. Particularly because hospitalists are becoming more common, this will ensure a seamless transition from the inpatient provider to the medical home. Reports will be generated by assigned PCP based on authorizations entered in TruCare and subsequent discharge dates. We will post the report to the Provider Portal and send an email alert to the provider letting them know the report has been posted. While the CRN or Case Manager will work with the PCP prior to discharge whenever possible in planning appropriate home health services, this notification will ensure that PCPs are immediately aware when the member has been discharged so the PCP's office can do their own outreach and follow up.

Monitoring Post-Discharge Home Health Services for Members in Remote Areas

Our ability to provide and monitor home health services for members in remote areas will be enhanced by the strengths of the unique partnership between Centene and the 19 FQHCs that own and comprise the Louisiana Partnership for Choice and Access (LPC&A) which created LHC. The strengths of this partnership include:

- Intimate knowledge of the rural access problems faced by Medicaid and CHIP members in Louisiana's 64 rural Parishes
- Facilities and professional staff that are well positioned to respond to the needs of Louisiana's most vulnerable citizens
- Centene's experience in delivering post-discharge care to rural Medicaid and CHIP recipients in 11 states
- Proven innovation that can be modified, if needed, to deliver immediate solutions for excellence in care to rural Louisiana

Post-Discharge Follow Up and Monitoring. If the member's diagnosis or needs meet criteria for Case or Chronic Care/Disease Management (see Section F2 for Case Management criteria and Section E2 for Chronic Care/Disease Management criteria), the CRN will send an electronic notification to Case Management staff via TruCare for post-discharge assessment and follow up within 48 hours of discharge. TruCare will contain all information about the member's discharge plan and timeframes for follow up individualized to the member's condition and needs. The Case Manager will outreach to the member to assess the need for and arrange, if necessary, an evaluation of the readiness of the home environment for the member's aftercare. For members not enrolled in Case Management, post-discharge follow up may be conducted by the CRN rather than a Case Manager.

The Case Manager, with ICT assistance, will monitor home health service delivery to ensure services are initiated according to the discharge plan and are meeting the member's needs. Monitoring will occur through regular phone contact with the member, at intervals based on member acuity and needs, as well as through other mechanisms described below for members with specific characteristics or needs. Our MCRs may make home visits for members with complex needs to provide additional one-on-one support and monitoring.

Monitoring will include assessing member and family/guardian/caregiver understanding of discharge instructions such as correct administration of medications, verifying the home health services are initiated as planned, ensuring the member is accessing needed follow-up appointments, and determining whether the home health services are meeting the member's needs. The Case Manager will work with the Health Coach and other members of our Integrated Care Team (ICT - see Section F2 for details) to ensure the home health services are coordinated with other aspects of the member's ongoing care, such as disease management or behavioral health services. Follow up will include education about contacting NurseWise,

our 24/7 nurse advice line, with any questions, concerns, or problems, including any issues the member is experiencing with home health services.

The Case Manager will also work with the ICT to assess the member for enrollment in our award-winning ConnectionsPlus[®] Program, which provides a restricted use cell phone for high risk members lacking reliable phone access. The phones are pre-programmed with numbers for the PCP, Case Manager, our nurse advice line, 911, and treating providers so that members can immediately report problems or ask questions about their condition or care.

To reinforce the importance of accessing appropriate post-discharge care, we will send an audio postcard to all members within two business days of discharge as an additional reminder for them to make or keep needed follow-up appointments. Keeping post-discharge appointments will allow the PCP or specialist to evaluate in-person whether home health services are meeting the member's needs.

Monitoring High Risk Pregnant Members. LHC will partner with Alere (previously Matria) to augment our Start Smart For Your Baby high risk pregnancy management program with home monitoring for certain high risk members, including those who live in rural areas and are discharged with home health services. Alere offers programs such as preterm labor management including provision of 17P, hypertension management, gestational diabetes, coagulation disorder management, hyperemesis management, and fetal surveillance that may include, but is not limited to patient education, home and telephonic assessment, clinical surveillance of medications, home uterine monitoring, 24/7 nursing and pharmacist support. Alere will provide a nurse to conduct home monitoring visits for these high risk members, at intervals dictated by the member's unique risk factors and condition. The Alere nurse will report monitoring results, including whether home health services are meeting the member's needs, to the provider within 24 hours of the visit. The Alere nurse will also provide updates to the Start Smart ICT weekly or sooner as dictated by member condition and needs. Start Smart staff will document Alere monitoring results in TruCare to ensure LHC maintains a full record of all member contact and monitoring, and that all clinical staff working with the member have a complete picture of the member's condition.

Telemonitoring. LHC will provide telemonitoring services to high-risk members (such as those at risk of readmission or with multiple co-morbidities) in rural areas for whom intensive monitoring is necessary and the condition is amenable to telemonitoring. Our patent-pending, FDA-approved technology is "device-agnostic", interfacing with virtually any medical home monitoring device via wireless or wired modem utilizing landline, cellular (including ConnectionsPlus phone), or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value, such as blood glucose level for a diabetic or a blood pressure or weight for a member with congestive heart failure, is transmitted electronically to the Case Manager and evaluated against patient-specific, evidence-based guidelines and analyzed for favorable or unfavorable trends. The system can be set at the member level to alert the Case Manager, trigger an interactive voice response phone call to the member, and/or alert other members of the ICT or the member's provider. The technology is entirely web-enabled; all members are provided a login card that enables them, their family, or their physician to access their biometric information from anywhere in the world at any time, as long as they have access to the internet. This will allow us to closely monitor members in their homes post-discharge to ensure their follow-up home health services are meeting their needs. The Case Manager will also work with the home health agency to ensure the member is using the equipment correctly. Because the home health provider is in the home, they will be able to provide one-on-one, in-person education about using the telemonitoring equipment, and immediately provide feedback if the member does not understand or is not using it correctly.

Centene's Ohio affiliate conducted a January 2011 analysis of its telemonitoring program using data from November 1, 2009-September 31, 2010. The analysis indicated the following results:

- Utilization directly related to the conditions being managed (diabetes, heart failure, heart disease) decreased for both inpatient admissions and emergency department visits.

- Per participant per month (PPPM) costs directly related to the conditions being managed decreased for each condition: diabetes -34.9%, heart failure -44.5%, heart disease -30.4%

Augmenting Case Manager Contact: The Special Health Care Needs Member (SHN) In-Home Video Pilot. Beginning in Q2 2012, we will implement our SHN In-Home Video Pilot with appropriate and interested members in a rural parish, which will improve our ability to monitor their care including post-discharge home health services by increasing the frequency of visual interactions between the remote member and the Case Manager.

Our In-Home Pilot will demonstrate the viability of on-demand video conferencing to dramatically increase the frequency and augment the quality of member contact with appropriate LHC staff. Together with Microsoft, we will integrate our Member Relationship Management System (MRM) with a combination of Microsoft's Kinect intelligent video system, Xbox console, and Lync Server unified communications software.

Once deployed in the home, the member can either initiate or receive a request to video conference with their LHC Case Manager and/or MCR. The member or their caregiver need only gesture with their hands at the Kinect camera, placed near their television, to accept a video call request from authorized LHC staff or to select from a menu the LHC staff person (displayed on the member's television) they wish to call (e.g. the member's Case Manager). The member does not have to leave their seat to interact with the Kinect/XBOX system. The Kinect camera also follows the member around if the member moves within the broad area of view in front of the camera. In addition, Kinect's intelligent video system pans and zooms to accommodate another person (e.g. the member's caregiver) who might join the member during the videoconference. Using this technology, our ICT staff will be able to increase the amount and quality of interaction with high risk members. By increasing the number of visual interactions, Case Managers will be able to more closely monitor health status and home health service delivery and quickly alert the PCP or other providers, should we see a need for a specific intervention while video conferencing with the member. For example, if the Case Manager is concerned about the quality of service being provided by the home health agency, she could request that the member initiate a video call so that the Case Manager can observe the home health nurse providing care.

Depending on the results of our LHC SHN In-Home Video pilot, we will refine the functional scope and timing of additional capabilities to potentially include support for interactive health content and programs (with supporting reward based incentives), and the secure, HIPAA compliant collection of health data (all with member consent). We are exploring opportunities with residential Internet Service providers (ISP's) throughout Louisiana to offer internet connectivity for members in the pilot programs without access.

ConnectionsPlus. Through our ConnectionsPlus[®] Program, we will provide pre-programmed cell phones to high risk Members who lack reliable phone access, allowing them to make and receive calls from providers, the ICT, other LHC staff, NurseWise, and 911. This will allow our Case Managers to contact members in remote areas by phone to ensure initiation of post-discharge home health services and monitor whether the services are meeting the member's needs. It will also facilitate the member's ability to contact the Case Manager or provider with questions or concerns about their condition or care, and report any problems with their home services such as a provider not showing up at the scheduled time.

The phones will also allow us to provide targeted member education to help them take charge of their own care and avoid preventable admissions and readmissions. For example, ICT staff will educate members on observing their health status and calling promptly for advice rather than waiting until the next appointment. The ICT can send the member a text message with health information targeted to the individual member's condition. The program will also provide MP3 players loaded with condition-specific podcasts in Spanish and English, which will be available for download from our website. Examples of podcast topics include diabetes, alcohol abuse, chronic kidney failure, COPD, depression, headaches, healthy weight, osteoporosis, hypertension, stress, taking your medicine, smoking cessation, generic drugs, heart attacks and advance directives. Centene's ConnectionsPlus[®] Program received

URAC's 2009 *Best Practices in Health Care Consumer Empowerment and Protection* Silver Medalist Award and was a 2009 Medicaid Health Plans of America (MHPA) *Best Practices Compendium* Honoree. There are over 3680 ConnectionsPlus cell phones currently in circulation among Centene members. Centene compared outcomes in the 90 days prior to receiving a phone to the 90 days following receipt of a phone for 347 adults with chronic medical condition enrolled in the program between April 2007 and March 2010. Review of the data showed a 27% decrease in inpatient admissions, an 18% decrease in average length of hospital stay, and a 12% decrease in Emergency Department visits.

Question F.5

Access to Specialty Care in Rural
Parishes and Ensuring Members with
Disabilities have Access to Care

F.5 Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?

Overview and Experience

Louisiana Healthcare Connections (LHC) offers experience meeting the needs of high-needs and rural populations and a commitment to innovation that will help DHH meet its goal of ensuring members in rural parishes and those with disabilities have access to needed specialty care. The relationship with our owner-partner LPC&A combines the strength of Centene, a national managed care company, with the local experience and knowledge of community-based health care providers.

Centene health plans have developed numerous strategies for ensuring specialty access for rural members and those with disabilities, refined through our experience in 11 states, some with significant rural populations such as Arizona, Georgia, Mississippi, South Carolina and Texas. For six of Centene's 11 health plans, at least half of the counties served are rural as designated by the Census Bureau. In total, 394 of the 709 (55%) counties served by Centene health plans are rural. In addition, Centene affiliates serve about 81,500 SSI members who require a wide range of specialty services to address their chronic and complex conditions and special health needs. The Centene Foundation has addressed workforce shortage concerns in some states through targeted provider scholarships to increase access to services for members in rural areas and/or with disabilities. The Centene Foundation will evaluate the feasibility of funding practitioner education loan repayment in Louisiana to increase rural access to specialty care. We have used this strategy successfully in other states to attract providers to fill a need in specific areas. For example, in Georgia, the Centene Foundation provided loan repayment to attract primary care physicians to an area in urban Atlanta to improve Medicaid and CHIP member access to primary care; to a rural OB/GYN provider in rural Valdosta to develop a teen pregnancy program; and to Columbus Regional to open a pediatric clinic which serves a large rural population. In Arizona our affiliate health plan was able to expand rural access for their Medicare members by providing a start-up loan and infrastructure support to a local provider of non-skilled home based services that allowed the provider to achieve Medicare certification.

LPC&A's FQHCs have extensive experience in supporting Medicaid and CHIP patient access to specialty services, which includes offering some specialty services onsite as well as formalized referral agreements with specialty providers in their communities. LPC&A FQHCs have intimate knowledge of the rural access problems faced by Medicaid and CHIP members in Louisiana's rural parishes, and their FQHCs' facilities and professional staff are well positioned to respond to the needs of Louisiana's most vulnerable citizens.

Centene. Centene plans have implemented numerous successful strategies to ensure access to specialty care for rural members and those with disabilities both during a new program implementation as well as on an ongoing basis. These strategies include, but are not limited to:

- Providing innovative solutions in rural areas where no specialists of a certain type practice to provide members with alternatives to traveling long distances. These strategies include bringing specialty services into rural clinics on a periodic basis, telemedicine, and in-home telemonitoring for members who need frequent monitoring for such high risk conditions as diabetes and congestive heart failure.
- Contracting with specialists already serving our members, including those within as well as near the service area. This may include specialists in the bordering state to follow local patterns of care.
- Securing non-network specialty care when a needed specialty type is unavailable in-network in the member's local area. Centene plans routinely attempt to contract with providers already serving our members but if a contract cannot be achieved, we will negotiate a Single Case Agreement to ensure the member's ongoing access to needed specialty services when necessary.
- Reducing provider 'hassle factor', thus increasing network participation. These strategies include increasing provider call center staff during the initial implementation period to handle the increased

volume of calls during the first 90 days of implementation and outreaching to every provider in the first 30 days to address concerns. These strategies also include simplifying referral requirements and the authorization process, which eases the burden on providers and prevents barriers to care. Centene plans typically require referrals for few if any specialty services, and only require prior authorization when review can positively impact quality of care.

- Increasing physical accessibility of existing specialists' offices and supporting disability-related expertise and accommodation beyond ADA requirements to enhance their ability to serve members with disabilities.
- Offering providers Pay for Performance (P4P) incentives that improve quality of care for members by offering additional reimbursement to providers for performing certain preventive services, such as diabetes screenings or flu vaccines.

