

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 G: Provider Network (Section § 7 of RFP)	200		
G-1	A, B, and C	<p>G.1 Provide a listing of the proposed provider network using the List of Required In-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.</p> <p>Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.</p> <p>The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)</p> <ol style="list-style-type: none"> 1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc. 2. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable. 3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code 	50		

		<p>4. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.</p> <p>5. New Patient - Indicate whether or not the provider is accepting new patients.</p> <p>6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate > 13.</p> <p>7. If PCP - the number of potential linkages.</p> <p>8. If LOI or contract executed.</p> <p>9. Designate if Significant Traditional Provider.</p> <p>10. GEO coding for this location.</p>			
G-2	A, B, and C	<p>G.2 Describe how you will provide tertiary care providers including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.</p>	15		

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G-5	A, B, and C	G.3 Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.	10		
G-10	A, B, and C	G.4 The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs.	20		
G-13	A, B, and C	G.5 Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services: <ul style="list-style-type: none"> o Primary Care o Specialty Care o Prenatal Care Services o Hospital, including Rural Hospital o Office of Public Health o Private Duty Nursing/Home Health Services; o FQHC o School Based Health Clinic 	5		

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G-18	A, B, and C	G.6 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.	20	
G-22	A, B, and C	G.7 Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.	10	
G-26	A, B, and C	G.8 Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.	5	
G-33	A, B, and C	G.9 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following: <ul style="list-style-type: none"> o Compliance with cost sharing requirements; o Compliance with medical record documentation standards; o Compliance with conflict of interest requirements; o Compliance with lobbying requirements; o Compliance with disclosure requirements; and o Compliance with marketing requirements. 	5	

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G-40	A, B, and C	G.10 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.	5		
G-41	A, B, and C	G.11 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.	10		
G-45	A, B, and C	G.12 Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.	15		
G-52	A, B, and C	<p>G.13 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.</p> <ul style="list-style-type: none"> ○ Submit sample quality profile reports used by you, or proposed for future use (identify which). ○ Describe the rationale for selecting the performance measures presented in the sample profile reports. ○ Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports. 	15		

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G-56	A, B, and C	G.14 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.	10		
G-61	A, B, and C	G.15 Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum: <ul style="list-style-type: none"> • What administrative functions, if any, you will subcontract to another entity; • How you will determine the appropriate mode of transportation (other than fixed route) for a member; • Your proposed approach to covering fixed route transportation; • How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions; • How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring; • Your approach to initial and ongoing driver training; • How you will ensure that drivers meet initial and ongoing driver standards; • How your call center will comply with the requirements specific to NEMT calls; and • Your NEMT quality assurance program (excluding vehicle inspection). 	5		

Question G.1

Proposed Provider Network Listing and GeoAccess Maps

Section G: Provider Network

G.1 Provide a listing of the proposed provider network using the List of Required In-Network and Allowable Out-of-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.

The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)

1. **Practitioner Last Name, First Name and Title** - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.
2. **Practice Name/Provider Name** - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.
3. **Business Location Address** - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code
4. **Provider Type and Specialty Code** - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.
5. **New Patient** - Indicate whether or not the provider is accepting new patients.
6. **Age Restriction** - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate > 13.
7. **If PCP - the number of potential linkages.**
8. **If LOI or contract executed.**
9. **Designate if Significant Traditional Provider.**
10. **GEO coding for this location.**

Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.

LHC's proposed provider network is depicted in the lists and GeoAccess maps provided in **Attachment G.1-A Provider Listing and G.1-B GeoAccess Maps**. As of June 27th, LHC has received signed agreements or LOIs from over 9,000 provider locations. In cases where detailed information was not supplied by the provider (such as age limits), we applied default formulas based on Medicaid managed care industry standards in order to capture all data and to ensure submission of the most complete and accurate records herein. It is understood that the number of potential linkages is not required for submission at this time. This data will be furnished for the readiness review. We continually monitor network development activities and measure results and we will continue to develop provider networks in all GSAs to ensure access to health care for all members.

Question G.2
Tertiary Care Providers

G.2 Describe how you will provide tertiary care providers including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

Developing a Tertiary Care Network throughout Louisiana

By familiarizing ourselves with the geographic layout, critical care hot spots and provider referral patterns within Louisiana, LHC is developing a substantial tertiary care provider network throughout the State.

Network Development Methodology for Tertiary Care. LHC's success developing contractual relationships with Louisiana's tertiary care provider system specifically for the new CCN Medicaid managed care model is enhanced by our partnership with LPC&A. LPC&A consists of 19 FQHCs which represents nearly 70 clinical sites staffed with a range of primary care providers that have been serving Louisiana's communities and coordinating access to tertiary care providers for many years. LPC&A member FQHCs serve many of the State's more rural areas where access to specialized care has presented accessibility, patient referral, and care coordination challenges in the past. In addition to leveraging our partnership with LPC&A, we have collected data from other resources such as

- the American Hospital Directory (ADH);
- state Medicaid volume reports; and
- other published listings of current rates paid to medical facilities in the State.

To identify trauma and burn centers within the State, we collected data that has helped us to identify and qualify those facilities and providers within the State that truly deliver tertiary care as defined by DHH. We also surveyed PCP and specialist providers outside of LPC&A to gain an understanding of the provider community's tertiary care referral patterns and preferences. Armed with this information, our teams of provider recruiters and contract negotiators have been building a solid foundation of tertiary care providers in each GSA. Their contracting efforts will continue until adequate networks have been developed in every GSA.

Building on Sub-Specialty Relationships. We will draw upon existing relationships between physicians and tertiary care providers in the State to determine the most important tertiary care providers for our network. These physician-hospital relationships are well established and will contribute to our success in finalizing network agreements or obtaining Letters of Intent (LOIs) with key providers. **Pediatric Sub-Specialty Care Services.** LHC's pediatric sub-specialty care will be delivered through in-network hospitals and other clinics and facilities that offer clinical services through a dedicated clinical department for Pediatric Care, and through in-network board-certified pediatric sub-specialists.

Rehabilitation Provider Network. The LHC provider network includes rehabilitation facilities and providers delivering "step-down" levels of care for those no longer in need of more intensive and costly inpatient hospital services, but who still require medical supervision as they recuperate.

Out-of-State Tertiary Care Network. As noted in RFP paragraphs 7.7.5.3 and 7.7.5.4, LHC is able to contract with and refer to out-of-state hospitals in the trade area, especially when no hospitals meet network requirements, when no hospitals exist within the parish (in particular, parishes near state borders for which an out-of-state tertiary care provider is more accessible than one in-state), or when a contract cannot be negotiated. When appropriate, LHC will utilize tertiary care facilities outside Louisiana. This may occur in instances of bed shortage in the State or for cases where the member's care is best provided by highly specialized centers of excellence.

Methods for Ensuring Access to Tertiary Services

LHC will ensure all members have access to tertiary hospital services regardless of the facilities' participation status. We assess not only geographical proximity but also which facility offers the most

appropriate services and expertise for treating the member's condition, the most appropriate mode of transportation, and any potential geographic barriers. Types of tertiary care services that Medicaid members historically have utilized include high risk prenatal care, cardiac care, neurology, oncology, psychiatry and orthopedic surgery.

Out-Of-Network Protocols. Whenever possible, LHC will transition out-of-network care to a participating network provider to ensure initial and ongoing quality of care and services provided. If a participating provider is not available to meet the service needs of the patient, we will authorize and coordinate services with an appropriate out-of-network provider. For tertiary care providers who elect not to join LHC's provider network, we will make arrangements that allow our members to access services on an out-of-network basis. These arrangements with out-of-network providers include established rates, written agreements (may include single case agreements), *patient transfer procedures* and *care review/care coordination processes to which the tertiary care provider must comply for LHC members.*

Emergent or Urgent Scenarios. For members in an emergency or urgent situation whose clinical condition warrants transfer to an appropriate tertiary care facility, the member may be stabilized at the local facility and then transported to a selected tertiary care facility. Means of transportation are matched to the patient's medical requirements. For example, patients being transferred to tertiary care facilities at some distance and with ongoing urgent medical conditions may be transported by medically supported airlift or ambulance.

Transfer Protocols. Whenever possible, LHC will strive to transition out-of-network care to in-network care. Transfer protocols are developed and coordinated by the patient's assigned LHC Case Manager. The assigned Case Manager (CM) will contact the out-of-network provider to assist them with the care coordination process and explain the requirements to ensure development of an appropriate care plan and transfer plan. Additionally, LHC posts our list of preauthorization requirements, Provider Manual and additional provider resources to LHC's public web portal, which enables out-of-network providers to review their compliance requirements while delivering specialized care to an LHC member. The assigned CM remains involved with the case until the transfer has occurred and patient care is fully directed by the member's PCP.

Out of Network Authorization Protocols. LHC recognizes that there are circumstances in which we will need to authorize medical care provided by out of network providers. When we find the best tertiary care alternative is an out-of-network provider, LHC Utilization Management (UM) and Integrated Care Teams (ICT) work closely with these providers to coordinate care using many of the same methods we use to coordinate care with contracted providers. Indeed, *out-of-network providers are held to the same policies and procedures as our contracted providers*, particularly regarding quality of care. The out-of-network provider is required to coordinate with the patient's PCP or a designated specialist that normally manages the patient's care. When an out-of-network provider calls LHC's Preauthorization Department, the Preauthorization Nurse (PA-Nurse) will educate the provider on services requiring authorization (all out-of-network services, except emergency and post-stabilization services, require prior-authorization), timelines for submitting authorization requests, how to submit authorizations, timeframes for notice of action, and the requirement for concurrent review (where applicable). The PA-Nurse will coordinate efforts with LHC's Provider Relations and Network Development departments to establish *a single case agreement* outlining preauthorization requirements, claims submission process, appeals process and rate of reimbursement. For some members, such as those with cognitive conditions, LHC Case Managers will arrange for a qualified caregiver or family member to accompany the member to the hospital and stay in a nearby hotel during the inpatient stay. In these cases, we pay the caregiver's transportation, lodging, and meals. Before a member's stay is concluded, Case Managers conduct thorough and extensive discharge planning to ensure a safe transition and reduce any complications to mitigate the risk of readmission to inpatient care.

Out-of-Network Authorizations: New Members. When new members are identified as being in an active, ongoing course of treatment, are within the third trimester of pregnancy or are currently receiving

inpatient care from an out-of-network provider, LHC will authorize continuation of medically necessary services, including home health services and medical supplies, for up to 90 days or through the postpartum period. If the out-of-network provider contacts LHC for authorization of the services, the PA-Nurse will determine medical necessity and authorize the services for up to 90 days. The caller will be transferred to the Integrated Care Team (ICT), who will work with the out-of-network provider to establish a transition plan that includes considerations about whether the LHC network includes a provider of the service or services being delivered. If medical equipment or supplies were ordered prior to the member's effective date with LHC, the TC will follow up with the provider to ensure that equipment or supplies are received without delay, and that there is no gap in service. For members who are hospitalized at the time of enrollment with LHC, the designated Care Coordinator will immediately begin concurrent review for medical necessity and work with the ICT to begin discharge planning for the member, identifying available in-network providers.

Out-Of-Network Authorizations: Established Members. When an established member is identified as needing out-of-network tertiary care services, the services will be authorized as per standard protocols. The ICT designee will reach out to the existing provider to communicate existing care plans for the member and incorporate any additional transfer-related requirements as identified by the out-of-network provider. The out-of-network provider will be informed of the member's PCP and requirement to coordinate with the established PCP. If we learn of established members who are receiving care from out-of-network providers, an assigned Case Manager (CM) from the ICT will proactively contact the out-of-network provider to gather information and authorize services, if indicated. The CM will request applicable clinical information regarding the member's condition and diagnosis, the course and estimated length of treatment, and any care plans in place for the patient. All information collected and authorizations provided are documented in LHC's integrated clinical documentation system, for incorporation into LHC's plan of care records for the member. When out-of-network services can safely be transitioned to an LHC network provider, the CM will contact the member and work with the member's PCP (or medical home) to identify an appropriate network provider who will assume the member's care. LHC's CM will work closely with members to ensure that *cultural concerns* as well as health and functional needs are addressed in transferring care to a participating provider. The CM will coordinate transition of medical records and plan of care from the out-of-network provider to the participating provider.

Out-of-Network Authorizations: Prenatal Care. For pregnant members at high risk for complications, particularly those with serious mental illness or developmental disabilities, LHC's policy emphasizes the critical importance of consistent prenatal and postnatal care for the health of women and their children. We will go beyond the minimum contract requirements to provide out-of-network prenatal and postpartum care to members in their third trimester of pregnancy, offering pregnant members the option to remain with their current out-of-network OB/GYN for the duration of their pregnancy and postpartum visit regardless of their current gestational age. Additionally, we do not require medical necessity review for prenatal or postpartum care. Members identified during the Health Risk Screening (HRS) or other means will be referred to a RN-CM on our Maternal Health Integrated Care Team (ICT) for follow-up and management. Any pregnant member is eligible to participate in our Start Smart for Your Baby pregnancy program which provides education and clinical support to members and is available regardless of whether or not the OB/GYN is a contracted provider.

Question G.3

Potential Loss of Hospital and/or
Providers in Certain Specialty

G.3 Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.

Successfully Handling Transition

LHC's parent company, Centene, has a proven track record of successfully maintaining high rates of provider satisfaction and managing dedicated, stable provider networks in all 11 states in which Centene currently manages state sponsored Managed Care programs. By applying the successful approaches to managing robust and stable provider networks in other markets and supporting LHC with effective administrative resources, Centene and LHC do not expect to experience substantial, rapid network losses that could upset the balance of care provided to members in Louisiana. Nonetheless, our network management process includes methodologies and proactive risk management procedures to address "worst-case" scenarios wherein access to care is threatened due to unforeseen natural disasters, power-outages, or impending network gaps.

Proactive Risk Management. A proactive step to reducing the impact of provider terminations or closures is advance notice gleaned from information gained from Provider Relations Specialists and other LHC staff members along with any "heads up" information that might be shared by providers or other outside sources. LHC is able to leverage LPC&A's stake in our organization to increase our odds of learning at an early stage what provider network change/loss risks are evident in Louisiana.

Additionally, LHC executive managers are cognizant of media reports that address financial, legal, or quality concerns that could compromise the viability of a network hospital or group practice. To ensure compliance with the State requirements and contract standards, and to protect the health and safety of members, LHC may increase the frequency of routine monitoring, conduct onsite visits, and, when needed, institute corrective action plans for facilities with a known viability problem or potential for closure. All of these activities are conducted in order to avert the loss of providers that threaten the continuity of care for our members.

"while some patients were initially nervous, the transition has gone smoothly"

"Grady patients will have little trouble finding new care"

Dr. David Williams
Executive Director, Southside Medical
Center

Excerpts from The Atlanta Journal-Constitution, January 6, 2010, Some Grady

Provider Notification Requirements. A cornerstone of how we manage network disruption risks involves notification clauses that are an integral and essential part of all LHC provider contracts. LHC requires immediate written notification if the facility or group practice becomes aware of financial solvency issues with the potential to result in the facility or practice's closure or suspension of activity. Physician contracts require terminating physicians or group practices to coordinate with LHC Case Managers, Member Services, and Provider Service Representatives to smoothly transition members to participating network providers. Hospitals are also required to notify LHC immediately of pending licensure/certification issues that could result in closure. Facilities and group practices must provide 90-day advance written notification of termination with or without cause. Notably, LHC's hospital contracts include language that requires the facility to cooperate and assist with the transfer of any inpatients to a contracted facility upon the termination of the network contract, regardless of the party terminating the agreement. Consequently, LHC has a contractually-established timeframe of approximately three months to respond to the prospect of planned provider terminations from our network. During this time, LHC personnel perform the following actions to gain a clear understanding of the impact this change will have upon the provider community as a whole and to minimize access to care issues for members:

- Conduct a network adequacy analysis to identify alternate providers with the capacity to assume additional caseloads resulting from the termination/closure
- Gather claims data, including claims look back, to find hidden potentials and further quantify providers and patients that will be impacted by the change
- Notify the State through our Compliance Officer of the impending network change, and discuss any role the State can play in mitigating risks to CCN operations and quality of care delivered
- Attempt to negotiate terms that would retain the provider in the network, if appropriate, or to extend the contract end date, if needed

These practices are far reaching and apply to any subcontractor in our network. Subcontractor agreements (such as those for non-emergency medical transportation and behavioral health services) contain the same or similar language and contractual obligations found in our standard provider agreements. If an agreement with a subcontractor is terminated, LHC will enact the same transition planning procedures outlined herein.

Transition Planning. Our primary goal in any provider termination scenario is *continuity of care for our members*. The comprehensive transition plans we develop and implement in collaboration with clinicians and health care administrators ensure little to no disruption, from the member's perspective, in terms of the quality and continuity of care patients are receiving during the transition phase. Policies and processes are in place to ensure that no member goes without continued care in the event of a hospital or group practice closure. LHC maintains a formal *Transition of Care Policy* that consists of two key components:

1. Development of a Continuity of Care Plan
2. Identification of alternate providers needed to assume additional caseloads

Activities involved in developing a Continuity of Care Transition Plan.

- Establishing a collaborative working relationship with the terminating hospital or medical group in order to identify and address all aspects of the transition plan and to agree on the roles, responsibilities, timelines and expectations of all parties involved in the transition process;
- Hosting regularly scheduled meetings (at least monthly) with key stakeholders, including DHH, facilities, clinicians and ancillary staff to communicate progress and address any ongoing concerns or challenges;
- Identifying specific members who potentially could or are currently receiving care at the facility or medical group
 - Current members identified through claims data from facility and physicians
 - Potential members identified through claims "look back" query
 - Members further identified based on diagnosis and treatments codes for certain types of tertiary or ongoing care (such as high risk pregnancy or chemotherapy)
- Establishing a dedicated toll-free telephone number specifically for the members and providers effected by the termination/closure (when warranted)
- Managing media exposure
- Assigning dedicated Integrated Care Team staff to assist each member and their provider throughout the transition process
- Auto-assigning members when terminating provider is a PCP
- Notifying each effected member of the impending departure of their provider from the network
 - Notification done via telephone outreach and letter

- Assistance with transition process from Member Services staff
- Response to member questions and concerns
- Instructions regarding next steps if member was reassigned a PCP and wants to select a different PCP
- Making provision for non-emergency transportation services to ease the transition experience for members
- Honoring prior authorizations given prior to the contract termination date
- Extending prior authorization beyond the contract termination date if member is an inpatient or in the midst of a course of treatment (such as high-risk pregnancy or chemotherapy treatments in progress)

These activities are conducted by dedicated teams including Member Services staff, MemberConnections Representatives (on the ground member outreach), and Case Managers who reach out to all members receiving ongoing courses of treatment from a facility or group practice that is closing and assist them in becoming established with the right facility and specialists to meet their needs. In this process, we also ensure that the safety, rights, and wishes of members are protected. LHC's procedures to address network changes that negatively affect member access focus first on members' immediate needs and second on recruiting new providers. In the case of a hospital or large group practice closure or termination, we assign a lead Case Manager from the Integrated Care Team to work with the departing facility or practice and coordinate services between our internal departments.

Activities Involved in Identifying Alternate Providers.

- Identifying participating providers (hospitals and physicians) who can assume additional caseloads
- Ensuring alternate providers are capable of handling additional members without compromising quality of medical care or access to care
- Identifying out-of-network providers needed to assume additional caseloads resulting from the termination/closure
 - seek their participation in the network
 - provisionally credential any providers in the process of contracting with LHC in order to transition members in a timely manner and reduce or eliminate network or care gaps
- Communicating with alternate providers regarding transition plans, volume of members to be transitioned and offering assistance throughout the transition process
- Assisting with the transfer of appropriate medical records to the member's new provider
- Relaxing prior authorization timelines and rules for out-of-network providers when the member's treatment plan could be compromised by transition to an in-network provider

LHC will also attempt to facilitate the transfer of medical records from the closing practice to the new PCPs.

An example of the effectiveness of our processes: In Texas, following immediate termination of a PCP, we reassigned 3,500 members to new PCPs within 48 hours and sent notification letters to all 3,500 members letting them know they could also choose a new PCP if they preferred.

Notification to State. As above, if LHC receives notification from a network hospital or large medical practice that it will be ceasing operations or terminating its contract, our Compliance Officer will notify the State within one business day and submit our assessment of how the loss of that provider will impact our ability to furnish covered services to our members and our plans for ensuring that care is not interrupted.

Handling Unanticipated Permanent Closure. In the event a hospital or large group practice is unexpectedly required to cease operations, for example due to a licensing or regulatory issue, or in the event that LHC is required to immediately terminate a provider contract for cause, such as imminent risk of harm to patient health or fraud, LHC will work as quickly as possible to ensure that members are transferred to a safe environment or to new specialists that are able to meet all of the member's care needs. Although hospitals and provider groups are contractually obligated to assist in this coordination, LHC realizes that an entity that is being shut down for regulatory reasons or terminated for cause may be uncooperative. LHC is prepared to manage transitions of care without their assistance.