LPC&A. Our FQHC owner-partners are already delivering many specialty services, including in rural parishes, and have initiatives in place to further ensure access to specialty providers. For example, all 19 LPC&A FQHCs offer behavioral health services (ranging from counseling to psychiatry services) either onsite or through a contract with a community provider. In addition, several FQHCs are offering telehealth services for behavioral health including PCPFHF, EXCELth, Franklin and Teche. Eight FQHCs offer podiatry services. Sixteen of the LPC&A FQHCs provide dental services, including school-based and mobile dental unit programs as well as partnerships with local Head Start and WIC agencies. For example, Primary Care Providers for a Healthy Feliciana (PCPFHF) has four school-based clinics in East Feliciana Parish in Region II that provide behavioral health and dental services. Innis Community Health Center (ICHC), located in Pointe Coupee Parish in Region II, has a mobile dental van unit that travels to schools during the year and provides full dental services including restorative treatment. Morehouse Community Medical Centers with sites in Bastrop and Mer Rouge offers non-OB Women's Health, Pediatrics, Pediatric Infectious Disease, Dermatology onsite, and lab and radiology services through a contract with Morehouse General Hospital and other local providers. Routine vision services are offered in David Raines Community Health Centers (Region VII), EXCELth (Region II), and PCPFHF. Southwest Louisiana Primary Health Care Center (SLPHCC) has plans to pilot a vision program later this year.

The graphic below shows the multiple site locations LPC&A's 19 FQHCs bring to the table throughout Louisiana. Given the excellent coverage in rural and remote areas of the state, LHC is well positioned to create unique solutions for expanding specialty access even further for members living in these areas. These traditional Medicaid/CHIP providers not only have clinics physically located in these areas, they also have established relationships with both Medicaid and CHIP beneficiaries and other providers in the area.



FHQCs in rural areas of the state historically found that the only way their Medicaid and CHIP patients could access specialty care was through inpatient admissions or emergency department visits. To help their patients access needed services more appropriately, many of our FQHCs have developed referral or contractual relationships with specialty providers (some examples are provided below).

Enhanced Provider Support to Maximize Network Participation

Difficulty ensuring specialty access within the Medicaid and CHIP programs is common nationwide, in part due to the perceived ‘hassle factor’ for providers. LHC will build on Centene’s experience minimizing the hassle factor and simplify the process of working with the health plan, thereby helping to maintain member access to needed providers.

Our support for specialty providers will begin at implementation. We will operate our provider call center with increased staffing during the first 90 days of implementation to handle the heavier volume of calls that are received during an implementation. Our Provider Relations Specialists (PR Specialists) will outreach to every network provider in the first 30 days to address concerns and ensure specialty providers understand our authorization processes. Because we will follow the Centene practice of hiring staff from within the communities we serve and will have offices in each GSA, and our PR Specialists will be familiar with local providers and better able to anticipate and head off any problems.

LHC will also pay providers to report missed appointments so we can help members reschedule and identify any barriers to keeping appointments. We will designate a billing code for providers to submit a claim when a member misses a scheduled appointment, and will monitor claims for missed appointments to ensure that the code is being used appropriately. By reducing a cause of provider dissatisfaction with participating in the CCN-P, this strategy will help us increase specialty provider willingness to serve Medicaid and CHIP members. We also will provide an incentive for providers to offer after hours appointments to make it easier for members to get and keep appointments.

Through our Provider Portal, we will notify providers of important member medical considerations via our Online Care Gap Notification (Care Gaps) feature. Care Gaps notifies Provider Portal users of the potential need for necessary preventive services including intervention needs based on diagnostic and lab results for members with special health needs (such as diabetes) who need or receive specialty care. Our Centelligence™ Foresight predictive modeling system will identify care gaps by analyzing medical,

behavioral, and pharmacy claims data, health risk assessment information, lab test results and other information housed in our Enterprise Data Warehouse (EDW). These care gaps are then systematically presented to Provider Portal users via our Care Gaps feature when the Provider Portal user views member eligibility. We will share this information with specialty providers to support their patient management efforts.

Simplifying the Referral and Authorization System. LHC will not require formal written referrals for specialty care. LHC will only require authorization for oral surgery, pain medication and plastic surgery. We will automatically approve the initial office visit consultation without treatment, but any treatment or follow up visits will require submission of an authorization request with clinical information and a treatment plan. For oral and plastic surgery, we will require pre-authorization of the initial visit since these services are often cosmetic in nature and not medically necessary. For pain medication, such as epidural steroid injections, we will require a pre-authorization because of the potential for abuse. However, to ensure continuity of care we will automatically authorize any course of treatment or existing authorizations the member already has in place at the time of enrollment. Please see F.1 for more details on our continuity of care policies and procedures.

Our annually revised prior authorization list (PA) will only include services for which review can favorably influence quality of care. In addition, we will leverage technology to simplify the authorization process for specialty providers and ensure a seamless system of care. Providers will be able to submit a request for authorization via our Provider Portal as well as via email, phone and fax through our authorization hotline staff or the Case Manager assigned to the member. Authorization staff will review the clinical information and document it in TruCare along with an authorization and information on the referring provider and the specialist.

Providers will be able to check status of an authorization from the Provider Portal or self-service IVR. If the request is for an out-of-network provider, authorization staff will contact the referring provider to determine the reason for the out-of-network referral and identify a network specialist available to provide the service. If a network specialist is not available within state access standards, LHC will authorize out of network specialty care until a network specialist is available and care can safely be transitioned. LHC will authorize a standing authorization or an authorization for multiple visits if the member needs ongoing specialty care. For all cases that involve authorization of out-of-network care, a PR Specialist will contact the treating specialist and attempt to execute a contract. If the provider chooses not to contract, the PRS will attempt to negotiate a Single Case Agreement (SCA). LHC will continue to authorize and reimburse for medically necessary Covered Services in accordance with the RFP and state requirements whenever a SCA is not achieved.

By reducing provider administrative burden related to referrals and prior authorizations, LHC will remove many of the barriers that discourage provider participation, thereby increasing access for members.

Provider Education to Ensure Continuity of Existing Specialty Access. Through Centene's national experience with new program implementations, LHC understands the critical importance of partnering with the local provider community to ensure that network and non-network providers understand continuity of care and access requirements and policies, as a state transitions from fee for service to a coordinated or managed care model. This is particularly important for members receiving specialty care prior to program implementation, as provider knowledge is key to ensuring no disruptions in care. LHC will educate all providers, particularly specialty providers, about continuity of care policies and procedures for new members enrolling in LHC during new provider orientation, through the Provider Manual, and on our Provider Portal. We will also educate providers when they call authorization or Case Management staff to inquire about referrals. In addition, we will provide education to local Medical Societies for distribution to their members so that providers receive the information whether they choose to contract with LHC or not. Education will include, but not be limited to the prohibition on providers making referrals to provider entities in which the provider or their family has a financial interest.

Education will also include the requirement that the specialist communicate with the referring provider about results of the initial consultation visit and recommendations for care as well as ongoing communication about any treatment provided.

Ensuring Rural Members Have Specialty Access

LHC will also implement network development and provider support strategies to maximize the number of specialists in our network. However, when LHC identifies an ongoing gap in services, typically due to scarcity or distribution of providers, we will identify innovative approaches to increasing access as described in great detail. In addition, because health status and care utilization are significantly lower in Louisiana's rural parishes than in other parts of the State, our Case Managers will prioritize members in those parishes for initial screening and assessment. We anticipate unmet needs for specialty care in these parishes, and prioritizing these members for initial screening and assessment will allow us to quickly provide referrals and ensure access to needed specialty services.

Innovative Solutions To Increase Rural Specialty Access. LHC will coordinate **specialty days at FQHCs and RHCs**, during which we help bring in a specialist and assist with scheduling members in the area for appointments that day. For example, we will identify cardiologists or other needed specialists from urban areas who are willing to travel on a regular basis, for example, every four weeks, to rural towns to provide services, potentially at FQHC sites with available space and equipment. We will negotiate appropriate reimbursement in advance and assist in scheduling appointments for members and facilitating member transportation.

Some of our FQHC partners have already implemented this strategy to improve access to specialty services that are otherwise unavailable in certain regions. For example, Southwest Louisiana Center for Health Services (SWLA), which is in Lake Charles but is the only FQHC within a five parish-region and draws patients from rural areas, contracts with a podiatrist to offer services onsite on specific days. The podiatrist is provided exam space equipped by the FQHC. SWLA makes appointments for multiple patients to come in for podiatry services on these days, including but not limited to patients with diabetes who need an annual foot exam.

LHC plans to use **telemedicine** to increase rural access to specialty care, leveraging the existing and planned capabilities of our LPC&A FQHCs. In partnership with Advanced Telemedical Services (ATS), a full service telemedical services company located in Covington, Louisiana, we will provide innovative telemedicine services and web-based healthcare solutions through our owner-partner FQHCs to increase specialty access for rural members. Through ATS we will offer state-of-the-art telemedical technology and equipment, professional training and technical and product support. ATS packages third party equipment with several proprietary elements into a cart, desk or portable telemedicine station that incorporates film industry-level video reproduction, audio reproduction and lighting to ensure high quality services. To ensure a high level of proficiency among users, FQHC staff who will use the equipment will earn certification through ATS' three-point training program, and product support will be available through ATS' 24/7 call center. Medical practitioners will also be required to complete training to be part of the telemedicine network. We will initially offer Psychiatry, Psychology, Wound Care, Urgent Care, and Neurology through telemedicine, and will work with ATS to develop additional services.

We also will work with the Centene Foundation to evaluate funding a **physician resident program or education loan repayment** for a health care practitioner in exchange for the practitioner's agreement to practice in a rural area.

We will offer providers, including specialist providers a **Pay for Performance (P4P) financial incentive** for performing services that are appropriate for a member's condition. For example, a specialist provider who performs appropriate diabetes screenings for a member would be eligible for an encounter based incentive that reimburses the provider beyond their contractually agreed upon rate. By offering this

additional payment, LHC can expand access by creating a financial motivation for a provider to become a LHC contracted provider.

Network Development to Increase Rural Specialty Access. Based on existing letters of intent (LOIs) we have secured, our specialty network of over 4770 specialists already exceeds the provider to member ratios for key specialties required by DHH in each GSA, including, but not limited to Cardiology, Gastroenterology, General Surgery, Hematology/Oncology, Neurology, Ophthalmology, Orthopedics and Otolaryngology. We also have LOIs with pediatric subspecialties in each GSA. LHC has been able to obtain these LOIs and create access despite significant skepticism among Louisiana providers about the CCN-P moving forward and many adopting a ‘wait and see’ attitude toward contracting with bidders (we more fully describe this issue in Section G5).

As we continue to build our network, including in rural areas, LHC will follow the Centene practice of prioritizing outreach to and recruitment of providers who have traditionally served the Medicaid and CHIP populations. This extends beyond LPC&A’s FQHCs to other traditional providers including specialists. Using DHH data to identify the providers Medicaid and CHIP members historically see, we have and will continue to prioritize outreach to these providers and ask them to identify specialty providers to whom they normally refer their Medicaid/CHIP patients. On an ongoing basis, we also will use historical claims data to identify and outreach to high volume non-network specialty providers used by the CCN-P membership. LHC staff will analyze service gaps for the covered populations, provider and member demographics, and explore non-specialist options for delivery of needed services, such as through other physician types, dentists, or mid-level practitioners. This initiative would supplement and complement the existing rural workforce incentive programs used by FQHCs.

To supplement the above targeted initiatives, we will use ongoing strategies such as identifying and attempting to contract with any new specialists who move into rural areas. For example, Centene’s Texas plan contacted a pediatrician’s office that had just opened in a rural area with a pediatrician shortage. With expedited credentialing, the provider began serving members within one month of the initial contact date. We also will offer contracts to other specialists who have not historically accepted Medicaid or CHIP patients. To achieve this, our Provider Relations (PR) staff will identify and outreach to other potential specialty providers through sources such as the Louisiana State Board of Medical Examiners, the Louisiana Hospital Association, Louisiana State Medical Society and its chartered Component Parish Societies and other local associations and organizations.

Last but not least, we will accommodate local patterns of care and consider such patterns in our provider recruitment strategy, particularly for specialty care. For example, to accommodate Medicaid members who live in border areas and access care across the state border, LHC is targeting specialists affiliated with Natchez Community Hospital, River Region Health System and Southwest MS Regional Medical Center along the eastern border of the state, as well as providers in Texas to support rural residents on the western border.

Ensuring Members With Disabilities Have Specialty Access

LHC will draw from the experience of other affiliate health plans serving people with disabilities and develop and implement processes for monitoring and evaluating sites to ensure accessibility for our members, including those with physical and cognitive disabilities. In addition to the strategies described above for ensuring access to specialty care, LHC will implement additional interventions to ensure members with disabilities have access to appropriate specialty care.

Facilitating Access To Specialists. LHC will ensure members with disabilities and special health needs have direct access to specialists by authorizing multiple visits when a course of treatment is needed. For new members already receiving specialty care, LHC will authorize care with current network or non-network specialists for at least 90 days, or until care can safely be transitioned with no disruption, whichever is less. To determine whether and how to transition the member, a Case Manager will complete

a comprehensive assessment. The Case Manager will work with the LHC Medical Director and UM staff, treating specialists, PCP, Member and family/caregivers to determine whether and how to transition the member safely. For members whose specialty care needs develop after enrollment, a Case Manager will authorize multiple visits for the few types of specialties for which LHC will require authorization.

Authorizations will specify the number of visits or unlimited access for a specified timeframe based on assessment results and PCP and specialist input. In addition, members with special health care needs, family/caregivers and providers may request a specialist as a PCP at any time. The Case Manager will schedule an assessment within three business days of request. Our Medical Director will review assessment results and approve requests after determining the member meets criteria and the specialist agrees to execute and fulfill requirements of a PCP Agreement.

Ensuring Sufficient Sites Are Equipped to Serve Members with all types of Disabilities. LHC recognizes that ADA regulations only require providers to *accommodate* people with disabilities. Our approach to ensuring appropriate access will go a step further, by identifying providers who also display a true interest and expertise in providing care to people with disabilities, and by encouraging and assisting other providers to make changes in their office sites to better accommodate the needs of these members. We will provide paid medical certified language interpreters, including those experienced serving people with disabilities whose ability to communicate is limited. We will encourage and facilitate the availability of manual (writing boards) and electronic means of written communication for members who cannot read sign language. Other strategies may include creating reimbursement incentives for home visits and provider visits to alternative sites that are ADA compliant or have special equipment to accommodate members; manual assistance in gaining access; and referrals to other providers with known ADA compliant sites and/or special equipment (see below for examples). Our provider education program will include training opportunities and seminars conducted by advocacy groups such as independent living centers, NAMI, and others. Our provider newsletters will include disability sensitivity tips. Our PR Specialists, Member and Provider Service Representatives and ICT staff will be trained to assist providers in becoming ADA compliant and accommodating members with disabilities.

Special Equipment. LHC will identify providers who provide special equipment or services such as adjusting exam tables or offer the option for certain exams or procedures to be performed while the member is in a wheelchair versus on an exam table. We will also identify providers that offer supports to ensure members with disabilities can easily access services, such as David Raines Community Health Center, which offers free wheelchair-accessible transportation to its health centers for services which include behavioral health and dental care, and Iberia Comprehensive Community Health Center, which can accommodate members remaining in their wheelchair during dental procedures if they are unable to move to the operatory chair. We will identify providers who have special equipment such as accessible exam tables or dental chairs that can accommodate members who use a wheelchair or have other physical disabilities that limit mobility. We will also determine where we can expand this approach for podiatry services for members with diabetes and other specialty care, depending on the level of member need and provider availability in a given area.

Provider Staff Training. In addition to the training we will offer all providers on serving members with disabilities (see Sections L.4 and L.5 for details on provider cultural competence training, which includes training on serving members with disabilities), LHC PR Specialists will offer focused training to providers and their office staff to further develop their capacity to meet the needs of members with disabilities. Training sessions will cover the societal and personal barriers people with disabilities face, and offer solutions to help accommodate their needs. For example, providers will be encouraged to be flexible with appointment times, help coordinate home visits where possible, and to expect that some people with disabilities may require additional time to understand health care concerns, ask questions, or prepare for examinations. LHC will also draw on the expertise of disability-related groups such as Families Helping Families to assist with this training. When LHC identifies a provider who excels at

providing care that is accessible for people with disabilities, we will ask this provider to serve as a mentor to other providers who are interested in improving their accessibility.

Increasing Access. As described above for increasing rural access, LHC will work with our FQHC partners to increase specialty access for people with disabilities by coordinating specialty days targeted at meeting specific special needs. For example, Rapides Primary Health Care Center in Alexandria sets aside two days each month to provide dental services to children with mental retardation/developmental disabilities who live at the nearby Pecan Grove Group Home. LHC will work with our FQHC partners to identify locations with a concentration of members with disabilities who may share the need for a specific type of accommodation or experience, such as provider staff trained to handle behavioral health issues. When we identify these members, we will work with the closest FQHC to arrange specialty days that accommodate their specific needs.

Question F.6

Influencing Healthy Behaviors and
Appropriate Utilization

F.6 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.

Louisiana Healthcare Connections (LHC) will use a comprehensive, multi-pronged set of strategies that have been proven successful in other Centene affiliate plans and will be tailored to meet the specific and unique characteristics and circumstances of our Louisiana members. Our strategies emphasize the importance and use of primary and preventive services and are based on best practices and nationally recognized guidelines for promoting healthy lifestyles and wellness, such as standards from the American Academy of Pediatrics, American College of Cardiology, American Diabetes Association, American College of Obstetricians and Gynecologists, and the National Heart, Lung and Blood Institute. The six sets of strategies include systems and approaches that help us:

1. Identify our **members' needs** and patterns of accessing care
2. Provide targeted and general **outreach and education**
3. Implement educational and incentive programs to **support self care and foster personal responsibility**
4. Work with **community-based groups** to promote healthy lifestyles
5. **Engage providers** in member education and reinforcing healthy behaviors
6. Continuously **monitor our strategies' effectiveness** and respond to opportunities for improvement.

Our strategies encompass written, telephonic, and online communications, and group and individual face-to-face interactions in a variety of settings. Our strategies are supported by information systems that connect member information among appropriate LHC staff and providers, so that care and education are coordinated and specific to members' needs.

Strategy Set 1: Meeting Members Where They Are

Fostering healthy lifestyles and appropriate use of services requires understanding our members, their health needs, traditional ways of accessing care, and how to transition to coordinated care. LHC has that understanding, based on the combined experience of LPC&A (our 19 Louisiana FQHC owner-partners), our experience serving Louisiana residents after Hurricane Gustav in 2008 and subsequent community involvement, and the 27-years' experience of affiliated Centene plans in full-risk Medicaid managed care. Centene now serves approximately 1.6 million Medicaid and CHIP members in other states, including Mississippi, Georgia, and South Carolina. Based on this extensive experience, we propose (as described below) proven and innovative programs and strategies to influence member adoption of healthy lifestyles and appropriate use of health care services. But we know that to *effectively* influence individual behaviors, we need to *meet members where they are*, and that means proactively and retrospectively assessing members' health, health risks and patterns of care to tailor interventions and education appropriate to their situation and communicating in ways that are culturally sensitive.

Identifying Members Needs. In addition to analyzing the two years of medical (and possibly pharmacy) claims data from DHH, LHC will draw on the extensive experience of our FQHC owner-partners in implementing effective member health education programs. Our FQHC owner-partners now see a significant percentage (on average 35% of their revenue) of Louisiana's Medicaid and CHIP members. Staff at FQHCs already have a deep knowledge of our members and how to best convey to them health education content. LHC also will draw on the considerable local knowledge, experience, and resources of partner FQHC executives such as Roderick Campbell, Rhonda Litt, William Brent and William White, all of whom serve on the LHC Board of Directors, and are CEOs of partner FQHCs, and Dr. Gary Wiltz, our Chief Medical Officer.

Member Screening and Assessment. We will first use DHH claims data to identify new members who could benefit from Case or Disease or Chronic Care Management (Disease Management) or other interventions and education. As previously mentioned, we will outreach to all new members to conduct a

Health Risk Screening, which will help us to determine who may be at risk of high Emergency Department (ED) use or hospitalizations, for example because they tell us they are having problems taking medications. For members with identified diseases, we will conduct disease-specific Clinical Health Assessments. These evaluations also will help us identify gaps in services, link members with appropriate providers, and determine whether to refer them to Case Management. Providers who have an established relationship with members, such as FQHCs, also may refer members for Case or Disease Management.

Innovative, Supportive Technology. LHC will quickly and regularly identify members who may benefit from interventions and education via our Centelligence suite of information technologies. Centelligence will help LHC and our providers identify members at risk of health deterioration or problems or who are due for check-ups or screenings and allow us to help with adopting healthy lifestyles. Centelligence will draw from medical claims, behavioral services claims (to the extent applicable), pharmacy claims (as available), health assessments, and lab test results. For example, Case and Disease Management staff can use Centelligence™ Foresight (Foresight), our proprietary predictive modeling and care gap/health risk software, to track conditions, monitor care gaps or health risks, identify members with co-morbid conditions and those at risk of developing chronic conditions, and identify those needing additional services or higher levels of management. Case and Disease Management staff then will use the resulting information to customize outreach and education for individual members to facilitate discussion and interventions that promote healthy behaviors.

In addition, Foresight will link providers and LHC staff for coordinated care and education. It will notify providers via an electronic Care Gap Alert of a member who is due for a test or check-up when the provider logs onto the Provider Portal to check member eligibility. When a member contacts us, call center staff will see on-screen that a member has a gap in care (using HIPAA-compliant, non-clinical statements) so that they can remind a member to seek appropriate care or refer the member to a Case Manager. Likewise, Provider Relations staff may identify which providers have members with care gaps, and then work with providers to ensure, for example, that appointment scheduling is not a barrier to timely care.

Utilization Management (UM) Program. Our UM Program will identify members who are under- or over-utilizing services, and if not already enrolled, refer appropriate members to Case or Disease Management. For example, LHC UM staff will use monthly reports from Centelligence to identify members who have gone to the ED three or more times in the previous three months and refer them to our Case Management Integrated Care Team (ICT) for evaluation. Using Foresight, our UM staff will generate monthly ED Potential Misuse Reports using medical and pharmacy (as available) claims data to identify additional members who are likely to misuse the ED or are exhibiting drug-seeking behavior. UM staff will participate in multidisciplinary Rounds, addressing members with current or high needs, identifying social and other barriers that hinder member use of preventive care or adopting healthy habits. All Centene plans have ED UM processes tailored to their members' medical and behavioral health needs and community resources; from February 2010-January 2011, affiliate health plans reduced overall ED use per 1,000 members by 11%.

Culturally Competent Communications. In the strategies and programs described below, we will ensure our communications are culturally competent, understandable and engaging. Because locally delivered services achieve the best outcomes, we will hire staff who are from and familiar with the communities they serve. We will locate around the state to be near our members. In addition to our headquarters in Baton Rouge, LHC will locate staff as warranted throughout the State in offices of network FQHCs and high-volume primary care providers. In 6 of the 11 Centene health plans, at least half the counties served are rural as designated by the Census Bureau. LHC will focus on rural member needs and collaborate with community organizations in rural areas.

LHC will implement the NCQA Standards for Culturally and Linguistically Appropriate Services in

Internal Revenue Service as health care expenses for a Flexible Spending Account and flagged by the retailers' Inventory Information Approval System.

Our Indiana affiliate has already seen indications of behavior change since its launch of the CentAccount program in July 2009. The completion rate for well visits linked to CentAccount incentives increased 20.1% for July through December 2009 compared to the same period in 2008. The rate of breast and cervical cancer screening increased 23.4% percent, also during the same period. Comparing full year 2009 to 2010, MHS members had the following improvements.

Improvement in HEDIS Performance MHS CY2009 – CY2010

<i>Measure</i>	<i>% change (CY2009 – CY2010)</i>
Well Child Visits First 15 Months of Life (>=6)	16.3%
Well Child Visits 3 rd , 4 th , 5 th & 6 th Year of Life	12.1%
Adolescent Well Care Visits	23.7%

LHC will provide incentives through CentAccount based on the following measures:

Incentive	Desired Outcome
Preventive Health Visits	
Well child visits: birth through 15 months	Promotes well child visits and ensures children receive the appropriate screenings
Annual well child visit: 3 to 20 years	Promotes well child visits and ensures children receive the appropriate screenings
Annual preventive health exam: 22 years and older	Ensures adults receive appropriate screenings and important information to improve their health
Preventive Health Screening	
Breast cancer screening (Women age 40-69)	Ensures adults receive appropriate screenings
Cervical cancer screening (Women age 21-64)	Ensures adults receive appropriate screenings
Chlamydia screening (Women age 16-24)	Ensures adults receive appropriate screenings
Diabetes screening	Ensures diabetic adults receive appropriate screenings (A1C, LDL, eye exams, nephropathy screening, DM completion)
Maternal	
Notification of Pregnancy	Ensures pregnant members contact us and their medical home early
Prenatal visits	Ensures pregnant members receive appropriate preventive care (3rd, 6th, 9th visits)
Postpartum visit	Ensures pregnant members receive appropriate preventive care

Health Care (**CLAS Standards**), which operationalize the CLAS Standards issued by the U.S. Department of Health and Human Services' Office of Minority Health. All written materials will be written at up to grade 6.9 reading level in People First Language, and in accordance with DHH's Person First Policy. Member education materials will be available in English, Spanish and Vietnamese and upon request in other languages. (See F.1, F.2, L.1 and L.4 for more on our cultural competency approaches.)

Community Partnerships and Resources. LHC will obtain input and feedback on cultural competency issues through our Member Advisory Councils, Community Advisory Committee, and Provider Advisory Committee, all of which will meet quarterly. These entities will review proposed written materials, performance data, and satisfaction survey results; make outreach and intervention recommendations; and assess health care and administrative service delivery. We will have an internal CLAS Task Force of LHC leadership staff, which will also meet quarterly.

We plan to collaborate with the non-profit Louisiana Public Health Institute (LPHI), a statewide 501(c)(3) founded in 1997 that serves as a partner and convener to improve population-level health outcomes, including in rural areas. We will also collaborate with the HealthCorps educators who now work with FQHCs. HealthCorps is the largest health-focused AmeriCorps program and promotes health care for America's underserved. HealthCorps members conduct outreach to individuals with no regular primary care provider, to increase health education and support appropriate use of health care services and improved self care.

Multi-faceted and Reinforcing Approaches. Member health education is most effective when provided in multiple formats (such as print, online, by phone, and in-person), using multiple strategies (such as Case Management-based, provider-based, mail, phone calls, and community events), and incorporated as an ongoing, reinforcing set of approaches, instead of a one-time or annual effort. For example, we offer general information on smoking cessation programs to all members, and specialized education and outreach to members in Case Management and to providers to support members who want to quit smoking. Our activities to curb inappropriate or preventable ED use will include approaches via new member and ongoing member education (such as newsletters), CentAccount incentives for preventive check-ups, and provider strategies, such as promoting and informing members about extended office hours. We implement ongoing reminders, for example, via messaging on our member helpline, in our Member Newsletters and on our online Member Portal.

Written and Member Portal Materials. LHC health education materials will be easy to understand and culturally relevant, with graphic elements that make them appealing to members. Some materials address general health and wellness topics such as nutrition, exercise, the importance of establishing a medical home, using preventive and Case Management services, calling our 24/7 NurseWise advice line or our call center, how to access services, what constitutes a true emergency, and how to obtain care for urgent conditions. Other materials target high-risk conditions, and provide self-help measures (such as how certain home environment practices can reduce asthma symptoms) and information on how to access appropriate care. Our written communications will include our Member Handbook, brochures on a variety of health-promotion topics, and quarterly newsletters. Many materials will be posted on the Member Portal. For community events and campaigns (as described below), we will also use posters, flags, signage (for example on public transportation), and community or church newsletters, as authorized and appropriate.

Personal Outreach. While LHC will provide culturally competent written materials, our strategies focus heavily on direct member and family contact, because telephone and face-to-face education and outreach are critical for members with low literacy and also take into account different learning styles. We will educate and involve family members and caregivers (in keeping with HIPAA requirements). For example, members with chronic or complex physical conditions may look to their caregiver or a family member for advice on or assistance with their health issues. Similarly, our Connections outreach staff will maintain personal contact with local and regional advocacy groups and social service agencies, to benefit from their observations and ideas on member needs and improving service delivery. Our community-

collaborations and provider-based strategies described below also help extend our personal outreach to members.

On-hold messaging. We will use on-hold messaging to reinforce the importance of primary and preventive services, such as getting flu shots, and the importance of hand-washing, annual PCP visits, and contacting LHC staff or NurseWise for any questions about seeking care.