To the extent possible, the steps outlined for closures and terminations with advance notice will also be followed in the case of sudden shut-downs, including identification of affected members, State notification, determination of member needs, family/support notification, and location and coordination of transfer to a new facility, specialist, or PCP. Should LHC experience initial challenges in identifying appropriate providers, we are prepared to enter into single case agreements with out-of-network providers to furnish care in the interim, while appropriate network providers are identified. Similarly, sudden closures or terminations trigger an evaluation of the network to determine if additional contracts with facilities and physicians are needed.

Unanticipated Closure Due to Natural Disaster. When a hospital is forced to evacuate its patients as the result of a fire, power failure, or a natural disaster such as the flooding that occurred in the Gulf Coast and City of New Orleans from hurricane Katrina, everyone involved must act quickly with little time for planning. Mindful that a range of rapid support can help avert tragedy, LHC takes a proactive approach in verifying that our other contracted hospitals are prepared to address the situation and ready to be involved in assisting with the actual transfer of our members to a safe environment until the temporary situation is resolved.

Disaster Recovery Plan. LHC will contractually require network hospitals to maintain a written *contingency/disaster plan* that outlines their plans for patient evacuation and ensures the safety of their patients. Their plan should include, at a minimum:

- guidelines for determining when evacuation is necessary;
- their plans to address a means of staff deployment and notification, particularly when a disaster strikes outside of normal business hours when staffing tends to be lower;
- available comparable facilities for transfer locally in the event that only their facility is impacted (as in the case of a fire) and outside the surrounding area in the event that the entire region is impacted (as in the case of hurricane Katrina);
- arrangements for transportation of their residents from their hospital to the alternate facility, including alternative plans in the event that their primary resource, such as a local emergency or non-emergent transportation vendor, is unavailable or unable to meet all of their transportation needs;
- transfer of critical medical information to accompany the member to the new location;
- family/support notification and health plan notification of the disaster and the member's new location, as soon as is reasonable, once member safety has been secured, but no more than 24 hours after the decision to evacuate; and
- plans for member return once the crisis has been resolved and it is safe and medically appropriate for them to return.

This plan is reviewed by LHC's Provider Relations Specialist at the time of initial contracting to verify that all of the requirements are met. In the event that a facility's plan falls short of expectations, the Provider Service Representative offers to meet with the facility's administration to explain the apparent deficiency, present our rationale for the requirement, and assist in developing the additional components.

LHC Intervention. Upon learning that a network hospital or clinic has been struck by a natural disaster, LHC's Case Manager will immediately contact the hospital or clinic administrator to assess the situation

and offer assistance. The type and amount of assistance will vary depending on the situation, but examples include making calls to family/supports to notify them of the incident and the hospitalized member's new location, arranging additional transportation, locating additional facilities for transfer, assisting in coordinating redeployment of the affected facility's staff to provide care in the temporary setting, and providing medical information of displaced members should the facility be unable to access medical records as a result of the disaster. LHC may also work with the American Red Cross to assist members in need of continued acute care in the disrupted environment. If patients are relocated to another facility, LHC Care Managers will evaluate the new care settings, verify the members are receiving all of their medically necessary services, and offer assistance in addressing any other unmet needs. LHC network development staff will work with any non-participating facilities where our members have been temporarily placed to obtain single case agreements as described above. LHC Provider Relations Specialists will work with the affected facility to determine the amount of time members will be displaced and offering assistance in restoring the facility's operations.

Question G.4
Significant Traditional Providers

G.4 The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs.

STPs Integral to Continuity of Care

Our commitment to enrolling Significant Traditional Providers (STPs) in our network is most evident in the business structure of Louisiana Healthcare Connections (LHC), which is a joint venture partnership between our parent company Centene Corporation (Centene) and Louisiana Partnership for Choice & Access (LPC&A), a group of 19 FQHCs that are STPs located throughout Louisiana. We recognize that STPs have been and will continue to be a strong component of the health care delivery system for Louisiana's Medicaid program. Because STPs have served a leading role in the delivery of health care services to Medicaid members, LHC considers them as a priority for participation in our provider networks in every GSA. We also recognize that relationships between STPs and members have been built, trust has been gained, and members have grown accustomed to seeking care from STPs. Therefore, we are doing whatever we can to continue to nurture the patient-provider relationship of trust that has been forged within the STP community.

By building a strong network of STPs, we will ensure a smooth transition for both members and providers to Louisiana's medical delivery system in 2012.

How LHC Encourages STP Network Participation

For 27 years, LHC's parent company, Centene, has successfully built provider networks consisting of STPs in other markets. Centene health plans have extensive experience working with FQHCs as providers, committee

members, and partners in innovation. Safety Net Providers currently serving on Centene health plan Boards include:

- Superior HealthPlan (Texas): Jose Camacho, Executive Director, Texas Association of Community Health Centers, Ernesto Gomez, Chief Executive Officer, El Centro Del Barrio, Dr. Elena Marin, Executive Director, Su Clinica Samiliar
- Managed Health Services (Wisconsin): Dr. Tito Izard, Chief Medical Officer, Milwaukee Health Services
- Managed Health Services (Indiana): Beth Wrobel, Chief Executive Officer, HealthLinc Community Health Center
- Absolute Total Care (South Carolina): George Newby, Chief Executive Officer Regensis Healthcare
- Peach State Health Plan (Georgia): Dr. Michael Brooks, Chief Operating Officer, West End Medical Center, Dr. David Williams, Chief Executive Officer, Southside Medical Center, Duane Kauvka, Georgia Primary Health Care Association
- Magnolia Health Plan (Mississippi): Dr. Jasmine Chapman, Chief Executive Officer, Jackson-Hinds Comprehensive Health Center

“Louisiana Healthcare Connections was the first plan to reach out and meet with our group. After several meetings, it was clear that LHC truly believes in and supports provider partnerships. At Pediatric Group of Acadiana, we have a significant Medicaid population and believe working closely with LHC represents the best opportunity to deliver the highest quality of care and best outcomes for our patients.”

Jibrán Atwi, MD
President, Pediatric Group of Acadiana

LHC will have four of their nine board members represented by FQHC executives; CEOs Roderick Campbell in New Iberia, Rhonda Litt in Baton Rouge, and William White in Shreveport, CFO William Brent in Franklin and Monroe, all serve on the LHC Board of Directors, and Dr. Gary Wiltz, FQHC CEO in Franklin and LHC Chief Medical Officer, will co-chair our Quality Assessment and Performance Improvement Committee.

Centene health plans contract with 233 FQHCs in eleven states and in Georgia, Massachusetts, Mississippi and Wisconsin we have contracted with 100% of the FQHCs in the service areas where we operate.

In Louisiana, LHC has already deployed the strategies and methodologies that have been highly successful with STP providers in other states, and we are achieving excellent results. In **Attachment G.4: STP Listing**, we furnish a listing of providers in our network (using the same list in our response to Question G.1) by GSA and provider type that are STPs. The positive feedback we are receiving from the STPs is supported by the number of LOIs and agreements we have collected to date. Our approach to building the STP provider network in Louisiana is identical to our standard network development plan. For example, reimbursement rates, claims processing timelines, credentialing standards, provider obligations and requirements, contract documents and other policies and procedures are the same for those STP and non-STP providers we endeavor to include in our provider networks. The key difference is our hierarchy of inviting potential providers to join the LHC provider network wherein the STPs have been the first group of providers to be invited, followed by non-STP Medicaid providers, then providers who have not traditionally served Medicaid members in Louisiana.

Data Collection. We started the STP network development process in 2010 by identifying the key STPs in each GSA. We continually update and validate our inventory of network prospects as we learn of provider additions, changes or terminations from the Louisiana Medicaid program. We have collected an extensive list of STPs using the most recent CommunityCARE 2.0 Linkage Report, the Louisiana Medicaid Provider SFY 2010 Top Percent of Claims posted 06.02.2011, the Louisiana Medicaid Provider SFY 2010 Total Payments posted 06.02.2011 and the Louisiana Medicaid Provider Listing provided on the DHH web site. In addition to surveying our joint venture partner, LPC&A (a consortium of FQHCs that are also STPs), we have surveyed members of local medical associations (such as the Louisiana Medical Association and the New Orleans Medical Association) regarding high volume Medicaid providers serving their region. During our ongoing network development process, we have been mindful of DHH's definition of STPs as "Those Medicaid enrolled providers that provided the top eighty percent (80%) of Medicaid services for the CCN-eligible population in the base year of 2010." Collecting the data and consolidating it into viable leads has been invaluable to our successful network development efforts in Louisiana – particularly for STPs. Our goal is to invite all STPs, especially PCPs, Specialist Physicians, OB/GYNs and Hospitals, to participate in our provider network.

Face-To-Face Meetings. Using the STP data we collected, we have scheduled and conducted on site meetings with most of the STPs. At these meetings, our teams of Provider Recruiters, who are currently based in specific geographic zones throughout Louisiana, have

1. introduced the LHC program,
2. distributed contract paperwork and pertinent program information; and
3. described how LHC's role as a CCN-P and their role as an STP intertwine in serving the state of Louisiana and its Medicaid members.

As each LHC Provider Recruiter reaches out to the STPs, they are building relationships and expressing gratitude to each STP for their longtime dedication to Louisiana's Medicaid members, and acknowledging the STPs' ongoing commitment to providing quality health care services to their patients

-- who are Medicaid members -- as the state of Louisiana transitions to the CCM model. In nearly every meeting, we find the STPs want to participate with LHC in order to continue providing services to their patients and to learn what they can do to ensure the transition process goes as smoothly and easily as possible for all involved. Significant Traditional Provider, **Pediatric Group of Acadiana**, along with its 18 providers who serve over 20,000 Medicaid beneficiaries **signed only one LOI – choosing LHC** because we developed a partnership proposal that rewards the group for delivering the right care, at the right time in the right setting while delivering the highest quality of care and improving health care outcomes.

Continued Outreach. The Provider Recruiters will continue to contact those STPs that did not complete the contract paperwork (application and LOI) at the initial face-to-face meeting. These follow up contacts are being done via telephone, e-mail or in person and occur weekly. The Provider Recruiters use these follow up contacts as relationship building opportunities and to

1. remind each individual STP of our desire to include them in the LHC network,
2. answer any additional questions they might have, and
3. arrange to collect the contract paperwork.

As an added level of service, the Provider Recruiters will assist the STPs in completing the contract documents in order to facilitate timely and accurate completion of the necessary paperwork.

Excellent Results

We are pleased with our progress to date, which shows **1,845 STPs have already signed an LOI or agreement with LHC**. Some STPs have opted to delay signing an LOI with any entity prior to the contract awards, but have told us they will work with us once we get an award. In our experience with start up markets like Louisiana, we have found this to be a common practice and have had no issue after being awarded the bid in finalizing contracts with these providers. In addition, our joint venture partner, LPC&A, consists largely of FQHCs that are STPs. Our provider based organization has long standing, solid relationships with other STPs throughout Louisiana. We have leveraged those relationships to encourage widespread participation by STPs in our network in every GSA. Please refer to **Attachment G.4 STP Listing** for a complete list of the Significant Traditional Providers that have signed LOIs with us to date.

Question G.5

Network Development Observations and Challenges

G.5 Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services:

- Primary Care
- Specialty Care
- Prenatal Care Services
- Hospital, including Rural Hospital
- Office of Public Health
- Private Duty Nursing/Home Health Services;
- FQHC
- School Based Health Clinic

Building on a Proven Model of Success

Louisiana Healthcare Connections success in building a solid provider network in Louisiana is a direct result of the expertise and resources that our parent company, Centene, brings to our partnership. It is important to note that Centene stands out from the crowd as the only company, since its inception, whose lines of business are dedicated solely to Medicaid managed care. Unlike other organizations that build provider networks from their existing commercial or Medicare networks, Centene and its affiliated health plans build provider networks from the ground up that are organically grown and nurtured. While LHC is new to Louisiana, the Medicaid experience and dedication we bring is a continuance of Centene’s more than 27 years of managed care experience *exclusively for Medicaid programs*. Long before the CCN-P RFP was released in Louisiana, our 13 dedicated provider recruiters were “in the field” educating Louisiana healthcare providers on LHC and the CCN-P initiative. To date, provider recruiters have met face-to-face with nearly **2,000 provider organizations** touching well over **10,000 individual practitioners** in the State. In addition, we supplemented our field team with a team of 10 “tele-recruiters” who spent months calling on providers in the state, gathering information, and educating them on LHC and the CCN-P program. **Many providers told us that LHC was the only plan that came to meet with them face-to-face.** We believe our hands on approach to building a network “from scratch” is the most effective way to rouse provider interest in participating with the program and to gain their unwavering commitment and willingness to serve Medicaid members. This “ground up” network building approach has been successfully deployed in LHC’s affiliate health plans in Georgia and Mississippi in a FFS to Managed Care environment, where today we have robust networks of approximately 15,000 providers and 140 hospitals (Georgia) and more than 3,000 providers and 90 hospitals (Mississippi) statewide. Centene’s legacy and its comprehensive and stable provider networks are testimonies to the success of its approach to developing provider networks in new markets.

LHC Observations Regarding Network Development in Louisiana. With Centene’s guidance and experience in developing provider networks to serve Medicaid populations in 11 other states, LHC has been able to quickly identify and address the challenges, objections and obstacles presented by providers and other key stakeholders whenever a new program or change is introduced. In Louisiana, the resistance to network participation and the objections voiced by providers are similar to those encountered in the early stages of developing networks with other Medicaid programs Centene manages. Examples of common remarks the Louisiana medical community has shared with LHC regarding their hesitation to join our network are:

1. “I want to *wait and see* which plan is awarded a contract, then I’ll join that plan”

2. “My colleagues and I are *holding out* because we are affiliated with a competing (potential) CCN-P”
3. “I am concerned about the impact this new program will have on my *reimbursement*”
4. “I will sign a Letter of Intent (LOI) only if the *hospital* to which I admit *signs* with your plan”
5. “I *don’t want* to join any program related to *Medicaid*”

Skepticism and uncertainty are inherent among potential providers in a program of this magnitude. All in all, these challenges are typical in the early stages of any network development process. While in the midst of encountering challenges and obstacles, we remain diligent in our efforts to engage providers and continue to “stay the course” by responding to potential providers in a collaborative, respectful and professional way that is ultimately conducive to forging strong network participation and stability long after the early stages of development and implementation have passed.

GSA A Network Challenges

Geographically, GSA A is by far the smallest of the GSAs. However, it has the highest concentration of CommunityCare members. This scenario lends itself to increased access to care needs, which means a greater number of providers will be needed to ensure access to care for all. Also, GSA A is slated to be the first to “go live” on January 1, 2012, which in itself presents a challenge due to the least amount of time to develop this network compared to GSA B and GSA C. Another unique challenge for GSA A is that it borders another state (Mississippi) where CCN-Ps will need to develop an adjunct provider network for those living nearest the border state. Several non-rural acute care hospital administrators have hesitation to sign an LOI with us or any of the other bidding CCN-Ps due to uncertainty with the current Medicaid system and in the State’s cuts in reimbursement. In GSA A, the two major hospital systems serving Medicaid populations, LSU Health System (LSU) and Children’s Hospital of New Orleans (Children’s), which are made up of several medical centers (including Touro Infirmary) and a variety of employed physicians are not signing LOIs because they are either submitting their own CCN-P bid (Children’s) or affiliated with another CCN-P bidder (LSU). Contract negotiators representing these hospital systems and their employed physicians have stated that after the awards are made, they will enter into contract discussions with the selected plans. LSU has gone one step further by stating to LHC’s CEO that they intend to contract with LHC if we are awarded a CCN-P contract.

Primary Care. The overall development phase of our primary care provider (PCP) network in GSA A has gone smoothly with minimal provider resistance; we have encountered some challenges in Southeast Plaquemines Parish and Southeast St. Bernard Parish due to the sparse population and availability of physicians in addition to the absence of acute care hospitals in the area. In spite of these challenges, we anticipate meeting or exceeding network adequacy requirements for this GSA.

Specialty Care. We are experiencing some resistance from specialist providers in GSA A. However, our network has been bolstered somewhat with the addition of an LOI from TPAC (as further explained in GSA B). We have also encountered some challenges in southeast Plaquemines Parish and southeast St. Bernard parish due to the sparse population and availability of specialists. A chief sentiment among the specialist providers who have not yet joined the LHC network is simply a general lack of urgency to complete the paperwork. Additionally, we cannot collect LOIs from specialists who are employed by or affiliated with LSU (except for those associated with TPAC) and Children’s at this time. Nevertheless, at this point we are satisfied with the number of LOIs we have obtained from specialty care providers in GSA A. In our experience with other markets, we find that specialty care providers are often slower to join the network, but will eventually join when the “go live” date nears or they want to keep their referral streams open for PCPs.

Prenatal Care Services. We are very satisfied with the network of prenatal care providers we have developed in GSA A and have no remarkable concerns or challenges for this provider type. We continue

to engage medical facilities and ancillary providers for network participation in support of the referral streams prenatal care providers have for their patients.

Hospitals. In GSA A, our greatest network development challenge has been to secure LOIs with hospitals that are connected with LSU and Children’s. Executives at the highest levels within these hospital systems have stated that after the awards are made, they will enter into contract discussions with the selected plans. Despite these challenges, we are one of only two bidders that succeeded in securing a *contract* with Tulane Medical Center as well as an LOI with Tulane University Medical Group. Having a contract with Tulane gives our members access to most tertiary care services in GSA A. The LHC hospital LOI network meets the State’s network adequacy requirements in GSA A.

Office of Public Health. LHC has secured a LOI from the Office of Public Health location and does not anticipate any contracting challenges.

Private Duty Nursing/Home Health Services. LHC does not anticipate any contracting challenges with home health or private duty nursing providers in GSA A.

FQHC. Due to the partnership between LHC’s parent company, Centene, and LPC&A (Louisiana Partnership for Choice & Access), we have secured a comprehensive network of FQHCs for GSA A. Five of the seven FQHCs in GSA A are part of LPC&A. We have secured an LOI with another FQHC as well. Therefore, six of the seven FQHCs, comprising 22 clinic sites, are part of our network in GSA A. Whenever possible, we are leveraging our relationship with LPC&A to further develop our specialist provider and hospital networks in GSA A.

School Based Health Clinics (SBHCs). SBHCs have shown great interest in joining the LHC provider network. We have received LOIs from 63 of 72 OPH certified SBHC locations we identified and are confident we will have a comprehensive SBHC network in GSA A.

GSA B Network Challenges

GSA B presents a few unique challenges. It contains the highest number of CommunityCare members and two of the three regions in GSA B have the highest Medicaid expenditures in the State. Also, a number of hospitals and physicians in GSA B are part of two large hospital systems: Franciscan Missionaries of Our Lady Health System (FMOLHS), and LSU. Both LSU and FMOLHS have formed an alliance with a CCN-P bidder and are refraining from signing LOIs with any other competing CCN-P bidders at this time. Over the past year, we have developed a strong rapport with FMOLHS and LSU and both organizations have stated that they intend to sign contracts with LHC after the awards are made. In the meantime, we continue to build relationships and develop our networks to be ready for the “go live” date and we have succeeded in securing an LOI with The Physician Alliance Corporation (TPAC), which is a large medical *group that includes primary care and specialist providers who are also part of LSU or FMOLHS*. All providers who are affiliated with TPAC assign power of attorney, thus giving TPAC the ability to bind them to its agreements. In addition, TPAC is at the forefront of using remote diagnosis software to advance tele-medicine services in the State of Louisiana. LHC embraces these efforts and intends to work closely with TPAC in our relationship to further these developments. LHC will leverage the TPAC relationship as we continue building provider networks. Finally, in order to maximize our network adequacy and access in GSA B, LHC has entered into an agreement with Verity Health Network (Verity), which represents 11 hospitals (including Baton Rouge General Hospital and Lafayette General Medical Center) and over 1,300 individual providers. These hospitals are, for the most part, only participating through Verity making this agreement an important component of our overall network strategy in GSA B.

Primary Care. We have encountered challenges in developing the network in the very southern portions of Vermillion Parish and Terrebonne Parish due to the sparse population and lack of physicians. In other parts of GSA B, we are experiencing little resistance from primary care providers and are confident of network adequacy for PCPs in those areas.

Specialty Care. We are experiencing little resistance from specialist providers in this GSA, and we are confident that our specialty care network will meet the State’s network adequacy requirements. Aside from the challenges associated with securing LOIs from LSU and FMOLHS specialists, challenges with specialists are similar to those in other GSAs and are centered on skepticism about the program actually happening, unwillingness to complete paperwork from every bidder when only a few will be selected, and concern about reimbursement. In our experience with other markets, we find that specialty care providers are often slower to join the network, but eventually will join as the “go live” date nears or they want to keep their referral streams open for PCPs.

Prenatal Care Services. LHC has developed an extensive OB/GYN provider network in GSA B and is one of only three plans to secure an LOI from Women’s Hospital in Baton Rouge. We also believe we are one of only two plans to sign a contract with Women’s and Children’s Hospital (HCA) in Lafayette as well as their employed physician group. We are very satisfied with the network of prenatal care providers we have developed in GSA B and have no remarkable concerns or challenges for this provider type.

Hospitals. In GSA B, our greatest network development challenge has been to secure LOIs with those hospitals and physicians affiliated with FMOLHS and LSU. Both organizations have stated that after the awards are made, they will enter into contract negotiations with the selected plans. In addition, there are no acute care hospitals in Vermillion Parish further south than Abbeville General and Abrom Kaplan – both of which signed LOIs with LHC. In Terrebonne Parish there are three hospitals; 1) Physicians Medical Center does very little with Medicaid and has indicated they may not participate in any CCN’s after the contract awards; 2) Leonard J. Chabert Medical Center is an LSU facility and as indicated previously will not sign with competing bidders and 3) Terrebonne General made the decision at the board level not to sign LOIs with any CCN entities. We have met directly with the CFO of Terrebonne General and have strong reason to believe they will participate with LHC in the CCN program once contract awards are announced. In the meantime, with the HCA and Verity agreements we have secured, our hospital network in GSA B is coming together nicely and meets the state’s network adequacy requirements.

Office of Public Health. LHC has secured a LOI with the Office of Public Health and does not anticipate any contracting challenges.

Private Duty Nursing/Home Health Services. LHC does not anticipate any contracting challenges with home health or private duty nursing providers in GSA B.

FQHC. We are very satisfied with the network of FQHCs for GSA B and have secured LOIs with the majority of FQHCs, comprising 35 clinic sites.

School Based Health Clinics. Several SBHCs in GSA B have signed LOIs with LHC. We do not anticipate any challenges pursuing contracts after the awards are made.

GSA C Network Challenges

The unique network development challenges we are encountering in GSA C are due in part to its large geographic size and relatively rural composition. Unlike the other GSAs, we’ve encountered many rural providers who were seemingly unaware of the State’s CCN initiative. Our team of 13 provider recruiters has taken extra time to explain the impending change and its impact, which has slowed the recruiting process a bit. There are four anchor cities within GSA C: Alexandria, Lake Charles, Monroe, and Shreveport. We are developing provider networks by focusing our recruiting efforts in these areas. The largest health systems in GSA C are LSU and Willis-Knighton Health System (Willis-Knighton). As with GSAs A and B, providers who are affiliated with LSU are not able to contract with LHC due to LSU’s affiliation with a competing CCN-P bidder. Willis-Knighton consists of more than 10 facilities and over 300 physicians in and around the Shreveport area. While Willis-Knighton is not signing any LOIs, they have indicated they will enter into contract discussions with the selected plans.

Primary Care. Overall, our network of PCP providers in GSA C is adequate. The network development challenge we are experiencing in GSA C stems largely from the PCP's affiliation with LSU or Willis-Knighton.

Specialty Care. We expect to augment our specialty provider network in GSA C through contracts with LSU and Willis-Knighton once award announcements are made. Specialists who are not affiliated with these organizations have shown slow-but-steady interest in participating with LHC. Some specialty types are not available in GSA C outside of the LSU system, but we are confident in their network participation should LHC be awarded a CCN-P contract.

Prenatal Care Services. We are satisfied with the network of prenatal care providers we have developed in GSA C and have no remarkable concerns or challenges for this provider type.

Hospitals. We have secured LOIs with hospitals located in some of the largest cities in GSA C along with a significant number of rural hospitals. Our hospital network meets the State's network development requirements. Although we have had great success with hospitals in GSA C, decisions by both Natchitoches Regional Medical Center and Winn Parish Hospital to not respond to our outreach during the LOI phase of network development has resulted in a coverage gap in the area where Grant, Winn, and Natchitoches Parishes come together. Although these facilities were unresponsive during this state of the network development; we have no reason to believe they would be unwilling to engage in discussion with LHC should we be awarded a contract in GSA C. Also, given that there is only one facility in Cameron Parish, South Cameron Memorial Hospital which has already executed an LOI with LHC, there is no further opportunity to provide for additional coverage at this time. As our GeoAccess maps indicate, we have already developed relationships with a comprehensive network of hospitals, including Christus Schumpert, HCA, and Lake Charles Memorial. However, our desire is to further augment access to tertiary care services, where available, by securing contracts with additional facilities. Most tertiary care facilities in GSA C are part of LSU or Willis-Knighton and have stated that after the awards are made, they will enter into contract discussions with the selected plans.

Office of Public Health. LHC has secured a LOI with the Office of Public Health and does not anticipate any contracting challenges.

Private Duty Nursing/Home Health Services. LHC does not anticipate any contracting challenges with home health or private duty nursing providers in GSA C.

FQHC. We are very satisfied with the network of FQHCs for GSA C. We have secured LOIs from eight FQHCs, comprising 22 clinic sites in GSA C. Whenever possible, we are leveraging our relationship with LPC&A to further develop our specialist provider and hospital networks in GSA C.

School Based Health Clinics. A significant number of SBHCs in GSA C have signed LOIs with LHC. We do not anticipate any challenges pursuing contracts after the awards are made.

Conclusion

Among Medicaid health plans, it is common to encounter resistance from providers in the early stages of developing health care networks. Provider resistance is most prevalent in the months prior to the posting of bid awards and diminishes during implementation of the new program. We appreciate the support State Medicaid administrators have demonstrated in the form of communicating messages to providers that corroborate with bidding health plans and encouraging all providers in the State to embrace the impending changes and participate with the CCN-Ps. These efforts will contribute to a successful transition for the State and to every bidder's overall network development success in Louisiana.

Question G.6
Monitoring Wait Times and
Appointments

G.6 Describe your process for monitoring and ensuring adherence to DHH’s requirements regarding appointments and wait times.

LHC Monitoring Activities for Appointments and Wait Times

A major benefit of implementing a new network based managed care delivery system successfully is the ability to actualize *improvements in access to care*. LHC recognizes that its ability to implement comprehensive and effective monitoring practices regarding provider performance in the areas of appointment and wait times will have a positive impact on improving the health care experience from the member’s perspective, improving health care outcomes from the provider’s perspective and reducing health care costs from the state and CCN perspectives.

Our provider accessibility monitoring activities extend not only to our immediate network of participating providers (PCPs and specialists), but also to our subcontracted vendors and providers that include, but is not necessarily limited to, non-emergency medical transportation, vision care and radiology services.

Establishing Benchmarks. Establishing benchmarks is the first requirement of an effective provider performance monitoring program. DHH has established these benchmarks and LHC will include the required appointment and wait time standards in its provider agreements and its Quality Improvement Policies and Procedures for Evaluation of Accessibility. DHH appointment and wait time standards specified in the RFP are shown in the table below.

DHH Appointment and Wait Time Standards

Appointment Type	Access Standard
Emergent Care	Immediately; availability 24/7
Urgent Care	Within 24 hours; availability 24/7
Non-Urgent – Sick Visit	Within 72 hours
Routine or Preventive Care	Within 6 weeks
Specialist Consultation	Within 1 month or sooner if clinically indicated
Maternity: 1 st Trimester	Within 14 days (measured from postage date of Welcome Packet for new members)
Maternity: 2 nd Trimester	Within 7 days (measured from postage date of Welcome Packet for new members)
Maternity: 3 rd Trimester	Within 3 days (measured from postage date of Welcome Packet for new members)
High Risk Maternity	Within 3 days of high-risk identification
High Risk Maternity Emergency	Immediately
Lab and X-Ray - Non-Urgent	Within 3 weeks
Lab and X-Ray - Urgent	Within 48 hours
Office Wait Time	Not to exceed 45 minutes (includes wait & exam rooms)
Transportation Drop Off	No more than 1 hour prior to appointment
Transportation Ride Home	No more than 1 hour after completion of appointment

Communicating Expectations. LHC communicates accessibility expectations to providers in several ways. First, the agreement between LHC and the provider includes State specific requirements for appointments and wait times. All LHC contracted providers must comply with the access standards established by DHH within their agreements. The LHC provider manual will contain DHH’s access standards and will be distributed to all participating providers during the initial onsite orientation session. The Provider Manual will also be posted on the LHC Provider Portal as a convenient reference tool for participating providers. During the orientation, providers and their staff will receive training regarding contractual obligations and requirements. Additionally, during the initial onsite orientation session, LHC

Provider Relations Specialists (PRS) will inform every provider of LHC’s Quality Assessment and Performance Improvement Committee (QAPIC) accessibility oversight activities, which include:

- ongoing measuring and monitoring of provider performance that focuses on several key indicators (including appointments and wait times),
- establishing policies and procedures specific to DHH accessibility requirements,
- analysis of appointment and accessibility data collected,
- annual evaluations,
- communication of assessment results to individual/group practitioners (via follow up letter after the audit is conducted) and the QAPIC,
- development of corrective action plans when performance standards are not met, and
- filing assessment results in each provider file.

Our overarching communication objective is to positively reinforce provider behaviors that improve customer satisfaction and access to care. For Medicaid members, the ability to make appointments with their providers without obstacles is a significant aspect of the satisfaction they experience with their providers and their health plan. Consequently, provider compliance with the contract terms related to timely appointments and wait times serves as an integral success factor for LHC in supporting implementation of the new CCN model.

Monitoring Performance. LHC will perform a range of monitoring activities to appraise provider performance against the access standards contained within provider contracts, and to manage this aspect of customer satisfaction both reactively and proactively. At least annually, LHC will analyze appointment accessibility including routine, urgent and after-hours care against DHH defined standards. The methods used to monitor provider compliance with scheduling appointments and office wait time standards include:

Site Visits. During an onsite visit audit, LHC’s QI or PRS staff conducts a survey to verify compliance using our Site Survey Tool. During the site visits, QI staff interviews the provider’s scheduler and requests appointment response time data that providers are expected to maintain. The provider must score 90% or better in meeting response time standards to appointment requests from CCN-P members. Providers who do not pass the audit must implement a Corrective Action Plan (CAP), and are re-surveyed within 60 days. If the provider fails the second audit, the provider is presented to our QAPIC for additional corrective action. While LHC will make every effort to assist providers in meeting minimum accessibility standards, continued non-compliance could result in a contract being terminated for cause.

“Secret Shopper” Audits. The QI or PRS staff conducts “Secret Shopper” compliance audits throughout the year to perform real time monitoring of appointment access for PCPs, high-volume OB/GYNs, and specialists. A Secret Shopper audit consists of QI or PRS staff calling the provider’s office during normal business hours and after hours, posing as a fictitious CCN enrollee. If the call is made during business hours, our staff requests the next available appointment. Once the office staff provides an appointment date and time, the surveyor identifies themselves, the purpose of the call, and provides the survey results. If the call is made after hours, our staff verifies that the provider has an answering service or a telephone recording instructing callers with after office hour care instruction. If an appointment is offered within DHH standards for the type of appointment, or appropriate after-hours procedures are in place, all providers in the office are credited with meeting the standard. If not, the surveyor immediately reviews the standards with the office staff and requires that corrective actions be implemented. Secret Shopper surveys are conducted annually.

Provider Self-Report Surveys. In addition to the secret shopper calls and site visits described above, LHC requests self-reported appointment availability information via an annual provider survey. Upon receipt of the completed survey, LHC Provider Relations Specialists follow up with providers to validate the results. LHC will adopt the Provider Survey Tool from its parent company, Centene, which has used this tool since 2007 for the Medicaid managed care contracts it manages in other states. Survey results indicate a positive trend in appointment availability across all appointment categories. LHC

communicates overall results to providers in a quarterly newsletter, along with reminders of our appointment availability standards. In addition, Provider Relations Specialists continue to educate practitioners regarding appointment availability standards during routine onsite visits. Survey results for the last two years are reflected in the table below.

Measure	2009	2010
Routine Non-Symptomatic visit within standards	85%	91%
Non urgent, Symptomatic visit within standards	92%	97%
Urgent visit within 24 hours	94%	98%
Are patients seen within standard (in # of minutes) of scheduled appointment time	94%	99%

Member Surveys. LHC will conduct comprehensive member surveys at least annually. Survey questions applicable to assessing member satisfaction with timeliness of access to health care services include a measure of the percentage of members who reported they “always” or “usually” got *regular or routine care* as soon as they requested it and the percentage of members who reported they “always” or “usually” got *urgent* appointments as soon as they requested them

Member Complaint/Grievance Reports. LHC also measures compliance with appointment availability standards through our ongoing analysis of member and provider grievance and complaint data. All appointment scheduling and wait time complaints are addressed immediately by our member services and/or provider relations staff. Similar to our response to noncompliance identified in onsite audits, we work with those providers whose patients have filed an accessibility complaint against them to reinforce expectations and contractual requirements regarding appointments and wait times. Corrective Action Plans may be initiated. As part of our Provider Network Compliance Review, the PRS and QI teams work together to monitor accessibility related activities among providers and review member and provider inquiries, complaints and appeals in order to identify accessibility trends associated with specific providers. If we identify a trend with a specific provider, a designated QI or PRS staff member will conduct a site visit and/or secret shopper compliance audit as described earlier. LHC also monitors complaints to ensure that services are provided to members without discrimination, including hours of operation.

Credentialing/Recredentialing. LHC will require all providers to specify their hours of operation on their credentialing application and during the recredentialing process (which occurs every 2 years). This enables us to identify providers who offer evening or weekend office hours.

Emergency Department (ED) Utilization Indicating Access Issues. LHC will track frequent emergency department (ED) users to identify potential barriers to PCP accessibility. Medical Management (MM) staff analyzes monthly ED Frequent Users reports that are prepared using claims data. These reports list members who visited an ED at least three times within three months, and include the assigned PCP as well as such information as number of visits, member identification and contact information, diagnosis, and whether the member’s care is being case managed by LHC. In addition, MM staff analyzes weekly claims reports containing similar information about pregnant members who visit an ED. Our Provider Relations staff will contact PCPs with a disproportionate number of assigned members with high ED use to explore potential issues related to access, such as appointment availability, office hours, and culturally-sensitive answering machine messages. In addition, LHC staff will continue documenting access issues identified through ED assessments in our TruCare Clinical Documentation System (TruCare). Medical Management staff will use TruCare to generate monthly access reports for review by QI staff. QI staff will forward to Provider Relations staff, the Chief Medical Director (CMD), and CEO quarterly reports on PCPs with access issues for review, outreach, and development of corrective action plans, if needed. QI staff will reassess provider accessibility quarterly until access meets minimum standards.

Incentive Programs. Physicians sometimes limit their hours of operation or use appointment restriction tactics as a way to keep appointment and wait time problems caused by their patients under control. Others have expressed concern and frustration regarding patients who routinely miss appointments. At LHC, we believe cooperation and communication between the patient and provider must exist in order to resolve these issues. To proactively assist in reducing wait times and increasing access to care, we will institute two important provider incentive programs:

1. **Missed Appointments:** LHC will designate a billing code for providers to submit a claim when a member misses a scheduled appointment. We will monitor claims for missed appointments to ensure that the code is being used appropriately. We will use the claims data to conduct member outreach and assist members to reschedule their appointment and to identify any barriers to keeping appointments.
2. **After-Hours Care:** To further encourage access to care and to offset the expenses of providing services after normal business hours, LHC will offer enhanced reimbursement to providers who extend appointment hours. LHC will designate an appropriate CPT billing code for providers to submit when services are provided after 5:00 p.m. and on weekends. This allows the physician to collect more than the standard reimbursement for the services provided after hours. In addition, LHC will be offering medical groups the opportunity to participate in “gain share” compensation models wherein savings resulting from an offsetting reduction to ER or Urgent Care services is shared with providers participating with the program.

Our provider incentive programs are designed to improve the health care management experience for both provider and member. We view our provider incentive programs as investment opportunities wherein we gain an important byproduct of this improved experience by reducing costs associated with missed appointments and inappropriate use of the emergency room.

Ongoing Provider Education and Training. We educate providers about our comprehensive, written policies and procedures to ensure that CCN members have access to screening, diagnosis and referral, and appropriate treatment. Upon joining the network, all providers receive an orientation that includes information on the access standards in the Provider Contract. These standards are included in the Provider Manual and on our Provider Web Portal. Ongoing training occurs during regular group trainings, provider newsletters, and through face-to-face sessions at provider offices. Initial and ongoing training topics include, but are not limited to, the following:

- Support available from LHC including calling members to remind them of appointments
- How LHC monitors compliance with access standards
- Incentives LHC offers for increasing access
- Review of appointment scheduling time frames and office wait time standards to which they are bound contractually

Drawing upon the experience and support of its parent company, LHC will deliver an effective system of provider oversight, communication and training that will lead to improved access to care for LHC members. We have a successful track record regarding provider accessibility and look forward to applying what we have learned about improving access to care in Louisiana.

Question G.7
PCP Assignment Process

G.7 Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.

Centene and its affiliate health plans have extensive experience in delivering member choice while ensuring that all of our members are assigned a Primary Care Physician (PCP) in a timely manner. Our experience shows that many of our new members already have established relationships with our network providers and that members who select their own PCP are more likely to access their medical home; LHC will ensure that all members have a PCP who provides an ongoing source of primary care appropriate to the member's needs, and LHC staff will assist members in the PCP selection process.

Centene has 27 years in the Medicaid managed care business and through this experience we have developed and refined an auto-assignment algorithm that analyzes claims history, family member PCP assignment, and finally, geo-access methodology to auto-assign a PCP if one has not been selected by the member. Across our 11 health plans, we have varying degrees of auto-assignment. For instance, in our Illinois affiliate, IlliniCare, all members come to the plan with an assigned PCP. However in other states, such as Mississippi, our Magnolia Health Plan, even though members are encouraged to select a PCP at upon enrollment with the enrollment broker, many members have not and we perform auto-assignment for members the majority of the time.

Encouraging Member Choice

LHC will employ a comprehensive outreach and education process to encourage our members to be active participants in the selection and timely assignment of their PCP. Members are encouraged to select a PCP upon enrollment with the enrollment broker. However, if one is not selected, LHC will deploy its PCP auto-assignment process to ensure members are assigned a PCP in a timely manner.

Member Education. Member education regarding PCP selection begins prior to enrollment and LHC will continue educating and encouraging member choice in selecting a PCP even after they have made their CCN selection.

Member Portal. Prior to contract start date, LHC will have information on its Member Portal explaining the importance of PCP selection as a medical home. Members will be able to use our Find-A-Doc function to check if their current PCP is a contracted provider or if they are not already seeing a PCP, to help find one in their area.

Member Call Center. LHC's Member Call Center will be available 30 days prior to our Contract Start Date to answer questions regarding PCP selection and to assist members in locating a PCP as needed.

LHC will continue educating and encouraging member choice in selecting a primary care provider even after they have made their CCN selection:

Welcome Packet. Although LHC will have 21 days during phase in implementation to send a welcome packet to each enrolled member, we will strive to do this within the 10 day requirement that is applicable after implementation. The packet will include a welcome letter highlighting major program features, the Member Handbook that includes information about how to change PCPs, the Member ID Card with either the member's chosen PCP or the auto assigned PCP indicated on the card and LHC's Provider Directory.

Welcome Calls. LHC will make welcome calls to new members within fourteen (14) business days of receipt of the enrollment file from DHH or the Enrollment Broker identifying the new enrollee. Although we will have up to 21 days during phase in implementation, we will strive to make all calls within the 14 day requirement during implementation. LHC will review PCP assignment if an automatic assignment was made and assist the member in changing the PCP if requested by the member.

To further encourage members to choose their PCP, LHC will not lock members in to their chosen or assigned PCP after the 90th day of enrollment allowing the member to change PCPs at any time. However,

in consideration of the importance of establishing a solid relationship with a medical home, LHC will monitor the frequency and reason for all PCP changes. LHC will conduct outreach and member education to continually reinforce the importance of the PCP and benefits of establishing a medical home.

Member Selected PCP Assignment

LHC will leverage existing Centene's standard member load logic that validates the member's chosen provider, if included in the enrollment file, is participating in our network, is appropriate for the member's age, gender and that the provider has not exceeded their panel capacity. The member will be assigned the PCP of their choice unless the selected PCP has reached their maximum physician/patient ratio or the member has selected a PCP whose practice is limited to groups to which the member doesn't belong. LHC will confirm the member's PCP selection via the member's ID card. LHC's enrollment department will use an exception report to identify any member PCP selections that cannot be completed and the Eligibility Specialist (ES) will research the reason the selected PCP could not be assigned and resolve issues if possible. If the ES is not able to resolve the issue, the member will be auto-assigned and LHC will assist the member to select another PCP during our welcome if the auto-assigned PCP does not meet their needs.