Strategy Set 2: Multiple Staff Involvement in Member Education

Centene health plan experience shows that member health improves and is sustained when members, their families, and informal supports are engaged in planning, directing, and evaluating their care. We will **use every member contact with LHC staff** to educate and reinforce the adoption of healthy habits and appropriate use of services.

NurseWise. NurseWise, our URAC accredited nurse advice line, will be available 24 hours a day, 7 days a week to answer member questions about their health and access to care. Centene offers NurseWise in all 11 affiliate health plans. NurseWise emphasizes primary care use by providing members immediate advice on home treatment, and education on the most appropriate source of additional care using nationally recognized telephonic advice standards and clinical interviews. NurseWise includes Spanish/English bilingual staff, and for other languages uses the same translation subcontractor as LHC, which translates for more than 200 languages. For members with hearing impairment, NurseWise will use Louisiana Relay or TDD equipment.

In 2011, Case In Point Magazine awarded Centene’s Nurse Response program an Honorable Mention for identifying and strengthening medical home utilization and avoiding non-emergent ED visits by pediatric Medicaid recipients. Case In Point Platinum Awards recognize the most successful and innovative programs in Case Management across a variety of settings. Centene plan data show that during the past two years (through the third quarter of 2010) over 80% of all members whose conditions did not indicate the need for ED care heeded NurseWise advice to seek care alternatives:

Metric	Q4 2009	Q1 2010	Q2 2010	Q3 2010
# NW Advised Other than ED	2,891	3,200	3,113	3,113
% Compliant with NW Advice	81%	80%	84%	80%

New Member Education. NurseWise staff will conduct new member Welcome Calls, thereby reinforcing NurseWise nurse accessibility, and will go over LHC health plan features and benefits, including how to appropriately access services. During initial enrollment, LHC also will use call center and Connections outreach staff to make welcome calls, especially for members who are difficult to contact. During our new member Welcome Call, we will educate members on the importance of establishing a relationship with the PCP prior to the onset of acute illness, how to access services, what constitutes a true emergency and care options for urgent conditions. Our new member Welcome Packet will include the Member Handbook, which explains the role of a PCP/medical home; plan services, benefits and features; appropriate reasons for visiting the ED; the availability of special LHC programs (described below); and using preventive and Case Management services.

Case Management and Disease Management. Using the UM and Foresight methods described above, members with conditions related to asthma, diabetes, hypertension, low back pain and congestive heart failure, and other members at risk of health complications will be referred to Case and Disease Management. Recognizing that multiple co-morbidities, including behavioral health and substance abuse conditions, often exist in chronically ill individuals, LHC will deliver Case Management services through an **Integrated Care Team (ICT) approach**, which is used by all Centene plans. This team will be composed of an LHC registered nurse Case Manager, social worker, behavioral health clinician Case Manager, Program Coordinator, along with Health Coaches from our URAC accredited Disease

Management affiliate, Nurtur. LHC will co-locate our ICTs in FQHCs, regional offices, and in high volume provider offices.

Member Education. Our multidisciplinary ICT staff will perform a comprehensive evaluation of members' risk factors and barriers to timely preventive services, and develop a service plan collaboratively with the member, family or caregiver, and PCP. Our ICT staff will provide ongoing member education, including how to recognize and prevent exacerbation of chronic conditions and the benefits of preventive care and early intervention. Member education about healthy lifestyles and appropriate use of services also will occur during the development and implementation of the individualized service plan and related outcomes monitoring. Our ICT staff will engage members in participating in healthy habits by helping members identify health-related goals they see as important to their quality of life (such as losing weight, going to work, or remaining in their own home) and monitor their own progress toward their health goals.

Additionally, ICT education for members in our Chronic Care Management Program (for members diagnosed with asthma, congestive heart failure, diabetes, hypertension, and low back pain) or in our weight management program will include quarterly newsletters, with topics such as condition-specific self-management, problem solving, decision-making, taking action, working with providers and disease-specific goals. The newsletter also will be available on our Member Portal. They also will receive reminders about preventive care and screenings for their conditions. These reminders are based on the clinical practice guideline for the particular condition. Each reminder, whether mailed to the member or communicated orally, will include information about the risks associated with progression of their disease and a reminder about available incentives for receiving the service.

Co-location of the ICT will facilitate coordinated and integrated member education that targets the whole individual, and not just components of a member's care. Our ICT member education will be further integrated and supported by our **TruCare** clinical information system, which provides our clinical staff with "one consolidated window" into the health risks, care gaps, service and authorization history, and other clinical test, assessment, and medication information.

ICT Success. The success of our ICT approach and incorporation of Nurtur expertise is shown in recent data analyses revealing a 24.6% reduction in asthma-related ED visits for children and 12.5% reduction in asthma-related visits for adults in Centene plans. Nurtur also achieved statistically significant reductions in condition-specific related admissions for pediatric asthma (12.9%), diabetes (23.4%), and heart (26.4%). At the Communities in Action National Asthma Forum, in June 2011, the U.S. Environmental Protection Agency (EPA) recognized Centene and Nurtur for their commitment to and leadership in improving the lives of people with asthma, along with two other organizations. Criteria for winning the award included implementing strategies to deliver positive health outcomes, forming strong collaborations with communities, exhibiting committed leadership, and conducting effective environmental interventions to improve the lives of people with asthma.

MemberConnections[®] Staff. Our MemberConnections Program will provide in-person, "feet on the street" interaction with our members – and thereby motivate and engage members to adopt healthy lifestyles and use health resources appropriately. MemberConnections (Connections) staff are health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people familiar with distinctive local characteristics and needs. Connections staff will receive comprehensive training and be an integral part of our Case Management teams. Connections staff will make home visits to high risk and hard to reach members. They will assist with member outreach, coordinate with social services, and participate in community events such as health fairs to provide health education and outreach. For example, Connections staff will work with providers and community organizations to organize Start Smart for Your Baby[®] events.

Discharge Planning After an Inpatient Stay. LHC staff will remind and reinforce appropriate use of services by educating members about their condition and post-discharge treatment plan. This is particularly important for members with co-occurring behavioral health or physical health diagnoses or

with complex needs because they are at risk for ED visits following discharge. LHC’s focus on successful transition from inpatient care will include identifying high-risk inpatients (for example, major surgery or complex treatment plan), or conducting a bedside conference (if our Concurrent Review Nurse is onsite) or telephone call by a Case Manager within 48 hours of hospital discharge to review the member’s understanding of the treatment plan, medications, follow up appointments, and needed home equipment or supplies. In selected cases, ICT staff will arrange a home visit shortly after discharge by the Case Manager, a home nurse, or Connections staff. To reinforce the importance of accessing appropriate post-discharge care, we will send an audio postcard to all members within two business days of discharge as a reminder for them to make and keep needed follow-up appointments and to encourage them to call for assistance with scheduling or arranging transportation.

Member Services Representatives. When members contact LHC via our call center, our Member Services Representatives will provide context-appropriate member education about healthy lifestyles and use of health care resources. Member Services Representatives (MSRs) will use our Member Relationship Management (MRM) system to engage and serve members in coordinated fashion, across the breadth of health care and administrative matters affecting members. For example, MRM will show MSRs (in a non-clinical, HIPAA-compliant fashion) care gap information so that staff will remind the member that her child is over-due for an EPSDT health screen, even when the member is calling about another topic. It will alert MSRs (or other LHC staff who receive a member call) if another department, such as Case Management, has been trying to contact the member.

Analysis by one affiliate health plan *prior to MRM implementation* showed that of the members for whom a Case Manager had made three unsuccessful attempts to reach them, *45% of the members had initiated an unrelated recent call to Member Services.* Thus, MRM will *significantly increase effectiveness of our outreach and education and by capitalizing on every member contact* – both outbound and inbound.

MRM also will automate, manage, track, and report on our outbound outreach, such as member campaigns and targeted interventions. We will train MSRs and Connections staff on both targeted campaigns and ongoing health promotion programs, such as DHH’s Tobacco Control Program, so that they can educate and motivate members who express an interest in quitting, or who are identified as being smokers during calls or outreach activities. MRM also supports co-browsing, through which MSRs may view (with member consent) what the member or caregiver is viewing on our Member Portal in order to help them use the portal.

Strategy Set 3: Supports that Foster Healthy Habits and Personal Responsibility

Member Portal. Centene increasingly uses our secure online Member Portal to provide self-service features and engaging content to motivate members’ self care. All adult members will have access to the Member Portal, and with DHH approval, we will also offer the Member Portal to parents or legal guardians of members less than 18 years of age. Member Portal features will include:

Feature	Description
Online Interactive Provider Directory/Search	A Provider Directory with search capabilities by location, type, specialty, gender, language, and proximity. It will also provide Google maps, showing proximity to public transportation.
Online Risk Assessments	Members can securely complete an online health-risk screening tool.
Online Member Update	Members can securely order replacement ID Cards; update member demographics; change PCPs.
Parent / Legal Guardian Support	For members less than 18 years of age, this will allow the member's parent or legal guardian to access the member's protected health information on the

Feature	Description
	Member Portal.
Email Alerts	Members can register for regular email alerts and reminders.
Secure Messaging	Portal allows members to send a secure message to LHC and receive secured response.
Preventive Care Gaps	Members can receive consumer friendly preventive and condition-specific care gap alerts.
Claims Information	Portal allows members to view information on claims for services rendered.
Section 508 Compliance	<p>We use web design guidelines that ensure that information we present is readily accessible and easy for our users to understand. Our approach includes:</p> <ul style="list-style-type: none"> • Having textual description alternatives for informative images displayed • Ensuring that information conveyed with color is also available without color • Allowing members to use assistive technology to fill in online forms • Our websites are designed so that users do not require significant memory, disk resources, or special software beyond a web browser
TruCare Service Plan	This feature allows members to view their TruCare service plan online. TruCare is our member-centric health management platform for collaborative care coordination and Case, Disease, and Utilization management, and is used by LHC Case Managers and other members of our Integrated Care Team.

Optional Personal Health Record. Access to a Personal Health Record (PHR) can help motivate and empower members to maintain healthy lifestyle habits, follow drug regimens and get recommended preventive care, and take responsibility for seeking needed care. LHC will offer members a free, Internet-based PHR provided by Microsoft’s HealthVault, where we will securely send their claims data for their review and use. Children and members with legal guardians would require parental or legal guardian approval for this service. PHR operations will be the responsibility of Microsoft and the member, but we will inform members how to set up a HealthVault account and monthly send claims data to it. LHC’s Indiana affiliate now offers this option to its members. Members will benefit by having access to medical information 24/7, which they may build upon with information from other providers, for example, if they transition from LHC to a commercial health plan. A PHR will be especially useful in the unfortunate event that another hurricane or other disaster strikes Louisiana.

CentAccount. LHC will use our CentAccount™ Member Incentive Program to reward members when they make healthy choices, such as when they obtain preventive services according to applicable periodicity schedules. All 11 Centene affiliate health plans use CentAccount. It promotes personal health care responsibility by offering financial incentives that are valued and appreciated. Rewarding members for targeted healthy behaviors increases the likelihood of continuing these behaviors through positive reinforcement. Eligible members can earn rewards for completing annual and other recommended preventive health visits or chronic disease screening, such as appropriate diabetes testing.

The reward will be loaded onto an LHC-issued CentAccount MasterCard® debit card. Members can use this card at many merchants they already use daily, such as Walgreens, CVS, Rite-Aid, Albertson’s, Winn-Dixie, Piggly Wiggly, Safeway, Kroger’s, Sam’s and Wal-Mart, and other stores throughout the State to buy a wide variety of health-related items, including some over-the-counter medications. Members may use the funds on their CentAccount cards towards health care goods and services not covered by Medicaid. Goods and services qualify for card purchases if they are recognized by U.S.

Connections Plus®. All Centene affiliates have implemented our Connections Plus® Program, which provides **pre-programmed cell phones to our high-risk members** who lack reliable phone access. This innovative program provides 24-hour instant access for our members, allowing them to make calls to and receive calls from their providers, Case Managers, LHC staff, NurseWise, and 911. The overall objective of the program is a reduction in preventable adverse events such as inappropriate ED use or hospital admissions through improved access to health care information and treating providers. Members are educated on observing their health status and calling promptly for advice rather than waiting until the next appointment. Case Managers can send the member a text message or voice mail with health information targeted to the individual member's condition. In rural areas, increased telephonic communication helps overcome the barrier to care that travel distances sometimes pose for members.

As part of the program, Centene health plans also provide members **MP3 players loaded with podcasts** (currently in English and Spanish), relevant to member conditions. (The podcasts will be available for members to download from our Member Portal.) Examples of podcast topics include diabetes, alcohol abuse, chronic kidney failure, COPD, depression, headaches, healthy weight, osteoporosis, hypertension, stress, taking your medicine, smoking cessation, generic drugs, heart attacks and advance directives. Connections Plus received URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award and was a 2009 Medicaid Health Plans of America (MHPA) Best Practices Compendium Honoree.

Start Smart for Your Baby®. All pregnant members will be eligible for this program, which will educate them about how to ensure a healthy pregnancy and first year of life for their babies. Centene offers Start Smart in all 11 affiliated health plans. Start Smart offers a range of Case Management techniques, including health screenings, educational materials, and MP3 players with educational podcasts designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease that can result from high-risk pregnancies. The program provides incentives for going to prenatal, postpartum, and well child visits. In 2010, Centene's Start Smart for Your Baby Program won a Platinum Award for Consumer Empowerment at the URAC Quality Summit, and the inaugural URAC/Global Knowledge Exchange Network International Health Promotion Award. In 2009 it was named an NCQA Best Practice.

- **Smart Steps for Your Baby®** is a program that will educate members on the benefits of exercise during pregnancy, and provides information on how to set up a safe walking program before and after delivery, a log for tracking steps, and a pedometer.
- **The Start Smart® Baby Shower Program** will educate pregnant members about prenatal and postpartum care for themselves and their newborn. "Baby Showers" are conducted in a class environment by health plan staff. Led by a registered nurse and assisted by Connections staff, the classes cover the basics of prenatal care, including nutrition, the risk of smoking and benefits of smoking cessation, the progress of a fetus throughout pregnancy, the importance of regular follow-up with medical providers, common health issues that occur during pregnancy, and a review of the LHC Start Smart® and MemberConnections programs. Upon completion of the class, participants may take part in a raffle, and the winner will receive a basic infant car seat.
- **Start Smart® Birthdays Program**. This program will promote for newborns through school-aged children good healthy habits in a fun way. Our Connections staff will provide a quarterly "birthday party" event for targeted children and their parents that will include health and parenting education, explanation of member benefits, the importance of well child checks and other age-appropriate health information. For example, topics typically include Crisis Care, Physical Fitness, Healthy Eating, Ask the Pediatrician, Child Safety, and Meet the School Nurse. Invitees will be selected by our Quality Management staff and target children who are not meeting HEDIS-related milestones, such as children who are not meeting their well child exams or who have, or are at-risk of having, a health condition that could be improved upon with special education and outreach.

In-Home Video and Exercise Pilots. Beginning in the second quarter of 2012, and through a partnership with *Microsoft Corporation*, we will pilot new ways to engage members in their care and adopting healthy lifestyles, through the carefully supported introduction of *home-based interactive technology*. The technology in both pilots described below is identical, and our overall goal is the same: to prove the feasibility of delivering additional services to our members in a home-based setting. Depending on the results of our pilots, we will phase-in additional functions and capabilities. For example for the exercise pilot described below, in the fourth quarter of 2012 we will phase in the customized use of Microsoft's Xbox Points incentive program, so that members are automatically rewarded when exercise goals have been met.

- ***Augmenting Case Manager Contact with Members with Special Health Care Needs (MSHN).*** We will conduct our MSHN In-HomeVideo Pilot with appropriate and interested members with complex or chronic conditions or disabilities who live in a rural parish. In this pilot, we will connect selected MSHN members (with member consent) via Centene and Microsoft technology to LHC Case Managers and Connections staff to demonstrate how on-demand video conferencing can increase the frequency and quality of Case Manager and Connections staff contact. We expect that by increasing the number of *visual* interactions we have with our members, our Case Managers will be able to better monitor their health status and service plan progress, and educate and guide them toward healthy habits, help prevent unnecessary health deterioration and possible ED care, and conduct other Case Management activities as necessary.
 - Together with Microsoft, we will integrate our MRM with a combination of Microsoft's Kinect intelligent video system, Xbox console, and Lync Server unified communications software. Once deployed in the home, members can either initiate or receive a request to video conference with their LHC Case Manager or Connections staff. The member or their caregiver need only gesture with their hands at the Kinect camera, placed near their television, to accept a "video call" request from authorized LHC staff or to select from a menu the LHC staff person (displayed on the member's television) they wish to call (such as the member's Case Manager). *The member does not have to leave their seat to interact with the Kinect/Xbox system.*
 - Kinect's intelligent video system pans and zooms to accommodate another person (such as the member's caregiver) who might join the member during the video conference.
- ***Reducing Childhood Obesity: The Child In-Home Exercise Pilot.*** Using the same technology platform as with our In-Home Video Pilot, we will conduct this exercise pilot in group settings, such as our owner-partner FQHC or other provider locations, for obese child members. In consultation with the member's PCP, and with the member and parent/guardian's permission and cooperation, we will program the Kinect/Xbox system with a carefully selected exercise program designed to *complement* members' dietary and any other exercise regimen.
 - The software will be customized for each member's specific exercise needs and will be interactively engaging, for example with the use of full motion "virtual reality" video scenery, avatars, and audio cues, prompts, and music. The exercises will mimic physical activities, for example using a virtual jump rope (with no possibility of tripping on a real rope), spinning a virtual hula-hoop, and knocking down virtual blocks.
 - Kinect measures the "visual vitals" of the member, including height, arm span, and leg length, in order to calibrate the prompted exercise movements and set the virtual scenery for each exercise. The software approximates and displays the calories expended during each exercise session, and can track calories "burned" against pre-set goals and challenges for the member. A "virtual coach" helps to encourage the member with positive reinforcement throughout each exercise, with audio and visual messages based on the member's exercise activities.

- As with the MSHN pilot above, staff at the site of the Kinect/Xbox, along with the member or parent, can initiate or receive video conferencing requests with the member's Case Manager.

In-home Telemonitoring. LHC will provide telemonitoring services to primarily rural, high risk members with diabetes, COPD, and congestive heart failure and other high risk members with multiple co-morbidities for whom intensive monitoring is useful and the conditions are amenable to telemonitoring. Our telemonitoring services will help members stay informed about their condition so that they may take appropriate steps to seek care when needed.

Our patent-pending, FDA-approved technology is “device-agnostic,” interfacing with virtually any home monitoring device via wireless or wired modem using landline, cellular (including a ConnectionsPlus phone) or VOIP communications links. Within seconds of a reading, the biometric value, such as a blood glucose or blood pressure level, is transmitted electronically to the member’s Case Manager and evaluated against patient-specific or national guidelines for favorable or unfavorable trends. The system also can trigger an Interactive Voice Response phone call to members informing them of their condition, or alert ICT staff or the member’s provider.

Three Centene health plans have implemented this program and initial data indicates that it is improving health outcomes for members. For example, in a review of the factors influencing the utilization and cost for telemonitoring participants at our Ohio affiliate, among the findings were a reduction in both inpatient admissions and ED use by members whose managed conditions were diabetes and heart failure/heart disease (data period January 1, 2009 – September 31, 2010).

Strategy Set 4: Community-Based Education and Investment

Our community-based strategies proactively connect LHC with community-based agencies and advocacy groups to encourage members to maintain healthy lifestyles, seek routine health screenings, and use preventive and primary care services. Connections staff organize and staff health promotion and education events, such as wellness clinics and health fairs. We will tailor our efforts to meet the needs of each community or organization. By bringing prevention education and screening to local communities and groups, we reinforce the importance of appropriately accessing primary care and adopting healthy habits.

Start Smart for Your Health™. This suite of strategies helps members manage various conditions by empowering members to be active participants in their health care. This program also identifies regional community health education needs, improves outreach and partnerships with community-based organizations, and actively promotes healthy lifestyles through disease prevention and health promotion, and includes the following components:

“This program has empowered and motivated me to strive for a better lifestyle,” said one participant in the Ohio-affiliate Centene plan. “I’ve learned many new things. This was a blessing to me—it helped me have a better outlook on life.”

Healthy Schools/Adopt-a-School Program. Through this initiative LHC partners with local schools to provide health outreach and education for children and supplies and support for School Nurses. The program includes:

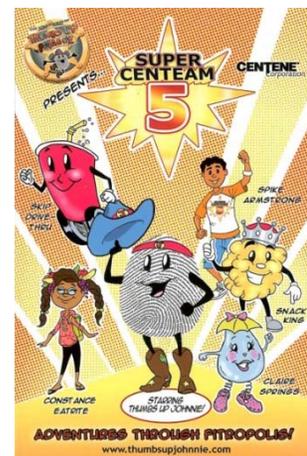
- **The Kids’ Club**, which educates children on a variety of health topics, focusing heavily on obesity prevention, using newsletters, contests (such as healthy recipe contests) and other events.
- **“Thumbs Up Johnnie” Program**, which is designed to raise community awareness about the dangers of

childhood obesity and preventing the spread of germs through proper hand washing. We use “Thumbs Up Johnnie,” a child-friendly, nationally recognized character to help educate children. Author Michelle Bain visits students in our adopted schools to read, “Super CENTEAM 5, The Adventures of Thumbs Up Johnnie” and “Super Centeam5 Cookbook.”

Students receive copies of the book, a character-themed bracelet or spatulas and a healthy snack. Children take pre/post presentation tests about healthy eating habits.

Teachers who turn in their post-presentation tests receive a set of Thumbs Up Johnnie books for their classroom and bookmarks for their students. We also donate a set of autographed books to that school's library. A review of our test outcomes shows that after testing more than 5,000 children in our adopted schools we see an impressive increase in correct answers to our standard five questions. The average is 33.6% increase in correct answers with a range from 73% to 13% depending on the question.

- Our **Brownie Badge** will provide a strong foundation for healthy choices using Brownie Troop badges. Upon completion of specified activities, the Troop Leader conducts a pre- and post- quiz to identify the Brownie member's knowledge level.
- **Off the Chain** is a book developed solely for our teenaged members that provides general information about teen-related issues, such as smoking, self-esteem, domestic violence, pregnancy, drugs, and personal hygiene.
- We will offer **Boys & Girls Club Memberships** to assist youth members in developing social and leadership skills. LHC will sponsor the membership fee to the local Boys and Girls Club in major metropolitan areas, including New Orleans, Greater Baton Rouge, Lafayette, Lake Charles, Alexandria, Shreveport/Monroe and Ruston.



Healthy and Safe Communities. Healthy Homes. Helping members improve unsafe, unhealthy living conditions is critical to supporting their efforts to adopt healthy habits and self care, and often requires the involvement of several community members and organizations. Our Healthy Homes initiative will assist individuals who live in low-income or public housing to identify and address health hazards in the home, particularly lead. We will initiate outreach to local law enforcement and housing authorities to improve conditions for members who live in high-crime or unsafe neighborhoods. For example, our Wisconsin affiliate partnered with the Safe Communities Coalition, which promotes among other things, traffic safety, preventing falls and other injuries at home, keeping children safe, and reducing suicide.

LHC will partner with entities such as parish health units, Councils on Aging, and community organizations that provide important non-health care services, such as assistance with housing, utilities and rent. LHC will collaborate, for example, with community organizations that can help remove old carpeting or other materials that contribute to breathing difficulty for members with asthma or chronic obstructive pulmonary disease. Areas that may benefit from LHC's Healthy Homes Program include neighborhoods such as Iberville/Treme, St. Thomas, Central City, St. Bernard, Desire, Dillard and the Calliope Project in the New Orleans area; East Brookstown, Melrose Place East, Scotlandville, Zion City and Monticello in Baton Rouge; and Allendale, MLK, Cedar Grove and Mooretown in Shreveport.

Orleans Neighborhood Health Implementation Plan. With funding from the Kresge Foundation, the Louisiana Public Health Institute is convening a wide variety of partners including public health specialists, architectural and urban planners, neighborhood outreach organizations, civic and nonprofit organizations, and health care providers to create a one-stop resource for data, tools and guidance to support and inform neighborhood and community health improvement efforts across New Orleans. The planning and development phase of this project is currently referred to as the Orleans Neighborhood Health Implementation Plan, which will ultimately lead into a new program that will address an array of community health issues and indicators including built environment, nutrition, active lifestyles, health services, economic development, education and more. LHC will assess how best to participate in and

leverage the resources developed by this project to benefit members and the housing and communities in which they live.

Healthy Congregations. This program, modeled on the successful program of our Indiana affiliate, focuses on bringing health education to faith-based organizations such as churches. Healthy Congregation sessions occur after scheduled church services and offer attendees preventive screening services such as blood pressure checks, body mass index (BMI) measures, and glucose or cholesterol testing. They also include health education and demonstrations such as cooking healthy on a budget. Our Healthy Congregation events are free and attendees have the opportunity to win health-related giveaways and talk to the LHC staff. These events give us an opportunity to connect with the local community and conduct outreach especially in rural areas. We have already initiated our outreach and plan to partner with churches in areas where many members live, such as North Crossings Church in Monroe, Star Hill Baptist Church in Baton Rouge, Faith Bible Church of Lake Charles, and Mary Queen of Vietnam Church in New Orleans.

Healthy Choices. This program focuses on removing barriers that make it difficult for our members to make healthy food choices. Centene offers Healthy Choices in other states, and tailors the program to meet local circumstances. For example, our Texas affiliate partnered with the Sustainable Food Center in Austin to provide its members a monthly \$10 voucher to the Austin Farmer's Market (a local 501(c)(3) non-profit) to encourage healthy eating habits. The voucher allows the member to purchase fruits and vegetables from local farmers at three different locations.

- **Healthy Cooking Demonstration.** A balanced diet is important to maintaining a proper weight and preventing disease. As part of our Healthy Lifestyles Program, LHC will hire a professional nutritionist, cook or chef to conduct a one-hour healthy eating and food preparation class at a local community center, church, or other facility equipped to provide such a class. The class will focus on healthy eating and choosing nutritious foods while on a tight budget. The use of food stamps and the WIC program will also be highlighted in the presentation. The classes will be held once a month on a Saturday or Sunday in each GSA in a major city (a city with more than 100,000 people).
- **LHC's Fresh Foods Health Fair:** LHC will match education with opportunity in order to inspire and support healthy behaviors. Through marketumbrella.org – the parent organization for Crescent City Farmers Markets – and Kingsley House, 500 vouchers redeemable for \$10 in market tokens at any of the three, weekly Crescent City Farmers Markets held in New Orleans were distributed at LHC's Fresh Foods Health Fair on June 10, 2011. Head Start, Kingsley House Summer Camp participants and Adult Services seniors may use the vouchers on field trips to the farmers markets where they can exchange them for seasonal, locally grown fruits and vegetables, eggs, dairy, meat, seafood, and fresh bread. Participants included more than 400 summer camp participants (age 5-12), Head Start enrollees, seniors with varying degrees of ability/mobility, and parents and other adults. We provided a box garden; various lesson, activity, display and tasting stations where participants could learn about healthy eating; and take-home reminders such as clip magnets, vegetable seed packets, and a grocery tote bags.

Flu Prevention: FLUVENTION. This annual campaign, offered at each of Centene's health plans, includes all members and provides targeted outreach to high-risk members. The program provides information about preventing transmission of the influenza virus by encouraging members to get the seasonal vaccine and adopt everyday precautions to prevent illness. It also provides information about what to do if an LHC member (or family member) becomes ill. Our integrated communications approach includes direct mail, phone calls, providing information via health plan websites, posting information in provider offices and pharmacies, and collaboration with community groups to host events where flu prevention information is

FLUVENTION!

provided. For example, to reach as many unique community locations as possible, our Indiana affiliate health plan created a contest where staff were rewarded for the highest team member participation in distributing Fluvention materials including in rural areas. As a result, they distributed materials to 92 different sites.

Centene health plans also conduct general community awareness through public service announcements on television and radio. During 2009, we targeted education related to health hygiene, preventive care and the benefits of appropriate care, for groups at higher-risk for contracting the H1N1 influenza virus, including pregnant women, children from 6 months old up to 24-year-old adults, and adults with chronic health conditions. Incentives in the form of gift cards were given to Centene plan members who received both flu vaccines.