No Member Selected PCP indicated in Enrollment File

New LHC members who have not proactively selected a PCP during the enrollment process or whose choice of PCP is not available will have the opportunity to select a PCP within LHC that has entered into a subcontract with LHC; and is within a reasonable commuting distance from their residence.

PCP Auto Assignment

To ensure that every LHC member is assigned a PCP in a timely manner, LHC plans to assign a PCP to all members who have not made a selection by the enrollment effective date. In collaboration with DHH, LHC will establish a methodology for PCP auto assignment when the member:

- Does not make a PCP selection after a voluntary selection of LHC as their CCN-P
- Selects a PCP from LHC's participating provider network that has reached their maximum physician/patient ratio or
- Selects a LHC Network PCP whose practice accepts members on restricted criteria that the member does not meet

For those members who have not proactively selected a PCP upon enrollment we will use the auto-assignment algorithm, matching for a previous claims history for the individual with a network PCP; then using the Case Number provided by the enrollment broker to identify family members and assign their selected PCP; and finally, using a geo-access methodology that matches the member's age, sex and address zip code with the nearest available appropriate PCP within DHH's required access standards. To qualify for member auto-assignment, a PCP must be configured in our system as a current provider with effective contract start and end dates, and be accepting new patients. Our system will assign members only to PCPs with available capacity to comply with contract service availability and accessibility standards. LHC will confirm the PCP through the new member welcome packet mailing which includes identification of the PCP and the phone number on the member's identification card. The new member welcome packet will also include a notice informing members of the process for changing the PCP assignment and encouraging them to make their own choice about the provider who will serve them.

LHC will monitor PCP assignments to ensure completeness and accuracy of member/PCP designations. LHC's enrollment department will monitor PCP error reports to ensure all members are able to be matched to a PCP. Members who are unable to be matched to a provider through the auto assignment logic will be manually matched to a PCP.

Newborn PCP Assignment

Educating the mother about the importance of selecting a PCP within 60 days prior to delivery ensures newborns are quickly connected to a medical home. LHC will take a multifaceted approach to capture every opportunity to directly educate our members and support our providers in their efforts to educate LHC members.

Member Education and Outreach

LHC takes a comprehensive approach to member education and outreach. In addition to member welcome materials and calls, LHC's Start Smart for Your Baby pregnancy case management and MemberConnections programs will include mechanisms for encouraging our pregnant members to actively select a PCP for their baby.

Start Smart for Your Baby[®] LHC's Start Smart for Your Baby focuses on early risk screening, case management and member education designed to have a stronger impact on pregnancy outcomes and NICU rates. Through Start Smart for Your Baby, we empower our members to make the right choices for a healthy pregnancy and baby including selecting the baby's PCP.

The Start Smart[®] Baby Shower Program. This Start Smart for Your Baby program component is designed to 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 MemberConnections, 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 including how and why it's important to select a PCP for the baby within 60 days of their due date.

MemberConnections. The MemberConnections Program allows us to provide a level of in-person, "boots on the ground" interaction with our members that other health plans cannot. MemberConnections Representatives (MCRs) are health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs receive comprehensive training and become an integral part of our Member Services and Case Management teams, which benefits our members and increases our effectiveness. MCRs will make home visits to members we cannot reach by phone and assist members who have not yet selected a PCP for their baby to do so.

Provider Education and Support

Prenatal Care Recommendations. LHC's provider relations will educate LHC PCPs and OBs to ensure that the PCP or the OB provides prenatal care in accordance with the "**Prenatal Care Recommendations**" of the American College of Obstetricians and Gynecologists through mechanisms including but not limited to: new provider orientation, the provider manual, ongoing provider training and provider newsletters. LHC will ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child once the child is added to LHC.

Text-4-Baby. LHC's Provider Relations Specialists will also support the efforts of LHC's network providers in promoting CMS's "Text 4 Baby" initiative and help providers, if desired, to develop SMS text messages about choosing a PCP for their new baby within 60 days of their due date.

Identifying Newborns. Concurrent review CMs monitor member deliveries through a Daily Delivery Admissions Report (DDA), which is based on authorizations from the medical management census on hospitalized members. The DDA, generated each morning, will reflect members for whom the hospital obtained an authorization for labor and delivery. LHC's onsite concurrent review nurses will also monitor

the daily medical management report that identifies all hospital admitted LHC members. Using these methods of identification, a dedicated concurrent review Case Manager will identify and validate deliveries on the daily census report and provide assistance to the member to select a CCN and PCP for her baby.

Member Choice. Despite our comprehensive approach, there will undoubtedly be members who have not yet selected a PCP for their baby at the time of delivery. LHC's concurrent review Case Managers (CM) will provide another opportunity to encourage the member to select a PCP for their baby.

Auto Assignment. If there is still no selected PCP for the baby, LHC will use the auto assignment process, described above, to assign a PCP. If LHC was unaware of the pregnancy until the member presents for delivery, LHC will assign a PCP for the newborn within 1 business day after birth.

Specialists as PCPs

Centene health plans routinely offer vulnerable populations including members with multiple disabilities, acute, or chronic conditions the option of selecting their attending specialists as their PCP so long as the specialist agrees with the arrangement and is willing to perform responsibilities of a PCP. LHC will make every effort to contract with the specialist of choice as a PCP if not already available to match to the member as a PCP. The specialist must agree to fulfill all PCP responsibilities for supervising and coordinating care, providing required preventive care (including for children, EPSDT), and after hours availability. If the specialist is not already contracted to act as a PCP with LHC, Provider Relations staff will work with the specialist to execute a PCP contract. Should the specialist not wish to contract as a PCP, LHC will refer these members for case management and disease management interventions, as appropriate. These members will also be monitored for adherence to disease-specific quality metrics by the Case Manager (CM). Our CMs may also recommend that a specialist serve as PCP based on member assessment and needs and during a case management call or visit.

PCP Assignment When a Provider Terminates

In the event that a provider is terminated from LHC, dies or re-assignment is ordered as part of the resolution of a grievance proceeding, LHC will notify the enrollment broker of the termination before the close of business on the next business day, actively assist the member in choosing a new PCP, and ensure member access to care during transition.

Provider Terminates with Notice. If a PCP provides the NCQA required 30 day notice of termination of their participation in LHC's network, LHC will provide the member with written notice within the PCP's notice period informing the member that their PCP is leaving our network. The notice will include instructions for the member to contact LHC's member services to select a new PCP. To ensure every member continues to have adequate access to quality primary care, we will assign affected members a new PCP that has entered into a subcontract with LHC; and is within a reasonable commuting distance from their residence and confirm the assignment in writing via a new member id card. With the ID card LHC will include information describing process for changing the PCP assignment and encourage them to make their own choice about the provider who will serve them.

Provider Terminates Without Notice. In instances where a provider becomes physically unable to care for members due to illness, a provider dies, or otherwise does not provide 30 calendar days' notice, LHC will notify the affected members in writing as soon as possible, but no later than 30 calendar days following receipt of the notification. LHC will provide updated ID cards to member when LHC changes the member's PCP. The notice will be issued in advance of the PCP change when possible or as soon as LHC becomes aware of the circumstances necessitating a PCP change. Members will still have the opportunity to change the assigned PCP if the assigned provider does not meet their needs.

Question G.8

NCQA Medical Home Recognition /
JCAHO Primary Home Accreditation

REDACTED

G.8 Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.

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Question G.9

Monitoring/Ensuring Compliance with Provider Subcontracts

G.9 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following:

Overview

Louisiana Healthcare Connections (LHC) knows that ensuring provider compliance with CCN provider subcontracts requires a comprehensive and, multifaceted approach. LHC will build upon the strategies other Centene health plans have used to monitor the provider subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards; educate providers regarding subcontract requirements and take the necessary corrective actions in the event a provider fails to comply with contractual obligations.

Under the supervision of the Vice President of Compliance, LHC will take an organization wide approach to ensuring provider contract compliance. LHC's provider services conducts formal provider reviews and onsite office visits, continuously monitors provider appointment availability and provider services trends; and conducts provider training evaluations. Through monthly delegates' reports and meetings LHC's member services, case management, quality improvement, credentialing and recredentialing, complaints, grievance and appeals, claims and medical management staff reports on their specific oversight responsibilities to the Performance Improvement Team (PIT). LHC's Quality Assessment and Performance Improvement team (QAPI) analyzes and synthesizes the PIT's oversight reports and applicable data for quarterly review by appropriate committees, including the Quality Assessment and Performance Improvement Committee (QAPIC) and provider related subcommittees such as the Credentialing Committee.

Compliance with cost sharing requirements;

Though there are no current cost sharing requirements for any LHC core benefits, LHC will contractually prohibit our provider subcontractors from billing, charging, collecting a deposit from, seeking cost sharing or other forms of compensation, remuneration or reimbursement from or having recourse against LHC members or persons acting on the member's behalf for core benefit healthcare services rendered to LHC members in all circumstances including, but not limited to, non-payment by LHC and insolvency of the LHC.

Payment in Full, and Member Hold Harmless. LHC will require, as a condition of payment, that subcontracted providers accept the amount paid by LHC (including supplemental payment by LHC to the member's third party payer), as payment in full for the service. If LHC is made aware that a provider, or a collection agency acting on the provider's behalf, bills a member, a Provider Service Representative (PSR) will notify the provider and demand that the provider and/or collection agency cease such action against the member immediately. If a provider continues to bill a member after notification by LHC, the Grievance and Appeals Manager will determine what, if any, corrective action may be required.

Limited Exceptions. Providers or collection agencies acting on the provider's behalf may not bill members for core benefit services. LHC providers may seek payment from a member only in the following situations:

- If the services are not covered services and the provider follows required procedures, including obtaining the member's written acknowledgement of non-coverage prior to rendering the service.
- If the member's DHH eligibility is pending at the time services are provided and the provider follows required procedures.
- If the member's DHH eligibility is pending at the time services are provided, and the provider collected payment from the member, but agreed to accept subsequent LHC assignment. All monies collected from the member (except copays) must be refunded as required by DHH.

Monitoring Cost Sharing Activities. LHC will monitor the provider network to ensure compliance with all current and future cost sharing provisions that may be amended by DHH primarily through member

inquiries and complaints received through NurseWise, member services and from our MemberConnections staff as they interact with our members during outreach and education. When any LHC staff receives an inquiry or complaint from a member regarding a provider bill, LHC staff will refer the complaint to the Grievance and Appeals Manager who is authorized to review and respond to grievances and appeals and require corrective action. Under the direction of the Grievance and Appeals Manager, G&A Coordinators monitor member inquiries and complaints and deliver monthly reports to the PIT. QI staff trend member complaints quarterly to identify provider, provider-type, service, area, or other patterns of inappropriate billing.

Ensuring Provider Compliance. If QI staff identifies a pattern of impermissible member-billing, they coordinate with the Grievance and Appeals Manager and Provider Relations. A Provider Relations Specialist (PRS) may visit the provider's office to investigate and forward their assessment to the Grievance and Appeals Manager who will determine if a corrective action plan is needed.

LHC takes a measured approach to addressing provider performance issues, preferring to support providers' efforts to improve before considering other actions.

Provider Education. LHC PRSs regularly schedule onsite visits with all network PCPs, specialists, and hospitals and arrange other visits on request or as needed, such as when noncompliance is noted. Education on cost sharing and the conditions under which providers may bill members are among the important refresher topics that PRSs cover during office visits. Such visits are helpful in monitoring and addressing knowledge gaps that may result from provider office staff turnover.

In addition, the provider newsletter periodically reminds providers that once they submit a claim to LHC, they may not balance bill or pursue collection from members.

Compliance with medical record documentation standards;

Overview

LHC monitors its practitioners for maintenance of medical records in a current, detailed and organized manner that permits effective and confidential patient care and quality review. Medical record standards that include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information are outlined and disseminated to all practitioners in LHC's Provider Manual and on LHC's website. LHC's medical record standards will require providers to maintain medical records at the site where services were provided for all members evaluated or treated that are accurate and legible; maintained in detail consistent with good medical and professional practice; safeguarded against loss, destruction, or unauthorized use; maintained in an organized fashion and accessible for DHH or LHC review and audit. Member medical records will provide medical and other clinical data required for quality and utilization management reviews and to enable a system of follow up care. LHC will further require provider medical records be prepared in accordance with all applicable State and Federal rules and regulations and signed by the medical professional rendering the services. LHC will require its providers to maintain confidentiality of medical records in accordance with 42 CFR § 438.224 and 45 CFR Parts 160 and 165 subparts A and E. Providers will be required to keep LHC member medical records in a secure location for a period of 6 years from the last date of service and be only accessed by authorized personnel. Providers' staff must receive periodic training in medical record confidentiality.

Medical Record Contents. LHC will contractually obligate providers to ensure member medical records include minimally, the following:

- Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);
- Primary language spoken by the member and any translation needs of the member;
- Services provided through the CCN, date of service, service site, and name of service provider;

- Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the CCN;
- Referrals including follow-up and outcome of referrals;
- Documentation of emergency and/or after-hours encounters and follow-up;
- Signed and dated consent forms (as applicable);
- Documentation of immunization status;
- Documentation of advance directives, as appropriate;
- Documentation of each visit must include:
 - Date and begin and end times of service;
 - Chief complaint or purpose of the visit;;
 - Diagnoses or medical impression;
 - Objective findings;
 - Patient assessment findings;
 - Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG);
 - Medications prescribed;
 - Health education provided;
 - Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and
 - Initials of providers must be identified with correlating signatures
- Documentation of EPSDT requirements including but not limited to:
 - Comprehensive health history;
 - Developmental history;
 - Unclothed physical exam;
 - Vision, hearing and dental screening;
 - Appropriate immunizations;
 - Appropriate lab testing including mandatory lead screening; and
 - Health education and anticipatory guidance.

Further, LHC will required all network providers to provide one (1) free copy of any part of member's record upon member's request and maintain member records for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

Transitioning Medical Records. LHC will inform and require its providers to fully cooperate in the event a member transitions to another CCN or provider. Upon notification of a member's transfer LHC will request copies of members' medical records, unless the member has arranged for the transfer. So that the transfer of records will not interfere with or cause a delay in the provision of services to the member, the LHC provider must forward a complete copy of the member's medical record and supporting documentation to the receiving provider within 10 business days of LCH', the member's or the receiving provider's request.

Monitoring Compliance

LHC will conduct medical record reviews of all LHC providers with more than 50 members at least once every 2 years. LHC' QM Coordinator will coordinate a schedule of ongoing reviews to ensure compliance. LHC will report on all reviews that have taken place in any quarter to DHH quarterly. LHC will assess network medical record keeping practices to ensure LHC providers deliver high quality healthcare that is documented according to established standards. LHC has written policies and procedures for ensuring provider compliance and will provide DHH with a written summary of its strategy for completing medical record reviews within 30 days of contract execution.

Medical Record Reviews. LHC will assess network medical record keeping practices against the established standards. Assessment may be accomplished by any of the following processes:

- Assess a sample of records selected for a review of HEDIS measures against its standards and identify deficiencies
- Assess a sample of practitioner records that did not pass HEDIS or other audits
- Review a sample of medical records based on past documentation deficiencies or other criteria.
- Additionally, any practitioner may be chosen throughout the year for focused chart reviews for purposes including but not limited to utilization review, quality management, medical claim review, or member complaint/appeal investigation

Selecting Records for Review. LHC will assess high-volume Primary Care Physicians (PCP) with 50 or more linked members and practice sights which include both individual offices and large group facilities.

LHC' QM Coordinator will generate a listing of all members currently assigned to the PCP targeted for review and who have been with the PCP during the entire period of time established as the review period. For OB/GYNs acting as PCP, a list of members who have accessed care with the provider at least 3 times within the designated time frame will be requested for random selection.

The QM Coordinator will randomly select a reasonable number of records at each site to determine compliance. The QM Coordinator will select at least ten (10) records for sites with a panel <500 and twenty (20) records for sites with a panel \geq 500. Member records chosen for review may include, but are not limited to:

- Members who have had claims for Emergency room or in-patient services, when possible.
- Members within a targeted age range or with a specific diagnosis, depending on the focus of the audit (i.e. 2 year olds to assess components of well child visits, asthmatics to assess compliance with associated clinical practice guidelines).

Notifying Providers of Medical Record Reviews. LHC will notify providers identified in writing that a medical record review will be conducted and provide a list of the members selected for review. The MRRC may schedule the audit at the practitioner's office location or request that medical records or components thereof be mailed to LHC. LHC will further notify the provider that should the health care provider fail to cooperate with providing the requested documents LHC may at its discretion or DHH directive impose financial penalties against the provider as appropriate.

Completing Medical Record Review. The QM Coordinator performing the review will utilize LHC' standardized Medical Record Review Tool. On completion of the review, the QM Coordinator will review preliminary results with the provider's designated office contact person. At this time, the QM Coordinator and the office person can work together to resolve any inconsistencies or disputes in the review findings. The contact person and the QM Coordinator sign and date the form indicating agreement of results.

Scoring. The QM Coordinator will then score the medical record audit tool and notify the provider of the outcome by mail within 15 days of the audit. The notification letter will include the overall score, any areas of deficiency and a copy of the completed/scored audit tool. Elements scoring below 80% are considered deficient and in need of improvement for which LHC will suggest action plan for improvement or include model record-keeping aids, such as standardized documentation forms, as applicable.

Continuous Monitoring. A follow-up review will be conducted within 6 months for any practitioner whose overall score is below 80%. Practitioners whose medical record compliance review score remains below 80% at the 6-month follow-up review will be discussed with LHC Medical Director for further action that may include but not be limited to:

- Medical Record review conducted by LHC' Medical Director

- Referral to the Quality Assessment and Performance Improvement Committee and/or Peer Review Committee
- Termination from the Plan Network

Medical record review results are filed in the Quality Improvement department and shared with the Credentialing department to be considered at the time of recredentialing.

Tracking Trends. An aggregate summary of medical record reviews completed and number above and below 80% are presented quarterly to the Plan Clinical Quality Committee. Medical record review results are trended by the Quality Improvement department to determine plan-wide areas in need of improvement. Issues may be addressed via network-wide and/or provider-specific education to improve elements of medical record documentation. An analysis of the results is included in the Plan's Quality Improvement Evaluation and is available to DHH upon request.

Compliance with conflict of interest requirements;

LHC will notify our providers that LHC is eligible to participate with DHH as a Prepaid MCO and does not have an actual or perceived conflict of interest that, in the discretion of DHH, would interfere or give the appearance of possibly interfering with its duties and obligations under any contract with DHH, and any and all appropriate DHH written policies. LHC will confirm that as an LHC subcontractor, the provider is accountable to the same standards and must notify LHC in the event that any conflict of interest may arise. Such conflicts of interest may include but not be limited to the provider having or acquiring any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under their Agreement with LHC. Should a provider provide LHC with notice of any such conflict, LHC will notify DHH promptly.

Compliance with lobbying requirements;

LHC will contractually require our provider subcontractors to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and including the Byrd Anti-Lobbying Amendment. LHC will file, and notify our provider subcontractors of the filing of the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier up to the recipient (45 CFR Part 3).

Compliance with disclosure requirements; and

LHC recognizes the value and importance of strong medical home and other patient provider relationships in improving the health of our members. In support of these relationships, LHC will notify our providers through the Provider Manual that LHC and our provider subcontractors will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient and providing information the member needs in order to decide among all relevant treatment options.

HIPAA Compliance

Through our provider agreements, LHC will ensure that all providers are fully compliant with patient confidentiality and nondisclosure requirements. Our provider contracts stipulate that each provider and

LHC shall abide by the administrative simplification provisions of the Health Insurance Portability and Accountability Act (“HIPAA”), its implementing regulations [42 C.F.R. parts 160 and 164] and all other federal and State laws regarding confidentiality and disclosure of medical records and other health and Covered Person information, including safeguarding the privacy and confidentiality of any protected health information (“PHI”) that identifies a particular Covered Person. Provider, as a “business associate” of LHC, as defined in HIPAA, shall execute LHC’ Business Associate Addendum. Provider shall assure its own compliance and that of its business associates with HIPAA.

Safeguarding Information. LHC’ provider agreements also stipulate:

Provider shall safeguard Covered Person information in accordance with applicable State and federal laws and regulations and the standards set forth below:

- Be at least as restrictive as those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La. R.S. 45:56;
- Identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- Require the written authorization of the Covered Person or potential Covered Person before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 C.F.R. § 164.508;
- Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- Subject violators to appropriate personnel sanctions.