Community Transformation Grant (CTG) Support. LHC will support DHH efforts to request federal funding for Capacity Building. We will continue dialogue with DHH to determine how we may best assist and collaborate. For example, we could participate in a Community Transformation Coalition and help with program development, community assessments, and data gathering, and offer Connections staff support for engaging local communities.

Community Investment. Centene additionally supports the ability of local organizations to provide health and wellness services with targeted foundation grants. The *Centene Charitable Foundation* provides charitable support for community initiatives that improve the quality of life and health in communities in which Centene Corporation does business. Sponsorships include, among others, Boys Hope Girls Hope, United Way, March of Dimes, St. Louis Crisis Nursery, and Youth in Need. The *Centene Foundation for Quality Healthcare* was established to improve the quality, access, effectiveness, and value of healthcare for low-income families and individuals, and focuses on activities that identify and address core causes of unequal access and treatment. Building on Centene's long-standing commitment to deliver health care at the local level, the Foundation develops partnerships to implement innovative approaches to promote healthy communities. For example, in 2009, the Foundation funded a \$50,000 grant to the *Louisiana Primary Care Association* to help support their initiative for member FQHCs to become NCQA recognized as *Patient-Centered Medical Homes*. Other Foundation grant awardees have included:

- ***Fragile Kids Foundation, Inc.***, a nonprofit organization based in Atlanta, to launch the Fragile Kids Partner Program for underserved, rural Georgia families caring for medically fragile children with a range of diagnoses, including cerebral palsy, spina bifida, muscular dystrophy, mitochondrial disorder and other genetic/trauma disorders. The goal of the program is to provide medical equipment and therapy tools.
- ***The Center for Black Women's Wellness, Inc.***, to support *Journey to Wellness*, a program designed to address the disparity of mental health among Black women in Atlanta, Georgia.
- ***Madison County Community Health Centers***, to support the development and implementation of a School Based Health Clinic in Alexandria, Indiana and increase accessibility to primary health care for school aged children. This Clinic specifically focuses on conducting health assessments for all elementary, intermediate, and high school students.
- ***Texas Parent to Parent***, to support its Medical Education Program that works with pediatric and family practice residents and other medical professionals to increase their knowledge of the needs of children with disabilities and chronic illness.
- ***Arizona Health Care Foundation***, to provide scholarships for continued, formal education in the healthcare field to qualified individuals who work in long-term care, such as skilled nursing facilities and assisted living communities.

Strategy Set 5: Helping Providers Educate and Motivate Our Members

Provider-Based Education and Incentives. Member misuse of EDs is reduced and their appropriate use

of the health home and primary care improved when PCPs are active participants in their patients' health care. LHC will educate our providers on our medical home policies, Case and Disease Management services, and availability of NurseWise, during provider orientations, in the Provider Manual and on our Provider Portal. LHC training will engage providers new to coordinated care and help them understand their role in educating our members on appropriate use of services. In addition, we will provide information about these policies in our quarterly provider newsletter and during Provider Relations follow up visits. For example, our Provider Relations staff follow up with PCPs that have a disproportionate number of members with high ED use to explore potential access issues, such as appointment availability, office hours, and well-translated answering machine messages.

We will also offer providers brochures, posters and tool kits on various health promotion or disease-related topics that they can use with members to reinforce appropriate use of services and taking responsibility for self care. For example, for smoking cessation, we will educate our providers about the DHH Tobacco Control Program, the Quitline, how to become a certified Fax to Quit Provider (if they are not already), and how to access important tobacco cessation resources for their practice, such as the Certified Health Care Provider Toolkit. In addition, LHC will implement a Notification of Pregnancy program with providers to enhance our ability to identify pregnant members, help them access prenatal care, provide them targeted education, address social needs and concerns, and coordinate referrals to appropriate specialists and Start Smart Case Management, as needed.

Our ICT staff will support provider-based member education and motivation by contacting PCPs within three days of members' Case Management assessment, informing PCPs of the service plan, including any gaps in care, and requesting PCP input on and support for the service plan. We also will work with providers to help meet the need for after-hours or urgent care services. For example, our Texas affiliate worked with a large physician group to develop a code-based per-visit financial incentive for evening and weekend office visits, which supports members going to their PCP rather than the ED. Our affiliate also worked with a large El Paso group practice that wanted to expand its urgent care services. Our affiliate helped finance the group's establishment of an urgent care center in Austin to meet growing demand for urgent care services there.

Provider Portal. Our Provider Portal will help network providers influence members' healthy behaviors and appropriate use of services. The Online Care Gap feature of the portal will allow network providers to see when checking member eligibility whether the member is due for a test, check-up or other health screen. Our monthly performance reports will give them feedback about their performance against an appropriate peer group, which will help show them opportunities for improvement in their medical home operations, including when members are over-utilizing or under-utilizing services (and could be better educated or treated in a different manner). Our portal ED check box prompts hospitals to indicate in real-time when a member visits the ED. The system will immediately notify the member's Case Manager, who then follows up with the member and contacts the member's PCP, to help engage the PCP in follow up care and, if appropriate, preventing future unnecessary ED visits. The Member Health Record will also include full clinical profiles for each patient, lab data with trending analysis, and summary clinical records for individual members, which will help give context to providers not only in treating our members, but also in educating and influencing them about self care and appropriate use of services.

Health Check Days. Health Check Days are preventive health check-up programs for LHC members. At these events, which will target well child/EPSDT visits, mammography screenings, and diabetic screenings, LHC will partner with provider offices and FQHCs across Louisiana to identify members who have missed preventive care visits. LHC staff will then contact the member to encourage them to make an appointment for the needed service on a certain day set aside by the practice. LHC staff will be at the providers' offices on these days to reinforce the importance of preventive care and answer questions about the member's health plan benefits.

Provider Summits. LHC will hold Provider Summits that are informal meetings with local providers to gather input on a wide range of issues, including but not limited to strategies for influencing member

behavior to promote health and appropriate access. We will invite contracted and non-contracted providers to the Summits, which will be held at locations around the State. Topics will typically include local issues affecting care, such as community patterns of access, housing issues, availability and use of transportation services, and how LHC can assist in improving member outcomes.

Strategy Set 6: Ensuring Effectiveness through Quality Management

We will ensure that our strategies are effectively influencing member behavior and use of services through our continuous quality improvement processes. Our Quality Assessment and Performance Improvement (QAPI) Program includes sophisticated data management, analysis, and reporting capabilities that facilitate performance monitoring and support effective service utilization. Our QAPI program is enhanced by the regular exchange of ideas among Centene's corporate Quality Improvement meetings and teleconferences with all 11 of our affiliate health plans and our behavioral health affiliate and subcontractor, Cenpatico Behavioral Health, LLC. LHC's QAPI Program also ensures development and use of high quality, accurate, and culturally competent member education materials. Our QAPI Program will detect inappropriate use of health services through the following monitoring:

- Acute and chronic care management
- Coordination with behavioral health care
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Drug utilization review
- Utilization Management
- Assessing the quality and appropriateness of care furnished to members with special health care needs

We also may detect problems in accessing appropriate services and the need for further member or provider education or interventions through monitoring of:

- Member grievances and member satisfaction survey results
- PCP changes
- Provider after-hours telephone accessibility
- Provider appointment availability
- Provider complaints and satisfaction survey results
- Provider network adequacy and capacity
- Provider credentialing and recredentialing
- Information received from the Member Advisory Council and Community and Provider Advisory Committees

Our Quality Assessment and Performance Improvement Committee (QAPIC) will oversee all QAPI activities and is empowered to direct operational and educational changes to influence member health behaviors. QAPIC will include senior management and at least three network providers and report directly to the Board of Directors.

Successful Outcomes. The following additional examples show the success of Centene's multi-pronged, innovative, and locally tailored approaches for educating and motivating members to adopt healthy lifestyles and use health resources appropriately.

Texas Cardiovascular Disease Success. Our Texas affiliate health plan meaningfully improved the cardiovascular health status of its members. They assessed improvement by generating a comparative control group using propensity scoring that matched each Disease Management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age, and gender. They excluded from the analysis program participants for whom no match was available. The results were very promising. For example, the incidence of heart-failure-related ED visits for members in the Disease

Management program was almost 30% lower than a matched non-participant, and the inpatient admission rate for acute myocardial infarction-related conditions was almost 81% lower for participants in the Disease Management Program.

Centene Well Child Success. Centene has improved the rate of well child visits and preventive screening and services such as immunizations. For example, from 2008 to 2009 Centene plans improved performance on the HEDIS measure Well Child Visits in the First 15 Months of Life (6 or more visits) by a statistically significant 7.6% (to 54.8%).

Successful Screening Rates for Women. Centene has improved breast cancer screening rates in Medicaid and other low-income women with initiatives similar to those described above for LHC. For example, our Wisconsin affiliate health plan achieved increases of 25% – 40% in screening rates for women 40-49 years and 50-59 years between 2006 and 2007. For 2008 to 2009 Centene plans improved performance on the HEDIS measure Breast Cancer Screening by a statistically significant 9.0% (to 47.0%).

Centene also has been successful in improving cervical cancer screening rates in Medicaid and other low-income women with similar initiatives. For example, our Georgia affiliate health plan increased their screening rate by 20% (to 65.5%) between 2007 and 2009. Our Arizona affiliate increased their screening rate in an SSI population by 36.5% (to 51.3%) between 2009 and 2010.

Question F.7

Leveraging Community Based
Organizations to Support Health and
Wellness of Members

F.7 Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.

Community Collaboration and Investment

Louisiana Healthcare Connections (LHC) was formed because our parent Centene understood that success in delivering high quality coordinated care means engaging with traditional Medicaid/CHIP providers, locating in communities where members live and work, and collaborating with community-based organizations to serve the whole individual in the context of family and informal supports. *We are creating not only a formal network of providers and programs to support member health and wellness, but we also are actively investing in community relationships to coordinate care and well being, including for non-covered services such as help with home safety.* Our sustained community involvement and investment are major factors in building member confidence and proficiency in adopting new ways to seek health care and establish healthy lifestyle behaviors.

Since 2008. Our community involvement in Louisiana began in September 2008 when Hurricane Gustav hit, and Centene helped DHH by contacting hospitals, nursing homes and other providers to determine whether and to what extent they were operational and serving low-income Louisianans. We also flew in mental health professionals and toiletries to help the thousands of people who were relocated to shelters. Our involvement formed the basis of continuing relationships with many entities, including the Louisiana Hospital Association and the Louisiana Rural Hospital Coalition.

FQHC Owner-Partners. Our involvement in Louisiana communities also deepened through our

“The LPCA contacted potential partners and selected Centene Corporation because of their proven experience and track record in working with FQHCs and Medicaid populations. Louisiana Healthcare Connections is the synthesis of this partnership and is poised to improve the health outcomes of Louisiana’s residents and its Commonwealth Foundation ranking of 49th in the country. I further believe improved health will result from Louisiana Healthcare Connections’ advanced disease and case management system—built on a strong health education and outreach foundation.”—Eric Taylor, Immediate Past-President, Louisiana Primary Care Association, and CEO, SWLA Center for Health Services

collaboration with FQHC staff who were operating hurricane shelters. Our involvement grew because we agreed with the vision of the late Eric Taylor, former CEO of Southwest Louisiana Center for Health Services in Lake Charles, who insisted that for coordinated care to work; traditional Medicaid/CHIP providers had to have ownership and authority in directing Medicaid/CHIP program operations.

The 19 FQHC owner-partners in LHC provide not only historical and extensive knowledge of patient needs, but also vibrant links through their board members, staff, and activities to significant organizations in the community, such as primary and secondary schools, Head Start programs, dominant employers, churches, specialty care practices, hospitals, and parish health units. In particular, LHC will draw on the considerable local knowledge, experience, and resources of partner FQHC executives such as CEOs Roderick Campbell in New Iberia, Rhonda Litt in Baton Rouge, and William White in Shreveport, CFO William Brent in Franklin and Monroe, all of whom serve on the LHC Board of Directors, and Dr. Gary Wiltz, FQHC CEO in Franklin and LHC Chief Medical Officer, who will co-chair our Quality Assessment and Performance Improvement Committee along with our full-time Chief Medical Director.

FQHCs are community-based, nonprofit organizations that must provide comprehensive primary health care services to all, be located in or serve a high need community, and be governed by a community board of directors, 51% of whom must be clinic users. FQHCs also offer support services such as health

education, translation, and transportation.⁷ Because “the community participates in the direction of the clinic and other decisions related to operations,”⁸ FQHCs are widely viewed as community-based organizations.

Thus as part of LHC, the 19 owner-partner FQHCs will have three roles. First, they will be owner-partners of LHC. Second, the FQHCs will participate in the LHC provider network and provide health care services to members. Third, they will continue their functions as community-based organizations that provide outreach, health education, and other services specific to the communities they serve. In this response we address how LHC will leverage the health education and outreach services of FQHCs and other community-based groups for the benefit of LHC members.

LHC and Centene Community Involvement – Proven Approaches. Community collaboration and investment are trademarks of Centene health plans. In Louisiana, LHC will follow Centene’s proven community engagement and feedback approaches and continuously identify local and regional needs and the organizations and individuals that are actively addressing them. Each state is unique, and our approaches to supporting member health and wellness will be tailored for Louisiana with help from a range of advisors in the communities we serve, for example, our owner-partner FQHCs, our locally-hired staff, and the LHC Community Advisory Committee, Member Advisory Council, and Provider Advisory Committee.

On March 18, 2011 at the Institute of Women and Ethnic Studies, LHC held the initial Community Advisory Committee (CAC) meeting with Louisiana experts on women’s and children’s health to identify priority issues and discuss how we may collaborate with participants and their organizations should LHC be selected as a CCN-P. March meeting participants are identified below. Our CAC will help coordinate our partnership with local community organizations and facilitate development and sharing of best practices across GSAs.