Provider further acknowledges that all material and information, in particular information relating to Covered Persons or potential Covered Persons, which is provided to or obtained by or through Provider’s performance under this Agreement, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement.

All information as to personal facts and circumstances concerning Covered Persons or potential Covered Persons obtained by the Provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the Covered Person/potential Covered Person, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Covered Persons/potential Covered Persons shall be limited to purposes directly connected with the administration of this Agreement.

Monitoring Compliance. All LHC staff will monitor PHI protection during interaction on any level with any member. Should a member report that a provider has failed to comply with these nondisclosure requirements, the LHC staff person receiving this information will report it immediately to the LHC Compliance Officer for investigation.

Compliance with marketing requirements

Overview

LHC will provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of members. LHC’ Provider Relations Specialists (PRSS) will conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. LHC will also conduct ongoing training, as deemed necessary by LHC or DHH, in order to ensure compliance with program standards and the Contract.

Provider Marketing Guidelines. LHC will communicate provider marketing guidelines through our provider manual and during initial and ongoing training by LHC PSRs. LHC' PSRs will instruct all providers regarding the following requirements:

LHC participating providers who wish to let their patients know of their affiliations with one or more CCNs must list each CCN with whom they have contracts;

LHC participating providers may display and/or distribute health education materials for **all** contracted CCNs or they may choose not to display and/or distribute for **any** contracted CCNs. Health education materials must adhere to the following guidance:

- Health education posters cannot be larger than 16" X 24";
- Children's books, donated by CCNs, must be in common areas;
- Materials may include the CCNs name, logo, phone number and Web site; and
- Providers are not required to distribute and/or display all health education materials provided by each CCN with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted CCN and that the distribution and quantity of items displayed are equitable.

LHC providers may display marketing materials for CCNs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all CCNs with whom the provider has a contract.

LHC providers may display CCN participation stickers, but they must display stickers by **all** contracted CCNs or choose to not display stickers for **any** contracted CCNs.

CCN stickers indicating the provider participates with a particular CCN cannot be larger than 5" x 7" and not indicate anything more than "the health plan or CCN is accepted or welcomed here."

Providers may inform their patients of the benefits, services and specialty care services offered through the CCNs in which they participate. However, providers may not recommend one CCN over another CCN, offer patients incentives for selecting one CCN over another, or assist the patient in deciding to select a specific CCN.

Upon termination of a contract with the CCN, a provider that has contracts with other CCNs may notify their patients of the change in status and the impact of such a change on the patient.

Monitoring Provider Compliance. LHC' PSRs will be trained to check provider compliance with all posted and distributed provider marketing materials during routine provider visits. Further, LHC' QI Coordinator will include a checklist of posted and distributed marketing materials if regular medical record review is conducted on site at the providers' location. Any observance of improperly displayed or distributed marketing materials will be reported to LHC' Compliance Officer for further investigation and follow up.

Question G.10

Example of Handling Provider
Noncompliance with Contract
Requirements

G.10 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.

The situation. In one Centene affiliate plan, the Director of Pharmacy noted in his claims review several members with unusually high numbers of narcotics prescriptions in a specific rural area. Further analyses by QI Department staff, revealed that many of the prescriptions were written by a physician in a small community in the same area. The physician was a PCP who had been a network provider with the plan through a number of recertifying cycles and had a clean file. However at this point, unless the PCP's members' needs and case mix were quite unusual, the potential types of provider noncompliance ranged from not meeting professional practice standards to violation of state and federal drug laws.

The investigation. Following a call to let the physician know about the concerns and review of patient medical records that she sent on request, the Health Plan Medical Director, QI Director and lead QI Coordinator traveled more than 100 miles to the physician's office and met with her to review staff observations and discuss the PCP's views regarding her patients. The physician said that the members were being treated for chronic pain. Typically, members had told her what pain medication they'd used in the past and found effective, and often if they wanted the same thing, she would prescribe it. Sometimes they were insistent, telling her that other medications hadn't worked or had had side effects. There was no pain management specialist in that rural area to whom to refer members. The Medical Director and QI staff reviewed with the PCP their historical claims analysis regarding the individual members, concerns about extended use of prescription narcotics, as well as the challenges of detecting a skilled patient impersonator who obtains prescriptions for the purpose of selling not taking them

Recommendations. The Centene Medical Staff explained additional testing and treatment options such as pain therapy. They discussed practices including requesting that a member sign a narcotics contract and conducting occasional urinalysis to verify that the member was taking the prescription and not diverting or selling it to someone else. In addition, the Medical Director and QI staff identified BH and substance abuse network resources for patients who may have become depressed while dealing with chronic pain or developed a drug dependency. They provided the PCP with DEA and professional resources on pain management and identifying drug seeking behavior. They also emphasized calling the Medical Director to discuss any future concerns. The physician was grateful and receptive and identified various changes she would make immediately in her practice. The meeting was documented with meeting notes on the changes in practice that the plan anticipated would occur. Given the PCP's otherwise good record with the plan, the limited specialty referral options in her area, and that the plan's analysis on quality of care issues for the specific members did not suggest any other potential deviations in the quality of treatment, the plan did not require a written corrective action plan.

The Result. The Director of Pharmacy and QI Department assessed the PCP's performance at six months and no further issues were identified. The health plan kept a good provider, maintained access and continuity of care in an underserved area.

Question G.11

Educating and Training Providers
about Billing Requirements

G.11 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.

Louisiana Healthcare Connections (LHC) realizes that changes in billing requirements is often one of the most daunting changes for providers when a state transitions Medicaid from fee-for-service to managed care. Our parent company, Centene Corporation (Centene) has more experience partnering with states during this transition than any other company; implementing new managed care programs in Georgia, South Carolina, Mississippi, Illinois and 174 rural counties in Texas. Our overarching philosophy is to emulate, as much as possible, the billing practices of the State whose Medicaid population we serve in order to minimize changes in the billing requirements from participating providers. LHC will draw on this experience and expertise to offer our providers a comprehensive billing education program that begins prior to commencing operations and continues throughout a provider's participation in the plan.

Prior to Start of Operations

In order to facilitate a smooth transition to managed care, LHC begins educating providers about billing requirements during our initial recruitment activities. Conducting these discussions prior to contracting with a provider allows us to understand the manner in which providers are currently billing for services and ensures that there is congruence between the provider's expectations and LHC reimbursement methodology. This information is then used to develop LHC's rate exhibits and payment guidelines, which ultimately become part of the provider's contract with LHC. This proactive approach not only allows us to educate prospective network providers about our billing requirements, but also affords us the opportunity to educate ourselves on local market and state nuances regarding billing and payment methodologies.

In addition, we will work with our partner FQHCs to adjudicate test claims prior to the start of operations. Magnolia Health Plan, our Mississippi affiliate implemented a similar process prior to the start of their operations and was able to identify billing patterns of local providers that would impact their ability to process claims. As a result, they were able to tailor their provider training to address these issues; LHC anticipates being able to customize our training as well based on this test claim process.

Initial Education and Training

Once a provider has contracted with LHC and completed the credentialing process, we will provide comprehensive education that includes information regarding billing guidelines. This training will be completed as part of LHC's initial *provider orientation and will be completed at least thirty calendar days before operations* commence in each service area.

Provider Welcome Packet. Within fourteen days of completing initial credentialing, LHC's Provider Services Department will mail all new providers a Provider Welcome Packet. This packet (discussed in full in our response to question G.12) contains all of the materials and information a provider requires to participate in LHC's network, including the following which include information for providers about billing requirements:

- Welcome Cover Letter
- Provider Quick Reference Guide
- Prior Authorization Requirements List
- Medical Prior Authorization Form
- PaySpan Brochure (Information and registration for electronic transactions)

Provider Orientations. In addition to the written materials sent to all new providers, LHC Provider Relations Specialists in conjunction with the Provider Claims Educator will conduct office orientations with providers and their office staff within 30 days from the date the provider became a participating provider. Orientations may be conducted in various ways, including but not limited to:

- Individual Meetings in the provider's office according to the provider's availability
- Group Workshops in a community location such as a local hospital, FQHC or community center during several days and different times. For example, we will work with our partner, LPC&A to participate in the *Louisiana Primary Care Association's (LPCA) Lunch and Learn*

Coding Series and with the *Louisiana Rural Health Association (LRHA) Coding Update Seminars*, which will allow us to provide billing education to a large group of traditional Medicaid providers.

- Webinars during several days and different times

Reference Materials. LHC offers our providers several resources that include information about billing requirements. We distribute these materials in Provider Welcome Packets and during initial orientations, both hard copy and on CD, and maintain copies available on our website.

LHC’s Provider Reference Manual describes the manner in which LHC manages its Medicaid program as well as operational procedures followed by our company. It includes a chapter on billing and claims submission requirements, including general billing guidelines; *timely filing requirements (365 days)*; electronic and paper claims submission requirements; *clean claim requirements*; LHC’s policy of *non-coverage for Provider Preventable Conditions*; common causes of claim processing delays and denials; and information about claim requests for reconsideration, claims disputes and corrected claims.

The Provider Billing Manual is LHC’s guide for providers that describes the manner in which providers are expected to bill for services covered by our program. The Billing Manual is comprehensive and addresses all aspects of claims submission and billing requirements, as demonstrated by the following excerpt showing the manual’s contents:

Procedures for Claim Submission.....	3
Claims Filing Deadlines.....	4
Claim Requests for Reconsideration, Claim Disputes and Corrected Claims.....	5
Procedures for ELECTRONIC Submission.....	7
Filing Claims Electronically.....	7
How to Start.....	7
Specific Data Record Requirements.....	8
Electronic Claim Flow Description & Important General Information.....	8
Invalid Electronic Claim Record Rejections/Denials.....	9
Our companion guides to billing electronically are available on our website at www.IlliniCare.com. See section on electronic claim filing for more details.....	9
Exclusions.....	10
Electronic Billing Inquiries.....	10
Important Steps to a Successful Submission of EDI Claims.....	11
EFT and ERA.....	11
Procedures for ONLINE CLAIM Submission.....	11
CLAIM FORM REQUIREMENTS.....	12
Claim Forms.....	12
Coding of Claims.....	12
Code Auditing and Editing.....	13
CPT® Category II Codes.....	19
Code Editing Assistant.....	20
Billing Codes.....	20
Claims Mailing Instructions.....	21
Rejections vs. Denials.....	22
Common Causes of Upfront Rejections.....	22
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Important Steps to a Successful Submission of Paper Claims.....	23
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LHC’s Provider Quick Reference Guide is a “cheat sheet” summarizing the operational policies and procedures that govern our program that includes information about billing requirements. The following represents an excerpt of the quick reference guide for IlliniCare, LHC’s Illinois affiliate health plan:

Claims Services

Electronic Claim Submission:
 For claim processing efficiency and cost savings to the providers, IlliniCare encourages its providers to file claims electronically. IlliniCare’s Payor ID is 68066. Please visit our website at www.IlliniCare.com for our electronic *Companion Guide* and our *Billing Manual* which offers more detailed information regarding claims billing instructions. Our Clearinghouse vendors include Emdeon, Envoy, WebMD, and Gateway EDI. Participating providers may receive electronic funds transfers (EFT) and electronic remittance advice (ERA) from IlliniCare, but to do so the provider must register with PaySpan by contacting 1-877-331-7154 or at www.payperformance.com.

Paper and Corrected Claims:
 Providers may submit paper claims and corrected claims to the following address. Corrected claims must be clearly marked as such to avoid denials as duplicate claim submission:
 IlliniCare Health Plan
 ATTN: Claims Department
 P.O. Box 4020
 Farmington, MO 63640-4402

Claim Requests for Payment Reconsideration:
 To request payment reconsideration, providers may contact the Claims Provider Services Unit at 1-866-329-4701, or they may submit a written request to:
 IlliniCare Health Plan
 ATTN: Claims Department
 P.O. Box 4020
 Farmington, MO 63640-4402

If the payment request for reconsideration is unsuccessful, providers may submit a Provider Claim Dispute Form (found in our website under Provider Forms) to:
 IlliniCare Health Plan
 PO Box 3000
 Farmington, MO 63640-3800

Timely Filing Guidelines
 180 Days (the date to file are from the DOS to the received date)
 45 Days to receive a corrected claim, Request of Reconsideration or Claim Dispute (date of EOP to the received date).
 * Please see provider or billing manual for more detailed information

Ongoing Education and Training

LHC’s efforts to educate our providers about billing requirements do not stop once orientations have been completed. We offer our network providers an ongoing training curriculum that ensures that providers remain updated on changes in billing requirements and maximizes their ability to submit clean claims and receive timely payment for services rendered. ***Any changes to claims coding and processing guidelines will be made available to providers no less than ninety days before implementing the changes.***

- *Office Site Visits* which are conducted by our local Provider Relations Specialists based on a set schedule and frequency by provider specialty and member volume
- *Train the Trainer*, where LHC identifies provider champions who receive extensive training and can then serve as a resource for other providers
- *Quarterly Newsletters* which address medical as well as billing and payment issues identified in the program (*Provider Watch*). Our “Provider Watch” newsletter is targeted to office managers, administrative, and billing staff. Topics include administrative support information such as billing and prior authorization changes, updates on key DHH programs and indicators and NPI information. The “Provider Watch” will be mailed to each contracted Provider office and also posted on the website.
- *On-demand Web-based Training*. Available 24/7 to providers at a time and location convenient for them, web-based training is self-paced and allows providers and their office staff to select courses of particular interest to them such as billing requirements.

- *Webinars.* More interactive than on-demand web-based training, this e-learning method includes audiovisual and action features and is conducted in real-time. With webinar meetings, LHC will share our desktop files and computer applications with participants. To participate, the provider simply needs a fast Internet connection and either conference-call-enabled telephones or VoIP (voice-over Internet protocol).
- *BlastFax and Customized mailings containing billing information and updates.* LHC will follow the best practice of other affiliate Centene health plans, who have found BlastFax to be especially efficient and effective in reaching providers with urgent information about regulatory, contract, or other changes – such as changes in billing requirements -- as provider staff are accustomed to receiving and acting on faxes. (BlastFax enables our staff to send from their desktop computer a fax to hundreds of providers simultaneously.) Short faxes work best and, when information on changes is less urgent or is lengthier than what is suitable for a fax, we use customized mailings to communicate with providers. LHC's practice for notifying providers of changes will be to include a return phone and fax number and other appropriate contact information so that providers can readily ask questions and ensure that communication is a two-way street.
- *Explanation of Payment EOP Stuffers.* LHC's affiliate health plans have used EOP stuffers a number of times over the past few years as an easy way to quickly circulate information to out-of-network as well as network providers. We will use this medium for reminders and information that are not specific to a certain provider type. For example, to encourage providers to move towards submitting claims electronically we included a stuffer on EDI information with the paper checks.
- *Provider Portal.* LHC's ***Provider Portal will be functionally equivalent to DHH's fiscal intermediary and will also house many tools for our provider partners***, including our Provider Manual, quick reference guide, billing manual and other claims submission and inquiry information and online training curriculum related to billing and claims submission requirements.

Tracking Provider Training

LHC will use our Provider Relationship Manager (PRM) to track all provider education and training. Built based on best of class contact relationship management and provider data management technologies, our PRM will allow us to more efficiently coordinate communications with our providers no matter the media (in person group trainings, phone, IVR, fax, email, or web). One PRM component is ProviderReach, our automated outbound provider campaign management application for efficient and coordinated launch of provider communications and notices. For example, we will use ProviderReach for an outreach campaign to recruit providers to submit claims via EDI and encourage claims payment through EFT. PRM will integrate with our other provider service applications, such as the Provider Portal. LHC will also request that all in-person and web-based training attendees complete a brief evaluation on each training session. Providers attending face-to-face training sessions are asked to complete a one-page survey at the end of the training. The survey includes a 5-point scale with 7 to 9 questions, and space for comments. Webinar training includes a built-in evaluation form at its conclusion. Provider Relations staff aggregate and review survey scores monthly to revise and update the curriculum and materials as needed. Performance reviews for Provider Relations staff are based in large part on their aggregate scores and feedback on evaluations. We also convene from time to time regional Special Provider Advisory Groups where LHC leadership solicit from and discuss with Providers key program issues including training needs. Copies of all Provider training attendance rosters, dated and signed by each attendee, will be kept on file. Web-based training will be tracked electronically.

Question G.12

Educating and Training Providers
Joining Network After
Implementation

G.12 Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.

Louisiana Healthcare Connections (LHC) provider education and outreach program will encompass all components of the Coordinated Care Networks (CCN) Program and DHH requirements. We will ensure that training is provided to all provider types, including physicians (primary care and specialists), hospitals, and ancillary and vision providers and that all Provider Relations Specialists and Provider Services Call Center staff are trained on all LHC programs and requirements so our providers receive efficient “one and done” service and are not transferred to other staff.

We will draw on the expertise of our parent company, Centene Corporation (Centene), whose affiliate health plans have been partnering with Medicaid providers since 1984 and continually enhancing and refining their provider education processes and materials. For example, in Texas alone in 2010 LHC’s affiliate health plan conducted 175 group trainings in which 1,572 health care providers or administrative staff participated. In addition to these trainings, in Texas in 2010 Provider Relations staff conducted approximately 1,500 on-site visits, ad hoc trainings, and other Provider in-service sessions.

LHC’s policy is to offer the same robust training to all providers who join LHC’s network, whether they are joining before or after program implementation. This training begins during initial recruitment activities and continues throughout the provider’s participation with LHC.

Initial Training and Orientation

Once a provider has contracted with LHC and completed the credentialing process, we will provide comprehensive education that addresses all aspects of plan operations, the CCN Program and DHH requirements.

Provider Welcome Packet. Within fourteen days of completing initial credentialing, LHC’s Provider Services Department will mail all new providers a Provider Welcome Packet. This packet contains all of the materials and information a provider will need in order to participate in LHC’s network, including the following:

- Welcome Cover Letter
- Provider Quick Reference Guide
- Prior Authorization Requirements List
- MemberConnections® Brochure and Referral Form
- Pregnancy Notification Form
- Medical Prior Authorization Form
- PaySpan Brochure (Information and registration for electronic transactions)
- EPSDT Tools
- Referrals for Case Management Services
- Panel Requests (Prebirth, Full, Hold, and Disenrollment)
- Claims Dispute and Appeal Forms
- Copies of recent provider communication letters/newsletters/forms

Provider Orientations. In addition to the written materials sent to all new providers, LHC Provider Relations Specialists in conjunction with the Provider Claims Educator will conduct office orientations with providers and their office staff ***within 30 days from the date the provider became a participating provider***. Orientations may be conducted in various ways, including but not limited to:

- Individual meetings in the provider’s office according to the provider’s availability (the most common means for completing orientations following program implementation)
- Group Workshops in a community location such as a local hospital, FQHCs or community center during several days and different times. For example, we will work with our partner, LPC&A to participate in standing *Louisiana Primary Care Association’s (LPCA) meetings, such as the Clinician Branch Committee or other meetings* and with the *Louisiana Rural*

Health Association and Louisiana Hospital Association to schedule orientations with groups of their constituents.

- Webinars during several days and different times

During these orientations all aspects of LHC, the CCN Program and DHH requirements are addressed, including but not limited to:

CCN	LHC Guidelines	LHC Benefits
<ul style="list-style-type: none"> • Program goals and objectives • CCN participation • Covered services • Program Eligibility and Benefits • Limitations on provider marketing • Requirements around identification of special needs members 	<ul style="list-style-type: none"> • Prior authorization and referral guidelines • Billing and reimbursement • Reporting requirements • Practice requirements, as applicable to the provider type (e.g., 24 hour access, covering physician) • Credentialing and recredentialing • Quality improvement 	<ul style="list-style-type: none"> • Claims adjudication performance • Pay-for-Performance • Member outreach services • Disease Management Program (population-based interventions, case management)

Reference Materials. LHC offers our providers several written resources that provide information about LHC and CCN Program. We distribute these materials in Provider Welcome Packets and during initial orientations, both in hard copy and on CD, and maintain copies available on our website.

LHC’s Provider Manual (approved by DHH 30 days prior to contract effective date) describes the manner in which LHC manages its Medicaid program as well as operational procedures followed by our company. The Provider Manual is distributed during initial orientations and is available online on the Provider Portal. It covers a broad array of topics, included but not limited to:

- A Description of the CCN Program
- Emergency Service Responsibilities
- Member Grievance System information
- Medical Necessity standards (DHH and practice guidelines)
- Medical record standards
- Claims submission protocols and standards
- Notice that provider complaints regarding claims payment shall be sent to CCN
- Provider Rights & Responsibilities
- Cultural competency information
- Value added services and benefits
- Quality Improvement program and requirements
- CCN Core Benefits and Services
- Process for filing a complaint
- Primary Care Physician responsibilities
- Description and requirements of a Patient-Centered Medical Home
- Prior authorization and referral procedures
- CCN Prompt pay requirements
- Practice protocols (including guidelines for treating chronic and complex conditions)
- Other provider contractual responsibilities
- Eligibility verification process
- EPSDT standards
- Credentialing and re-credentialing information

The Provider Billing Manual is LHC’s guide for providers that describes the manner in which providers are expected to bill for services covered by our program. The Billing Manual is comprehensive and addresses all aspects of claims submission and billing requirements, as discussed above in our response to question G.11.

LHC’s Provider Quick Reference Guide is a “cheat sheet” summarizing the operational policies and procedures that govern our program that includes information about billing requirements. The following represents a sample of a quick reference guide for IlliniCare, LHC’s Illinois affiliate health plan:



Provider Quick Reference Guide

Provider Services

Contact the Health Plan Provider Services Department at 1-866-329-4701 for assistance with the following services:

- Answer questions regarding claim status
- Provider education/ orientation
- Network participation
- Member eligibility/ verification
- Change, update or correct demographic information

Providers can visit IlliniCare Provider Portal at www.IlliniCare.com to access the following:

- Provider Manual
- Provider Forms
- Billing Manual
- Companion Guide for Electronic Transactions
- Wellness Information
- IlliniCare News
- Clinical Guidelines
- Provider Newsletter (If you are not able to access the newsletter via web, please contact Provider Service)

The following information is available via the secure portal at www.IlliniCare.com:

- Member Eligibility
- PCP Verification
- Submit Claims
- Claims Inquiry
- Request Prior Authorization for Services
- View PCP Panel (patient list)

Claims Services

Electronic Claim Submission:

For claim processing efficiency and cost savings to the providers, IlliniCare encourages its providers to file claims electronically. IlliniCare's Payor ID is 68066. Please visit our website at www.IlliniCare.com for our electronic Companion Guide and our Billing Manual which offers more detailed information regarding claims billing instructions. Our Clearinghouse vendors include Emdeon, Envoy, WebMD, and Gateway EDI. Participating providers may receive electronic funds transfers (EFT) and electronic remittance advice (ERA) from IlliniCare, but to do so the provider must register with PaySpan by contacting 1-877-331-7154 or at www.payperformance.com.

Paper and Corrected Claims:

Providers may submit paper claims and corrected claims to the following address. Corrected claims must be clearly marked as such to avoid denials as duplicate claim submission:

IlliniCare Health Plan
ATTN: Claims Department
P.O. Box 4020
Farmington, MO 63640-4402

Claim Requests for Payment Reconsideration:

To request payment reconsideration, providers may contact the Claims Provider Services Unit at 1-866-329-4701, or they may submit a written request to:

IlliniCare Health Plan
ATTN: Claims Department
P.O. Box 4020
Farmington, MO 63640-4402

If the payment request for reconsideration is unsuccessful, providers may submit a Provider Claim Dispute Form (found in our website under Provider Forms) to:

IlliniCare Health Plan
PO Box 3000
Farmington, MO 63640-3800

Timely Filing Guidelines

180 Days (the date to file are from the DOS to the received date)

45 Days to receive a corrected claim, Request of Reconsideration or Claim Dispute (date of EOP to the received date).

* Please see provider or billing manual for more detailed information

IlliniCare Health Plan
1-866-329-4701
www.IlliniCare.com

Medical Management

IlliniCare Medical Management team provides oversight for utilization management, care coordination/case management, and disease management. Authorization must be obtained prior to the delivery of certain elective and scheduled services. For more information on services that require prior authorization, please refer to the list attached or visit our website at www.IlliniCare.com. To secure an authorization to provider services, providers may call 1-866-329-4701.

Member Services

Members can visit our website to access our Member Handbook and learn more about our programs and services. Member Services is available Monday thru Friday from 8:00 a.m. to 5:00 p.m. CST to answer questions regarding the following issues for your patients:

- Find a Doctor
- Benefits Eligibility
- ID Card Replacement
- PCP Changes

Member Service Line (Monday thru Friday 8:00 a.m. to 5:00 p.m. CST.
 1-866-329-4701 or 1-866-811-2452 TDD/TTY

Value Added Member Benefits

IlliniCare provides the following value added benefits to our members to enhance their benefits and improve their healthcare:

NurseWise®
 1-866-329-4701

NurseWise is a 24 hour free health information phone line. The nurse triage service provides access to a broad range of health-related services including health education and crisis intervention.

MemberConnections® is an educational outreach program designed to educate members about how to access healthcare services and benefits. The program conducts one on one education with members to ensure they understand their benefits, the role of the Medical Home (PCP) and why it's important to establish and maintain a relationship with the Medical Home. Contact Member Services if you have a patient that needs help understanding the program.

Start Smart for Your Baby®
 Is our special program designed to educate women who are pregnant.

- Nurtur®** provides a full spectrum of Disease Management outreach and education to members with chronic conditions such as:
- Asthma
 - Congestive Heart Failure (CHF)
 - Diabetes
 - Hypertension
 - Obesity
 - COPD
 - Coronary Artery Disease (CAD)

Vendor Services

Behavioral Health
Cenpatico Behavioral health
 Phone: 1-866-329-4701

Opticare
 Customer Relations:
 1-800-334-3937

Pharmacy Benefits Manager
US Script
 Prior Authorization:
 • Phone: 1-866-399-0928
 • Fax: 1-866-399-0929
 • Help Desk Line 1-877-861-6724

CVS Caremark:
 Phone: 1-800-237-2767
 Prior Authorization Fax line:
 1-800-323-2445

Non-emergent Transportation
First Transit
 Phone: 1-866-329-4701

Radiology Services
National Imaging Associates (NIA)
 1-866-329-4701
www1.radmd.com

Dental Services
DentaQuest
 1-866-912-6285

Sample Member Card (Front and Back)



Clinical Practice Guidelines. LHC educates providers on clinical practice guideline (CPG) application and how our Case and Disease Management Programs support use of CPGs. CPGs and related educational materials are available on our website and upon request.

Examples of the clinical practice and preventive health guidelines we will provide include:

- ADHD
- Adult Preventive Care
- Asthma
- Bipolar Disorder
- Diabetes
- Immunizations
- Lead Screening
- Major Depressive Disorder
- Pediatric Preventive Care
- Perinatal Care
- Schizophrenia
- Sickle Cell
- Autism/pervasive development disorder
- Chronic kidney disease
- Congestive heart failure
- Coronary artery disease
- Schizophrenia
- Hypertension – prevention, diagnosis, and treatment

Ongoing Education and Training

Training Modalities. LHC’s efforts to educate our providers does not stop once orientations have been completed. We offer our network providers an ongoing training curriculum that ensures that providers remain updated on LHC and DHH requirements and any changes in clinical guidelines.

- *Office Site Visits* which are conducted by our local Provider Relations Specialists based on a set schedule and frequency by provider specialty and member volume
- *Train the Trainer*, where LHC identifies provider champions who receive extensive training and can then serve as a resource for other providers
- *Town Hall/ Open Invitation Trainings.* At least quarterly, LHC will hold trainings for our providers and their office staff throughout the State and will post video of the trainings on our website. Ongoing training targets new and revised CCN Program requirements or addresses a particular need for further education and cyclically reviews all matters covered in the initial orientation. Refresher training is important for Providers that experience high turnover in direct care or office staff.
- *Ad Hoc/Customized Training.* This is conducted when we determine that a provider needs additional or customized training, for example, based on a provider request, monitoring, claims submission errors, member complaints, or provider profiling. These trainings usually are held in provider offices or by teleconference.
- Because clinical and non-clinical staff needs vary, LHC will publish two *quarterly newsletters*:
 - *Provider Watch.* Our “Provider Watch” is targeted to office managers, administrative, and billing staff. Topics include administrative support information such as billing and prior authorization changes, updates on key DHH programs and indicators, and NPI and EPSDT information. The “Provider Watch” is mailed to each contracted provider office and also posted on the website.
 - *Communicator.* The LHC “Communicator” is distributed to all LHC network providers. The “Communicator” is a Centene national provider publication that updates providers on important clinical and quality of care information. The “Communicator” is customized to address the specific needs of LHC providers.
- *On-demand Web-based Training.* Available to providers 24/7 at a time and location convenient for them, web-based training is self-paced and allows providers and their office staff to select courses of particular interest to them such as billing requirements.
- *Webinars.* More interactive than on-demand web-based training, this e-learning method includes audiovisual and action features and is conducted in real-time. With webinar meetings, LHC will share our desktop files and computer applications with participants. To

- participate, the provider simply needs a fast Internet connection and either conference-call-enabled telephones or VoIP (voice-over Internet protocol).
- *BlastFax and Customized mailings containing billing information and updates.* LHC will follow the best practice of other affiliate Centene health plans, who have found BlastFax to be especially efficient and effective in reaching providers with urgent information about regulatory, contract, or other changes –as provider staff are accustomed to receiving and acting on faxes. (BlastFax enables our staff to send from their desktop computer a fax to hundreds of providers simultaneously.) Short faxes work best and, when information on changes is less urgent or is lengthier than what is suitable for a fax, we use customized mailings to communicate with providers. LHC’s practice for notifying providers of changes will be to include a return phone and fax number and other appropriate contact information so that providers can readily ask questions and ensure that communication is a two-way street.
 - *Explanation of Payment EOP Stuffers.* LHC’s affiliate health plans have used EOP stuffers a number of times over the past few years as an easy way to quickly circulate information to out-of-network as well as network providers. We will use this medium for reminders and information that are not specific to a certain provider type. For example, to encourage providers to move towards submitting claims electronically we included a stuffer on EDI information with the paper checks.
 - *Provider Portal.* LHC’s **Provider Portal** will be functionally equivalent to DHH’s fiscal intermediary and will also house many tools for our provider partners, many of which will be distributed during trainings or mailings prior to being posted online. LHC posts DHH-approved materials to our provider website no later than three business days after distribution and typically within one business day of distribution. Provider materials posted to the website are organized in a user-friendly, searchable format by communication type and subject and include:
 - LHC & CCN Provider Manuals
 - LHC Quick Reference Guide
 - Billing manual and other claims submission and inquiry information
 - CCN-relevant DHH bulletins
 - Information on upcoming training events, such as webinars
 - Information on limitations on provider marketing
 - Information on the provider grievance system
 - Information on and ability to obtain prior authorizations and referrals
 - Contact information for LHC’s Provider Services Department

Curriculum. Topics will vary according to recent developments and identified need. Topics for quarterly training are based upon:

- Provider satisfaction survey results
- Trends in Provider Call Center inquiries
- Trends in member grievances and provider complaints
- Changes in DHH or LHC policies and procedures
- LHC quality improvement initiatives
- LHC priorities such as cultural competency and incentives.

Tracking Provider Training

LHC will use our Provider Relationship Manager (PRM) to track all provider education and training. Built based on best of class contact relationship management and provider data management technologies, our PRM will allow us to more efficiently coordinate communications with our providers no matter the media (in person group trainings, phone, IVR, fax, email, or web). One PRM component is ProviderReach, our automated outbound provider campaign management application for efficient and

coordinated launch of provider communications and notices. For example, we will use ProviderReach for an outreach campaign to recruit providers to submit claims via EDI and encourage claims payment through EFT. PRM will integrate with our other provider service applications, such as the Provider Portal. LHC will also request that all in-person and web-based training attendees complete a brief evaluation on each training session. Providers attending face-to-face training sessions are asked to complete a one-page survey at the end of the training. The survey includes a 5-point scale with 7 to 9 questions, and space for comments. Webinar training includes a built-in evaluation form at its conclusion. Provider Relations staff aggregate and review survey scores monthly to revise and update the curriculum and materials as needed. Performance reviews for Provider Relations staff are based in large part on their aggregate scores and feedback on evaluations. We also convene from time to time regional Special Provider Advisory Groups where LHC leadership solicit from and discuss with providers key program issues including training needs. Copies of all provider training attendance rosters, dated and signed by each attendee, will be kept on file. Web-based training will be tracked electronically.

Question G.13
Provider Profiling

G.13 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.

- Submit sample quality profile reports used by you, or proposed for future use (identify which).
- Describe the rationale for selecting the performance measures presented in the sample profile reports.
- Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.

Overview

The LHC Provider Profiling Program is designed to analyze utilization data to identify PCP utilization and quality issues. Provider Profiling is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and quality of care in alignment with evidence-based clinical practice guidelines. LHC's Program and Provider Overview Reports will increase provider awareness of performance, identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. Our Profiling Program will incorporate the latest advances in this evolving area.

Following the successful approach adopted by other Centene affiliate health plans, we will jointly develop our approach with our owner-partner FQHCs and other network providers, to ensure the process will have value to providers, members, and LHC. Through our Quality Assessment and Performance Improvement Committee (QAPIC), we will work closely with providers to select profile indicators, build useful analyses and help providers understand and use feedback to improve care. This collaborative effort has fostered provider acceptance of profiling results in our affiliate plans and will help LHC motivate providers to continuously improve performance in targeted areas. Chosen profile measures differentiate physicians and other providers with superior performance, and our financial and non-financial incentives, aligned with these measures, will encourage continuous improvement.

To ensure the best possible results, we will use both plan and Centene analysis capabilities as the foundation for profiling, since effective improvement requires complex analysis and feedback at several levels of the care process. Our Overview Reports will be produced from Centelligence™, our robust, integrated business intelligence platform, supported by Centene's TerraData-powered Enterprise Data Warehouse. Centelligence components can generate all required performance indicators, and have the additional capabilities of producing refined peer-to-peer comparison groups within specialties, regions, and programs, and risk-adjusting performance scores based on member acuity. Please see Question R.10 for more information on Centelligence.

Program Authority and Components

Our Chief Medical Director (CMD) has final authority and responsibility for our Profiling Program. Prior to the start of each profiling year, the QAPIC, which includes network primary care (including OB/GYN) and other specialist providers, will review and approve the types of providers to be profiled; the participation criteria for individual providers or group practices; and the performance indicators to be used in the Overview Reports. The QAPIC considers the average number of members served and the specific needs of enrolled members when determining the types of providers to include.

Participation Criteria. LHC will review Program participation criteria annually to ensure that we include as many providers as possible in our Profiling Program, but will target providers with sufficient panel size to allow statistically valid comparisons. To this end, we will initially profile PCPs with a total panel size for an individual or group practice of 250 or more members. We will also profile key specialty types that address the special needs of the CCN-P population, such as cardiology and allergy/immunology, as well as acute care hospitals. The QAPIC will re-evaluate this panel size criterion

and specialty types after the 2012 profiling cycle to ensure that we are achieving our goal of maximum participation. Participation criteria are summarized below.

Provider Type	Criteria
Family Practice, Internal Medicine, Pediatrics	Providers with panel size of 250 or more members
OB/GYN, Cardiology and Allergy/Immunology	Providers who served 50 or more Members during the reporting year
Acute Care Hospitals	Facilities with 300 or more claims during the reporting year

Profile Indicators. Each year, LHC’s QAPIC will approve profile indicators that provide a multi-dimensional assessment of performance, using clinical, administrative, and member satisfaction related data. Initially, our selection of profile indicators will be guided by the required activities in 8.7.3 and clinical performance measures in Appendix J. In subsequent years, the QAPIC will consider supplementing DHH-required indicators with additional measures that are measurable, reliable, and valid; have available, reliable benchmark data; are relevant to our members, providers, and our QAPI program; and are actionable by providers. To establish trends and to permit assessment of improvement efforts over time, we will measure the same indicators for multiple years. Our Overview Reports for different provider types will have unique sets of indicators that are relevant to the services rendered by those providers, and that promote compliance with evidence-based clinical practice guidelines.

Benchmark Data. Annually, the QAPIC will identify and establish performance thresholds and improvement benchmarks for each selected indicator. The QAPIC will derive benchmarks from LHC network-wide data, DHH goals, national Medicaid NCQA Quality Compass, and other credible published data. LHC will disseminate all approved participation criteria, profile indicators, and performance benchmarks to providers before each measurement cycle through the Provider Newsletter and Provider Portal.

Profile Generation and General Distribution. Approximately three months after the close of each profiling year (to allow for claims lag), Centene’s Quality Improvement and Health Economics staff will collect indicator data and generate individual and summary annual Overview Reports. Prior to profile distribution, an LHC inter-departmental data analysis team will analyze profile results to confirm validity, clinical relevance, and accurate data interpretation. LHC will post Overview Reports for all provider types on our secure Provider Portal and provide targeted feedback to select providers as described below.

Targeted Provider Feedback. After Overview Reports are generated, the CMD or Provider Relations staff will meet face-to-face with each provider whose combined score on all indicators is below the 5th percentile to develop an action plan for improving identified measures to a target level of performance. Part of the discussion will focus on identifying actions we can take to support the provider’s improvement efforts. Staff may help the provider identify resources such as the American College of Physicians ACPNet web-based continuing medical education (CME) on QI methodology¹ or the American Academy of Family Practice TransforMED program for becoming a patient-centered medical home². Such help might also include data or support from QI staff or referrals to another high-performing network provider for support. QI staff will re-evaluate the provider’s performance every three to six months, until an acceptable level of performance is achieved. They will also meet with select providers above the 95th percentile to identify best practices that can be shared with other network providers.

¹ www.acponline.org/running_practice/quality_improvement/projects/acp_net/

² www.transformed.com

Submit sample quality profile reports used by you, or proposed for future use (identify which).

For sample future Provider Overview Reports for PCPs, please see *Attachments G.13-A: PCP Adult Overview Report; G.13-B: PCP Child Overview Report; and G.13-C: OB/GYN Overview Report*. For sample current Provider Overview Reports for high volume specialists generated by our Texas Affiliate, Superior HealthPlan, please see *Attachments G.13-D: Orthopedics; G.13-E: ENT*; and for sample current Acute Care Facility Overview Reports generated by Superior HealthPlan, please see *Attachment G.13-F: Acute Care Facility*.

Describe the rationale for selecting the performance measures presented in the sample profile reports.

LHC selected the indicators presented in the sample PCP Provider Overview Reports based on the following rationale:

Multi-Dimensional Assessment. LHC selected profile indicators within the Institute of Medicine’s framework for quality: safe, effective, patient-centered, timely, efficient, equitable, and with the goal of meaningful provider participation. We ensure maximum provider involvement by selecting indicators that are credible to and actionable by providers. Our profile reports contain utilization measures to indicate how the provider’s panel is using services. Specialist Visits per 1000 members, Emergency Department Visits per 1000 members, Congestive Heart Failure Admission Rate, and Prescriptions per 1000 members. Clinical quality measures, such as Adult Access to Ambulatory Health Services, EPSDT Screening Ratio, Cervical Cancer Screening, and Annual Hemoglobin A1c Testing for diabetics are also included to measure, for example, how effectively a PCP provides and promotes access to key preventive health services and complies with select clinical practice guidelines. These indicators may also measure the impact of certain clinical interventions. We may also include non-clinical quality indicators, such as complaints or average months of enrollment, to measure member satisfaction with providers.

Accurate and Measurable. The accuracy and measurability of profile indicators are critical to the credibility of the profiling process. Providers are less likely to participate in a profiling program if they question the validity of profile measures, which is why we use nationally-recognized and standardized HEDIS and AHRQ measures whenever possible. We may, however, modify the age and eligibility requirements, when appropriate, to ensure an adequate number of members for each indicator. LHC will also test any custom profile indicators for accuracy and measurability before full implementation. We may use certain custom measures that were developed, tested, and implemented in other Centene affiliates and have established credibility. In addition, we may reject non-required indicators due to validity concerns, such as a lead screening measure for which an affiliate plan could not access required data from a state lab database.

Availability of Benchmark Data. LHC considers the availability of benchmark data to be an important rationale for measure selection. Established benchmark data is part of sound QI methodology and can be a strong motivating factor that appeals to a provider’s competitive nature. Benchmarks show providers how their members are doing and how their own performance compares to their peers. LHC will use national Medicaid NCQA Quality Compass benchmark data for HEDIS measures, network-wide average scores for all measures, and DHH performance standards whenever available.

Relevance to Enrolled Population. We include only those indicators that are relevant to our membership and for the provider type profiled. For example, our PCP Adult Overview Report indicators include access to preventive care, cervical cancer screening, and management of common chronic conditions, such as diabetes. Our PCP Child Overview Report includes pediatric measures, such as immunization status, child access to primary care services, and ADHD medication management. A measure such as chlamydia screening that is relevant for both age groups is in both the Adult and Child PCP Overview Reports.

Relevance to QI Initiatives, Clinical Practice Guidelines, and DHH Priorities. Profile reports include indicators that measure compliance with clinical practice guidelines and are relevant to our clinical

initiatives. To focus on DHH priorities, such as preventive services and the management of chronic conditions, our PCP Overview Reports will include indicators for adult access to preventive care and comprehensive diabetes care.

Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.