Participants at LHC’s Inaugural Community Advisory Committee		
Ragan Collins, MPH <i>Institute of Women and Ethnic Studies</i>	Lisa Richardson, PhD <i>Institute of Women and Ethnic Studies</i>	Rheneisha M. Robertson, MPH <i>Institute of Women and Ethnic Studies</i>
Mary Joseph <i>Children’s Defense Fund</i>	Christine S. Brennan, PhD, RN, FNP-BC <i>Nurse Family Partnership</i>	Julie Mickelberry <i>Planned Parenthood Gulf Coast</i>
Mary Troupe <i>MS Coalition for Citizens with Disabilities/Magnolia Health Plan Advocacy Committee</i>		LHC Representatives: Sonya Armstrong; Joia Crear Perry, MD, <i>Consultant</i> ; Sarah Kracke, <i>Consultant</i>

We will establish a **Member Advisory Council in each GSA we serve**. Each Council will include local and regional community-based organizations. To the extent practicable and relative to where committee members reside, LHC plans to hold some Member Advisory Council meetings in different towns within each GSA to increase opportunities for local input. For example, in GSA A, locations may include New

⁷ National Conference of State Legislatures: Community Health Centers: A Guide for State Policymakers (web-based site; updated April 2011). <http://www.ncsl.org/default.aspx?tabid=22346>. Federally Qualified Health Centers (FQHCs) are also known as Community Health Centers.

⁸ Texas Association of Community Health Centers, web site. <http://www.tachc.org/programs-services/community-development/benefits-of-fqhc-designation1>

Orleans, Slidell, and Franklinton; in GSA B, Baton Rouge, Lafayette, and Thibodaux; and in GSA C, Lake Charles, Alexandria, Shreveport, and Monroe.

So that our Case Management staff – both Case Managers and MemberConnections outreach staff – are personally familiar with local community resources, issues, and activities, we will **co-locate our Integrated Care Teams (ICT) staff in selected FQHCs, other high-volume provider practices, or a regional location**, just as we do now in Mississippi. Our Manager of MemberConnections (Connections) will serve as **our grassroots community liaison**. Among other things, the Manager will work with community-based organizations that provide non-covered services to members to establish streamlined processes for member referral.

As our Centene health plan affiliates do, LHC will create and maintain a **written and online Resource Guide to State and local community-based services for each GSA** in which we serve members. The Guide will include information on non-covered services and programs and how to access them. Our Connections outreach staff, who will be hired from the communities where they work, will be invaluable in identifying non-covered services needed by members and helping them access these services.

Community Investment and Participation. Centene additionally supports the ability of local organizations to provide health and wellness services with targeted foundation grants. The **Centene Charitable Foundation** provides charitable support for community initiatives that improve the quality of life and health in communities in which Centene Corporation does business. Grants and sponsorships are based in part on recommendations from Centene affiliate health plans. The **Centene Foundation for Quality Healthcare** was established to improve the quality, access, effectiveness, and value of healthcare for low-income families and individuals, and focuses on activities that identify and address core causes of unequal access and treatment. Building on Centene’s long-standing commitment to deliver health care at the local level, the Foundation develops partnerships to implement innovative approaches to promote healthy communities. For example, in 2009, the Foundation funded a \$50,000 grant to the **Louisiana Primary Care Association** to help support their initiative for member FQHCs to become NCQA-recognized as **Patient-Centered Medical Homes**.

With our FQHC owner-partners, in 2010 LHC **sponsored more than a dozen FQHC health fairs** in the Parishes of Assumption, Beauregard, Iberia, Livingston, Orleans, Ouachita, St. James, St. John, St. Martin, St. Mary, Tangipahoa, Terrebonne, and Vermilion, among others. In addition, LHC has **initiated community partnerships** in Louisiana as a sponsor of and participant in the following:

- Rural Hospital Coalition Annual Conference
- CityBusiness Healthcare Heroes Awards Luncheon
- Louisiana Medical Association Conference
- National Organization of Black Elected Legislative Women Annual Conference
- Louisiana Hospital Association Annual Meeting
- “Eat For Life” Fresh Foods Health Fair held June 10th at the Kingsley House Courtyard

In short, LHC is well on the way in developing the community relationships that facilitate leveraging community resources to support the health and wellness of our members and providing services that respect and reflect Louisiana’s cultural diversity and uniqueness.

In the following narrative we will address how LHC will leverage community resources to:

- Reduce Obesity and Improve Nutrition
- Address Chronic Disease
- Promote Well Baby, Well Child, and Well Family Health
- Promote Behavioral Health
- Help Create Healthy and Safe Communities

We will comply with all DHH notification and approval requirements prior to sponsoring or attending any community activities.

Leveraging Community Resources to Reduce Obesity and Improve Nutrition

Obesity and poor nutrition compromise the effectiveness of health care services and members' quality of life. According to the 2010 Trust for America's Health Report, Louisiana ranks 5th highest among states in obesity issues. Other studies show that about 65% of Louisiana adults and about 48% of school-aged children are overweight or obese. LHC will collaborate with community-based groups to prevent and reduce obesity and improve nutrition and fitness.

Healthy Choices Program. Our Healthy Choices Program focuses on removing barriers to members' ability to make healthy food choices. By increasing access to healthy foods and educating members on the choices they make every day, we can improve health outcomes and members' quality of life.

Fresh Food Health Fairs. *On June 10, LHC sponsored and helped organize Eat For Life*, a fresh foods health fair promoting healthy foods and healthy eating habits and diet at the Kingsley House Courtyard in New Orleans. LHC initiated Eat for Life and implemented it with the following nine partners: Kingsley House, Marketumbrella.org, Prevention Research Center at Tulane University, Crescent City Farmer's Market, William Carey University, LSU Agricultural Center for Smart Choices, Radio Disney, Parkway Partners, and Just Kids Dental. We offered a box garden; various lesson, activity, display and tasting stations where participants could learn about health eating; and take-home reminders such as clip magnets, vegetable seed packets, and a grocery tote bags. The more than 400 attendees included summer camp participants (ages 5-12), Head Start enrollees, seniors with varying degrees of ability/mobility, and parents and other adults.

Healthy Cooking Demonstrations. In addition to sponsoring fresh foods health fairs, LHC will also offer Healthy Cooking Demonstrations and will hire a professional nutritionist, cook or chef to do a one-hour healthy eating and food preparation class at a local community center, church, or other facility equipped to provide such a class. The class will focus on healthy eating and choosing nutritious foods while on a tight budget. The use of food stamps and the WIC program will also be highlighted in the presentation. The classes will be held once a month on a Saturday or Sunday in each GSA in a major city (a city with more than 100,000 people).

Healthy Choices Community Collaborators. We plan to continue our participation in and sponsorship of events such as Eat for Life around the State. For example, we will contact 4-H Clubs, including those that are participating in Louisiana's 4-H Seeds of Service School Garden program. Seeds of Service is an interdisciplinary approach designed to educate youth while they serve their community; 10 schools in high poverty areas already are maintaining school gardens. For New Orleans and its 10-parish region, we plan to contact:

- Edible Schoolyard New Orleans
- Head Start Center at Columbia Parc, to develop a community garden
- Tulane's Grow Dat youth farm program
- Share Our Strength's Cooking Matters, which holds cooking classes with expert volunteer teachers on good nutrition and low-cost ingredients
- Marketumbrella.org, the parent of three Crescent City Farmers Markets that outreach to low-income individuals and families
- The new Tulane/Fertel Clinic
- Food Policy Advisory Council

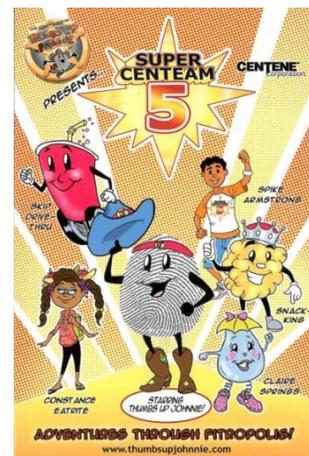
We will also evaluate our potential role in the initiatives to increase sustainable, local food access that are expected from the legislative Louisiana Sustainable Local Food Policy Council. The Council is conducting a year-long study of a variety of farm-to-table and farm-to-school/institution efforts, and is expected to submit recommendations in January 2012.

Healthy Eating and Fitness for Children – Preventing Child Obesity.

Healthy Schools/ Adopt-a-School Program. LHC will partner with local schools to provide health outreach and education for children and supplies and supports for School Nurses. We will identify communities with high needs, schools that have School Based Health Clinics or who are partnering with our network providers, and offer our programs to promote healthy eating and exercise.

The Kids' Club. Our Kids' Club Program educates child members on a variety of health topics, with a significant focus on obesity prevention. LHC will provide schools help with educational and motivational outreach and materials such as newsletters, contests (such as healthy recipe contests), and other events.

“Thumbs Up Johnnie” Program. This program uses a child-friendly, nationally recognized character to help educate children about fighting obesity and preventing the spread of germs through proper hand washing. Thumbs Up Johnnie himself will visit selected schools as part of the “Adopt-a-School” program to read, “Super CENTEAM 5, The Adventures of Thumbs Up Johnnie.” Students receive copies of the book, character-themed bracelets, and take part in pre/post presentation tests about healthy eating habits and proper hand washing.



Teachers who turn in their post-presentation tests receive a set of Thumbs Up Johnnie books for their classroom and bookmarks for their students. We also donate a set of autographed books to that school's library. A review of our test outcomes shows that after testing over 5,000 children in our adopted schools we see an impressive increase in correct answers to our standard five questions. The average is 33.6% increase in correct answers with a range from 73% to 13% depending on the question.

Fitness Awareness Brownie Badge. Centene and affiliated health plans partnered with the Girl Scouts to create a fitness awareness program that leads to Girl Scouts earning a badge. For specified activities, the Troop Leader conducts a pre- and post-program quiz to identify participants' knowledge level.

Other Collaborations. In addition, we will approach youth-oriented organizations such as the YMCA, YWCA, and Big Brothers/Big Sisters to identify opportunities to collaborate on educational events and programs on healthy lifestyle and exercise. Case Managers also may refer members to these groups for activities and mentoring.

Leveraging Community Resources to Address Chronic Disease

LHC will provide Chronic Care and Disease Management Programs (Disease Management) for members with asthma, diabetes, congestive heart failure, hypertension, and low back pain. Using information from historical claims, health assessments and our Centelligence Foresight predictive modeling runs, we will identify members who can benefit from Case and Disease Management.

Community-Based Education, Assistance, and Peer Support. In addition to providing extensive one-on-one member education, Case Managers link members to community resources that reinforce condition-specific messages and offer members the chance to interact with peers facing similar challenges. For example, a number of our owner-partner FQHCs, in preparing to become a PCMH, evaluated their data to identify their top diagnoses. The FQHCs then implemented education and health management support programs as described below.

FQHC Name	Prominent Diagnoses	Health Management Support Programs
EXCELth, Inc.	HypertensionHTN, Hyperlipidemia, Diabetes, Obesity, and Asthma	Dietician;, Diabetes Education, and Weight Management mgmt Sessions
Iberia Comprehensive Community Health Center	Diabetes, Hypertension, and Hyperlipidemia	Dietician, Personal Trainer, and contract Certified Diabetes Educator. Sponsors 12-week Diabetes Academy twice a year
Innis Community Health Center	High Obesity, Hypertension, Cardiovascular Disease, and Diabetes rates	Dietician Dietician at New Roads location
Outpatient Medical Center	Hypertension and Diabetes	Nutritionist
Primary Health Services Center	Health Education, Nutritional Education, Diabetic Classes, Asthma Seminars Diabetes, Hypertension, Asthma, and Obesity	Health Education including Nutritional Education, Diabetes Classes, and Asthma SeminarsDiabetes, Hypertension, Asthma, Obesity,
Rapides Primary Care Center	Chronic Diseases and Childhood Obesity	Nutritionist provides ed classes to patients with/ chronic diseases. Provides education to obese children kids through Wii Fit Program.
Southwest LA Primary Health Care Center	Diabetes, HypertensionHTN, Depression and Other Mood Disorders, Anxiety Disorders, Obesity, ADHD, Dental, and HIV	Diabetic Awareness Classes, Annual Health Fair, Cardio Zydeco Workout, and Support Group
Teche Action Board, Inc.	Diabetes, Hypertension, Stroke, Heart Disease, Obesity, Tobacco Use, and Alcohol Use	Nutritionist and Certified Diabetes Educator.cert diabetic educator

Other partners that we will work with in a similar manner, and whose services relate to members with disabilities, include:

- **Families Helping Families** – This family-directed resource center for individuals with disabilities includes 10 independent resource centers throughout Louisiana. Peer communication and peer-based learning are powerful tools for helping our members with disabilities move beyond their physical and cognitive limitations to take charge of their lives and take initiative in their self care.
- **Louisiana Assistive Technology Access Network (LATAN)** – This statewide non-profit connects people with disabilities and older persons with assistive technology that enables independence in employment, school, and community living. LHC will provide to members assistive technology that constitutes covered durable medical equipment (DME). Members’ independence and quality of life may also be significantly enhanced through assistive technology that does not qualify as DME. Our

Case Managers will be familiar with options for access non-covered assistive technology via LATAN and other disability resources.

Puffletown Program for Children with Asthma. LHC will collaborate with School Nurses and School Based Health Clinics to provide education on asthma. Children with asthma will enjoy and benefit from the Thumbs-Up Johnnie comic book, *Puffletown: Helping You Understand Asthma One Breath at a Time*. The 20-page comic book offers a colorful and complete explanation of how children can identify and rate the severity of their symptoms, identify their triggers, and how they can explain their condition to their friends. LHC staff will use the book to engage children and motivate self care, and work with School Nurses to identify health issues on which LHC can provide assistance or resources.

Diabetes Collaborations. We describe below three diabetes collaborations that address adults, children, and neighborhood health issues.

ABCD Program for People with or At-Risk for Diabetes. The FQHC EXCELth has worked with the Morehouse School of Medicine, Louisiana Primary Care Association and others to implement the ABCD Program, an educational program that promotes healthy lifestyles for individuals with diabetes or at risk for diabetes. (ABCD stands for **A**1c, **B**lood pressure, **C**holesterol, and **D**epression.) ABCD is a cardiovascular risk factor reduction intervention that uses Community Health Workers (similar to LHC Connections outreach staff) to provide community-based education about diabetes risk factors and how to prevent or keep diabetes under control. LHC will assess options with EXCELth, Louisiana Primary Care Association, and other local organizations for expanding the ABCD Program, which can play an important role in reducing diabetes related health disparities among African American members.