LHC will produce and distribute annual Provider Overview Reports to PCPs, including OB/GYNs, specialists, and acute care hospitals that meet Program participation criteria. In addition to the summary annual Overview Reports, PCPs will also receive quarterly reports throughout the year. These quarterly Overviews use rolling 12-month data and establish LHC network average and DHH goals as benchmarks for each indicator. The distribution frequency will support continuous quality improvement by providing more frequent feedback to providers. Quarterly Overview Reports will also help us to engage PCPs throughout the reporting period, since they will be able to see how their scores are progressing over the course of the year. Armed with this information, PCPs can adjust their processes or approaches and improve their performance, so they can positively impact their ability to achieve eligibility for financial incentives and recognition by year end. Since we expect the network average to improve over time, we also anticipate continuously raising the performance bar for each indicator. Our profiling approach aligns with recommendations from the AMA Physician Consortium for Performance Improvement, NCQA, and the National Quality Forum. LHC will submit all PCP profile reports to DHH quarterly with a summary report annually.

Question G.14

Provider Inquiries, Complaints, and
Requests for Information

G.14 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.

Overview

Louisiana Healthcare Connections (LHC) will leverage the experience of its parent company, Centene Corporation and its joint venture partner LPC&A to build strong provider relationships and work collaboratively with providers to design, monitor and improve all aspects of plan operations. Centene plans go the extra mile to provide excellent customer service, education and support to our providers. This requires a focus on identifying and reducing the ‘hassle factor’ that can result in provider dissatisfaction. Centene plans have experience transitioning providers from fee-for-service Medicaid to managed care. For example, we have contracted with over 15,000 providers and 140 hospitals in the transition to Medicaid managed care in Georgia. Most recently, we have contracted with over 5,000 providers and 90 hospital in the transition to Medicaid managed care in Mississippi which began operations through Magnolia Health Plan earlier this year. We have also recently transitioned thousands of providers in Illinois through our IlliniCare Health Plan, which began operations on May 1, 2011. We understand the critical importance of starting a new program off on the right foot. This requires constant attention to provider concerns and reliable responsiveness during implementation and ongoing. Through 27 years of experience of LHC’s affiliate health plans, we employ various proactive strategies to reduce provider dissatisfaction in the beginning of an implementation. These strategies include, but not limited to, provider training and education, processing member ID cards timely, waiving authorizations for non-par providers for a period of time, employing resources to handle provider/member nomination requests for providers, and ensuring member continuity of care for ongoing services.

LHC will develop and maintain a consistent process for managing provider inquiries, complaints, and requests for information that ensures prompt resolution and relaying of **accurate** information. We will use the information garnered from provider inquiries to make improvements in our policies and processes. In-network and out-of-network providers may submit inquiries, complaints or requests for information by phone, in writing, via email or secure messaging, or in person. For each method of receipt, the staff handling the issue receive training at the time of hire, and on an ongoing basis, to ensure they are able to provide accurate information to providers in a timely manner.

LHC will operate a toll-free provider call center, located in Baton Rouge, which will be staffed Monday through Friday, 7:00 a.m. to 7:00 p.m. Central Standard Time, by Provider Service Representatives (PSRs) in our Provider Services (PS) Department. After-hours and on state designated holidays, providers can speak with customer service representatives from NurseWise, our 24-hour nurse advice line, to verify eligibility; obtain benefits, claims and administrative information; and discuss physical or behavioral health issues, including urgent or emergent member issues, with a Registered Nurse. In addition to our call center PSRs, our Provider Relations Department employs a team of Provider Relations Specialists who are field liaisons working actively with our providers in the communities we serve, and are knowledgeable of all aspects of provider services. Our PSRs and Provider Relations Specialists will be equipped to respond to provider questions in all areas, including provider complaints regarding provider responsibilities, and assist with any provider access concerns including prior authorization requests. To further enhance our service to providers, our staff will include a Provider Claims Educator position, with specialized EDI expertise, and designated Centene Claims, EDI Operations and Information Systems staff. Our team will engage providers to work through any issues or barriers they may have with claims submissions, resolutions and adjustments; identify trends and provide the necessary training. They will be empowered to facilitate rapid resolution of provider issues, such as the initiation of immediate claim adjustments, through collaboration with their Centene designated counterparts.

Innovative and Integrated Technology

LHC's call management and provider data systems are the primary tool used by call center and Provider Relations staff to manage provider inquiries, complaints, and requests for information. LHC's Provider Services Department shares the same call management platform as all internal LHC departments and NurseWise. The Avaya Call Management System (Avaya) provides seamless and efficient call answering capabilities, reporting, and transfers. During the call, staff will document all inquiries in our **Provider Relationship Management** system (PRM). PRM is our provider services inquiry system powered by Microsoft Dynamics CRM[®] customer relationship management software and by our Portico enterprise provider data management system. PRM is sophisticated and goes beyond traditional call tracking modules. It combines, **integrates**, and deploys data from multiple internal systems, such as AMISYS Advance, our claims and eligibility transaction processing system, and TruCare, our integrated, member-centric health services management platform, presenting a single view patterned by user type or user need. PRM presents staff with all relevant information right at their fingertips so they may quickly and accurately address inquiries without having to access multiple systems independently. PRM has several components to support the activities of our PSRs, such as **ProviderConnect**, our new application for creating, routing, tracking, managing, and reporting provider inquiries. This application provides our PSRs with information and functionality to facilitate a complete response to provider inquiries including but not limited to:

- **Claims and Payables:** PSRs can search and review claims activity within ProviderConnect; view detailed claim submission information or related correspondence; respond to status queries about a claim or payment; and, if needed, route the call to a work queue for a Claims Liaison to address.
- **Authorizations:** PSRs can view authorization requests submitted by the provider and their status.
- **Care Gaps:** If the member at the center of a call from the provider has a gap in recommended care, a visible alert will display prompting the PSR to ask the provider if they would like to speak with the member's assigned case manager.
- **Provider Inquiry History:** The system displays a real-time summary of historical inquiries received from providers or their office staff. This summary highlights repeat or similar inquiries and potential provider educational opportunities. For example, if the system detected repeated calls from a provider regarding billing issues, the PSR may offer immediate support or initiate a request to the Provider Relations Specialist to provide an in depth review and retraining for the provider so they have a clear understanding of how to address the billing issue. With PRM, PSRs have one data source for all interactions with the provider, giving them a **comprehensive** overview with which to effectively facilitate the call they are handling in real time. For example, they can see what issues the provider has been involved with recently and they can proactively approach these activities with the provider to ensure satisfaction. A sample conversation would be "I see you had a visit from your Provider Relations Specialist last month regarding this topic. Has the issue been resolved, or would another visit or call from her be beneficial for you and your staff?"
- **Provider Demographic Information:** Information such as NPI, affiliation number, participation status, Tax Name, practice number, Taxpayer Identification Number (TIN), practice restrictions, languages spoken, service and billing locations, and panel size.
- **Member Information:** Includes contact and eligibility information, other insurance coverage (traditional Medicare or Special Needs Plan, for example), PCP assignment, languages spoken, any special needs or additional assistance required, and authorized callers who may act on the member's behalf.

Accepting and Managing Inquiries or Requests for Information

Providers may contact LHC regarding an inquiry or request for information through our provider call center, during an in person visit with their Provider Relations Specialist, submitting an email or secure message via our Provider Portal, or correspondence via fax or US Mail.

General Inquiry Calls to the Provider Call Center. When providers call, the Avaya system immediately will greet the incoming caller, and callers are presented with prompts that immediately connect them to 1) eligibility verification; 2) medical management; or 3) claims inquiries and provider information. Callers selecting option 3 are transferred to a PSR. Calls are answered promptly, in the order received, and by the first available PSR. If at any point the caller wishes to speak to a “live person,” they may bypass the prompts by pressing “0” for immediate connection or they can stay on the line and the system will route them to a PSR at the conclusion of the phone prompts. We will be implementing an **Integrated Voice Response** solution with voice activated and touch tone recognition that will allow providers access 24/7 to information such as eligibility, PCP assignment, and claim status including paid date and amount. Call transfers to other departments are minimal and generally occur when the inquiry involves clinical or administrative issues that need to be answered by a clinician.

Claims Inquiry Calls. PSRs handle most claims inquiries. However when they receive a complex claims inquiry, they advise the caller of the need for research and provide a time estimate within which the provider can expect a response. PSRs route via PRM the record of complex claims inquiries to our local Claims Liaisons who complete the research and provide feedback to the PSR regarding necessary next steps. This arrangement frees PSRs to focus on answering other calls, and the caller receives a return call from the same person they initially spoke with who is most familiar with the case. This approach holds the PSR **accountable** for the entire inquiry, from receipt through research to response, offering a seamless customer service experience for our providers.

In Person Inquiries at Provider Offices. When Provider Relations Specialists receive provider inquiries during an onsite meeting, they follow the same approach and protocols as our call center PSRs by accessing PRM remotely via their laptops. If the Provider Relations Specialist is unable to answer the question during the onsite visit, the Provider Relations Specialist will contact the provider within three business days with the answer or provide a status report along with the expected timeframe for resolution.

Inquiries Via Secure Messaging, Fax or US Mail. LHC’s Provider Portal enables providers to submit inquiries via secure messaging. Using the Portal, providers select from a drop down menu and complete a standard form based on their menu selection. When the provider clicks “submit,” the web server time stamps the secure message to allow for tracking of response time. The inquiry is systematically routed to a designated PSR for resolution and, upon completion, the PSR emails the provider that a response is available on the secure Provider Portal and that they must log in to access the response. This notification ensures that we comply with HIPAA security requirements. Correspondence received via fax or US Mail is scanned and attached to the call record in PRM for reference and documentation, and the inquiry is routed to the designated PSR for resolution. Regardless of the method of submission, our PSRs acknowledge all inquiries within three business days and respond with resolution within 10 business days. If unable to resolve an issue within 10 business days, the PSR notifies the provider and gives an estimated date of completion not to exceed 30 days from receipt.

Documenting and Managing Inquiries or Requests for Information

PSRs document all inquiries and requests for information in PRM, assigning a “call type and sub-type” category for inquiry tracking and monitoring purposes. Examples of these categories include *Provider Updates/Status Information* for inquiries related to provider status and demographics, provider number, TIN or NPI information; *Provider Requests* for information related to requests for manuals, copies of Explanation of Payment forms, and check copies or requests for a Provider Relations Specialist visit; and *Provider Education* for inquiries related to requests for support with the claims submission, Electronic Data Submission, Electronic Funds Transfer or Authorization processes. Each category has a predefined timeframe within which the inquiry should be addressed and aids in our monitoring of established call management metrics. The Supervisor monitors the rate of FCCR as well as the age of inquiries that require further action and a callback by a PSR to a provider. This ensures that inquiries do not age beyond the predefined timeframes. For example, should assistance from an internal department be needed for a

complex claim, the PSR will document the request and systematically route the inquiry to that department via PRM. Should the inquiry remain open beyond the defined timeline for the call category, PRM prompts the PSR to initiate follow up activities and highlights the aged item for the Supervisor.

Accepting, Managing and Documenting Provider Complaints

LHC will provide implemented written policies and procedures which detail the operation of the Provider Complaint System to DHH for review and approval. This submission will occur within thirty (30) days of the date the Contract is signed with DHH. LHC's Provider Complaint System policies and procedures will contain, at a minimum, a description of how and under what circumstances providers are advised that they may file a complaint and the timeframes for resolution. We will include a complete description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact LHC Provider Relations Staff, including the Grievance and Appeals (G&A) Coordinator, who receives and processes provider complaints.

LHC will employ and maintain dedicated provider relations staff, available to respond to provider inquiries or filed provider complaints and concerns or issues. PSR staff may be reached via telephone, electronic mail, surface mail, or in person, and are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf, then receive and document provider complaints that are not related to the provider grievance and appeal process in the same way as for all other provider inquiries or requests for information. PSRs categorize all provider complaints in PRM with sub-type categories, drilling down to the specific type of complaint the provider wants to register, such as related to authorizations or locating a participating specialty provider. Once the complaint is documented in PRM, the PSR routes the complaint to the Compliance Department where it is managed by the G&A Coordinator. The Coordinator mails an acknowledgement letter to the provider within five business days. The Coordinator thoroughly investigates each provider complaint, collecting all pertinent facts from all parties and processing the complaint per LHC policies and procedures. The Coordinator works with the applicable department when researching complaints and ensures each matter is investigated using applicable statutory, regulatory, contractual and provider subcontract provisions. Upon completion of the investigation, the G&A Coordinator will issue a written decision letter to the provider, including the legal and factual basis for the decision and the right to an Administrative Hearing. For example, complaints regarding a PSR's conduct are coordinated with the Provider Services Department and complaints about preauthorization policies are coordinated with the Medical Management Department. Once a complaint is resolved, the G&A Coordinator issues a resolution letter to the provider and adds the resolution date and description along with all related documents and information to the PRM record. Our standard for complaint resolution is 15 days or less. By monitoring "inquiry age" within PRM, the Provider Services Supervisor ensures adherence to **resolution timeliness**. On a quarterly basis, the Provider Services Department will report identified trends to the Quality Assessment and Performance Improvement Committee (QAPIC) for review and recommendations for interventions or additional action. The QAPIC will track any implemented interventions, responsible parties, and outcomes which may include the development and intervention of a corrective action plan (CAP) and monitoring of the CAP through resolution.

Monitoring and Reporting

Call Center Monitoring. LHC will perform on-going call center monitoring which will include the Provider Services Supervisor silently monitoring a minimum of ten calls per PSR per month to evaluate the accuracy and effectiveness of PSR interaction, accuracy of call documentation, and ability of the PSR to identify and pursue opportunities to educate the provider. Since accurate call documentation is critical because we use trend analysis of data elements such as the "call type and sub-type" to **drive process improvements**, the frequency of call monitoring will increase during 'start-up' and implementation, with

more intensive oversight to ensure quality is demonstrated throughout all call-center activities and that all calls are handled promptly, appropriately. We rapidly disseminate this information to the staff best suited to analyze each trend and initiate immediate remediation or education. The Provider Services management team reviews PRM reports each month and presents a quarterly report of trends to the QAPIC for review, along with recommended actions to improve the effectiveness of our provider communications and education. PRM allows the management team to manage overall performance of the department, using tools such as ProviderConnect, to provide results of operational metrics, staff performance, call types, routing statistics and volumes; and Centelligence™ Insight, to provide desktop reporting and Key Performance Indicator Dashboard capabilities. These tools will help management quickly identify performance issues, monitor trends, identify opportunities for process improvement, and evaluate the effectiveness of our provider communication.

Provider Complaint Monitoring and Reporting. LHC will perform on-going monitoring of provider complaints, tracking turn-around-times to ensure the issuance of timely resolutions as well as conducting periodic internal audits to ensure the appropriate applications of regulations. LHC's PRM system will serve as a mechanism to capture, track, and report the status and resolution of all provider complaints whether received by telephone, in person, or in writing, and will include all associated documentation. Through use of the PRM system, LHC will be equipped to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.

Self-Monitoring Through Weekly Staff Meetings. Provider inquiry activity is further monitored during weekly staff meetings. All Department staff, including PSRs, and Provider Relations Specialists attend and share occurrences, trends, progress on the previous week's issues and plans for the next week's activities and challenges for their location and GSA, and identify when and what type of additional provider education or office visits may be needed. The process facilitates the identification of **emerging trends**, in order to proactively avert potential service problems, and holds each attendee accountable for specific follow up action. Meeting minutes are available to all staff online and are submitted to QAPIC quarterly.

Subcontractor Monitoring. LHC's subcontractors must comply with LHC and DHH requirements and apply similar approaches and protocols for accepting and managing provider inquiries, complaints and requests for information. Our Compliance Department monitors each subcontractor in monthly or quarterly oversight meetings (depending on the subcontractor) to ensure compliance.

Question G.15
Non-Emergency Medical
Transportation

G.15 Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:

- What administrative functions, if any, you will subcontract to another entity;
- How you will determine the appropriate mode of transportation (other than fixed route) for a member;
- Your proposed approach to covering fixed route transportation;
- How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;
- How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;
- Your approach to initial and ongoing driver training;
- How you will ensure that drivers meet initial and ongoing driver standards;
- How your call center will comply with the requirements specific to NEMT calls; and
- Your NEMT quality assurance program (excluding vehicle inspection).

LHC's Plan for the Provision of Non-Emergency Medical Transportation (NEMT)

For decades, NEMT management companies across the nation have demonstrated their important role in the overall delivery of health care services to the most vulnerable, needy and underserved Medicaid and Medicare beneficiaries in our nation. Managing this unique benefit along with developing and managing a network of non traditional, non medical providers is challenging for every Medicaid program. The unique non medical aspects of NEMT programs also lend themselves to fraud, waste and abuse in the absence of diligent oversight and the resources needed to effectively manage such transportation programs.

Historically, neither states nor health plans have been able to draw upon their internal expertise and resources to effectively administer its NEMT programs. Therefore, for the Louisiana CCN-P program, LHC has made the decision to subcontract with LogistiCare, a national NEMT manager currently managing programs in 35 states, for the provision of NEMT services in all GSAs. By subcontracting with an experienced transportation management company that is recognized as an industry leader, we expect to improve the quality of service to members, decrease complaints, and reduce NEMT fraud and abuse in the State.

NEMT Administrative Functions to be Subcontracted. With oversight from our Quality Assessment and Performance Improvement Committee (QAPIC), LHC is planning to subcontract the full array of administrative functions related to the provision of NEMT services to LogistiCare. Below is the list of administrative functions and services to be delivered by LogistiCare along with a brief description of each function:

- Call Center Operations
 - Establishment of toll free NEMT call intake number exclusively for LHC Health Plan
 - Dedicated NEMT call center
 - Eligibility Verification
 - Benefit Verification
 - Provider Verification
 - Scheduling of one-way and round-trip transportation
 - Selection of most appropriate, cost-effective transportation
 - Dispatch of trip assignments to NEMT providers
- Development of NEMT Provider Network
 - Lead verification through local and telephonic recruitment activities
 - Credentialing and re-credentialing

- Contract execution
- Management of NEMT Provider Network
 - On-site vehicle inspections
 - NEMT Provider Training Programs
- NEMT Claims Management
 - Claims Processing and Reconciliation
 - NEMT payment and remittance advice to providers
 - Submission of Encounter Data to Payor
- Quality Management Services
 - Development of transportation protocols exclusively for LHC members and NEMT providers
 - Complaints Reporting and Management
 - Provider Report Cards
 - Member satisfaction surveys

Determining the Appropriate Mode of Transportation. LHC is committed to delivering the most appropriate and cost efficient mode of transportation for every member needing NEMT services. The process for determining the appropriate transportation resource for our members begins at the time the member or someone calling on the member's behalf, requests transportation. Using LHC's customized call script, the LogistiCare Customer Service Representative (CSR) begins gathering information from the caller. After information has been obtained to verify the member's eligibility with LHC, the CSR will ask a standard series of questions to ascertain the member has exhausted all other avenues for transport to their medical services prior to obtaining transportation through LHC. Questions asked include:

- How has the member been getting to their medical appointments?
- How does the member get to other services (such as going to the bank, grocery store or church)?
- Does the member have a friend, relative or neighbor who can transport them?
- Does the member live near a bus route or similar public transit system?
- Is the member able to walk without assistance to their appointment?

While asking these questions may seem redundant or unnecessary, doing so helps to further assist the member in other ways and gain a clearer picture of the member's NEMT needs. LogistiCare takes many precautions to ensure that members are using these services only for the accepted and approved reasons. This is an important step to ensure that all trips are for compensable services and is a part of the fraud and abuse detection process.

Once benefit eligibility has been verified, answers to additional questions will guide the CSR to select the most appropriate mode of transportation for the member. Below is a list of questions asked to determine the most appropriate mode of transportation and level of service:

- Is the member ambulatory?
- Does the member use a wheelchair (W/C), walker or cane? If yes, what is the extent of use (i.e. if W/C, does member use it all the time)?
- What type of medical service or treatment is the member receiving?"
- Does the member have steps at the pick up or drop off locations?"
- Is the member able to transfer into a sedan type vehicle?"
- What type of wheelchair does the member have (i.e. standard, extra-wide, electric, Geri-chair, scooter)?
- Does the member need to be accompanied to their medical appointment?
- Will the member need a vehicle that has additional safety equipment (i.e. safety restraints, safety locks for members prone to jumping out of the vehicle)?

During the entire telephone call, the CSR documents questions asked and answers given in the member's electronic file. All calls are digitally recorded and can be pulled for review on an as needed basis. Once complete information regarding the member's ambulatory abilities and their medical care needs is obtained, the CSR is then able to make arrangements for the most appropriate level of transportation while the member is on the telephone. If the member is receiving treatments for an extended time period (i.e. chemotherapy, dialysis) every effort is made to select the same transportation provider the member has used in the past for the series of trips. If LogistiCare is unable to secure the same NEMT provider, the facility and the member will be contacted prior to their first scheduled trip and advised of the new provider.

How LHC Will Cover Fixed Route Transportation. LHC and LogistiCare will make every effort to encourage use of available public transit in Louisiana for LHC members. As a matter of course, LogistiCare participates in local and regional transportation organizations whose missions are to provide a community of education, communication, and advocacy in which their members can improve public transportation services. Through participation with these organizations, LogistiCare has continued to build a firm understanding of non-emergency medical public transportation needs and services in the numerous areas they serve. LogistiCare also has established liaison relationships with transit agencies to ensure they receive updated information on available routes and timely trip-planning advice for member's trips. Using current fixed-route maps and data from these public transit systems enables the CSRs to determine the most efficient and cost-effective trip options. Also, LogistiCare's transportation management software application, LogistiCAD, contains a transportation module that can upload actual mass transit stops and routes. With the actual routes in the system, CSRs are flagged whenever a member's trip can be completed using mass transit. Based on the member's physical condition, LogistiCare is then able to assign the member to the most appropriate, lowest cost transportation.

Determining Member Eligibility for Public Transit. Using LHC's customized transportation protocols, LogistiCare will have built-in thresholds that help to identify members who are eligible for fixed route (i.e. public transit) services. In addition to asking the series of questions listed herein, the CSR will confirm the member's address and his/her status as an ambulatory individual by asking an additional series of questions designed to further determine whether public transit is appropriate for the member. Once all public transit eligibility check points have been verified, the CSR will then advise the member that they are eligible for the public transit program in their area and will receive public transit passes to use for their NEMT needs. If the member meets all of these requirements but does not wish to use public transit, LogistiCare will fax a physician confirmation form to the member's physician so that they may determine the appropriateness of mass transit considering the member's specific needs and medical condition. The physician will complete and return the signed form to LogistiCare. This will relieve both members and case managers from the responsibility of obtaining that information. If the physician advises that the member can use public transit that is the level of service LogistiCare will assign to the member's trip. Otherwise, LogistiCare will assign an ambulatory/livery provider for the member.

Advance Notice and Reports. Members are asked to provide at least 10 days notice prior to their appointment in order to ensure that the passes arrive prior to their trip. In some areas, members will obtain their bus passes directly from their healthcare facility. The healthcare facility will send a log to LogistiCare either requesting reimbursement for the amount of passes distributed to members or replenishment of passes. In either case, LogistiCare will still confirm that the member was eligible at the time of the trip and that the trip was to a plan approved service. Once this information is verified, these trips are entered into LogistiCAD and LogistiCare will report these trips to LHC via monthly reports and encounter data.

LHC Pick Up and Delivery Standards. LHC will require LogistiCare to incorporate DHH pick up and delivery standards in its NEMT program and will include these standards in its NEMT policies and procedures. LHC will also include DHH pick up and delivery standards within its contract requirements

for LogistiCare and will require pick up and delivery standards to be incorporated into LogistiCare's agreements with transportation providers. Drivers are required to pick up the member within 1 hour of their scheduled appointment. This time may be increased for long distance trips as needed. Delivery to the appointment site should be no more than 1 hour prior to the scheduled appointment. Upon completion of the appointment, the member should be picked up within 1 hour of placing the call for their ride home.

Training. LHC will require LogistiCare to train all transportation providers and drivers regarding pick up and drop off standards for LHC members. Training will occur during initial orientation sessions held on site for new drivers and transportation providers. NEMT Operation Manuals will be distributed to all contracted transportation providers and will contain the written pick up and delivery standards. Additionally, pick up and delivery standards will be posted on LHC's provider portal, not only for NEMT providers, but for members and health care providers as well. LogistiCare will train all drivers on the proper procedures to follow when picking up and dropping off a member, which includes calling the member within 24 hours of the trip's occurrence to reconfirm the pick up time and address and to remind the member to be ready at least 1 hour prior to their appointment time. When the member is delivered, drivers are required to give the member a card that has the NEMT provider's telephone number on it and to instruct the member to call that number once their appointment is completed for their ride home. To aid in ensuring a satisfactory transportation experience for all, members will also receive training and reminders regarding their role in timely pick up and delivery. At the time of trip set up, the CSR will advise the member to be ready for their ride at least 1 hour prior to their appointment (or sooner if it is a long distance trip). The CSR will also advise the member that the assigned NEMT provider will call to confirm pick up time and address within 24 hours of the trip's occurrence. The CSR will also advise the member what to do if they need to cancel or reschedule their ride or if the driver is late. By including members in the overall education of the NEMT program standards regarding pick up and delivery timeframes, we promote a satisfactory experience for the members, their health care providers and assist the NEMT providers in delivering timely, safe and excellent customer service to our members.

Monitoring. LogistiCare monitors pick up and delivery practices and measures performance in several ways. Real time monitoring is facilitated through its call center. If a "Where's my ride" call is received, the CSR immediately documents the call as a complaint to be captured in the complaint report generated each month. The CSR will further assist the caller by contacting the transportation provider to inquire about the trip in question and to communicate the trip status to the member (for example, driver stuck in traffic but will be there within 10 minutes). If warranted, the CSR will schedule another transportation provider for immediate pick up of the member. LogistiCare also monitors pick up and delivery practices by individual NEMT providers through *Member Satisfaction Surveys*. Within the surveys, several questions pertain to the member's experience regarding a past trip, including whether the driver was on time for both parts of the trip. We also require the NEMT providers to report actual pick up and delivery times to us via the Trip Log, which must be included with every claim. *Provider Report Cards* are prepared and distributed to NEMT providers each month. Data regarding the NEMT provider's overall on time performance is captured in the provider report cards in two ways: 1.) percent of trips dropped off at the "A" leg destination on time or within 15 minutes of on time, and 2.) percent of trips picked up at the "B" leg destination on time or within 15 minutes of on time. Using URAC (Utilization Review Accreditation Commission) performance metrics as a guide, NEMT providers must score 95% or better to be considered within compliance. The Provider Report Cards and the monthly complaint reports are effective tools for improving driver behaviors for on time performance. These reports demonstrate to the transportation providers the sincerity of our expectations and our commitment to assisting the transportation providers to succeed in their efforts to provide the utmost in quality transportation services to LHC members.

Sanctions. In the event a *NEMT provider* falls below established performance thresholds, LogistiCare will develop a Corrective Action Plan (CAP) in order to give the provider the opportunity to improve performance prior to removing them from the network. The CAP may include limitations to the number

or types of trips assigned to the transportation provider. It may include specific requirements regarding driver training or vehicle maintenance expectations along with other items to address specific performance inadequacies. The CAP may be developed by LHC's Quality Assessment and Performance Improvement Committee (QAPIC) or LogistiCare. If information or a complaint involving possible criminal activity or serious unsafe driving (i.e. drunk driver, accident) is received, LogistiCare will immediately cease to assign trips with the NEMT provider in question and reassign existing trips scheduled with that provider to another provider while the complaint or situation is under investigation. If *LogistiCare's* oversight performance falls below LHC's established performance thresholds, we will develop a CAP. LHC will comply and will require LogistiCare to comply with applicable DHH provider performance standards. Failure to meet certain NEMT performance standards may lead to sanctions until performance levels are within compliance, or termination of the transportation agreement, and will be specified in the agreement between LHC and LogistiCare.

How LHC Will Ensure Vehicle Safety. Regularly scheduled, annual inspection of every vehicle in every NEMT provider's fleet is required for initial and ongoing participation in the LHC NEMT provider network. Vehicle inspections are conducted by qualified LogistiCare staff. Initial vehicle inspections are conducted during the credentialing phase of the provider contracting process. All vehicles must pass inspection in order for the provider to be credentialed.

Comprehensive Safety Inspections. To ensure safe, well-maintained vehicles are used to transport members, LogistiCare requires documentation of a "passing" score on each of the following criteria. Please note, the list provided herein is not exhaustive and additional items may be added as required or as local and state laws pertaining to vehicle safety are changed or introduced. Each vehicle must display the NEMT provider's name and telephone number on the vehicle's exterior and interior and each sedan, van and wheelchair vehicle must have:

- an operating 2-way communication system between driver and provider (pagers are not acceptable)
- matching Vehicle Identification Number (VIN) on the vehicle and license plate
- a map of service area or GPS
- a windshield free of cracks (in accordance with local laws)
- working windshield wipers
- fully operational headlights, high beams, brake lights, reverse lights and tail lights
- fully operational turn signals
- a rear-view mirror and unobstructed view through back window using mirror
- at least one fully viewable and operational exterior mirror on driver's side
- tire tread depth of at least 1/16th of an inch
- fully functioning brakes
- fully operational emergency brakes
- operational opening and closing mechanisms for all windows
- operational opening and closing mechanisms (locks and handles) for all doors
- fully operational air conditioner and heater
- fully functional seat belts for all passengers
- functional interior lighting
- securely installed floor mats made of commercial grade anti-skid ribbed rubber material or carpeting
- a clean interior that is litter free and absent of tears or holes in seats, doors or ceiling.
- visible signs posted in the vehicle stating "No smoking, eating or drinking" and "All passengers must use seatbelts".

Additional certification and safety equipment required in every vehicle includes:

- an active vehicle registration for the vehicle
- a valid vehicle insurance card for the vehicle
- a supply of accident/incident report forms
- two extension seatbelts
- seatbelt cutters
- a First Aid kit
- a Spill kit (liquid spill absorbent, latex gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer)
- Fire Extinguisher(s) mounted and secured within reach of the driver and visible to passengers for use in emergencies if the driver is incapacitated
- 3 Emergency Triangle Reflectors (flares are prohibited and may not be carried onboard)
- a spare tire and jack
- extra electrical fuses
- Operational flashlight
- Vehicles with step up entry must carry a retractable step, step stool, or running boards, as approved, to aid in passenger boarding
- Child safety seat, including booster seat, where appropriate
- Ice scraper

All wheelchair vehicles must meet the Americans with Disabilities Act (ADA) regulations. Such added regulations require wheelchair equipped vehicles to have:

- access doors with greater width to accommodate a wheelchair and attendant
- higher floor-to-ceiling headroom
- hydraulic lift mechanisms that require the driver to engage the engine-wheelchair lift interlock system (an important safety feature). Mini-vans with slide out ramps are not required to have a lift mechanism but should apply parking brake
- a metal mesh/non-skid plate and reflector tape at the end of the lift ramp
- a sturdy lift
- a sturdy safety rail, manual ramps or walk-on board
- operational lift controls that are accessible from inside and outside the vehicle
- four forward facing functional floor straps

Upon completion of the inspection, the vehicles receive a pass, provisional or fail score. For vehicles passing inspection, a sticker denoting the month and year of the inspection along with the pass status is placed in the vehicle's lower left windshield. A provisional score requires re-inspection within 10 days and is denoted using a provisional sticker on the vehicle's lower left windshield with the expiration date.

A fail score will result in the placement of a fail sticker in the lower left windshield with the initial inspection month and year. Also the vehicle receiving a fail score must be removed from service until repairs are made and the vehicle passes re-inspection. Inspection forms are kept on file and are available for review by LHC or DHH.

Additional Monitoring of Vehicles. Another tool LogistiCare uses for gathering information regarding vehicle safety is the *Member Satisfaction Survey*. The Member Satisfaction Survey contains a Vehicle Assessment section with a series of questions to capture the member's impression of the vehicle's condition. Examples of questions regarding vehicle condition include;

1. Was the heating or air conditioning working properly in the vehicle?
2. Was the vehicle clean on the inside?
3. Did the vehicle have working seat belts?
4. Were the vehicle windows intact and in good condition?
5. Was the company name visible on the outside of vehicle?

From time to time, a *complaint* may be filed by a member regarding the vehicle's condition. If the LHC call center receives this or any NEMT-related complaint, the issue is tracked and immediately reported to LogistiCare for follow up and resolution. If the complaint presents a safety issue (e.g. seatbelt not working) LogistiCare personnel will conduct an on site inspection of the vehicle in question and proceed with the implementation of corrective actions as warranted by the results of the inspection. Such action may include immediate removal of the vehicle from service and the development of a corrective action plan. Additionally, LogistiCare's Field Monitor, who is assigned to serve a particular "territory" of NEMT providers, may conduct surprise inspections at any time if he/she suspects a vehicle safety or maintenance issue or is notified that a problem may exist. Regardless of the technique used to uncover vehicle safety practices, each complaint, inquiry and action is documented in the provider's file and reported to the QIC at least once per year.

Driver Training Programs. LHC and LogistiCare require each driver to attend a driver training session conducted by LogistiCare. Driver attendance at each training session is captured and documented in the NEMT provider file. LogistiCare's driver training program helps drivers to understand how their role is integral to the delivery of health care services for our members. Topics covered during the *initial driver training session* include company and DHH overview, explanation of NEMT benefits, trip assignment and scheduling procedures, dispatch requirements, driver service standards and communication requirements, quality assurance, monitoring and dispute resolution programs, basic first aid, and defensive driving techniques. Materials distributed to providers and drivers during the training session include handouts of the driver training program topics, defensive driver informational materials and handbooks, previous NEMT provider newsletters, and the Provider Operations Manual. LogistiCare provides additional driver training via its web portal that covers topics related to the unique transportation needs of persons with disabilities. These helpful training programs describe tips and techniques for helping a person from a bed or chair into a wheelchair and from a wheelchair into and out of a vehicle. The online driver training programs also express the importance of treating each passenger with dignity and respect and teaches drivers how to effectively communicate with individuals who have special needs or are cognitively impaired. Because there are sometimes frequent changes in drivers, we conduct *driver training programs on an ongoing basis*. Typically, LogistiCare will schedule monthly training sessions that are conducted on site for newly hired drivers. The ongoing driver training sessions are well attended and their frequency helps to ensure all drivers receive proper training in a timely manner. The materials and educational topics covered in the initial driver training session are also presented in the ongoing training sessions. Also, each driver's attendance is captured during the training session, documented in the provider's file, and compared to the NEMT provider's list of eligible drivers to ensure ongoing quality assurance.

How LHC Will Ensure Driver Quality. LogistiCare's credentialing process for NEMT providers was developed using URAC guidelines. Driver quality is ensured by applying the same credentialing criteria and standards for each NEMT, their drivers and their vehicles. For acceptance in the LHC NEMT provider network, each driver must meet or exceed the following standards:

1. LHC reserves the right to disallow any driver from performing services under the Transportation Agreement between LHC and its subcontracted transportation manager.
2. Each driver must be legally licensed by the State of Louisiana, to operate the transportation vehicle to which he/she is assigned, and be at least 21 years of age.
3. Each driver shall receive training within 30 days of assignment to perform services under the Transportation Agreement with LHC or its subcontracted transportation manager, for defensive driving, first aid, CPR, "spill kit" use, biohazard removal, passenger assistance, safety and sensitivity training. Each driver shall also attend additional training sessions for ongoing safety and sensitivity.

4. Each attendant shall receive training within 30 days of assignment to perform services under the Transportation Agreement with LHC’s subcontracted transportation manager, for first aid, CPR, passenger assistance, safety and sensitivity training.
5. Each driver must be competent in his or her driving habits.
6. Each driver must be courteous, patient and helpful to all passengers.
7. Each driver must be neat and clean in appearance.
8. No driver may have more than two (2) chargeable accidents or moving violations in the last year.
9. Each driver must have no prior convictions for a substance abuse or sexual crime or a crime of violence.
10. Drivers who are known abusers of alcohol or known consumers of narcotics or drugs/medications that would endanger the safety of members are not permitted. If the NEMT provider suspects a driver to be driving under the influence of alcohol, narcotics or drugs/medications that would endanger the safety of members, the NEMT provider shall immediately remove the driver from providing service.
11. Any individual who has had within the past three (3) years or currently has a suspended or revoked driver’s license, commercial or other, is prohibited from driving for any purpose.
12. All drivers must pass screening of the Office of Inspector General Exclusion Program, which means they must not have been convicted for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.

The list above will be extended or augmented to include DHH requirements and other requirements LHC deem appropriate as part of its NEMT provider credentialing program. Driver quality is also ensured through ongoing monitoring of driver performance using data collected from complaint reports, provider report cards, corrective action plans and information collected from Provider Relations, Member Services, and QM staff.

Call Center Requirements for LHC NEMT Program. Our goal is to establish seamless access to scheduling transportation services for our members through the LHC Member Services call center, which enables quick connection to the LogistiCare call center. Adding a transportation prompt to the existing toll free Member Services telephone line will be an easy and efficient way for members to navigate through the customer service menu and will facilitate quicker scheduling of their transportation by LogistiCare. Like LHC, LogistiCare uses the Avaya Communications Manager with Automatic Call Distribution (ACD) in its call centers to provide the required ACD functionality. They use TASKE Contact Call Management and Reporting System to carefully monitor, audit, and track all calls to measure their performance for continuous improvement and have achieved an outstanding track record for responsive service. TASKE provides a complete reporting suite using data from the Avaya ACD system. This gives LogistiCare the flexibility to easily examine, aggregate, and report vital telephony data such as talk time, call volumes, speed to answer and call abandonment rates. Standard and ad hoc call center performance reports are prepared and delivered to clients in accordance with contractual requirements. For the CCN-P program, LHC will require LogistiCare to adopt the DHH call center performance standards, which are described below:

Call Center Activity	DHH Performance Threshold
Calls answered by a live person	≥ 90% of calls answered within 30 seconds
Average Speed to Answer	≤ 30 seconds
Average Calls Abandoned	≤ 5 %

LHC will require the same call center performance standards of its NEMT program as is required for any other type of call made to our Member Services center.

LHC's Quality Improvement Program for NEMT Services. LHC's Quality Improvement (QI) Program was developed using NCQA guidelines. However, NCQA does not extend accreditation for NEMT programs, providers or program managers. Due to the unique, non-medical nature of the benefit and the providers, the development of a sound accreditation process for NEMT has been slow, but appears to be gaining speed. In fact, in 2010, URAC rolled out the first ever accreditation certificate for transportation broker enterprises and LogistiCare was the first recipient of this distinguished accreditation. The LHC Quality Improvement Program for NEMT services will incorporate specific DHH requirements for performance, oversight and outcomes and will be developed in collaboration with LogistiCare. Key components of the NEMT Quality Improvement Program are outlined below.

A. Tracking and Reporting Key Performance Metrics

- Call Center Performance – metrics measured include call volumes, call duration, speed to answer, abandonment rates
- NEMT Provider Performance – metrics measured include, but not limited to, on time performance, complaint rates, passenger satisfaction (via Member Satisfaction Surveys), vehicle maintenance
- Driver Performance – metrics measured include on time performance, complaint rates, training and certifications
- Complaint Management and Reporting – metrics measured include complaint rates by provider and call center, complaint type, complaint severity, resolution rates, CAPs

B. Report Preparation and Distribution

- Call Center Statistics – reports prepared and delivered monthly or more frequently per client requirements
- Trip Volume Report – delivered monthly or per client requirements
- Complaints Resolution Report – delivered monthly or per client requirements
- NEMT Provider Report Cards – delivered monthly

C. Conducting Surveys

- Members – conducted at least annually or per client requirements
- NEMT Providers – conducted annually or per client requirements
- Health Care Providers - conducted annually or per client requirements
- Clients - conducted annually or per client requirements

D. Training and Ongoing Service Support

- Call Center staff – training conducted for new staff and ongoing training for existing staff
- Drivers – for new drivers and ongoing training for established drivers
- NEMT Providers - for new NEMT providers and ongoing training for established providers
- Operations Manuals – updated at least annually and distributed to all contracted NEMT providers

E. Credentialing and Recredentialing

- Drivers - must have/pass necessary licensure, certification, and background checks
- NEMT Providers - must properly maintain vehicles and conduct appropriate business practices
- NEMT Providers and Drivers - must implement mechanisms to protect PHI (Protected Health Information)
- LogistiCare – must demonstrate commitment to quality through URAC accreditation

F. Information Security

- HIPAA Compliance – required in all operational areas and for all system functions for LogistiCare, NEMT providers and drivers and applicable employees, business associates and subcontractors

- Protecting Member PHI – required in all operational areas and for all system functions for LogistiCare, NEMT providers and drivers and applicable employees, business associates and subcontractors

G. Risk Management

- Field Inspections – all vehicles and driver records undergo on site inspection
- Trip Audits – conducted routinely and compared against claims and reservation records to uncover fraud and abuse
- Accident and Incident Disclosure – all drivers must report accidents or incidents and are trained on procedures to follow

The Quality Improvement program for NEMT services is extensive and addresses every operational area within the LHC and LogistiCare organizations. Policies and procedures will be customized and implemented in accordance with DHH requirements for NEMT standards and performance measures.