Healthy Neighborhoods-New Orleans. LHC may target certain programs for grants and sponsorships, such as the Neighborhood Partnership Network in the Greater New Orleans area. For example, the Louisiana Public Health Institute's Healthy Neighborhoods-New Orleans initiative gives qualifying neighborhood associations or organizations a chance to participate in a program focused on improving neighborhood health and specifically factors involved in Type 2 diabetes. Chosen neighborhoods will receive technical assistance and financial support to create community action plans that address poor nutrition, being overweight, and lack of physical activity – the risk factors for Type 2 diabetes.

Summer Camp for Children with Diabetes. LHC will evaluate sponsoring children age 6 - 4 to participate in the ADA Louisiana Lions' Camp Victory, on Lake Vernon near Leesville. At the camp, children develop diabetes self-management skills, gain confidence, and learn from other children with diabetes. Each summer more than 50 health care providers, dietitians, and social workers volunteer their time to ensure campers' medical needs are met. The camp also provides parents much needed respite because they know their child is well cared for.

Additional Community-Based Organizations. LHC will also work with the local chapters of national groups that our affiliate health plans regularly work with such as the American Diabetes Association, American Heart Association, American Lung Association, and YWCA's/YMCAs. We will partner with organizations such as these, for example, on outreach and educational events and placing information in their and our newsletters.

Recognized Expertise. Centene's success in collaborating with communities to improve member health was recognized in June 2011 at the Communities in Action National Asthma Forum by the U.S. Environmental Protection Agency (EPA), which recognized Centene and its Disease Management specialty affiliate, Nurtur, along with two other organizations, with the National Environmental Leadership Award. Criteria for winning the award included implementing strategies to deliver positive health outcomes, forming strong community collaborations, exhibiting committed leadership, and conducting effective environmental interventions to improve the lives of people with asthma.

EPA Administrator Lisa P. Jackson said, "I'm proud to work alongside environmental stewards like those we're recognizing with this year's National Environmental Leadership Award. These organizations are true examples of communities in action working together to find collaborative and innovative ways to safeguard the health of all Americans."

Leveraging Community Resources to Promote Well Baby, Well Child, and Well Family Health

Perinatal and Well-Child Education and Services. Community involvement will expand LHC's ability to help reduce Louisiana's high incidence of low birth weight, preterm births, teen births, and infant, child and adolescent mortality.

Community Education Events. For Start Smart, well child care, and healthy lifestyle community education programs and events, we will leverage the current relationships of our FQHC partners with local Women, Infants, and Children (WIC) programs, Head Start, and School Based Health Clinics (some of which are run by an FQHC), either to jointly schedule and participate in events, or to coordinate scheduling, with the goal of maximizing outreach. For example, with Head Start and school events, we will help provide immunizations and examinations that children need prior to program or school enrollment. Community events such as these also help identify unenrolled children who may be Medicaid or LaCHIP-eligible and provide a chance to educate parents on the benefits of a medical home and follow-through on EPSDT screenings.

In addition, we will collaborate with state and regional organizations and programs that target women who are pregnant or in their child-bearing years, such as Louisiana's Maternal and Child Health Coalition, Louisiana Breastfeeding Coalition, the statewide Maternal and Child Health Initiative of the Louisiana Public Health Institute, and local programs of national groups such as the March of Dimes. We also will collaborate with the National Healthy Start Association, which has funded programs in Baton Rouge, Bossier City, Lafayette, and New Orleans. The National Healthy Start Association promotes development of community-based maternal and child health programs, particularly those addressing infant mortality, low birth weight, and racial disparities in perinatal outcomes.

LHC will identify targeted education opportunities with community groups other than social service agencies and advocacy groups as well. For example, our Texas affiliate is collaborating with African-American service sororities such as Zeta Phi Beta and Delta Sigma Theta and other partners to improve prenatal care for African-American Medicaid members.

We will support the work of the Children's Cabinet Advisory Board, which advises the Governor's Children's Cabinet on issues affecting children

Mobile Outreach and Service Delivery. We will seek to collaborate with mobile health care programs such as the March of Dimes Mom and Baby Mobile Health Center, which is now providing services via the Southwest Louisiana Area Health Education Center. Mobile projects offer opportunities to provide not only health education, but also needed direct medical services, including in rural areas. The original mission of the mobile health unit program was to provide prenatal and well infant care to women and children in hurricane affected regions of Louisiana. During prenatal visits at the Mobile Health Center in

Regions 4 and 5, we will encourage members to complete a Notification of Pregnancy and select a PCP for their baby.

Boys & Girls Club Memberships. To assist youth members in developing social and leadership skills, LHC will sponsor the membership fee to the local Boys and Girls Club in major metropolitan areas such as New Orleans, Greater Baton Rouge, Lafayette, Lake Charles, Alexandria, Shreveport/Monroe and Ruston.

Recognized Expertise. Centene's expertise in community collaboration on healthy baby education is demonstrated by the award won by our Ohio affiliate, the Community Outreach/Partnerships Pinnacle Award for the program, "Community Care: A Partnership in Nurturing," and a Healthcare Programs Pinnacle Award for its 17P Program.

Participation in Local Events Such as Health Fairs. In many communities, social service agencies, advocacy groups, and some schools and churches have local, periodic events such as health fairs that LHC will seek to participate in and support. One example of a local annual health fair is the upcoming July 23 event cosponsored by St. Paul the Apostle Catholic Church and Star Hill Church in Baton Rouge. Local agencies and groups know their audience and how to reach them. We will gladly support established, successful local events whenever possible, and are always open to new ideas, developed in collaboration with community leaders.

We will prioritize locations and events based on the geographic distribution of our membership and their identified needs in order to maximize the impact of State dollars on the health status of our members. Like our affiliates, we will take a hands-on approach: Connections outreach staff assist in event planning and will participate, in person, throughout the events themselves. We also provide financial support such as paying for event promotion and signage, but our primary goal is to connect personally with members and their families and peers in their own community settings.

LHC will bring significant value to local health fairs and related events through our Connections outreach staff and use of our well-tested and award-winning health education materials, such as Start Smart for Your Baby and healthy eating and fitness materials. Our Marketing and Communications Manager also may provide support in planning first-time and large scale events, such as the recent Eat for Life event at the Kingsley House Courtyard. At larger events, staff in addition to Connections staff may participate at the event.

Healthy Congregations. This program, modeled on the successful program of our Indiana affiliate, focuses on a range of health issues in partnership with faith-based organizations. Healthy Congregation sessions will occur after scheduled church services and offer attendees preventive screening services such as blood pressure checks, body mass index (BMI) measurement, and glucose or cholesterol testing. They will include health education and cooking demonstrations, such as cooking healthy on a budget. Depending on the nature of each church and its congregation (or organization and its focus), health education may target prenatal and well-child care, or chronic care or other issues affecting adults with disabilities, including issues for caregivers. Our Healthy Congregation events are free and attendees will have the opportunity to win health-related giveaways and talk with LHC staff.

Some targeted regions and churches include:

North/Northeast Louisiana

- North Point Community Church, Bossier City
- North Arkansas Street Church of Christ, Springhill
- North Shreveport Baptist Church, Shreveport
- North Crossings Church, Monroe

South/Southeast Louisiana

- Star Hill Baptist Church, Baton Rouge
- Zion Travelers Baptist Church, New Roads

- Isabel Baptist Church, Bogalusa
- St. Francis Chapel, New Roads
- Grand Isle United Methodist Church, Galliano
- Our Lady of Assumption Church, Carencro
- Mary Queen of Vietnam Church; nhà thờ Maria Nữ-vương Việt-Nam, New Orleans

Southwest Louisiana

- Faith-Bible Church of Lake Charles, Lake Charles
- Morning Star Seventh-Day Adventist Church, Lafayette

Children of Migrant Farm Workers. Ensuring continuity of EPSDT services for children of migrant farm workers throughout their temporary migration to other states is a long recognized challenge for State Medicaid Programs. Multipractice Clinic, a bilingual FQHC in Independence, is the only federally funded and designated Migrant Health Center in Louisiana and has provided care to migrant and seasonal farm workers and their children in five parishes for 13 years. In addition to primary and specialty care, the Clinic provides Migrant Education Training, which is a vocational training program to assist migrant farm workers in qualifying for better-paying jobs. Our Texas affiliate health plan recently earned the highest incentive awarded by the State Medicaid Agency for improving services for children of migrant workers (17% greater than the next highest amount awarded), based on the effectiveness of its provider training and initiatives with community groups. LHC will build on the expertise and success of the Multipractice Clinic and our Texas affiliate and collaborate with community organizations in rural areas to ensure continuity of EPSDT services for children and support for migrant worker families in Louisiana.

HealthCorps. LHC will coordinate outreach and education initiatives with the Community HealthCorps Program, which Louisiana FQHCs established in 2005. HealthCorps is the largest health-focused, national AmeriCorps program that promotes health care for America's underserved, while developing tomorrow's health care workforce. HealthCorps members serve racially and culturally diverse rural and urban communities, as well as migrant farm worker, homeless and public housing populations. They conduct grassroots outreach and health education and also work to establish formal and informal collaborations with other organizations. LHC looks forward to a productive working relationship with HealthCorps, given their affiliation with Louisiana FQHCs and the goals we clearly share.

Tobacco Cessation. LHC will fully support DHH's Tobacco Control Program and publicize through our community education activities the resources available through the program, such as the Louisiana Tobacco Quitline and the Freedom from Smoking Clinics, which provide information on topics such as recovery symptoms, weight control, stress management/relaxation techniques and how to calm the urge to smoke, as well as materials to help develop a quit plan.

Community Transformation Grant. LHC will support DHH efforts to request Community Transformation Grant funding for Capacity Building. We will continue our dialogue with DHH to determine how we may best assist and collaborate. For example, we could participate in a Community Transformation Coalition with community-based groups and help with program development, community assessments, and data gathering, and provide support through our Connections staff for engaging local communities.

Organizations Providing Direct Medical Services. Although most community-based organizations with which LHC will collaborate provide social services or conduct outreach and education, rather than providing direct medical services, some groups also provide certain medical services. In working with community-based organizations that provide direct medical services, our primary goal is to establish with them coordination mechanisms that support members' understanding and use of their medical home and prevent duplication of services. One example for children is requiring our providers to report immunization data to the Louisiana Immunization Network for Kids (LINKS) administered by the Louisiana Office of Public Health (OPH). Our Clinical Portal for providers will help PCPs track immunizations and other preventive services provided outside the medical home, when external interfaces

are available for obtaining data on such services. In addition, some community-based organizations may provide or arrange for certain medical or dental services for adults that are not Medicaid covered services.

We will coordinate our public health related activities with OPH. LHC will implement public health coordination mechanisms and operational protocols reflecting Louisiana public health priorities, as agreed among OPH, the Bureau of Health Services Financing (Medicaid), and LHC, such as through memoranda of understanding. LHC will offer a contract to OPH for provision of personal health services offered within the parish health units (for example, for immunizations, STD testing, and family planning services).

Leveraging Community Resources to Promote Behavioral Health

One of the initial recommendations of our Community Advisory Council was the need to address behavioral health issues in Louisiana. We expect to quickly develop meaningful relationships and dialogue with other key behavioral health organizations by leveraging the expertise and community involvement of our affiliated FQHCs, most of which provide behavioral health services. For example, Jefferson Community Health Care Centers, in Region 1, are working with the Jefferson Parish Human Services Authority to integrate primary care into its system that currently serves persons with severe and persistent mental illness and substance use disorders. In addition, some of our owner-partner FQHC staff now participate on the SAMHSA/ CMS/HRSA Task Force that recently was formed to improve integration of behavioral health and primary care. We also will collaborate with organizations that advocate for people with mental illness and substance use disorders such as Mental Health America of Louisiana and NAMI Louisiana.

We will explore innovative ways to partner with or leverage local behavioral health resources, similar to what our affiliate plans have done in other states, for example:

- Our Mississippi affiliate has partnered with Kids of Katrina Art Camp.
- Our Georgia affiliate has partnered with the Child Abuse Prevention Coalition.
- Our Ohio affiliate collaborated with an FQHC in Akron to provide primary care for members with primary behavioral health disorders and a carved out behavioral health benefit. The program was named a Pinnacle award-winning best practice by the Ohio Association of Health Plans.

Leveraging Community Resources to Help Create Healthy and Safe Communities

Healthy Homes. Helping members improve unsafe, unhealthy living conditions is critical to supporting their efforts to adopt healthy habits and self care, and often requires the involvement of several community organizations. Our Healthy Homes initiative will assist individuals who live in low-income or public housing to identify and address health hazards in the home, particularly lead. We will initiate outreach to local law enforcement and housing authorities to improve conditions for members who live in high-crime or unsafe neighborhoods. LHC will partner with entities such as parish health units, Councils on Aging, and community organizations that provide important non-health care services, such as assistance with housing, utilities and rent. LHC will collaborate, for example, with community organizations that can help remove old carpeting or other materials that contribute to breathing difficulty for members with asthma or chronic obstructive pulmonary disease.

Areas that may benefit from LHC's Healthy Homes Program include neighborhoods such as Iberville/Treme, St. Thomas, Central City, St. Bernard, Desire, Dillard, and the Calliope Project in the New Orleans area; East Brookstown, Melrose Place East, Scotlandville, Zion City, and Monticello in Baton Rouge; and Allendale, MLK, Cedar Grove and Mooretown in Shreveport.

Orleans Neighborhood Health Implementation Plan. With funding from the Kresge Foundation, the Louisiana Public Health Institute is convening a wide variety of partners including public health specialists, architectural and urban planners, neighborhood outreach organizations, civic and nonprofit organizations, and health care providers to create a one-stop resource for data, tools and guidance to

support and inform neighborhood and community health improvement efforts across New Orleans. The planning and development phase of this project is currently referred to as the Orleans Neighborhood Health Implementation Plan, which will ultimately lead into a new program that will address an array of community health issues and indicators including built environment, nutrition, active lifestyles, health services, economic development, education and more. LHC will assess how best to participate in and leverage the resources developed by this project to benefit members and the housing and communities in which they live.

Question F.8

Moral and Religious Objections

F.8 Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g. birth control) to members who are entitled to such services.

Louisiana Healthcare Connections has no moral or religious objections to providing any services covered under Section §6 of the RFP.